St Christopher's Personal Care Services Ltd

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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

St Christopher's Personal Care Service is a domiciliary care service that provides people care to people in their own home. At the time of the inspection the service was providing personal care for approximately 100 people in their homes.

At the last inspection of the service in August 2016, we rated the service good.

The service had a registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service provided end of life care to people in their own homes that enabled them to actualise their wishes and experience a comfortable, dignified and pain free death. People and their relatives spoke highly of the personalised service they received. Care plans were person-centred and focused on achieving the best possible outcomes for people and enabled people to achieve their wishes and promoted their preferences. The service adopted an individualised approach and focused on giving people positive experience and fulfilment. The service actively involved people and their relatives in planning their care and considered their views. They worked with a range of health and social care professionals to ensure people received timely and appropriate care and support. Staff were very experienced in delivering end of life care because they benefitted from comprehensive training and they were well supported to do this. Staff respected people's dignity and knew to preserve the dignity of the dead in line with people's cultural and religious beliefs. Relatives were given support in form of counselling and bereavement support groups to cope with their loss and bereavement. The service had a system in place to ensure they continued to receive the support they needed when they moved between services.

There was solid leadership and management. The service focussed on delivering a high quality, personalised service to people and enabling people to die as they wished. The person-centred approach and care people received was evident in all aspects of the service. Staff were passionate about their roles; they felt listened to, supported and empowered to develop their knowledge and skills. The service valued the views of people, their relatives and staff regarding the service provided. Regular feedback was obtained, and an annual survey was conducted to gather the views of those involved in the service. Actions were developed to addressed areas requiring improvement. The quality of the service was monitored closely through audits, checks and quality improvement meetings. The provider put steps in place to constantly improve quality. People received care and support from a team of health and social care professionals both within and outside the service. Staff liaised effectively with these professionals to ensure people's symptoms and conditions were well managed. The provider worked in partnership with local and national agencies to develop best practice guidance and training on end-of-life care.

Staff were supported to undertake various training courses to improve their skills and knowledge in the job.

Staff were also supported through reflective practice, group supervisions, and workshops. Staff had access to one-to-one counselling to help them cope with difficult deaths they might have experienced. There were enough numbers of experienced staff to support people. Staff recruited were vetted to ensure they were suitable to deliver care and support to people. Staff were trained to keep people safe from abuse.

Senior, qualified and experienced staff members carried out an assessment of people's needs and risks. The service followed best practice guidelines in assessing people's needs and risks. The likelihood of people experiencing avoidable harm was therefore reduced. People received their medicines from staff who were trained to do so in line with safe administration procedures. People were supported to maintain their nutrition and hydration. Incidents and accidents were reported by staff and these were reviewed by senior management and lessons shared with staff. Staff followed procedures to reduce the risk of infection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People consented to their care before it was delivered. People and their relatives were involved in making decisions about their care. Staff and the registered manager understood their roles and responsibilities under the Mental Capacity Act (MCA) 2005.

People received care from staff who were compassionate and caring. Staff supported people to make day to day decisions about their care. People were encouraged to maintain their independence. People's privacy was respected, and their dignity was promoted. Staff maintained positive relationships with people.

People's care was delivered in a flexible manner and met their preferences and requirements. People knew how to complain if the wished. The registered manager investigated and addressed each complaint received about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

St Christopher's Personal Care Services Ltd

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This announced inspection took place on 13 and 26 February 2019. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure the registered manager or member of the management team would be available to give us access to records. One inspector and a specialist nurse advisor visited on the first day and two inspectors visited on the second day. An expert-by-experience made phone calls to people and their relatives to gather their views about the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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Prior to the inspection we reviewed the information we held about the service including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We also reviewed the Provider Information Return (PIR) we received from the provider. PIR 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. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information in the planning of the inspection.

During the inspection, we spoke with three people, and 11 relatives about the care they received. We spoke with the registered manager, deputy manager, nominated person/head of personal care service and members of the administrative team. We conducted focused group meeting with 11 care workers. We reviewed 10 people's care records including risk assessments and medicines administration record charts. We looked at five staff files which included recruitment checks, training records and supervision notes. We

looked at other records relating to the management and running of the service; such as the provider's quality assurance systems, complaints and compliments.

Following the inspection, we received feedback from one professional involved in the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe with staff and in the way they were supported. One person said, "They [staff members] are all entirely trust worthy. I never have any concerns about my belongings." People's safety was promoted by staff who were trained to identify abuse. All staff had completed safeguarding training and understood the provider's safeguarding procedures. They were clear about the various types of abuse, possible signs to look for and actions they would take. Staff also knew how to whistle blow to relevant authorities if they felt they needed to do so to protect people. One staff member said, "If I had a concern relating to abuse, I would report it to the manager. If nothing is done I will take it higher and higher until something is done." The registered manager, deputy manager and nominated individual knew their responsibilities to protect people and were aware of their duty to respond to alleged abuse. This includes alerting the local safeguarding authority, carrying out investigation and notifying the Care Quality Commission (CQC). Records showed that they had followed their procedure in addressing one safeguarding concern received and a notification was sent to CQC.

People were protected from risk associated with their care and support. Qualified nurses carried out risk assessments which covered pressure sores, moving and handling, nutrition and the home environment. Management plans were developed for staff to reduce any risks identified. Where necessary, relevant health professionals were involved in developing risk management plans to give staff guidance to support people safely. For example, records showed an occupational therapist had been involved in developing moving and handling plans for people. They had also ensured suitable equipment was available to aid safe transfers. Staff confirmed that they had received trained in moving and handling and they felt confident using equipment in people's homes. Risk management plans were updated as and when required to reflect changes in people's situations.

Staff were recruited safely. Prospective staff submitted applications and were interviewed as part of the process. One relative commented, "The carers are carefully selected." The service explored gaps in applicant's employment histories if any were identified. All staff we spoke with told us references, proof of identify, right to work in the UK and criminal records checks were obtained before they could start work. Records we checked confirmed what staff had told us. This meant staff were suitable to work in a caring role.

There were enough staff available to deliver care to people. People told us that they received support from staff with their care needs but did not always know who would be attending to them in advance. One person said, "There is a lot of variation on the carers and I have discussed this as regularity would be preferable. I think that they try their best." A relative mentioned, "Carers seem to be allocated on a broad basis and this may not be ideal for some." The service had plans in place to address this concern from people.

The service used an electronic monitoring system to schedule care visits and reduce the risk of missed or late visits. The system required staff to log in and out when they arrived and left a visit. That way the office knew when there was a potential late or missed visit. The office then followed up with the staff scheduled to undertake the visit or arranged immediate cover. We reviewed a month's report of scheduled visits and there had not been any missed visits recorded. This confirmed what people had told us. People told us that

staff spent enough time with them. One person said, "They are never trying to get away or make you feel rushed." Care visits times and durations were determined based on people's needs." A member of staff said, "On the whole staffing is enough. There are occasions we go over the time, we let the managers know and if it is an ongoing thing they increase the time to complete the person's visits. We are reminded to never rush people."

People received their medicines as required. The service had a policy and procedure on the administration and management of medicines. This included a protocol for the administration of 'As when required medicines' (PRN). Only trained and staff assessed as competent were authorised to administer and manage medicines. The support people needed to administer and manage their medicines was established during the need's assessment process. People told us, and records confirmed that staff provided the appropriate level of support to people to take their prescribed medicines. The registered manager and deputy manager regularly monitored and audited medicines administration records [MAR] sheets to ensure people were receiving their medicines as prescribed. We saw that MAR sheets were fully completed. However, we noted that one person's PRN medicine was administered to them on a regular basis. We spoke to the deputy manager about this and they agreed to call for a medication review so it could be established if the person needed it as a routine medicine or only when required and then devise a clear protocol around the use of this medicine. Staff knew what actions to take if a medicine error occurred. They said they would contact the registered manager or deputy manager for advice; or they would call GP and pharmacist if it was urgent.

People were protected from the risk of infection. Staff were trained in infection control. The provider had an infection control policy and procedures in place. Staff confirmed that they always wore protective gloves when attending to people's personal care and when administering medicines to reduce the risk of infection and contamination. Staff also explained that they practiced effective and frequent hand washing before and after delivering care, using personal protective equipment (PPE) and disposing of waste appropriately. Infection control practices was checked and discussed during supervision sessions.

The service had systems in place to manage and learn from incidents and when things go wrong. All staff understood the reporting procedures, the importance of reporting and told us they were committed to doing so. Records of incidents and accidents were maintained and the registered manager reviewed each incident and accident and took actions as required when things went wrong. For example, an occupational therapist had been involved in assessing a person's home environment following concerns reported by staff. Appropriate actions were taken to reduce risks identified. Incidents and accidents were discussed at management meetings. Patterns and trends were monitored and analysed and any learning was shared with staff during supervision sessions or team meetings.

Good

Is the service effective?

Our findings

People's care needs were thoroughly assessed and planned in line with best practice guidance. Qualified nurses carried out assessment of people's needs following the receipt of referrals for a service and this was done a responsive manner. The nurses visited people for a face-to-face assessment. This enabled a holistic assessment to be carried out which included observation and a discussion of what people wanted. Relatives were involved in the assessment process where possible. The assessment covered people's physical health, mental health, personal care, skin integrity, nutrition, behaviour, and end of life wishes. The registered manager liaised with other professionals for advice and support on how they could best support people with their needs in line with the National Institute of Clinical Excellence (NICE) best practice guidance. These included occupational therapists, district nurses and the palliative care team based at the hospice run by the provider.

People received care and support from staff who benefitted from a training programme which equipped them with the knowledge and skills to support people. One person said, "There seems to be a consistency in the training as we have different staff but they all know what they're doing – and they do it well." Another person told us, "Their good training makes them very efficient and they have time to chat."

The provider had a comprehensive training programme which was tailored to enable staff to deliver care to meet the needs of people they supported. All staff had undergone a full three days of training as part of their induction period when they first started and then worked at least 12 supervised shifts under the mentorship of an experienced senior care worker to gain practical experience and skills. Staff also received ongoing mentorship in their roles. All staff were assessed as competent before they were permitted to work with people on their own. All new staff were required to complete training in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the standard for new social care workers. The providers Care Certificate which was developed as part of the Cavendish review and accredited by City and Guilds. The Cavendish review is independent review that made recommendations on how the training and support of both healthcare assistants and support workers could be improved to ensure they provide care to the highest standard. The programme is nationally recognised and focused on end-of-life care and covered key areas of care standards, values and principles including staff roles and responsibilities, equality and diversity, person centred care, communication, and privacy and dignity.

All staff had completed the provider's mandatory training. This covered safeguarding adults and children, the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS), moving and handling, infection control, food handling, first aid, and health and safety. Staff were provided with training specific to the needs of the people they supported. These included palliative care for people living with dementia, coping with bereavement, Namaste, massage and CPR. Staff told us how the training courses they had done had enabled them to support people appropriately. Staff were also supported to complete a level 3 programme in medication administration in care settings and they could also complete the level 5 diploma in health and social care if they wished.

Staff were supported to be effective in their roles through regular group reflective practice sessions which

gave staff opportunities to share best practice, develop their knowledge and experience and share any concerns. The qualified nurses also carried out practice observations and spot checks. These were used to assess staff competencies and to provide feedback to them on their performance. Records showed that annual appraisals of staff performance were conducted and all new staff underwent a probationary review meeting before they were confirmed in post. All staff confirmed that they felt supported in their roles. One staff member said, "The support they give us is outstanding. We feel listened to and you are able to ring at any time for support."

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. We checked whether the service was working within the principles of the MCA.

People and their relatives told us they gave their consent before care and support was delivered. Records showed that people and their relatives were involved in deciding their care and support needs. Care records contained signed copies of consent to deliver care and support including managing medicines and, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. The registered manager, deputy manager and care staff members understood the MCA principles and their responsibilities to promote it and ensure people consented to their care and support. Best interest decisions were made involving relatives and or other professionals where there were doubts about a person's capacity to make decisions. This ensured decisions were made in people's best interest. People also had appointees in place where required, to manage their care and financial needs.

People received the support they required to meet their nutritional and hydration requirements. A relative said, "If the carer notices that milk or meals are low then they let us know and make sure things are topped up." A second relative said, "A ready meal is prepared and dished up and it's as presentable as these things are." Care plans indicated what support people needed to meet their nutritional needs and how staff should support them with this. Staff supported people to shop, prepare meals in line with their requirements and preferences and maintain a healthy balanced diet. Records also showed where required, people were supported to meet their hydration needs.

People were supported to access a range of healthcare services in the community such as GP, district nurses and other professionals to maintain and manage their day-to-day health needs. One person said, "When they [carers] arrived I told them that I wasn't feeling well and they called the doctor." One relative told us, "The carer noticed that the catheter needed attention, brought it to my attention and we called the District Nurse who came out." Another relative said, "When (named) was unwell recently they contacted the nurses at St Christopher's for advice. That gives me a lot of confidence." People also had the involvement of the provider's multi-disciplinary staff team which comprised of specialist palliative care doctors and nurses, physiotherapists, and occupational therapists. We noted examples of how effective joint working had improved people's care. Staff had involved the hospice consultant to carry out an urgent review of a person's medicine as the original medicine prescribed could not be sourced. To make sure the person received the right medicine to effectively manage their pain, the hospice consultant changed the medicine to one that could be sourced and managed by the person and staff. This meant the person's received the medicine they required to manage their pain and prevented a possible hospital admission.

People's care and support was well coordinated to ensure they received consistent care. One relative told us, "(Named) is often in hospital and things change but the carers keep up with the changes." Records showed, and the registered manager told us they shared information as required with other services

involved in providing care and treatment to people. For example, regular multi-disciplinary meetings took place to discuss people's care and treatment. People had personal information sheet which contained details of their medical history, care and support needs, communication requirements, allergies, list of medicines, next of kin and GP details. Staff ensured people took this sheet with them when to go to the hospital along with their DNACPR form and list of medicines. Staff gave handover to the ambulance and hospital team, so they knew about people's history. Before a person was discharged from hospital, staff visited to reassess their needs and get a handover from the hospital staff. Staff also reviewed the discharge summary and updated their care plan and list of medicines. This ensured people received consistent and on-going care and support in line with their needs.

Good

Is the service caring?

Our findings

People were supported by caring and compassionate staff. One person told us, "Staff respect us, we have a laugh and they always have a smile.' Another person said, "I call them my caring friends. I didn't want to have carers because of bad past experiences but these have restored my faith. They are very respectful and asked me what I would like to be called." Relatives also commented about how caring staff were. One relative told us, "Their loveliness means that we can still stay at home and be together. They talk to loved one and pay attention to them but most importantly they take the time to listen to her." Another said, "It makes me feel so happy that someone comes in who really cares about loved one and has taken time to know them."

People however commented about not having regular and consistent care staff allocated to them. One person said, "Consistency of carer isn't the best, but the high standard is consistent." A relative commented, "When someone comes that we've never met it makes my [family member who looks after another family member] feel uneasy as family member who receives care is more relaxed with someone that they know. Strangers also don't know where things are kept so that makes more work for [family member providing care]. I have heard them say that it's not worth carers coming if they have to be there telling and showing carers what to do all the time." People confirmed that the quality of care was not affected because of the irregular care team. The provider already knew about this problem. They explained the actions they were taking to address it.

People and their relatives told us they were involved in their day to day care delivery and that staff listened to them. Care records showed people and their relatives contributed in planning people's care, and in deciding what people needed and how their care should be delivered to meet their needs. One relative said, "They are attentive to any changes and they discuss changes with us." Another relative told us, "(Person name) is non- verbal and the carers watch for their blinks and nods to make sure they are including them and gaining their consent. They are very caring and patient." Care plans indicated the names of those involved in people's care, so staff knew who to contact for advice and support if needed. Staff told us it was important to give people choice and let people lead in their care delivery.

Staff understood the needs of people they supported. Care plans stated people's likes and dislikes, backgrounds and what was important to them. One relative said, "I feel that they have got to know my parents and talk about things that are dear to them, like their love of greyhounds." Another relative commented, "Staff talk to [family member] and pay attention to them but most importantly they take the time to listen to them." And a third relative stated, "Staff understand dementia and how it can change from day to day. (Named) gets very stiff but staff know how to help them relax." Staff explained that they worked with people in a flexible manner and they allowed people to control how they wanted to be supported. They told us if people chose to use the time allocated to them to do something else, as far it is within their remit and achieves positive outcomes for the person, they were happy to support the person with it. For example, one person would sometimes ask to be supported to their local café to have a drink. Staff explained that it brightened the person's day each time they went with them to the café.

Staff were compassionate towards people and showed them empathy. People told us staff knew what to do to help them relax and feel cheerful. One person said, "I had flowers on my birthday – I was very touched." A relative stated, "[family members] face lights up when the carer sings to them." Staff told us they provided people with emotional support when they were distressed or unhappy. Staff said people could show signs of distress or anxiety by withdrawing or becoming quiet or restless. Staff told us they gave people hand and foot massages and carried out Namaste which helped people relax and gave them comfort. Namaste is a sensory care programme which incorporates all the senses including smell and touch. It aims to help people relax and feel comfortable. Staff gave examples of how they had provided comfort and reassurance to people's family who were distressed.

Staff maintained people's dignity and treated them with respect. Staff had received training in dignity in care and showed they understood how to promote this in practice. Staff knew to maintain the dignity of people even when they had died. They gave us an example of how they had gone to make the body of a person who had just died presentable. They had cleaned the body, dressed them and made sure they were lying in a peaceful state in line with the family's wishes.

People were supported, to maintain their independence. One person said, "They [Staff] let me do what I could, they encourage me to keep trying." Care records stated what people could do for themselves. Staff understood the importance of enabling people with their independence as much as possible. Staff told us that they encouraged people to do things they can do for themselves as it "preserves their self-worth."

Good

Is the service responsive?

Our findings

People received personalised care which met their individual needs and preferences. One person said, "I would give them 110% for the care they provide." Another person told us, "The standard of care delivered is of the highest and best quality; and its consistent." A relative said, "We felt very much on our own before we became involved with this agency and now we feel supported – not just with the help that (named) needs but emotionally as well It's been very difficult. The agency has given all the support [family member receiving care] needs and the support we [relatives] need to cope."

The service provided end of life care to people in their own homes that enabled them to actualise their wishes and experience a comfortable, dignified and pain free death. The service provided a nurse led service and staff had been trained to deliver an effective end of life care. The nurses responded to referrals and assessed people's needs in a flexible manner and putting the individual needs and wishes of people first. They worked closely with the palliative care team, people's GP's and hospital teams to devise care plans focused to meet people's individual needs, preferences and wishes that people want to fulfil before they die. Individualised care plans were completed with the agreement of people and their families. People had end of life care plans in place with their advanced care wishes and decisions clearly stated and where required, people had an up to date Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms completed. This meant staff were aware of the person's wishes. Staff demonstrated they knew what people's wishes were and they enabled people to achieve their wishes as much as possible. One staff member said, "We know what people have asked for regarding their end of life care and we go out of our way to see if we can make their life as best as we can when they are poorly."

We tracked some examples of how St Christopher's Personal Care Service had responded and provided people with a personalised end-of-life care that met people's wishes and requirements. One person who was at the final stages of their life had wished to be able to sit around the table and have Christmas meal with their family one last time. The person's family also wished for this to happen. The person was being cared for in bed due to their frailty and condition. The service worked with community occupational therapists to assess and to find a safe and suitable equipment to fulfil this person's wish. After numerous assessments and referrals to various services suitable equipment was provided and installed. Staff were given training on how to use the equipment and to move and transfer the person safely. The service provided support to this person and enabled them to sit and have a Christmas meal together as they had wished. The person's relative feedback to the service, "It meant a lot to them to sit together with their loved one on Christmas Day and hold hands."

In another example, St Christopher's Personal Care Service had been involved in the care of a person who was as the final hours of their life. The person had wished to die at home. The service facilitated discharge from hospital within a few hours and made the person comfortable in their home environment. They administered pain management medicines as prescribed. The person and their family spent their last hours together in their own home as they wished. The person later died that evening while staff were on their way to provide the evening care visit. Staff however still went and cared for the body making sure it was clean and in a good and dignified state for the family to see.

We also reviewed cases of how staff had gone the extra mile to fulfil people's wishes and to make their last days meaningful and enjoyable. We also reviewed cases of how staff had gone the extra mile to fulfil people's wishes and to make their last days meaningful and enjoyable. Staff went to the coffee shop on behalf of one person who was no longer able to go to the coffee shop themselves but had always enjoyed a particular type of coffee. The person's care plan included that staff should go out to buy the particular coffee for this person. This support helped developed working relationship with this person as they were reluctant accepting care from staff initially. Another person who loved to feed chickens had requested to do this one more time before they died. Staff and people's relatives arranged for this to happen to fulfil this person's wishes.

Staff supported families who were going through bereavement. One relative said, "Staff have personal experience and are very empathetic – they know what I am experiencing with (named). They listen and show great understanding which helps." Another relative told us, "It's a lonely time and staff help us through it." Staff had knowledge and experience on death and the grieving process which were covered as part of their end-of-life training. Staff told us how they gave family members the space and time they required to spend time with their loved one who were dying and after their death. One staff member said, "It's a painful thing for anyone to go through so we make sure we are there for them too providing them with the comfort they need." Another staff member told us, "All we can do sometimes is to be there, listen to them, offer them a drink and empathise with them. They appreciate these little things at the moments of grief." The service sent bereavement cards to families and would signpost them to other services if needed. Families also had access to bereavement support groups and counselling sessions ran by the provider St Christopher's Hospice.

The service respected people's cultural and religious beliefs including their practices around dying and death. Staff had completed training in equality and diversity. Staff cared for people in line with their wishes and beliefs. For example, if people's wish was to have a religious leader visit them before and after their death, staff arranged for this to happen. Where people's beliefs required their body to be cared for in a certain way, staff were trained and supported to do so. Staff we spoke to showed understanding of various cultural and religious groups and they told us they cared for people according to their requirements and preferences.

The service adopted a personalised approach in the way they designed and delivered people's care and support. They tailored care and support provided to meet people's individual needs in a way that achieved the best possible outcomes for them. People and their relatives were actively involved in their need's assessment and care planning process. One person told us, "They put in everything I asked for and managed times that suited us." One relative commented, "We wanted our morning call quite late and they were able to do that – told us that what we want is the important thing." Care plans detailed people's physical, mental, emotional and social needs, personal history, individual preferences, interests and aspirations. It also contained their preferred visit times, tasks to be undertaken, how they preferred these be completed and key people involved in delivering aspects of their care. Where people received night time care, this was also stated in their care plan.

Records of care visits showed staff followed people's care plans and supported them in a way that met their needs. People received support as required with their personal care, meal preparation, mobilising, transferring, medicine management; socialising, managing and keeping hydrated and nourished. Care plans were regularly reviewed and updated to reflect changes in people's needs and requirements. When people's needs changed they had a reassessment to establish the support they needed. For example, if a person had a fall or hospital admission. People told us the care they received was regularly reviewed and adjusted based on their needs and requirements. One person said, "You can ask them anything at the office. Very

soon we had to increase the visits, but it wasn't a bother and the care plan was adjusted." Staff confirmed they were informed about changes in people's care by reading through the care plans, and phone calls from management staff. Changes were also discussed at team meetings.

The service used assistive technology to ensure people received timely care and support. They considered appropriate equipment and technology needed to help meet people's needs as part of the initial assessments and when people's needs changed. Technology used to aid and respond to people's care appropriately included pendant and bracelet alarms which people to use to call for help emergency. Door alarms were also installed in people's homes that were at risk of wandering.

From April 2016 all organisations that provide NHS care or public funded adult social care are legally required to meet the requirements of the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand to support them to communicate effectively. The service users guide which was given to people when they started using the service included information of how people can request for information in different formats. The registered manager told us that information would be made available in different formats or language when it was required by people. They said people's care plans were stored electronically but could be printed out if they wished to have a paper copy.

People's concerns and complaints were listened and responded to and used to improve the service. People and their relatives confirmed they knew how to raise their concerns and complaints about the service and they felt confident that any issues would be addressed. One person said, "I complained about three months ago that someone was rude and heavy handed – I haven't seen that person." Another person told us, "I did make a complaint, but I don't want to share what it was about, and it was resolved to my satisfaction so that's OK." People received information about the provider's complaints procedures when they began using the service. The complaint procedure included how to escalate concerns if not resolved internally by the provider. Records we reviewed showed that the registered manager investigated and responded to complaints and concerns raised about the service. They had followed their procedure to resolve issues.

Good

Is the service well-led?

Our findings

There was a visible, clear and stable management team who provided leadership, direction to staff; and delivered the organisational objectives including providing compassionate care to people. The registered manager understood the requirements of their CQC registration including submitting notifications of significant incidents. They demonstrated solid leadership and showed commitment to delivering safe, effective, responsive and high-quality care to people. Records showed people received the care they required at home and over 70 percent of people were supported to die at home as they preferred and wished for.

People, their relatives, and professionals we contacted told us the organisation was exceptionally well managed and they described the service delivered as outstanding. Comments from people and their relatives included, "They are the top on the league.", "They are gold standard – I have to use the word Outstanding. They are an outstanding service. You cannot improve on perfection.", "Having senior managers of high calibre at the top influences the quality of staff. They have set high standards for staff and in my experience the care staff meet them.", "Thank you for giving me the chance to say how wonderful this agency is. When they started they left masses of paperwork about the company and they have lived up to everything they said. I would highly recommend them."

The provider was committed and innovative in designing and delivering effective training programmes. The provider was committed and innovative in designing and delivering effective training programmes. The service was involved in developing a care workbook for the Care Certificate covering the 15 standards of Care following the recommendations made by the Cavendish review in 2013. The Care Certificate had an emphasis on end of life and had been accredited by City and Guilds. The service was also a City and Guilds accredited centre to deliver the care certificate training and they worked with a number of satellite centres which delivers the care training too.

The provider worked in close partnership with health and social care service, NHS, local authorities service commissioners, and academic and research institutions to develop their experience and practice around end of life care. They had been involved in various research work, pilot programmes and projects focused on learning and finding effective care for people with advanced conditions, palliative care needs and end of life care. For example, people benefitted from therapy sessions such as Namaste and massage provided by staff. Staff had gained these skills through workshops and projects the service had participated in. One person commented, "They have good connections with other groups like Care UK and Dementia Support and they tell us how to get in touch with all sorts of groups."

The provider had a multi-disciplinary approach to delivering high-quality care to people. They had a team of in-house professionals specialised in palliative care. These included doctors and nurses, physiotherapists, occupational therapists and counsellors. Some people receiving care in the community had access to these in-house professionals if required to be involved in their care and treatment to manage risk and prevent unnecessary hospital admissions. For example, a consultant had been involved to review one person's medicine in an urgent situation. This prevented the person being sent and admitted to hospital. The service

also worked closely with health care professionals in the community such as GP's, district nurses, and clinical nurse specialists and the London Ambulance Service (LAS) who they regularly liaised with to meet people's needs and preference and prevent hospital admissions.

Staff also spoke positively about the management and vision of the organisation. They told us people were at the centre of the organisation and the provider's emphasised this. One member of staff said, "Fantastic workplace. We are completely supported in every aspect of our work and we are taught to provide compassionate and quality care to people. I would recommend someone I truly love to this service." Another staff member stated, "The best place and best job in the world. We provide person centred care to people and help them receive the care they wish for. We not only support people but their families too. It gives a good feeling to be able to support people and their families through those difficult times. I love working here, I wouldn't work for anyone else." Another member of staff stated, "The support they give us is outstanding. We feel listened to, you can ring at any time for support. They invest in staff because they know that the staff team are crucial to providing good care to people. We are treated well, and we are one big happy family."

Staff were provided with the leadership, support and direction they needed to deliver to achieve positive outcomes for people. Regular team meetings were held to discuss various issues for people using the service, their work, team work and policies and procedures. Staff told us they felt listened to and could make suggestions and share ideas on how to improve the service. Staff understood their roles and responsibilities. Staff could explain the expectation of the service which was focused on delivering person-centred end of life care to people. They confirmed they had a copy of the job description, staff handbook which sets out the values and aims of the service, standards expected and key policies and procedures. Staff received weekly newsletters from a member of the senior management team. This was used to share information and provide update about the service, new systems and processes, policies and procedures, training opportunities and changes in the social care world.

Staff felt supported in their roles which reflected in the result of the recent staff survey. Staff were generally satisfied and secure working for the provider; and they felt listened to. Staff received regular training, group supervisions, appraisals, reflective practice and workshops. On the first day of our inspection, 11 care staff had attended a workshop and group supervision which was focused on best practice guidelines on record keeping. It covered key aspects of good record keeping in line with National Institute for Clinical Excellence (NICE) best practice guidance. The session was interactive. Staff told us they found these sessions 'very useful'. Staff also had access to one-to-one counselling if they required this to deal with the effects of someone dying. One staff member said, "It is very distressing to see dying and to cope with death generally whether the person is a relative a someone you care for, but this organisation supports and helps you cope with it. It really helps. Because of the support they give, I am able to continue doing the job."

The service valued the views of people, relatives, staff and professionals as part of quality assurance process through surveys, satisfaction questionnaire and reviews. Feedback was obtained from people or their relatives when they stopped using the service. Regular ongoing telephone mystery shopper (spot check) was conducted which aimed at gathering feedback about staff performance, pick up any concerns about the service and building relationship and encourage two-way communication between people and office-based staff. Feedback received was collated and analysed and where action was needed it was addressed immediately.

An annual survey was also conducted. The most recent quarterly data showed high level of satisfaction from people and relatives. Comments from people included in the survey report included, "I will give them 10 out of 10. Nothing is too much trouble for the care team. They looked after my loved one marvellously always

taking care to speak with me too and ask how I was. They always left me with a cup of coffee as well", "I couldn't have cared for my loved one at home without your help. You are quite an amazing team", "You provided a good service at a very difficult time", "The care provided to family member was exceptional… carers made them feel special and treated them very well", "Every time I needed help, you [the service] have been responsive and helpful which is much appreciated. The carers without exception are kind, efficient and full of respect for our loved one." We saw an action plan in place to address areas where people were unhappy about the service. For example, people had commented about not having regular and consistent team of staff attend to them. The service had reviewed their process to identify the problem. They were having discussions with service commissioners to address this matter. We saw an action plan in place and a note of a meeting with board members to address this issue.

The service placed strong emphasis on assessing the quality of service delivered and monitoring the overall performance of the service. Regular audits of care plans, medicine administration record, infection control, staff files including recruitment records and other records relating to the management of the service were conducted to identify pitfalls. There were no issues identified in the records we reviewed. Members of the management team held various meetings including monthly managers meetings and weekly dashboard meetings to discuss the day-to-day performance of the service. There were also various groups and committees set up to monitor and improve the performance of the service including safeguarding committee, information governance committee and workforce development group. These groups discussed any issues, findings from surveys and actions required with quality and governance committee so any areas for improvements could be agreed and addressed. The board of Trustees who were also members of the governance committee met every two months to review key performance indicators and improvement plans in place.

The provider had continuously focused on improving and developing the service. There was a service development plan in place which they reviewed periodically to identify further areas for improvement. For example, the provider was reviewing their service level agreement with their service commissioners following on-going feedback to people relating to staffing. Following feedback about the lack of continuity and consistency in care staff, the provider was reviewing their business plan to enable them plan and deliver continuity. Incidents, accidents and complaints were also regularly monitored, analysed and used to identify training needs for staff and areas for improvement.

The service had also invested in Information Technological (IT) systems to improve the effectiveness and efficiency of the service. IT systems were used for care planning, staff rostering/care visits schedule, training management and lone worker protection.