East Riding of Yorkshire Council

Community Support Services

Inspection report

47-49 Manorfield Road
Driffield
Humberside
YO25 5JE

Tel: 01482395277

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 and 7 July 2017. The first inspection day was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the service's office who could assist us with the inspection.

The service is registered to provide the regulated activity personal care. Community Support Services specialises in providing two distinct services; a community support service that focuses on re-ablement from hospital discharges, chargeable services, intermediate care and palliative care, and a carer relief sitting service to support people who are caring for someone who is living with dementia which includes carer emergency cover to support carers in a crisis situation. People are supported with activities such as personal care, the provision of meals and the administration of medicines. On the day of the inspection people were receiving assistance from 98 community support workers, ten of whom were employed on a casual basis. In addition to this, there were 11 office staff and managers. The number of people using the re-ablement service changed constantly. Two hundred and fifty people had used the carer relief sitting service and 2,500 were registered with the carer's emergency service. The office is situated in Driffield, in the East Riding of Yorkshire, and staff work over the whole of the East Riding of Yorkshire. There is parking available for people who wish to visit the office by car.

The provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). They were not currently managing the service and the provider had informed us of the interim and the planned future management arrangements. 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. Throughout this report we will refer to the registered manager as 'the manager'.

Prior to this inspection we received information from the provider to inform us that they had suspended the whole service for a period of six weeks. This was as a result of a series of errors when community support workers were assisting people with their medicines. It had been recognised that these errors were due to staff not understanding or following the policies and procedures in place, as well as system concerns such as pharmacy error and inconsistencies, lack of information at the point of hospital discharge and complicated processes within the current medicines policy. Whilst the service was suspended, community support workers had refresher training on the administration of medicines and had competency checks carried out on their practice. The provider introduced robust governance systems and was able to demonstrate that they were transparent and applied learning in each instance. These are still in the process of being embedded within the on-going operation of the service.

We found that the service had followed their policies and procedures when recruiting new staff and this had resulted in people receiving support from staff who were considered suitable to work with people who might

be vulnerable.

We saw there were sufficient numbers of community support workers employed to meet people's individual needs, and that people received the level of support they required to meet their agreed support package.

People were protected from the risk of harm or abuse because the provider had effective systems in place to manage any safeguarding issues. Staff received training on safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. Staff understood their responsibilities under the Mental Capacity Act.

People expressed satisfaction with the support they received from community support workers. The feedback we received confirmed that people had positive relationships with community support workers and it was apparent that community support workers genuinely cared about the people they were assisting.

Community support workers told us they were well supported by office staff and managers, both on a day-to-day basis and in supervision and staff meetings.

Community support workers confirmed they received induction training when they were new in post and told us that they were happy with the training provided for them. The training records showed that community support workers had completed induction training and the training that was considered to be essential by the service, although some refresher training was overdue.

There was a record of any accidents or incidents involving both people who received a service and staff. This allowed the provider to monitor whether any patterns were emerging or if any improvements to staff practice were required.

There was a complaints policy and procedure and this had been made available to people who received a service and their relatives. People who we spoke with told us they had not needed to make a complaint.

There were systems in place to seek feedback from people who received a service and we saw that most of this feedback was positive.

We found the provider was in breach of one of our regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were robust medicine procedures in place and staff had completed appropriate training, but errors were made which meant people did not receive their medicines as prescribed.

Staff were recruited safely, and there were sufficient numbers of staff employed to ensure people received the service they required.

Accidents and incidents were monitored to identify any patterns that were emerging or improvements that needed to be made.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training to enable them to carry out their roles and were supported through regular supervision and appraisal.

Staff understood their responsibilities under the Mental Capacity Act and told us they supported people to make decisions about their care and support.

People were supported with meal preparation and to maintain good health.

Is the service caring?

Good

The service was caring.

People were treated in a kind and compassionate way by staff.

Staff knew people well and supported them to maintain their independence.

People told us that community support staff respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs had been assessed and support plans had been developed. These included information to assist staff in providing person-centred care.

People we spoke with were aware of how to make a complaint or raise a concern. There were systems in place to deal with any complaints made to the service.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post although they were absent from work at the time of the inspection.

Quality audits were being carried out to monitor the effectiveness of the service, including the management of medicines.

People were given the opportunity to give feedback on the service provided by the agency.

Community Support Services

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.

The site visit to the agency office took place on 4 July 2017 and was announced. On 5 and 7 July 2017 we visited people in their own homes. The inspection was carried out by one adult social care inspector.

Before this inspection we reviewed the information we held about the agency, such as information we had received from commissioners and feedback from people who used the service. The provider was asked to submit a provider information return (PIR) before this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with the provider, the service manager, a temporary manager, the deputy manager, a team leader, two support workers and two community assessors. We also spent time looking at records, which included the care records for four people who were currently using the service, the recruitment records for two community support workers and other records relating to the management of the service, including quality assurance, staff training, health and safety and medicines management.

Following the inspection we spoke with eight people who used the service, two relatives and four community support workers. We visited three people in their own home. We also asked six social care professionals to give us feedback about the service but did not receive any responses.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection we received information from the provider to inform us that they had suspended the service. This was as a result of a series of medicines errors made by staff, resulting in people not receiving their prescribed medicines. It had been recognised that these errors had been made because staff had not understood the policies and procedures in place or were not following the policies and procedures, as well as system concerns such as pharmacy error and inconsistencies, lack of information at the point of hospital discharge and complicated processes within the current medicines policy. The service was suspended for a period of six weeks, and during this time community support workers had refresher training on the administration of medicines, attended workshops and had competency checks carried out on their practice.

The provider had employed two new staff to work as community assessment officers who would take a lead role in ensuring medicines were safely administered and that medicine records were audited. Community assessment officers took a photograph of each person's medication administration record (MAR) each month. Support workers were required to ring the office at the time they had to administer medicines to inform a team leader of the medicines and doses they would be administering. This was seen as a way of checking that staff were administering the right medicines at the right time. The service had also introduced a personalised medicines administration form where staff had to note any changes in the person's prescribed medicines. We saw a copy of the updated medicines procedures that had been sent to all staff, and the one page summary to highlight the important points that was ready to be sent out.

These were all positive actions by the provider, who recognised that improvements needed to be made for the service to operate safely and effectively.

The service had started to take referrals again for people who required assistance with the administration of medicines, with the exception of people who were prescribed Warfarin. It was felt that staff needed more experience before they were asked to assist with the administration of Warfarin due to the particular dosage requirements of this medicine.

We recognise that there will likely always be a small number of errors in relation to the management of medicines and it is important that the service has in place a robust and open system to report, identify and manage the training and learning from these.These are still in the process of being embedded within the on-going operation of the service.

The provider told us that all medicines errors were being looked at carefully on an individual basis. The three people who we visited in their own home did not require support with the administration of medicines. One person who we spoke with over the telephone told us that staff had prompted them to take their medicines and they had never had any concerns.

The staff who we spoke with confirmed they had received training on the administration of medicines as part of their induction training. They told us about the recent medicines concerns and confirmed they had

received refresher training and competency checks

People told us they felt safe when care workers were in their home. Comments included, "Yes, they are trustworthy and honest" and "They are all very good. [Name] is a nice young man." Some people required the assistance of two community support workers due to the specific nature of the support they required. All of the feedback we received indicated that two staff attended people when this was required.

We looked at the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults.

There were sufficient numbers of staff employed to ensure people received the correct level of support. People who we spoke with told us that community support workers arrived on time and stayed for the right length of time. One person told us the community support workers initially spent 30 minutes with them but they felt as though they were being hurried. Staff had fed this back to office staff, and the time allocated to them increased to 45 minutes. Staff told us they worked a set number of hours per day. They had a number of people to support during that time, but could spend a little bit more or less time with people depending on their needs at each visit. They felt this worked well and met people's varying needs. They added, "We try not to rush people." Staff had set 'rounds' and efforts were made to provide people with a consistent group of staff.

The provider told us they had a loyal group of staff, some of whom had worked for them for a number of years. However, they were having some difficulty in recruiting and retaining staff. The current job description required staff to hold a driving licence and have a car. This was due to change, as the provider felt this was a barrier for some people who would otherwise apply for a position of community support worker. They were considering supporting people to learn to drive and having a 'pool' of cars available for staff.

We checked the electronic and paper care plans for people who received a service and saw they contained a risk assessment that recorded any identified risks with the person's environment and how these could be minimised to protect the person concerned and any staff who visited their home. In addition to this, there were risk assessments that were specific to the person whilst they were in receipt of support, such as making a hot drink. Checks were made during supervision meetings on documents regarding staff's car insurance and MOT certificate to ensure their vehicles were safe to use for work. Any mobility equipment used by people was maintained by the company that supplied it, although a team leader told us that staff knew how to check the equipment to ensure it had been serviced by the required date.

We looked at the folder where information on safeguarding adults from abuse was held. This included a copy of the agency's policies and procedures and information about the local arrangements for reporting concerns to the safeguarding adult's team. The provider told us they believed the services threshold for submitting safeguarding alerts was previously too high. Although there was a management overview of all safeguarding incidents each month, because not all medicines errors were referred to the safeguarding adult's team, a true picture of the number of errors was not identified. As part of the internal review of the service, staff were instructed to apply the safeguarding threshold tool as part of their analysis of incidents for every medicine error.

Training records showed that staff had received training on safeguarding adults from abuse. The support workers who we spoke with were able to describe different types of abuse and were clear about the action

they would take if they had any concerns. They told us that they would report any concerns to managers, and were certain the information would be shared with the relevant professionals. There was a financial transaction form in people's care file so any assistance with shopping carried out by support workers could be recorded. However, we were told that support with shopping was infrequent.

The provider told us that there had previously been a lack of analysis of accidents and incidents, and consequently a lack of evidence of any learning. The analysis of accidents and incidents was now included in the audits undertaken by technical assistants. These audits were shared with the manager, service manager, quality assurance officer and the nominated individual on a monthly basis, so they had an overview of all accidents and incidents that occurred in local authority services. This meant there was a system in place to ensure accidents and incidents were analysed to check for any patterns that were emerging or any improvements that needed to be made. The analyses of accidents and incidents was now included in the information collated by the Technical Assistants and this reported back to the manager, service Manager, Quality Assurance Officer and Nominated Individual on a monthly basis.

There was a local authority contingency plan that recorded how staff should deal with emergency situations such as loss of IT equipment. This was supported by a 'bad weather' policy that provided staff with advice on the action to take during severe weather conditions. Another document recorded how staff should deal with a medicine error, a missed call, a team concern or a service incident. This listed the action that needed to be taken by the relevant team leader and manager, including submitting notifications to CQC, submitting a safeguarding alert, completing a concerns log and informing senior managers.

Good

Is the service effective?

Our findings

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 MCA 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection. We checked whether the service was working within the principles of the MCA, and found that people using the service did not have any restrictions in place at the time of this inspection and that no applications had been made to the Court of Protection.

MCA e-learning was considered to be essential by the service and was completed by all staff prior to their attendance at level 2 safeguarding adults training. Community support workers who we spoke with had some knowledge of the principles of the Act, and were aware of their responsibilities. We saw in the minutes of staff meetings that staff had been given a leaflet to read and told that they needed to be aware of the five important principles of the MCA.

People's re-ablement plans included information regarding whether they had the capacity to make decisions about their care and support, and the provider told us that only people with capacity received support from the re-ablement service. We noted the medicines procedure recorded that people who required assistance with the administration of medicines (or their advocate) were required to consent to this support, and that this consent had been obtained.

People told us that support workers had the skills they needed to carry out their roles. One person said, "Very much so. They are caring and kind." New staff completed a thorough induction training programme. They spent one day with a team leader to become orientated to the service, and also attended a corporate induction day. Staff completed the Care Certificate with the local authority training department and this included observations of their practice by an experienced worker. We were told that community support workers were not allowed to work with people in the community, unless they were accompanied by an experienced care worker, until they had completed the Care Certificate and other training considered to be essential by the provider. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards. Care workers confirmed they received induction training when they were new in post. The provider told us they would increase the shadowing period for some staff if they were not confident following their initial induction and shadowing period to increase their level of confidence.

Technical assistants supported the manager to maintain the training record for the service. The record showed that staff had completed training in safeguarding adults from abuse, moving and handling, the prevention and control of infection, basic life support, fire safety, the MCA and medication. These records

also showed that staff who had not completed the required training were already booked on a training course, with the exception of food hygiene. We fed this back to the manager following the inspection. The provider told us that a medication training tool had been devised. This contained 50 questions and each team were required to answer ten questions at each team meeting. We saw evidence of this in some recent staff meeting minutes.

Support staff had been issued with a staff handbook that contained information about their employment, the standards they were expected to adhere to and a job description. This meant that staff were aware of what was expected of them.

There was a staff supervision structure in place that identified which staff provided supervision to people at each level, and staff told us they were well supported. One community support worker told us that they felt supported personally as well as professionally. They said, "My manager is fantastic. They deserve more credit than they get. They go the extra mile." Other comments from staff included, "I am well supported – managers are interested in my welfare" and "I have a good manager – they are very approachable." One staff member told us that they also felt well supported by senior managers in the organisation, who "Listen to our comments".

Most people we spoke with received support with the preparation of meals and drinks, and were satisfied with the support they received. One person told us, "The main support I need is with meals and I have no concerns about that." Care plans recorded the assistance people required with the preparation of meals.

Care plans included information about people's general health and any medical conditions that had been diagnosed, and this information was readily available for staff. There was evidence that support workers liaised with health care professionals who were involved in people's care when this was appropriate.

Good

Is the service caring?

Our findings

The people who we spoke with were receiving support to regain their independence following their discharge from hospital. Everyone said that the assistance they received from community support workers had helped them to regain some of their daily living skills and increased their level of independence. One person said, "I could do some things for myself and they just supported me. They watched me prepare food at lunchtime to make sure I could manage" and "My service has just finished today. They helped me with meals – the support definitely helped me to get better."

People told us they felt staff genuinely cared about them. Comments included, "Yes, nothing is too much trouble for them", "There are some really nice ones [support staff]" and "They [staff] have the right kind of skills. They are kind and caring." One person said they would have liked it if staff had spent more time chatting with them and we fed this back to the manager at the end of our inspection. Support workers told us, "We are dedicated to the job – we receive a lot of compliments" and "We get to know people and their family."

People told us that support staff respected their privacy and dignity. One person said, "I felt embarrassed at first when they helped me with a shower. The support worker washed my back and dried me. I can't fault them." Another person told us, "I said I would prefer a female and it's a female who helps me. I'm not embarrassed – I feel quite comfortable." One person added, "I have seen lots of different faces but they have all been marvellous."

We asked staff how they ensured they protected people's privacy and dignity whilst assisting them with personal care. They told us they would have a chat with people first and take their time. They would help them to undress but 'let them take the lead'. They told us they would make sure doors were locked, curtains were closed and that people were covered to protect their modesty. One member of staff added, "It's their home and their rules."

Some people told us they could express whether they would prefer to receive assistance from a male or a female community support worker. However, other people told us they were not asked this question when they first started to receive a service.

One community support worker told us that people were sometimes reluctant to receive support from a 'carer'. They told people, "We are a friendly bunch of staff. We are not carers, we are support workers. That seems to put people at ease."

The staff handbook included information for staff on data protection and the need to protect people's confidentiality. During the assessment process, information about data protection was read out to people who would be receiving a service. No-one who received a service expressed concerns about confidentiality during our inspection.

Most people told us they usually received a service from the same group of staff. Comments included, "I get

a regular group of staff. Staff are usually able to tell me who is coming to me next", "I've had two regular carers. They have all been absolutely lovely." Staff who we spoke with confirmed that efforts were made to reduce the number of different staff who provided people with support. One community support worker said, "We try to keep the same staff with people so they have the same group of regular carers." A team leader told us there was no formal process for informing people about staff changes and that this was explained when the service commenced. However, if the original support worker was going to be late, the call would be reallocated to avoid delays in people's care needs being met.

We asked if the service would be able to put people in touch with an advocate. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. None of the people currently using the service required the assistance of an advocate but we were told that the person's care manager would be asked to arrange this for people if this type of support was required.

Good

Is the service responsive?

Our findings

People had a thorough assessment of their support needs prior to the service commencing, and this information was developed into a plan of care. Staff had an electronic copy of each person's care plan on their work mobile phone. In addition to this, people had a copy of their re-ablement (care) plan in their own home.

Re-ablement plans recorded people's goals to regain independence, such as being able to bathe or shower independently or to prepare themselves a meal. They included a 'one page profile', risk assessments and a copy of the person's re-ablement review. We saw that some re-ablement assessment forms contained detailed information to guide staff on the support the person required. However, other forms would have benefitted from more specific information being included. Diary sheets recorded the time staff arrived and left the person's home, and details of the tasks they had assisted the person to carry out. People told us that community support workers read these notes when they arrived at their home and made notes about their visit, to make sure all staff were aware of people's current support requirements. Any significant changes were communicated back to the office to ensure prompt actions.

People told us that their care re-ablement plans were reviewed on a regular basis and the plans we saw in people's own homes contained up to date information. At the end of the re-ablement period a reviewing officer from the service visited the person in their own home to check that the support people had received had met their needs, and to review their on-going support needs. When people required on-going support, the local authority were able to assist in arranging this.

The folder of information given to people who used the service contained a compliment / comment / complaint / concern form that was ready for use. This invited people to express concerns if they were dissatisfied with any aspect of the service. People told us they or a member of their family would ring the office if they had a concern or complaint. Although none of the people we spoke with had felt they needed to complain, they told us they were confident their concerns would be listened to. One person said, "I have never had to complain. I've had various care workers but I wouldn't complain about any of them" and another said, "I know who to contact – it's recorded in my green folder."

Staff told us they would make a complaint on a person's behalf if they felt the service had not lived up to expectations. One member of staff said, "I wouldn't hesitate to report any concerns to a manager." We checked the electronic complaints record, and saw there was a record of any complaints received, the action taken and the outcome. When appropriate, a letter of apology was sent to the complainant. A monthly report was completed by one of the team leaders to help with analysis.

There was no system to record occasions when staff failed to turn up at someone's home but people who used the service had capacity and were able to ring the office if they had queries about their support worker. The provider was exploring a system that would record when staff arrived at and left a person's home. No one reported any occasions when they had had a 'missed call.

We met with the technical assistant responsible for maintaining quality assurance records. They told us that the service used three different surveys; an interim survey at the time the person's service was reviewed, a review at the end of their six week service and a telephone survey that was conducted 90 days after the service ended. The interim survey was a new development so no analysis of responses had taken place; the technical assistant intended to analyse these surveys every two weeks. The feedback from the other surveys was developed into a 'You Said / We Did' document that was placed in the folder of information given to new service users, and shared with staff.

Good

Is the service well-led?

Our findings

There was a manager in post who was registered with the CQC to manage the service. The manager was not managing the service at the time of this inspection. The provider had informed us of the management arrangements during the manager's absence, as required by regulation.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. Notifications had been submitted appropriately by the service when required.

People told us that the service seemed to be well managed. One person said, "They [managers] are well organised and very professional." Another said that staff always turned up when they were expecting them. All community support workers had been issued with a mobile phone and the service used a system called Webroster that sent all relevant information to support staff. This included their work rota for the week, the details of the support each person required and other important information about the person that would assist staff to get to know their individual support needs. Staff who we spoke with felt this had improved the efficiency of the service.

The provider had recognised that previous quality audits had not been robust. This, along with the number of medicines errors, led to a full review of the service. The provider suspended the service for a period of six weeks, apart from a small number of people who could not be supported by another care provider. During this six week period no new referrals had been accepted and the service had been redefined. The first stage of the review has been completed and the service was re-introduced, with the focus being the provision of support to people who were ready to be discharged from hospital but needed additional support to return home. The nominated individual identified during their analysis of the service, and medicines errors in particular, that the current joint medicines policy required improvement and discussions were taking place about suggested amendments.

The manager now carried out quality audits and these were collated and stored by the technical assistants and fed back to the service manager and nominated individual. The manager was required to submit information each month that was recorded on a quality assurance checklist. This included information about the number of deaths, accidents, outstanding staff supervision, staff training and safeguarding incidents. Technical assistants used this information to produce a three-monthly report that included this information for all of the local authority services. A document was produced in a graph / diagram format that clearly highlighted any shortfalls. This was submitted to the service manager for monitoring purposes. Managers attended a monthly meeting and we were told that this information was discussed openly.

Surveys were sent out by the central quality team to people who used the service, family and friends and staff. The staff survey was distributed every September and approximately one third of staff responded. The manager checked the responses and told the technical assistant what action they had taken. The technical assistant then recorded these actions in a 'You Said / We Did' document. This was displayed in the office for staff and included in the service's newsletter.

Staff were divided into five zones, with a team leader in each zone. Meetings were held by team leaders in their zone every one or two months, and staff were required to attend four meetings a year. We saw a sample of staff meeting minutes; these evidenced that there was an update on the actions identified at the previous meeting, and discussions about operational issues, the administration of medicines, staff vacancies, care records, customer feedback, safeguarding and health and safety. Staff told us they could raise issues and make suggestions at these meetings.

We observed that staff working in the office had a positive attitude and they were helpful in providing information for us on the day of the inspection. People who used the service told us that they had contact numbers for the office, both within and outside of office hours, so they were always able to contact someone for advice or to pass on information. We saw that these numbers were recorded on the front of the information packs held in people's homes.

Community support workers had a direct telephone number they could use that went straight to the office mobile telephone. Office staff had been instructed to answer this telephone immediately. After 10.00 pm calls were transferred to the local authority Lifeline service or the emergency duty team. This meant that support staff working in the community could always contact a colleague or more senior member of staff for advice and support. One support worker told us, "If you ring the office you can always get hold of someone, even at weekends."

We asked staff to describe the culture of the service. One member of staff said they felt the service was losing it's identity. We fed this back to the nominate individual who said that this was understandable, given the recent review of the service. However, through regular meetings and consultations the staff were being kept informed of any developments and encouraged to contribute their ideas. Other comments from staff included, "We're friendly", "I love my job" and "I've worked all over – this is by far the best." We found that community support workers were positive, enthusiastic and clearly enjoyed working for Community Support Services.

We did not speak with people who used the carer relief sitting service. This service provided support for people living with dementia whilst their family carers had a break. People received support every two or three weeks for up to six hours each visit. They were able to request that they received support from a specific support worker but might be offered an alternative. However, staff from this 'arm' of the service told us that people and their family carers knew most of the support workers who provided this service.

It was apparent from the information we saw that the provider and managers were aware of good practice guidance in respect of supporting people who lived in their own home, such as safeguarding adults from abuse and the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.