Kent Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 and 13 October and was announced. We gave '48 hours' notice of the inspection, as this is our methodology for inspecting domiciliary care agencies.

Kent Home Care Limited provides live-in care staff for people in Kent and the London Borough of Bromley. Staff provide personal care and support to older people, including people living with dementia and people with a physical disability in their own homes. At the time of the inspection the service was providing live-in personal care support for thirty people.

The service has a registered manager who was available and supported us during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in August 2015, when it was rated as Requires Improvement. At this time we found three breaches of Regulation and issued requirement actions. Regulation 12, the provider failed to ensure the safe administration of medicines. Regulation 18, the provider failed to ensure staff had the necessary training and supervision for their role. Regulation 17, the provider had failure to ensure there were effective systems for the governance of the service. The provider sent us an action plan telling us how they would address the breaches and that this would be completed by March 2016. We found this action had been effective in addressing the shortfalls as no breaches of Regulation were found at our inspection on 12 and 13 October 2016.

People felt reassured and safe in their own homes whilst being supported by staff. Staff had received training in how to safeguard people and a system was in place to regularly check they had the knowledge and skills to report any concerns so that people could be kept safe.

Comprehensive checks were carried out on all potential staff at the service, to ensure that they were suitable for their role. People had their needs met by regular staff that were available in sufficient numbers.

Assessments of potential risks had been undertaken in relation to the environment that people lived and worked in and in relation to people's personal care needs. This included potential risks involved in moving and handling people, supporting people with their personal care needs and with eating and drinking. Guidance was in place for staff to follow to make sure that any risks were minimised.

A medicines policy was in place to guide staff. Staff had received training in the administration and storage of medicines and a system was in place to regularly check they had the knowledge and competence to manage people's medicines safely.

New staff received an induction which ensured that they had the skills they required, before they started to support people in their own homes. Staff undertook e-learning training in essential areas and face to face practical training in how to move and handle people safely. People said that staff had the skills and knowledge they needed to support them.

Staff had undertaken training in The Mental Capacity Act (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People's health care and nutrition needs had been comprehensively assessed and clear guidance was in place for staff to follow, to ensure that their specific health care needs were met. Staff were knowledgeable about people's health care needs and liaised with health professionals and family members when appropriate.

People were supported by a member of staff who had been matched as compatible due to shared interests or hobbies. Staff knew people extremely well as they spent their day together and so could quickly respond to any changes in their well-being. People said staff were kind and caring, enabled them to make their own choices and decisions. Staff demonstrated they treated people with the upmost dignity.

People's needs were assessed before they were provided with a service and people and their relatives were fully involved in this process. These assessments were developed in to a personalised plan of care. The care plans gave detailed guidance to staff about how to care for each person's individual needs and routines. Most people had a main live-in member of staff and staff were knowledgeable about people's preferences and preferred routines.

People were informed of their right to raise any concerns about the service and when people had raised issues, the service had resolved them and used them as lessons of learning to improve the service.

There were effective systems in place to assess and monitor the quality of the service. People said that they would recommend the service and that their views were listened to. Staff understood the aims of the service and put them into practice by providing personalised care. Staff had confidence in the management of the service which they said was supportive.

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.

Staff were trained and their competency checked so they knew how to safeguard people and manage their medicines.

Checks were carried out on staff to make sure they were suitable for their role and they were employed in sufficient numbers to meet people's needs.

Risks associated with people's care had been identified and staff followed appropriate guidance to help keep people safe.

Is the service effective?

Good

The service was effective.

People received care and support from staff who were trained and whose competency had been assessed to make sure they had the knowledge and skills for their roles.

Staff were knowledgeable about supporting people with their health and nutritional needs and liaised with relevant professionals.

Staff ensured people had the information they needed to make their own decisions.

Is the service caring?

Good

The service was caring.

Staff were matched with people who had similar interests. Staff knew people's preferences and life histories and engaged people in conversations about things that were important to them.

Staff were kind and caring. People were supported by people who valued their contributions and treated them with dignity and respect at all times.

People were enabled to make daily decisions and choices.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and a detailed plan of care was in place to guide staff in how to care for them in an individual way.

Staff were knowledgeable about people's daily routines and preferences.

People's views about the support they received were regularly sought and people felt confident to raise any concerns with their live-in member of staff.

Is the service well-led?

Good

The service was well-led.

Monitoring systems were in place to assess the quality of service that people received.

People, their relatives and staff were asked for their views about the service and they were acted on.

People benefitted from being cared for by a staff team who felt well supported.

Kent Home Care Limited

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 12 and 13 October and was announced with 48 hours' notice being given. The inspection was carried out by one inspector. On the 12 October we visited people and spoke to them on the phone about their experiences and on 13 October we visited the service's office.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). 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 provider returned the PIR within the set time scale. Before the inspection, we looked at information about the registration of the agency and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

We visited three people and spoke with them and their support member of staff about their package of care. We also telephoned two people and one relative to gain their views about the service. We spoke to the registered manager, the senior manager, care assessment officer and office manager. We also received positive feedback from a health care professional.

During the inspection we viewed a number of records including six care plans and three sets of daily notes; the recruitment records of the five most recent staff employed by the service; the staff training and induction programme; medication and safeguarding policy; service user guide; compliments and complaints logs; staff spot checks and quality assurance questionnaires.

Good

Is the service safe?

Our findings

People said having a member of staff in their home during the day and night time gave them the reassurance they needed to make them feel safe. One person told us, "I am very anxious and worried but having a carer here makes me feel better. I feel safe when they are around as I am worried about falling: And it also means I sleep well at night". A relative told us they did not have any worries or concerns when they left their loved one as they had confidence in the care and support provided by the service. People told us that having a live-in member of staff meant that there was always someone around when they needed them.

At our last inspection in August 2015, staff had received training in how to administer medicines but their competency had not been checked to ensure they knew how to do so safely. At this inspection we found that staff's knowledge in managing medicines was checked as part of their induction. In addition, staff competency, including direct observation of their practice, was undertaken as part of staff spot checks. Staff read the service's medicines policy which had also been summarised into key points so it was easier for staff to understand and refer to. The medicines policy had been reviewed and set out staff and other professionals' roles and responsibilities as well as containing guidance about the storage, administration and disposal of medicines.

Each person's ability to manage their medicines had been assessed and a list of their medicines and what support they required was recorded in their plan of care. This included where their medicines were kept, who was responsible for ordering their medicines and any allergies. A medication administrative record was kept and completed for each person detailing the name, dosage and time each medicine was given and any additional information, such as if a medicine should be taken before with food. There were no gaps in these records indicating that people were given their medicines as prescribed by the doctor.

When people had been prescribed strong pain killers, these were monitored to review their effectiveness. Staff recorded when patches for pain relief were applied to people. Clear guidance was in place indicating that they needed to be rotated on the site of skin to which they are applied. Staff understood this guidance and described how they put it into practice to ensure people's skin integrity. Applications of non-medicated creams such as barrier and moisturising creams contained details of where they should be applied in order for people to maintain healthy skin.

The service had a safeguarding policy which incorporated guidance from the Kent and Medway, local authority adult protection protocols. The policy set out how to recognise abuse, staff's responsibility to report any concerns and the responsibility of the service to contact the local authority and other professionals as appropriate. A summary of the safeguarding policy was contained in the staff handbook, with the contact details of the local authority. Staff had received training in how to safeguard people and their knowledge of how and to whom they should raise a safeguarding concern was assessed at regular staff spot checks. Staff demonstrated they knew people well. They understood the importance of raising any concerns about changes in their mood or behaviour and in maintaining accurate records of the care and support they provided in order to safeguard people.

Risks to people's personal safety and in their home environment were thoroughly assessed before the service commenced. This included all areas of the person's daily needs such as moving and handling, continence, personal hygiene, eating and drinking and medicine administration. Each potential risk was identified together with the appropriate action that staff needed to take to minimise their occurrence. Each activity was rated as high, medium or low and so alerted staff to which could have the greatest impact on people. Detailed moving and handling assessments were in place which recorded if a person was independent or required assistance with all aspects of their mobility such as getting in and out of a chair, standing up and sitting down and walking indoors outdoors. For example, one person was at risk of falling. They walked with a frame to help their balance and a member of staff accompanied them and verbally reminded them of any trip hazards in their home. Another person required specific equipment and two members of staff to assist them and consideration to be given to any pain the person may experience. For people at risk of developing pressure ulcers the specialist equipment they required, including airflow mattresses and cushions had been provided. Staff knew at what pressure this equipment should be set and checks were in place to ensure they provided effective relief.

Staff knew to report any accidents or incidents to a member of the management team. As staff supported people for a consistent period of time they had a good overview of any significant changes such as if a person had had an increased number of falls. In addition, daily notes were reviewed by a member of the office team to identify any patterns or trends. Incidents were used as learning events. For example, when a medication recording error had occurred, a memo had been sent to the whole staff team and the medicines policy updated to ensure staff were aware of the correct guidance.

The serviced used specialist live-in carer recruitment agencies to screen potential staff. Applicants completed an application form and were interviewed either face to face or via the internet, as many applicants did not live in the Kent area. Before staff supported people in their own homes a number of checks were undertaken including two references, checks of the person's identity, their right to work in the UK and a Disclosure and Barring Service (DBS) check. A DBS identifies if prospective staff had a criminal record or were barred from working with children or vulnerable people. All these checks helped to minimise the risk of people unsuitable people being employed by the service.

The service had an on-going recruitment programme in place. The management team kept in close communication with the staff team so that additional staff could be recruited to any vacancies. Staff leave or extended leave was planned in advance and in agreement with the service, so that an alternative member of staff could be provided. Everyone received 24 hour care and most had an assigned live- in staff member who provided their care. Staff had a two hour break each day which was covered by family member or an alternative member of staff. Staffing levels were flexible and took into consideration the people's changing needs. For example, one person had received a 'home from hospital' package whereby two or more staff supported them due to their high needs when leaving hospital. Overtime, the staffing levels had been reduced to one live-in staff as the person had recuperated.

The service could be contacted at any time, seven days a week. Outside office hours the senior manager was available, who was knowledgeable about the care and support needs of each person who used the service. Other members of the management team provided on call support when required.

Good

Is the service effective?

Our findings

People and relatives told us staff had necessary skills to support people so they could remain in their own home. One person told us about their live-in member of staff: "Yes, she defiantly has the skills and temperament to care for me. She is very thoughtful". People also told us that staff provided them with meals they enjoyed eating. "She cooks well and feeds me well", one person told us. A relative told us how staff's skills and attention to detail had been effective in making improvements to their family member's health and well-being. "They had given up and were in a low mood when they came home from hospital. Staff encouraged them to eat and they have put on a stone in weight although they still need motivating to eat. Their skin integrity is now intact due to staff attention. They are now happy and cheerful. The superb care has made a massive difference". A health care professional told us that staff raised relevant concerns about a person's health with them and they listened to and acted on advice they gave them.

A detailed assessment of people's health care needs was undertaken which included their needs in relation to sleeping, breathing, mobility, skin integrity, medicines and their mental well-being. The senior manager was a registered nurse and therefore had a professional knowledge and experience in nursing care. Guidance was in place about how to support people effectively and staff understood how to put this into practice. If people were admitted to hospital, live-in care staff continued to support the person. Staff liaised with health professionals, such as the district nurse and occupation therapists to ensure people had the right equipment to support their health needs. One person was expecting a delivery of new equipment. The staff member said they would be present so the occupational therapist could explain how to use the equipment. Staff gave examples of when they had contacted health care professionals and/or the emergency services to seek further advice or assistance. They had the contact details of the relevant professionals so that swift and appropriate action could be taken. One person, who was responsible for taking their own medicines was not taking a nutritional food supplement they had been prescribed. The service had gained this person's consent to be responsible for administering their medicines and this person was now taking their food supplement to help maintain their health.

People's need in relation to food and fluids were assessed and the support they required was detailed in their plan of care. For people who had difficulties with swallowing, there was specific guidance in place for staff, such as if people needed to be offered regular drinks, their food needed to be mashed or thickeners provided for their drinks, so they were easier to swallow. Staff demonstrated they understood how to follow this guidance and the specific details such as the ratio of thicken to liquid that should be used. A record was made of what the person ate and drank each day including the levels of fluids a person drank to monitor their intake.

At our last inspection in August 2015 staff did not complete a comprehensive induction programme and not all staff had received training in essential areas. At this inspection we found that new staff received on-line training in essential areas including first aid, infection control, safeguarding, fire, medication, food hygiene and health and safety before they supported people. Staff were required to take a test at the end of the training to assess their understanding in each topic. The senior manager was a 'train the trainer' in moving and handling and so was able to provide practical training in this area. The induction also included checking

staff's understanding of the services policies and procedures and commencing the Care Certificate. The Care Certificate includes the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised.

A training matrix was in place which identified when each member of staff had completed essential training and when it was due to be refreshed. Staff also undertook specialist training. Half the staff team had completed training in nutrition and dementia. The senior manager was a Dementia Friends Champion. Dementia Friends Champions are volunteers who complete further training and on-going support to talk to people about improving the quality of life for people living with dementia.

Since the last inspection the agency had made improvements in the number of staff holding a Qualification and Credit Framework (QCF) level two or above in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard. Just under half the staff team had achieved a level 2 or above in this qualification.

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 the best interests and as least restrictive as possible. Staff had received training in mental capacity and their understanding was checked at induction. Staff understood that it should be assumed people had capacity. They said that sometimes people got confused so they explained things to them to ensure the person fully understood the decision they were making. People or their representatives had signed records to show their consent for the care and support people received in line with their care plan. The service knew who had a Lasting Power of Attorney. This is where a person appoints one or more people to help them make decisions on their behalf about their health and welfare and/or finances. Some people had a Do Not Attempt Resuscitation (DNAR) in place. These forms were kept at the front of people's care files so they were easily accessible by medical staff.

At our last inspection staff observations to check their skills and competence once they had undertaken their formal training had not been carried out for a significant period of time. At this inspection, a part-time care assessment officer was employed whose role it was to ensure this was done on a regular basis. This included that staff understood how to follow infection control procedures, what to do if a replacement member of staff did not arrive and what to do in the event of an emergency. Observations of staff practice such as moving and handling, providing support and food preparation were also undertaken.

Staff said they felt well supported by the management team. They said a member of the team visited them regularly to ask how they were and that they could contact a member of the team at any time for advice and support. At our last inspection staff did not receive regular supervision. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Regular supervision of staff was in place which included a discussion about their role, their level of satisfaction and any additional support or training they might need.

Good

Is the service caring?

Our findings

People and relatives told us there were caring relationships between staff and the people. They said these had developed as consideration had been given to the personality and interests of the person and the staff member when matching them. One person told us they shared a joint interest in planes and spitfires with their live-in carer. Another person had been a skilled at sewing and knitting and their live-in carer knitted whilst they watched television together. People spoke positively about the staff member that supported them. One person told us, "She wakes me up cheerfully. She is always cheerful". Another person told us, "All my carers have been nice, reliable and thoughtful". A relative told us, "They matched the carer to get on with Mum. The carer watches TV programmes with her and looks at photo albums. Mum is now cheerful again". A health professional described the relationship between the member of staff and person they were supporting as "Warm, intuitively helpful and cheerful". They added that the live-in carer had developed a good relationship with their family members.

The service had received a number of compliments whose theme was the caring nature of the staff and the personalised support they received. Comments included, "The carer was so conscientious and hard-working and my mother was very happy with her care"; "I can't thank you enough for the amazing care that mum's receiving. Having the same two carers has helped immensely and they are both lovely. I also really appreciate their patience"; and "The carer has been so caring and professional and has supported my relative really well. She has been outstanding and has used her initiative and communicated really well at all times".

Staff knew the people they were caring for, including their preferences, personal histories and individual characteristics. This meant that staff could tell when people were upset, content or in pain by their mannerisms. When the inspector was looking at one person's care records with their consent, the live-in staff observed that the person had become anxious, although they had not vocalised this. The staff member spoke calmly to the person and reassured them that they had no need to worry. Information about people's life history and interests were contained in people's care plan. Staff were knowledgeable about this and so were able to talk to people about their past lives, hobbies and people who were important to them such as friends and family members. Staff explained how they regularly communicated with family members about the well-being of the person and feedback from relatives confirmed that this occurred.

People were treated with dignity and respect and their contributions were valued. When introducing the inspector to a person, the live-in member of staff told us they had celebrated their birthday. The person responded by smiling and they enjoyed talking about this event that had great significance for them. Sometimes when we spoke to people they did not immediately respond. When this occurred staff gave the person time and did not attempt to speak for them. One live-in staff member said the person's name which enabled the person to regain their concentration. Another person looked at their live-in staff member when speaking to us. This member of staff maintained eye contact with the person which gave them the confidence to continue their conversation. During conversations with people and their live-in carer we observed there were relaxed, caring and trusting relationships as both knew each other well.

People said they made all decisions in their daily lives. They said they chose when to get up, go to bed, how to spend their time and what they wanted to eat. "I ask him and he does it", a person told us whilst pointing and smiling at their live-in member of staff. One person told us that when there was a change of staff they were involved in the process. "I have a handover of staff and I say what I want the staff to know, so it works well". Another person told us they wanted to be more independent and do things for themselves such as making meals. They said they had taken the first steps by cutting up vegetables for their evening meal.

People were given information and explanations when required. When people first started to use the service they were given a copy of the Service User Guide which set out the aims and values of the service and people's rights and responsibilities. The document was also available in large print. Staff said they always informed people if there were short periods when they were unavailable so that people did not become anxious. Before accompanying the inspector out of the building, a member of staff explained to the person what they were doing and reassured them they would not be gone for long. A staff member explained how the person they supported sometimes got confused and did not remember if they had eaten. To aid the person, the staff member wrote on a white board what they had eaten and at what times. This information was placed by the person so they could see it and refer to it throughout the day.

Good

Is the service responsive?

Our findings

People told us they did not have any concerns about the service they received. They said if they had, they felt confident that a discussion about the issue with their live-in carer would sort the problem out. People said if they had serious concerns or a complaint, they would speak to a family member who would contact the service on their behalf. People and their relatives were given information about how to make a complaint when they first started to use the service. This set out that a complaint could be made verbally or in writing and would be investigated by a member of the management team. The contact details of relevant organisations were listed for the person to contact if they were not satisfied with how their complaint was dealt.

The care assessor met with people on a regular basis which gave people the opportunity to raise any concerns, worries or complaints they may have about the care provided. Feedback from questionnaires sent to family members and their representatives was that any problems had been sorted out effectively. For example, there had been an isolated incident when one member of staff had been delayed in returning from their break and the main carer had left the person before this member of staff had arrived. The service had taken appropriate action and used this as a learning event to improve the service. A memo had been sent to all staff to remind them of their responsibilities and staff were asked what they would do if a replacement member of staff did not arrive at handover time as part of the staff spot check.

A relative told us that when they contacted the service, the senior manager talked to them about their relatives care needs. The senior manager then met the person and their relative to undertake an assessment of their needs. They said this was in the form of a conversation whereby the manager got to know the person, about their interests and the type of carer they would like. This included whether they wanted a male or female member of staff and any particular requirements. On the first day the service commenced the senior manager, who was known to the person and their relative, introduced them to the assigned member of staff. A review of the placement was carried out after 48 hours and seven days which included feedback from the person and checks to ensure the member of staff was supporting the person according to their individual needs.

A health care professional told us that the live in member of staff engaged the person they supported in conversation and occupations that they were interested in. A detailed plan of care was developed for each person before they were supported by staff. If an emergency placement was required, experienced staff were used to first support the person. Care plans included individual information about people such as who they lived with; people who were important to them; and how they liked to spend their time. This was to make sure that staff knew about people's personal lifestyles and preferences. Care plans included personalised guidance for each aspect of care that people required, such as their mobility, nutrition, communication needs and continence. For a person who required assistance to move from their bed, the plan directed staff to first adjust the bed to the correct working height. It stated that two carers should use the rolling technique to roll the person on one side so that the sling could be placed under them. The hoist should then be positioned close to the bed before it could be used. It advised staff to communicate how the person was being supported at all times and to be vigilant to any pain the person may verbalise or communicate

through their body language or facial expression.
Each person's daily routines were recorded together with the support staff should offer during the day. For example, one person said they would like to go for a daily walk when their needs were assessed. This was written as part of the person's daily routine and they told us that staff supported them to do this.

Staff wrote daily reports about people's well-being, the tasks they had supported them with during the day and how their night had been. A relative told us they read these records as they gave them a good picture of their loved one's day. Most people had a main live-in member of staff and a second staff member who supported them when their main carer was on a break. This ensured that people were provided with consistent care that was responsive to their needs.

Good

Is the service well-led?

Our findings

People and relatives said that the service was well run. People told us that the care assessor and senior manager regularly visited them to check that they were satisfied with the level of care they received. Feedback from relatives was that if they needed to contact a member of the management team, they were quick to respond to their requests. People said they would recommend the service based on the service they or their relative had received. Comments included, "I would recommend the agency at is reliable"; a relative told us, "I would recommend it as I am absolutely delighted. They go above and beyond".

At our last inspection in August 2015 the provider did not have effective systems to monitor and improve the quality of the service. At this inspection we found that there were processes in place so that all aspects of the service were assessed and audited. A care assessor had been employed to ensure people were visited on a regular basis of every four to six weeks. People were asked about their satisfaction with their personal care and support, such as whether their privacy and dignity was maintained and if they felt listened to. They were asked if they would like to add or amend to the service they received and their plan of care updated accordingly. At this visit a selection or records, and equipment and environmental checks were carried out to ensure they were to a satisfactory standard. Staff skills and competencies were assessed at spot checks which included checking their knowledge in key areas, such as safeguarding and what to do in an emergency and observations were made of their practice including preparing food and giving medicines. At each visit, the actions from the last visit were re-visited to ensure they had been met. The registered manager reviewed all documentation to monitor the quality of care provided by the service and to check that any necessary improvements were made.

In addition to gaining the views of people, an annual questionnaire was sent to their relative or representative. The last time these were sent was in May 2016 and the results were positive about the care and support people received. The responses were that people's privacy and dignity was always respected, that people were given choices, listened to and there were good and caring interactions between staff and people. One person commented, "Super service from the live in carer and the boss. Thank you very much for getting us out of an impossible situation".

At our last inspection in August 2015 we found that not all information was up to date. At this inspection we found the registered manager had introduced processes to improve the agency's record keeping. Each policy and procedure was assigned a review date to make sure they were kept up to date. The training matrix had been colour coded so it was clear when staff had received their necessary training and the future date in which it needed to be refreshed. A computer programme had been introduced which aided communication between members of the management team. When a member of the team received information, they were required to record the action they had taken to deal with it appropriately. The information could also be assigned to another member of the team, if their response was required. The members of the management team said they worked well together. They had a clear understanding of their own individual roles and how they related to one another, to benefit the people who used the service.

The registered manager was supported by a senior manager, who was a registered nurse, a care assessor

and an office manager. Staff told us that the service was well led and that they felt well supported by the management team. They said a member of the management team visited them on a regular basis to check on their well-being and that they could ring the office at any time if they required further support. Staff were asked as part of their review, how long they intended to work for the agency and what action the service could take which would encourage them to stay longer. Staff told us that their views had been listened to and improvements made to their role. Some staff told us they had worked for alternative live-in care services but they preferred this service due to the quality of support they were given in their role.

The values of the service were set out in the service user guide, these included promoting people's independence and dignity and delivering exceptional services. Staff clearly understood the aims of the service to enable people to stay in their own homes and to provide care that was personalised and caring. Staff were provided with a staff handbook which contained the agencies policies and procedures, their roles and responsibilities and specific guidance on living in someone else's home as a live in member of staff.