Private Home Care UK Limited

Private Home Care UK Limited (Leicester)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This announced inspection took place on 5,6 and 7 March 2018. This was our first inspection of this service since they registered with us.

Private Home Care UK Limited is a domiciliary agency. It provides personal care to people living in their own homes and flats in the community. It provides a service to older adults, younger disabled adults and people living with dementia or mental health problems. Many of the people using the service live within Asian communities and the service is able to provide staff who are conversant with a range of cultures. Not everyone using Private Home Care UK Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection there were 58 people using the service.

There was a registered manager in post. 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.

People received safe care. Staff had completed training to enable them to recognised the signs and symptoms of abuse. They knew how to report any concerns they may have and were knowledgeable about how to report within the structure of their organisation or externally to other regulators or local authorities.

Potential risks people were exposed to had been identified. Risk assessments included information and guidance to support staff to follow measures to reduce the risk of harm. People were supported to take their medicines safely.

The service had a robust recruitment process in place. These helped to ensure staff were suitable to provide care and support. There were enough staff available to meet peoples' needs as detailed in their care plans.

Systems were in place to ensure staff followed safe infection control procedures to prevent the risk of infection when providing care. Systems and processes were in place to ensure lessons were learnt in the event of accidents and incidents.

Staff were supported through a period of induction where they were introduced to people. Essential training was completed during induction and further training identified through regular supervisions. This helped to ensure staff had the skills and knowledge they needed to provide effective care.

People's needs were assessed and their choices, wishes and preferences formed the basis of their care plan. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive ways. Staff sought consent before providing care and support and respected people's right

to decline their care.

People received enough to eat and drink and were supported to maintain their nutritional health if required. People were supported to access health appointments when required to make sure they maintained their health and well-being.

People were treated with kindness, respect and compassion. People were supported to express their views and be actively involved in making decisions about their care. Staff protected people's right to privacy and dignity and maintained confidentiality when providing care and managing records.

People received personalised care that was responsive to their needs. Staff identified and took action where people were at risk of social isolation. Care plans provided staff with details and information to ensure the care provided was focussed on each person as an individual. Suitable provisions had been made to support people at the end of their life to receive care and support in line with their wishes.

People, relatives and staff knew how to raise concerns and make a complaint if they needed to. The provider ensured people were provided with the information they needed when they began to use the service.

The registered manager promoted a positive culture in the service that was focussed upon achieving good outcomes for people. Care staff were supported to understand their responsibilities to develop good team work and felt able to share their views and make suggestions. Diversity was recognised, supported and promoted within the service.

The provider had systems in place to monitor the quality of the service to ensure people were receiving good care. People and those important to them were supported to share their views about the quality of care they received. The provider was clear on their strategy to develop and improve the service whilst ensuring people continued to receive good care.

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 were protected from the risk of abuse and staff were aware of and understood safeguarding procedures.

Risks were managed to keep people safe from harm or injury.

People received their medicines in a safe way and staff received training from the provider.

Staff were recruited safely and there were enough to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people.

People's needs were assessed and people were supported to maintain their health and well-being.

Staff understood the principles of the Mental Capacity Act 2005, including gaining consent to care and people's right to decline their care.

Is the service caring?

Good

The service was caring.

Staff were skilled in communicating and sharing information with people and were knowledgeable about the people they supported.

People and relatives were involved in the planning of their care.

Staff protected people's privacy, dignity and confidentiality and were respectful to people and their relatives.

Is the service responsive?

Good

The service was responsive.

Care plans and assessments were personalised to meet individual needs. Step by step guidance was provided so that staff had adequate knowledge to manage and respond to people's needs.

People were provided with support and information to make decisions and choices about how their care was provided.

A complaints policy was in place and information readily available to people and their relatives. People knew how to complain if they needed to.

Is the service well-led?

Good

The service was well-led.

There was clear leadership and management of the service which ensure staff received the support, knowledge and skills they needed to provide good care.

People, their relatives and staff were supported to share their views about the service.

People and staff diversity was recognised, respected and promoted.

Audits were undertaken to review the quality of care provided.

Private Home Care UK Limited (Leicester)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection site activity started on 5 March 2018 and ended on 7 March 2018 and was announced. It included a visit to the office location on 6 March 2018 to see the registered manager, review records and visit people in their homes. On 5 and 7 March we made telephone calls to people, their relatives and staff. We gave the office 48 hours' notice of the inspection because we wanted to arrange to speak with people and staff and ensure the registered manager was available.

The inspection team consisted of one inspector for the site visit and two experts-by-experience who made telephone calls to people and their relatives. 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 the inspection we reviewed the information we held about the service, including notifications. Notifications are changes, events or incidents that the provider is legally obliged to send us within required timescales. We asked local authority commissioners, responsible for funding care for some of the people using the service, for their views about the service. We used this information to plan the inspection.

At this inspection we spoke with the registered manager, the deputy manager and six members of care staff. We visited four people in their own homes. We also telephoned and spoke with seven people and six relatives of people who used the service.

We sampled four people's care records, including assessments, care plans and risk assessments. We looked at five staff recruitment files and staff training records. We also looked at a selection of documentation

relating to the management and running of the service. This included key policies and quality assurance information.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe with the staff that supported them in their own homes. Comments included, "I use a frame sometimes to help me walk. The carers take the time to let me know this. They show me how to be safe," "I feel safe with my carers because they know what I want to do," "No one has ever been unkind to me and no one has ever been rough or ever hurt me," and "[Carer] never leaves without making sure that I have everything I need and it's where I can reach it." A relative told us, "I know that [family member] is safe with the care staff; they really know how to look after her." Another relative said, "[Family member] does feel safe with carers because they are very competent. They know how to handle him."

People and their relatives told us they had never had any concerns regarding how they were treated by staff. They told us if they did, they would speak to staff or the registered manager and felt confident they would be listened to and supported.

Staff were able to tell us about the signs and types of abuse. Staff were confident about how they would report any allegations or actual abuse. One staff member told us, "I have completed training in safeguarding. I would feel confident to raise concerns with [registered manager] and ensure I documented the circumstances. I know I can whistleblow to police, social services and the CQC if I needed to." Another staff member told us, " I would report any concerns to the office and [registered] manager. We work closely as a staff team and this helps us identify if something is not right quickly." Records confirmed staff had completed safeguarding training which helped staff to understand the actions they needed to take to keep people safe.

The information provided by staff related to the guidance in the providers safeguarding policy and showed us that staff had a good awareness of them. The policy also included Leicester and Leicestershire and Rutland multi-agency safeguarding procedures detailing best practice for responding to safeguarding concerns within the local areas, contact details of external agencies, case studies and a template to use for safeguarding referrals. This enabled the provider to understand their role and responsibilities in responding to safeguarding concerns and helped to ensure people were treated fairly when raising concerns.

We found people were protected from the risks associated with their care because the provider followed appropriate guidance and procedures. Each person's care plan had an assessment of the risks the person may be exposed to. Risk assessments included areas relating to the environment, for example access and potential hazards around people's homes and risks to the individual. For instance, risks associated with people's health conditions, such as skin integrity and the use of equipment, such as transfer aids.

Risk assessments were used to identify what action staff needed to take to reduce the risk whilst meeting people's needs and promoting their independence. For example, where a person was assessed as at risk of falling, their risk assessment included measures staff should take to reduce the risk. Measures included two-to-one staff support to assist the person to walk, and equipment the person needed to undertake tasks, such as personal care and daily living. The risk assessment also identified any factors that staff needed to be

aware of that may have increased the risk for the person. For instance, health conditions or moods and behaviours. In most care plans we sampled, risk assessments had been reviewed and updated as necessary. However, in one person's care plan, we saw some of their risk assessments had not been updated to reflect changes in the person's needs and in the support they required. Following our inspection, the registered manager told us they had reviewed and updated the person's risk assessments. They told us they had completed an audit of all risk assessments and found this person's to be the only records that had not been updated.

Staff demonstrated they understood the risks people faced and were knowledgeable in what they needed to do to reduce potential risks. We observed staff supporting people to move around their homes safely by using equipment, such as hoists, in line with best practice. Staff engaged with people and asked if they were happy to be supported. They provided reassurance during transfers and encouraged the person to do as much as possible for themselves.

We saw sufficient numbers of staff were deployed to meet people's needs. People and their relatives provided consistently positive feedback about staff reliability and punctuality. A relative told us, "[Family member] has about four carers who come on a regular basis so we never really have a problem with not knowing the carers." Another relative said, "They [staff] always come on time. They haven't let us down once, not even in the snow." Rotas were planned in advance and staff allocated according to their skills and compatibility with the person. Where people required two staff members to support them, records showed two staff were always allocated and arrived at the same time.

The registered manager told us the service had an electronic monitoring system for home visits. Staff had to log in and out when they entered a person's home using a free system through the person's telephone. An alert was sent to the office if a staff member failed to log in and office staff followed up with a telephone call to the staff member and to the person. We saw staff followed this procedure when we visited people in their own homes. This helped to ensure staff were punctual, stayed the right amount of time and ensured people's calls were not missed. The registered manager operated a 24-hours' on-call procedure which ensured continuous monitoring of this system.

Robust recruitment practices were followed to make sure new staff were suitable to work in the service. These included application forms, interviews, references, identity checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and helps prevent unsuitable people from working with people using care and support services.

People told us staff supported them to manage their medicines safely where required. One person told us, "Sometimes I forget about my tablets and without staff reminding me, I would forget to take them." Another person told us they organised their own medicines but staff prompted them to check they had taken them. The person told us they were grateful for the reminder. A third person told us staff supported them to take their medicines from a blister pack. They told us staff always gave them the pack at the right time, after they had had something to eat.

People's care plans included an assessment of the support they needed to manage their medicines and people, or their representatives, signed consent to the support provided by staff. The registered manager ensured that, where staff supported people to take their medicines, medicine administration records (MARs) were in place for staff to sign to confirm they had provided the appropriate level of support, Information included details of the person's current medicines, any allergies and times they needed to take their medicines. The providers' medicines policy was based on National Institute for Health and Care Excellence (NICE) best practice guidance. Staff told us and records confirmed they had completed training in

administering medicines. We saw staff supported people to manage their medicines where they had no other form of support. For example, staff telephoned a person's pharmacist to ensure the correct medicines had been ordered and to check on delivery date. The person was grateful for the support as it helped to put their mind at ease.

People told us and we saw staff left their homes clean and tidy and followed safe procedures to prevent the risk of infection. One person told us, "She [staff member] puts cream on me each morning. She washes her hands before and afterwards as well as wearing gloves." We observed staff followed infection control procedures. We saw staff wore clean gloves and aprons when supporting people with their personal care and when preparing meals. Staff told us they had their own supply of protective equipment, such as gloves and aprons, and always had access to supplies through the office which ensured they never ran out. We saw staff disposed of protective equipment safely in people's homes.

The provider understood their responsibilities to review concerns in relation to accidents, incidents and near misses. At the time of our inspection, there were no recorded incidents or accidents. The registered manager told us there were systems in place for staff to document incidents and accidents and provide this information to the registered manager in a timely manner. This included incident forms which were available in people's care plans.

Good

Is the service effective?

Our findings

People and their relatives were positive about the care and support they received. They told us that staff knew what they were doing when they attended to people, they were competent and knowledgeable about each person's needs, wishes and choices. People's comments included, "My carer is very well trained because she knows how to do everything," "He [carer] knows what to do. He has got to know me; he knows where everything is kept and what I like," and "My carers know what they are doing. When I wasn't very well, they made hot water bottles for me and gave me extra drinks." A relative told us, "The carers that look after [family member] are well trained. They really encourage him to do what he can for himself."

Staff told us they felt they had access to a range of training deemed 'essential' by the provider and had completed an induction following their recruitment which included working alongside experienced staff. They told us they were only able to support people once they had been assessed as competent by a senior staff member and when they felt confident themselves. Two staff told us they had requested further development training, over and above essential training, to enhance their skills and knowledge and the provider had supported this.

The registered manager showed us the induction programme for new staff, which was based on the Care Certificate. This helped to ensure staff received a standardised induction in line with national standards. Induction lasted for two weeks or longer, depending on the staff member's confidence and ability and supported new staff to be introduced to people and get to know about their needs before they began to support them. The registered manager was in the process of arranging a training provider as a 'key partner' to take on the assessment of the Care Certificate and vocational qualifications for all staff to ensure they had the support and guidance they needed to complete the awards.

Staff told us they felt well supported by the registered manager and received regular supervision. Staff supervision is used to advance staffs' knowledge, training and development by regular meetings between the management and staff group. One staff member told us, "I have supervisions which let me know where I can develop and where I am doing well. If I am struggling I can let them [managers] know and they will help. I don't have to wait." Another staff member told us they felt well supported and could contact the registered manager at any time for advice and guidance and always received "a positive response."

People's needs were assessed prior to them using the service. The assessment covered people's physical and social needs, their wishes and preferences. This enabled staff to meet diverse needs and ensure care was personalised. Assessments included the impact that people's health conditions had on their emotional well-being and how staff needed to support people to manage this. Assessments and care plans were shared with other health and social professionals who were involved in the person's care, such as mental health nurses and occupational therapists. The service worked collaboratively with agencies to ensure people's care was provided in line with best practice.

People were supported to use technology to improve their safety and well-being. Staff supported people to access pendants that could be worn around the neck, wrist or arm that detected if people had fallen and

were linked to emergency assistance. One person was at risk of leaving their home unsupervised. This risk had been reduced through the installation of a door alarm which activate a pre-recorded voice message. This provided reassurance for the person in their first language and encouraged them to go back inside and wait for assistance.

People spoke positively about the support they received to maintain a healthy, balanced diet. One person told us, "I usually have the same each day for my breakfast so [carer] usually brings it for me. Before she goes, we decide together what I am going to eat at lunchtime." The person told us their family cooked main meals and staff supported them to choose these and re-heated them in line with their choice.

People's dietary needs were detailed in their care plan and we saw staff had a good understanding of these. For instance, where people expressed a wish to have meals served in line with their cultural preferences; staff respected these preferences and consulted people as to quantities and accompaniments. Staff afforded people privacy where they wished to eat alone and offered companionship and encouragement where people were at risk of poor nutrition. Staff washed and cleared away cooking utensils and ensured people had access to fluids during each visit.

People's care plans included guidance about their health needs and the support staff needed to provide. Most people received support from family to access routine healthcare and told us they had confidence that staff were able to support them in the event of a health emergency. Where staff provided support, they demonstrated they were knowledgeable about people's needs. One staff member was able to describe how they had identified a change in how a person ate which put them at risk of choking. They told us they had raised concerns with the registered manager who had contacted Speech and Language Team (SALT) for support and advice. The dietary advice had been implemented into the person's care plan and as a result the risk of choking had significantly reduced. Staff worked collaboratively with agencies such as occupational therapy to ensure people's health was maintained.

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 any decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People told us staff sought consent before providing care. Comments included, "[Carer] always asks me before she does anything and I like that," and "[Carer] knows how I like things and asks me if it's okay, it's routine now." We observed staff sought consent before providing care and support. For example, with personal care or assistance to move and transfer using equipment. Staff checked people were happy with what they proposed to do before they began to support the person.

Care plans included details of decisions people were able to make and the support they needed to make more complex or specific decisions. For example, one person was able to make day to day choices of what to eat and how they wanted to spend their time, but were supported by a family member to make complex decisions, such as healthcare. Records showed the family member had appropriate legal authority to do so and staff had referred to them when required. This helped to ensure people were supported to make decisions and choices about their care.

One care plan we reviewed contained conflicting information about the person's mental capacity. For example, in one section of the plan the person was assessed as having mental capacity and in another section the person was noted as lacking mental capacity. The provider told us this was a recording error and

reviewed and amended the care plan following our inspection visit.

Good

Is the service caring?

Our findings

People were satisfied with the care and support they received from staff and shared positive comments with us. These included, "I am treated well by my carer. He is friendly and never rushes me. He is patient and takes his time," "She [carer] is so caring and brushes my hair which makes me feel better," "He [carer] has always taken an interest in me and my life. He talks to me, we chat about all sorts of things," "We never stop talking from start to finish and we are always laughing as well," and "My carer has really go to know me by chatting and taking an interests in me. Some of the care I need is embarrassing but they [staff] don't make me feel bad at all." A relative told us, "I couldn't ask for any better care for [family member]. I have total confidence that they [staff] want what's best for [family member]. We are very lucky."

Staff understood the best communication methods for people and were knowledgeable about the people they supported. For example, the provider had ensured that the staff team were able to converse in a number of Asian languages to support people who were not able to communicate fluently in English. We saw staff were matched with people who shared the same language and culture. This supported not only people but also their relatives to be involved in their care. Staff were able to share information with people in their preferred language and we saw people responded positively to this. This helped to ensure people were supported to express themselves, share their views and make decisions about the care provided.

Staff demonstrated a person-centred approach when providing care and support. They were knowledgeable about people's needs, preferences and interests. Staff told us this was because they were given time to get to know people, read care plans and spend time chatting with people. The provider had ensured that, as far as possible, people had carers with shared interests. This included culture and hobbies, such as walking or socialising. We saw staff talked with people and listened with interest, discussed current issues and shared information. This encouraged a relaxed and informal atmosphere for people in their own homes.

People and, where appropriate, their relatives, were supported to be involved in planning their care and support and making decisions about how their needs were met. People and relatives explained they were involved in setting up their package of care to ensure it met their requirements. Their wishes and views were listened to during this process and their care plan developed using this information. For example, for one person it was important to maintain links in their local community. Staff supported this by helping the person to walk around their local community and introduced them to people who had moved to the area. For another person, it was important to maintain links with their place of worship. Staff had establish links at the place of worship and supported the person to walk there each week. This showed us that people were supported to be as independent as possible and to be in control and make decisions about their care and support.

All the people we spoke with told us they were treated with respect by staff. We observed staff addressed people respectfully, by their preferred term of address. Staff were respectful of people's home and towards any relatives who were present. One relative told us how staff respected their role as the main carer and asked before they did anything to help.

Staff had signed confidentiality agreements as part of their induction training and demonstrated they protected people's right to have their information protected. People's care plans were stored in an agreed place in their home and staff returned care plans once they had completed the record of their visit. Copies of care plans and records were stored securely at the office, accessible only by relevant personnel.

People told us staff respected their right to privacy and dignity. One person told us, "Staff always close the door and put a towel over me when I use the bathroom. " Another person told us staff closed the curtains and ensured the door was properly closed when they provided support with personal care. We observed staff closed curtains and doors when they supported people with personal care. People had time where they required this and staff knocked on doors and checked with the person before entering a room.

The registered manager ensured people were provided with contact details of agencies, including health and social care agencies and specialist organisations such as advocacy services. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard. This provided people and their relatives with information about independent agencies who could offer support or advice if needed.

Good

Is the service responsive?

Our findings

People and their relatives felt the service was responsive to their needs and that care was provided in line with their wishes and preferences. One person told us, "I am happy with the carers and the times they come, it is really convenient. If I need to change the time, [registered manager] does everything they can to accommodate me." Three people told us they told staff what they wanted them to do and staff provided care and support in line with their wishes. A relative told us, "We just tell the agency if anything needs to be adjusted or changed. I haven't had any difficulties doing this."

People received care from regular carers who were known to the person and familiar with their needs. Where regular carers were absent, the registered manager ensured suitable temporary carers were allocated who had supported the person previously. This helped to ensure people had continuity in how their care was provided. Staff were required to log in and out of visits using electronic monitoring. This ensure the provider was able to respond quickly in the event staff were late or had not arrived for a visit.

Care plans and assessments were detailed and personalised. Records included information about the person, their life history, people who were important to them and how they preferred their care to be provided. Plans contained step by step guidance for staff to follow. For example, each visit had details of the person's preferences in how staff entered and left their home, routines the person liked to follow, what they liked to have around them and any specific needs. We observed staff had knowledge and understanding of this detail which had a positive impact on their ability to care for people and provide them with individualised support.

People and their relatives were involved in reviews of their care to ensure the care provided met their current needs. The registered manager told us reviews were held regularly in person or by telephone or when people's needs changed. However, records did not always reflect this. For example, one person's care plan showed their care was reviewed on an annual basis and the outcomes were clearly recorded. For another person, the most recent review was dated 24 August 2016. Records showed the person had requested support to obtain additional equipment to enable them to move around their home and staff had responded this by making the appropriate referrals. However, records did not show care had been reviewed since this date. A third person had recently experienced a significant change in their needs. However, their care plan had not been updated to reflect this. We did observe that staff were familiar with changes in the person's needs and provided care and support to meet their current needs. The registered manager told us they would review all care plans to ensure they reflected people's current needs and records reflected when reviews had taken place. The registered manager contacted us after the inspection visit and told us they had completed updating the records.

Staff were aware of people who were at risk of social isolation. They spent time talking with people and engaging with them in areas of interest. Staff told us they were aware that, for some people, staff were the only people the person had contact with through the day and therefore made the most of the time they had together. Where required, staff supported people to access the local community, such as places of worship, shopping and community centres. The registered manager was proactive in seeking funding for 'social

inclusion' calls to support people who were isolated to go out with staff each week.

People were supported to access information in the way they needed it. For example, where people preferred information in their first language, this was provided in written format or directly in person. At the time of our inspection, the provider did not have a policy detailing how they complied with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager implemented a policy following our inspection.

The provider had a policy in place providing details about they managed and responded to complaints about the service provided. People were provided with information about how to raise concerns and complaints when they began to use the service. At the time of our inspection, the provider had not received any complaints about the service but did have systems and processes in place to manage these. People and relatives told us they felt comfortable to raise concerns with staff or the registered manager but had not had to do so as yet. They told us they were confident their concerns would be listened to and acted on.

The service supported one person who received end of life care. The registered manager and staff worked closely with health agencies to provide care as part of a joint package. The person was at the forefront of their care and had determined how they wanted their care and support to be provided. Staff had a good understanding of the person's cultural needs and wishes as part of their end of life plan. The provider had an end of life policy in place and the registered manager told us they were in the process of arranging training for staff to develop their skills and knowledge in supporting people through end of life care. This was based on NHS best practice "When I Die" guidance which helped services understand the roles of responsibilities of agencies involved in end of life care.

Good

Is the service well-led?

Our findings

All the people and relatives we spoke with were positive about the management and leadership of the service. Comments included, "The staff do what they are supposed to do when they are supposed to; that's positive," "I don't think the service could improve, it's great," "The staff and the [registered] manager are approachable and very able to manage the service," "I like the fact that the agency is multi-cultural and it's good for [family member]," and "The service is flexible and listens to what I have to say and keeps me informed. They care about the people they are dealing with and the carers always have a smile." Many people told us they would recommend the service to others, and indeed some had already done so.

The service had a registered manager in post who was also the provider. They were supported by a care co-ordinator who also deputised for them and an administrator in the office. Both the registered manager and the care co-ordinator had many years of experience working in social care and used these skills in leading and managing the service. There was a clear leadership structure in place that was supported and encouraged others to be included in decision making and information sharing.

Staff told us the registered manager had an open approach and was very supportive and easy to talk to. Comments included, "Care staff are satisfied because they get what they want. Leadership depends on a happy team and there is good communication. Managers are approachable and we can make suggestions. They help us to develop. Things can always be improved but it is a good service," "We have good back-up and support from managers. We can ring [registered manager] at any time. He cares about us as people, not just staff and helps us personally. He is always polite and respectful," and "There is good management, always available if you need them. We can say if we think something isn't working and [registered manager] will listen and make changes. I am happy working here and happy with the company."

Staff were supported to share their views through supervisions and staff meetings. Records showed staff had opportunities to discuss key issues and best practice in terms of the care provided.

The registered manager and staff told us the staff team worked well together. The staff team was diverse, with a range of cultures and faiths, and this was recognised and promoted in all aspects of the service. The provider had a policy promoting equality and diversity within the service. This included measures to reduce the risk of discrimination and guidance about key cultures, such as Muslim, Hindu, Jewish and Jain. Staff were supported with to understand key festivals and celebrations and important information to know, such as end of life and death. The registered manager ensured staff had cultural awareness and were able to communicate effectively with the people they supported. Staff supported each other by being flexible at key festivals and celebrations. The registered manager spoke about an open culture where all staff were treated equally and this was confirmed by staff we spoke with.

The quality of care was regularly monitored. Audits were carried out and included care records, health and safety, medication and observations of staff working practices. These helped to highlight areas where the service was performing well and the areas which required development. For example, audits had identified improvements were needed in the completion of medicine records. The registered manager had discussed

what was required of staff in meetings and individually with staff and continued to monitor through audits. This had resulted in an improvement in the completion of medicine records overall. This demonstrated that the registered manager used improvements to drive developments in the service.

Surveys had recently been sent out to people and relatives to gain their views of the service. These were available in Gujarati and English, the two main languages spoken by people using the service. The registered manager was in the process of reviewing feedback and results. We saw initial feedback was largely positive with praise for the interactions between people and staff. The registered manager told us they would share the results with people, relatives and staff and advise on any actions they took to address areas for improvement.

The registered manager and care co-ordinator were readily available to speak with people and their relatives and this resulted in an open culture. People and relatives confirmed the registered manager and office staff were accessible. They were able to share their views and raise queries through day-to-day conversations and these were always responded to in a timely manner.

The registered manager had a vision of how they wanted to develop the service. They were clear on the level of needs the service was able to meet, including the duration of calls to ensure staff had sufficient time to care. They kept themselves up to date on best practice by linking with a number of organisations, locally and nationally. They demonstrated they understood the challenges and limitations of the service and had developed a strategy to develop the service whilst ensuring people continued to receive good care. For example, they had recently reviewed the training requirements and needs of staff and as a result had changed the way training was to be delivered. They told us this would improve the support for staff to complete training and ensure they had the skills and knowledge they needed to develop in their role.

The registered manager was aware of their legal responsibilities including their obligation to notify us about certain events. Commissioners, responsible for funding some of the people using the service, had recently completed a quality visit and had no concerns with the care staff provided.