RNHS Limited

Rosie Nightingale Homecare

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 inspection took place on 14 and 16 March 2016 and was announced. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be in to facilitate the inspection. The service has not been inspected since re-registering at a new location address on 16 January 2015.

Rosie Nightingale Home Care is a domiciliary care service, registered to provide personal care within people's homes. The office is situated in Bolton. Services are provided across Bolton via private arrangements or through local authority and clinical commissioning group (CCG) contracts.

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 we spoke with told us they felt safe using the service. The service had appropriate systems and procedures in place to protect people who used the service from abuse. The service had a safeguarding policy and associated procedures which were up to date. Staff we spoke with were able to tell us about the different forms of potential abuse.

The service had a whistleblowing policy in place and this told staff what action to take if they had any concerns.

Care and support records of people who used the service were very comprehensive, well organised and easy to follow. We saw that the service communicated regularly with peoples' relatives who did not live nearby or who lived in another country.

We looked at how the service managed people's medicines and found that suitable arrangements were in place to ensure that people who used the service were safe. We looked at the medicines administration record (MAR) charts for people when we visited them in their own homes and found that these had all been completed correctly, were up to date and stored securely. All staff administering medication had received training.

There was an appropriate and up to date medicines administration policy in use which included information on medicines to be taken 'as required' (PRN).There was an up to date accident and incident policy and procedure in place and details of any accidents and incidents were recorded appropriately, including any remedial action required to reduce the risk of any future potential harm. There was an up to date business continuity plan in use.

People who used the service told us they felt that staff had the right skills and training to do their job. There

were robust recruitment procedures in place and required checks were undertaken before staff began to work for the service. There was a comprehensive process of staff induction in place which was used to audit the progress of new staff relative to the induction process.

We found that all staff had completed training in the Mental Capacity Act in general as part of the process of induction. At the time of the inspection no person using the service was subject to any restrictive practices.

We reviewed the service's training matrix and staff training certificates, which showed staff had completed training in a range of areas, including dementia, safeguarding, first aid, medicines, infection control and health and safety.

Staff received supervision and appraisal from their manager and the service which kept a record of all staff supervisions that had previously taken place.

The service used an electronic staff scheduling and planning tool called 'People Planner'. This system enabled real-time live updates to be sent to care staff members which reduced the potential for missed or late visits.

We looked at the way the service managed consent for any care and support provided and found that before any care and support was given the service obtained consent from the person who used the service or their representative.

We found that each person who used the service had a comprehensive health assessment which was easily accessible within their individual care and support plan.

People who used the service and their relatives told us that staff were kind and treated them with dignity and respect. We found the service aimed to embed equality and human rights through well-developed person-centred care planning. The views and opinions of people were actively sought.

The service did not provide end of life care directly but supported other relevant professionals such as district nurses and Macmillan Nurses

The service had a Customer Services Guide which was given to each person who used the service, in addition to a Statement of Purpose.

Regular reviews of care needs were undertaken by the service and a schedule of reviews had been drawn up for 2016.

People who used the service and their relatives told us that they felt confident in talking to the manager directly and had regular discussions with management. The service had a complaints policy and procedure and we saw that they followed this consistently.

Staff told us they felt they were able to put their views across to the management, and felt they were listened to. The staff we spoke with told us they enjoyed working at the service and said they felt valued.

The service undertook audits to monitor the quality of service delivery. There was a schedule of field observations for 2015 which was fully completed and dates for checks due in 2016 had been scheduled.

We found the service had policies and procedures in place, which covered all aspects of service delivery

including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control. These policies were all up to date.

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 we spoke with told us they felt safe using the service.

The service had appropriate systems and procedures in place which sought to protect people who used the service from abuse.

Care and support records of people who used the service were very comprehensive, well organised and easy to follow.

There were suitable arrangements in place to ensure that the administration of medicines was safe.

Is the service effective?

Good

The service was effective.

People who used the service told us they felt that staff had the right skills and training to do their job.

There was a comprehensive process of staff induction in place and staff had completed training in a range of areas. Staff received supervision and appraisal from their manager.

Before any care and support was given the service obtained consent from the person who used the service or their representative.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us that staff were kind and treated them with dignity and respect.

The service had a Customer Services Guide which was given to each person who used the service, in addition to a Statement of Purpose.

The service aimed to embed equality and human rights through well-developed person-centred care planning.

Is the service responsive?

Good

The service was responsive.

People who used the service and their relatives told us they were involved in developing and reviewing care plans.

People who used the service had a care plan that was personal to them.

Regular reviews of care needs were undertaken by the service.

Is the service well-led?

Good

The service was well-led.

People who used the service and their relatives told us the manager was very approachable and held regular discussions with them about the quality of care.

The service had policies and procedures in place, which covered all aspects of service delivery.

The service undertook audits to monitor the quality of service delivery.

Staff told us they felt supported and were able to put their views across to management.

Rosie Nightingale Homecare

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 inspection took place on 14 and 16 March 2016 and was announced. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be in to facilitate the inspection. The service had not been previously inspected since registering with the Care Quality Commission at the present location address on 16 January 2015.

The inspection team consisted of one adult social care inspector from the Care Quality Commission. Before the inspection visit we reviewed the information we held about the service, including information we had received since the service registered such as notifications of incidents that the provider had sent us. We also liaised with external agencies including the contract monitoring team from the local authority and the local Healthwatch.

We reviewed the care records of five people that used the service and records relating to the management of the service. We looked at documentation such as care plans, five staff personnel files, policies and procedures and quality assurance systems.

During our inspection we went to the provider's head office and spoke with the nominated individual/registered manager and the office manager. Because staff were not office based, we spoke with six carers over the telephone as part of the inspection. We visited two people in their own homes and spoke with six other people who used the service and three relatives of people who used the service over the telephone as part of the inspection. This was in order to seek feedback about the quality of service being provided.

At the time of our inspection there were 53 people who were using the service, which employed 30 members of care staff.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe using the service. One person who used the service said: "The staff are very kind and friendly and are on time". Another person said: "I have a key safe and they (the staff) can let themselves in if I'm in bed. I feel safe". A relative told us: "I never feel anybody is taking advantage of (my relative) and she is safe". Another relative commented: "(My relative) feels safe and we trust the staff." The registered manager told us that it was vitally important for every visit to take place at the identified time as some people who used the service did not have any other people visiting them regularly.

The service had appropriate systems and procedures in place which sought to protect people who used the service from abuse. The service had a safeguarding policy and associated procedures which were up to date. Staff we spoke with demonstrated a good understanding of local safeguarding procedures and how to raise a concern. All care staff had undertaken safeguarding training as part of the induction process or thereafter and the care staff we spoke with confirmed they had recently undertaken this training.

We asked one member of staff what they would do if they suspected signs of abuse against people who used the service and they stated that they would contact the office and speak to their manager. Staff we spoke with were able to tell us about the different forms of potential abuse.
The service had a whistleblowing policy in place and this told staff what action to take if they had any concerns. Staff we spoke with confirmed they were aware of the policy.

We looked at the care and support records of people who used the service and found these were very comprehensive, well organised and easy to follow and included range of risk assessments to keep people safe from harm. These included areas such as pressure sore care, eating and drinking, moving and handling. Each person had a personal care and support plan that had been completed with the person and included specific details of the care tasks required and how and when they should be delivered.

There was a separate 'workplace risk assessment' document in use which considered issues relating to the home environment of the person receiving care and support, such as lighting, temperature checks, window opening checks, sanitary conveniences, alarm bell (if fitted), grab rails (if fitted), bed safety, tripping hazards and the condition of external pathways and steps. This meant that staff considered any environmental risks to the person receiving care and support or to themselves at each home visit. Each risk assessment had a corresponding form that identified the specific risk or hazard, the existing control measures and further control measures required to reduce any further potential risk.

We found there were robust recruitment procedures in place and required checks were undertaken before staff began to work for the service. Personal details had been verified and at least two references had been obtained from previous employers. Criminal Records Bureau (CRB)
checks or Disclosure and Barring (DBS) applications had been obtained. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. There was also evidence of identity and address checks. This showed us that staff had been recruited safely.

New staff were given an employee handbook at the start of their employment which identified the principles and values underpinning the service. These referenced privacy and dignity, confidentiality, key-holding, medicines administration, control of infections, protection from abuse, safe working practices, quality of service, diversity in care, assessment of care needs, complaints and protection.

The manager told us that as part of the staff induction training there was discussion about the company's policies around safeguarding, the routes for reporting abuse including individual responsibilities from alerting and investigating cases of abuse, and the whistleblowing policies. This was verified by the staff we spoke with.

We looked at how the service managed people's medicines and found that suitable arrangements were in place to ensure that people who used the service were safe. We looked at the medicines administration record (MAR) charts for people when we visited them in their own homes and found that these had all been completed correctly, were up to date and stored securely. We looked at records and saw that the service regularly undertook competency checks of staff who administered medication, using a 'MAR sheet audit form.'

There was also a 'field observation form' which was used to assess other staff competencies such as moving and handling, use of equipment, personal care tasks, communication skills, infection control, recording procedures and financial transactions. All staff administering medication had received training, which we verified by looking at training records. Some people did not require assistance with taking medicines and one person told us: "If I'm not well the staff encourage me to see a doctor but I can do my own medication though".

The service did not administer any controlled medicines. There was an appropriate and up to date medicines administration policy in use which included information on medicines to be taken 'as required' (PRN). Staff we spoke with told us they had received a copy of the policy.

During the inspection we looked at five staff personnel files. We saw evidence in these files of appropriate disciplinary action being taken where relevant and there was an up to date disciplinary policy and procedure in place.

We looked at how the service managed accidents and incidents. There was an appropriate up to date accident and incident policy and procedure in place and details of any accidents and incidents were recorded appropriately, including any remedial action required to reduce the risk of any future potential harm.

There was an up to date business continuity plan in use which covered areas such as loss of utility supplies, loss of IT systems, influenza pandemic, fire and flood and adverse weather. Staff were informed of the existence of the plan and provided with an overview and understanding of its content. The business plan had associated risk assessments which identified the area of concern, a review of the risk and identification of possible risk-reducing measures.

Rosie Nightingale is a domiciliary service providing care to people in their own homes. We saw that adequate supplies of personal protective equipment (PPE) were available in the office premises for staff to collect at any time before supporting people, including gloves, aprons and sterilising hand-gel which would assist with minimising the potential spread of infections. When visiting people in their own homes we saw that staff wore PPE as required/appropriate.

At the time of our inspection visit, we found staffing levels to be sufficient to meet the needs of people who used the service. We saw that new referrals were not accepted into the service unless there were sufficient staff available to meet people's needs safely. We verified this by looking at new referral information.

Good

Is the service effective?

Our findings

People who used the service told us they felt that staff had the right skills and training to do their job. A relative of a person using the service told us they were always informed if care staff had any concerns about (their relative). One family member said: "The attention to detail is very good and communication is good". Another relative told us: "The girls who have been coming here have been very good. They have all been ok with (my relative) and they get on well. I'm happy with what they do. They go out of their way to do their best."

We saw that the service communicated regularly with peoples' relatives, some of whom did not live nearby or lived in another country. For example we saw evidence of email discussions between the service manager and a family member who lived abroad regarding their relative. One communication identified the need for an electrician after the service had noted an electrical lighting fault at the home of the person using the service. Other communications showed that regular updates were provided to distant family members regarding various aspects of their relative's care and support situation, such as nutrition/hydration, or refusals to go out on a planned 'outing' visit.

Staff confirmed that they had received these documents and undertaken a process of induction which included 'shadowing' more experienced colleagues until they were assessed as being competent to work individually. One staff member said: "I shadowed a colleague for two weeks and had a lot of training and tests before I went out on my own and I felt confident and prepared when I had done this."

There was a comprehensive process of staff induction in place which was used to audit the progress of new staff relative to the induction process and included a 'new employee checklist' which was used to record progress against initial starting checks and training.

An 'induction sheet' was also used to structure the first induction session with new carers, and there was a 'documents record' which identified that staff had read and understood the policies and procedures. We found the staff induction programme for new staff was robust and aligned with the requirements of the Care Certificate.

During the inspection we observed a new member of staff who was visiting the office and undertaking part of the process of induction, including training and completion of a workbook linked to the fifteen standards identified in the Care Certificate. We saw that following this the staff member spent several hours with the office manager discussing the training undertaken, including food hygiene, nutrition and hydration and infection control. We saw that interactions between the manager and the staff member were positive, encouraging and supportive.

We saw that staff were given a copy of the organisation's policies and procedures which were available electronically or in paper format and staff knowledge of these policies and procedures was tested out at supervision meetings and as part of the process of induction. This meant that staff were clear about the standards expected by the service and how the service expected them to carry out their role in providing

safe care to people in their own homes

Staff told us they felt they had received sufficient training to undertake their role competently. One staff member told us: "I have done dementia training, stroke training, and training in understanding Parkinson's Disease and Motor Neurone Disease." Staff told us that undertaking training helped them to feel confident in meeting people's care needs.

We reviewed the service's training matrix and staff training certificates, which showed staff had completed training in a range of areas, including dementia, safeguarding, first aid, medicines, the Mental Capacity Act 2005, infection control and health and safety. We saw that additional staff training dates had been arranged throughout 2016 for a number of refresher courses such as moving and handling, safe use of equipment and emergency first aid.

Staff received supervision and appraisal from their manager and the service which kept a record of all staff supervisions that had previously taken place. These processes gave staff an opportunity to discuss their performance and identify any further training they required. We found that staff were actively encouraged by managers to share their views and opinions through the mechanism of supervision. Staff told us they received supervisions every two to three months in addition to an annual appraisal. We checked records to verify this and saw that supervisions were scheduled on the staff rostering system throughout the year.

At the time of the inspection the service was using an electronic staff scheduling and planning tool called 'People Planner'. This system enabled real-time live updates to be sent to care staff members which reduced the potential for missed or late visits. The system also enabled messages and updated documents to be sent to the staff member's mobile phone such as changes to any policies and procedures, in addition to any real-time information regarding the care and support needs of people who used the service. The system was linked to each individual staff members' name which helped managers to track individual staff performance. During the course of the inspection we observed a real-time alert being sent to the manager regarding traffic congestion which could potentially have resulted in delays in attending scheduled visits. We saw that the manager circulated this information to the rest of the staff group so they were aware of the potential traffic hold-up.

We spoke with staff to ascertain their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). 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 found that all staff had completed training in the Mental Capacity Act in general as part of the process of induction. At the time of the inspection no person using the service was subject to any restrictive practices.

Care plans contained a 'care needs assessment' form that was used prior to service commencement which considered areas such as the person's preferred language, any existing support already being received, family details, social history, nutrition, person care/hygiene, if a key safe was required, hearing sight and communication, mobility, mental health, medicines and medical history and allergies. This enabled the service to identify if the person had been suitably referred to the organisation or whether a more specialist service was required.

We looked at the way the service managed consent for any care and support provided and found that before any care and support was given the service obtained consent from the person who used the service or their

representative. We were able to verify this by speaking to people who used the service, checking people's files and speaking with staff. One staff member told us: "If it's a new client, I always introduce myself, ask if they are okay and confirm with them what they want me to do first." A person who used the service told us: "Everything is done in agreement with what I want". A relative of a person who used the service said: "The staff always ask if its ok to do things and then (my relative) will either say yes, or no". We found that care planning documents held in the people's own homes had been signed and dated by the person or their relative where appropriate.

We looked at how the service supported people to maintain good health and to access healthcare services. We found that each person who used the service had a health assessment which was easily accessible within their individual care and support plan. This gave clear information and appropriate guidance about people's individual health needs and how best to manage their on-going health issues.

We also saw that the service completed a holistic assessment of people's wider health needs which included mental and emotional health, family and social relationships, lifestyle and culture, and daily living skills. Where staff supported people with their meal preparation, we saw that accurate records of people's nutritional intake were recorded in the daily recording sheets in people's own homes.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that staff were kind and treated them with dignity and respect. One person told us: "The staff are caring and I have no complaints about them". Another person told us: "The staff couldn't be any more caring". Another person commented: "The staff are very kind and friendly and are on time." A relative said: They (the staff) are very caring, really helpful and nice people". Another relative told us: "The staff seem to be very caring and I'm quite satisfied with them all so far".

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through well-developed person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people received the appropriate help and support they needed to lead fulfilling lives and meet their individual and cultural needs.

The views and opinions of people were actively sought. People who used the service and their relatives told us they were involved in developing their care and support plan and were able to identify what support they required from the service and how this was to be carried out.

One person said: "The staff are wonderful and I love them all; very good indeed." Another person commented: "(My carer) is an excellent carer and I have an arrangement for her to come in the morning. It's a relationship based on friendship."

Staff we spoke with were able to describe the principles of person-centred care and said they supported the same people most of the time. We found that most people were receiving support from no more than two different staff members. This enabled the development of positive long-standing and trusting relationships between people who used the service and the staff who supported them.

One staff member said: "Support plans are based around the support that people need. Understanding the person receiving the care is important so that people get the care and support they feel they need." A person told us: "The staff are good at what they do. They are very supportive." A relative told us: The girls who have been coming here have been very good. They have all been ok with my partner and they get on well. I'm happy with what they do. They go out of their way to do their best".

The service did not provide end of life care directly but supported other relevant professionals such as district nurses and Macmillan Nurses. People who used the service and their relatives told us the service worked in a way which promoted peoples' independence. One person said: "I can just about shower myself and the staff let me do that on my own still with their help." A relative told us: "The service does promote (my relative's) independence; they don't push him to do things but at the same time they also encourage him."

The service had a Customer Services Guide which was given to each person who used the service, in addition to a Statement of Purpose, which is a document that includes a standard required set of

information about a service. These documents provided a wide range of information such as the care philosophy; principles and values that the service followed; the standards of care that people should expect; a description of the services and facilities provided; how to make a complaint and dignity and respect. There was key contact information for the local authority, care quality commission and registered manager.

People we spoke with told us they were treated with dignity and respect. One person told us: "Staff speak to me how I like and how I want to be treated". Another person said: "There has never been an argument or an element of disrespect. The staff always call (my relative) by her first time and make sure she is nicely presented".

Good

Is the service responsive?

Our findings

A relative told us: "One particular staff member is very caring but they all are. I'm quite happy with them overall and they can't do enough for you. They always ask if there is anything else they can do." Another relative told us: "(My relative) has been using the service a few weeks. Someone came out and did an assessment. I was involved with the care plan as well." Another relative said: "The service did an assessment at the beginning. The family were here and were involved in everything that was available." A third relative commented: "The review is due and they (the service) update the file each time they visit. Both me and (my relative) are involved."

We looked at how new referrals to the service were assessed. The needs of people were assessed by experienced members of staff before being accepted into the service and pre-admission assessments were completed. This included gathering background information from a variety of sources including other health and social care professionals and from those individuals who were important in people's lives. The manager told us that the service did not accept any new referrals until it was determined that the service could meet the needs of each individual referral.

During the course of the inspection we observed that staff members who were out supporting people in their own homes were provided with update information regarding the people they supported. For example one person who used the service had got a new dog and the manager updated staff accordingly so that they were aware of any potential new risk. We found that for another person, the service had identified that the care hours commissioned were insufficient to meet the person's needs. The service had subsequently reviewed the number of care hours allocated in partnership with the referring organisation and additional care hours were granted.
This showed that the service was pro-active and able to respond to a change in need immediately.

People who used the service had a care plan that was personal to them with copies held at both the person's own home and in the office premises. This provided staff with guidance around how to meet their needs, and what kinds of tasks they needed to perform when providing care.

The structure of the care plans was clear and easy to access information. The care plans were comprehensive and person centred, and contained details regarding the person's background and life history, interests and social life, any existing support network, spiritual needs and recorded details of people who were involved in care planning such as family members and other relevant professionals.

We saw that prior to any new package of care being provided an assessment was carried out with the person and their relative(s), where appropriate, which we verified by looking at care records. Before care and support was provided to any person the service completed a series of initial assessments which covered areas such as health, medicines, social history, mental health, preferred activities, moving and handling, environment.

The manager also told us that they visited people in their own homes to identify their views and

experiences which was confirmed by the people we spoke with. We saw records of meetings with people who used the service and their relatives. For example one record included discussion about how the person who used the service felt their care package was progressing and if the service was meeting their needs. The person who used the service had identified that they were 'delighted with the service' they were receiving and that they now 'felt like they were actually being looked after.'

Regular reviews of care needs were undertaken by the service. We looked at records and saw that a schedule of reviews had been drawn up for 2016.

There were systems in place to record what care had been provided during each call or visit. Care plans contained a document, which was completed by staff at each visit. This included when personal care had been provided, any food preparation, medicines given or any creams applied. We checked these documents and found they were being filled in correctly by staff.

People who used the service and their relatives told us that should there be a need to complain they felt confident in talking to the manager directly and had regular discussions with management. One person said: "I've never made a complaint. I'm hoping it would be handled correctly". Another person told us: " I've never had to complain. I only have to ring the manager and he will come and see me". Another person commented: "I would ring the office and it would get sorted". A relative told us: "I've never complained but if I did I think it would be handled properly."

The service had a complaints policy and procedure and we saw that they followed this consistently. We saw evidence where complaints had been recorded and investigations had been carried out following issues raised.

The service sought the views of people using the service and their relatives through the provision of questionnaires and though home visits by the manager. We looked at the responses received and found feedback from people who used the service and their relatives was very positive. One person commented 'This is the best care team ever. All the staff are caring, professional and very friendly.' We saw that where the service was unable to meet the needs of new referrals information had been communicated to the referrer. This showed that the service was responsive to individual needs and did not accept referrals for people whose needs they were unable to respond to effectively.

Good

Is the service well-led?

Our findings

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.

An up to date registered manager's certificate was on display in the office premises in addition to an appropriate certificate of employers' liability insurance.

A person who used the service told us: "The manager is very approachable. When I first started with Rosie Nightingale the manager came out and we had a good chat. They were very approachable." Another person said: "The manager is wonderful. He is very caring and is always ringing me to make sure I am ok. I can't fault them." A staff member said: "I feel management listen to you and value you. You know if you've done something wrong but we always get praise as well."

Staff told us they felt they were able to put their views across to the management, and felt they were listened to. The staff we spoke with told us they enjoyed working at the service and said they felt valued. They said they thought the management were fair and approachable, and also told us the staff team worked well together. It was clear from our observations that the management team worked well together in a mutually supportive way.

People we visited all told us that the registered manager had visited them in their own homes.
The manager told us that it was important for the manager and senior office staff to visit people in their own homes to establish positive relationships and to demonstrate respect for each individual.

The service undertook audits to monitor the quality of service delivery. We saw a number of audits in place such as medication audits and spot checks on care staff, using a 'filed observation form' to verify their competence in providing safe and good quality care. There was a schedule of field observations for 2015 which was fully completed and dates for checks due in 2016 had been scheduled.

The field observation included checks on staff competencies in moving and handling, use of equipment, personal care tasks, communication skills, infection control, recording procedures, medication procedures and financial transactions. There was also a 'care certificate field observation form' which was used to track progress against the fifteen standards of the care certificate. The field observation form also included a series of questions for the person receiving care and support regarding the quality of care received. This demonstrated that the service regularly reviewed and questioned their own practice.

Most care staff had been in employment with the service for several years and this ensured consistency of care staff deployment and familiarity with the people who used the service, who told us they valued the same staff. The relative of a person who used the service told us that the service was always available to contact and actively encouraged discussions and contributions from family members regarding the

provision of care and support.

We found the service had policies and procedures in place, which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control. These policies were all up to date.

Where the service used any hoisting equipment, for example for transferring people, we saw that the service worked in partnership with the equipment suppliers to ensure it was safe before being used. We checked equipment test certificates and found these were all up to date.