Bespoke Home Care Limited

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Inspection report

Suite 7
Kelvin House, Kelvin Way
Crawley
West Sussex
RH10 9WE

Tel: 01293270466

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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

We inspected Bespoke Home Care on 15 November 2016. It is a domiciliary care service that provides personal care and support services for a range of people living in their own homes. These were predominantly older people and some people were living with dementia. At the time of our inspection, 39 people were receiving a care service.

As part of this inspection, we checked what action had been taken to address the breaches of legal requirements we had identified at our last inspection on 21 October 2015. We found areas of practice that required improvement. There was not a robust quality assurance framework in place and systems were not in place for reviewing, monitoring and assessing the delivery of care and support. We also found employment procedures were not robust. The provider had not always obtained all the information required such as references from previous employers. Therefore, the provider could not be assured these staff were suitable and safe to undertake their role. After our last inspection, the provider wrote to us to say what they would do to meet legal requirements and sent us an action plan detailing how they intended to ensure they met the requirements of the law. We looked at the improvements made as part of this inspection. At this inspection, we found improvements had been made and sustained and all the breaches previously identified were addressed.

The service had a registered manager. 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 felt safe when staff supported them in their own homes. Systems were in place for staff to follow which protected people and kept them safe. People and their relatives told us they felt safe, that staff were kind and the care they received was good. One relative told us, "Yes, we feel safe with them in the house I can just leave them with him. I trust them and have no concerns."

There were systems and processes in place to keep people safe. Assessments of risk had been undertaken and there were clear instructions for staff on what action to take in order to mitigate them. Staff knew how to recognise the potential signs of abuse and what action to take to keep people safe. The provider made sure there was enough staff at all times to meet people's needs.

People were supported by staff that were familiar to them for the most part. One person told us, "We do have different carers and they are very nice and polite and if there is a new one they are introduced to us," Care calls were monitored by the office team to make sure staff arrived on time and stayed for the agreed amount of time. Checks were completed on potential new staff before they started work to make sure they were suitable to support people living in their own homes.

Staff had the skills and knowledge to understand and support people's individual needs. These skills were

kept up to date through regular training and staff were also supported in their roles by managers and colleagues.

Staff considered people's capacity using the Mental Capacity Act 2005 (MCA) as guidance. Staff asked people's permission before they helped them with any care or support. People's right to make their own decisions about their own care was supported by staff. One relative said, "They encourage [named person] to use the walking frame which she likes to do if she can." People were supported by staff who knew them well and were caring in their approach. A member told us, "We give plenty of time for those needing a lot of care; an hour or more sometimes and if we think someone needs more time because they are unwell, the office do listen." Staff made sure people were involved in their own care and listened to what people and their relatives had to say.

People and their relatives had opportunities to give their opinions on the service that was provided and about the staff that supported them. People and relatives knew how to complain and were confident that the registered manager would listen to their concerns. People and their relatives had regular contact with the service's office staff and found them approachable, polite and helpful. One person said, "I've met [named manager] several times and they are very approachable. Sometimes it can be difficult to get through to them at the busy times but if I leave a message they do get back to me."

Staff felt supported within their role and described an 'open door' management approach. The management team were always available to discuss suggestions and address problems or concerns. A staff member said, "It feels like a family atmosphere. Everybody gets on really well. I think that comes through in the care we give."

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 told us they felt safe receiving care in their own home.

There were processes in place to ensure people were protected from the risk of abuse. Staff were aware of safeguarding procedures.

Environmental and individual risk assessments were up to date to reduce and manage risks to people.

There were enough care staff deployed to meet people's needs safely.

Safe recruitment practices were in place.

People were supported to receive their medicines safely.

Is the service effective?

Good

The service was effective.

Staff understood and acted in line with the principles of the Mental Capacity Act 2005.

Staff received an induction and regular training to undertake their roles and responsibilities.

People were supported at mealtimes to access food and drink of their choice in their home.

People were assisted to access healthcare services.

Is the service caring?

Good

The service was caring.

People were cared for by kind and friendly staff.

People's preferences and decisions regarding their care were respected.

People were supported to express their views.

Is the service responsive?

Good

The service was responsive.

Care plans were centred on the person. They provided comprehensive information about people's care needs and how people wanted to be supported.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident that complaints would be listened to and acted on.

Is the service well-led?

Good

The service was well-led.

There was open communication within the staff team and staff told us the management team listened to them.

People and relatives told us the management team were approachable and supportive.

There were regular audits to monitor the quality of the service and drive improvements.

Bespoke Home Care Ltd

Detailed findings

Background to this inspection

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

We previously carried out a comprehensive inspection at Bespoke Home Care on 21 October 2015. At that inspection, we identified areas of practice that needed improvement in relation to systems in place for reviewing, monitoring and assessing the delivery of care and employment procedures for new staff. The service received an overall rating of 'requires improvement' from the comprehensive inspection on 21 October 2015. This inspection took place on the 15 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We wanted to be sure that someone would be in the office to speak with us. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events that the service is required to send us by law. We used this information to decide which areas to focus on during our inspection. A Provider Information Return (PIR) was not requested prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During our inspection, we conducted telephone interviews with four people who use the service and six relatives. We spoke with five care staff, a care co-ordinator, the office manager, registered manager and provider. We observed staff working in the office as they dealt with issues and spoke with people and staff over the telephone.

We reviewed a range of records about people's care and how the service was managed. These included the care and medicine administration (MAR) records for four people. We looked at four staff training, support

and employment records. We examined records relating to the management of the service including quality assurance audits, survey feedback and incident reports.

We contacted six health and social care professionals after the inspection to gain their views of the service.

Good

Is the service safe?

Our findings

Previously, we found the provider had not made suitable arrangements to obtain all the information they are required to hold about staff before they were deployed to work at the service. Therefore, they could not be assured these staff were suitable and safe to undertake their role. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had followed their action plan, this breach had been addressed and the improvements had been sustained.

At our last inspection we found pre-employment checks had not always been completed. At this inspection, we found the provider had taken action to ensure that, as far as possible, staff were suitable and safe to work for Bespoke Home Care. This was because the provider obtained references in relation to the character of all staff. Where staff had previously worked in care, this included a reference as to their conduct whilst working for that employer.

People and their relatives told us that they felt safe. One person told us, "I do feel safe because I have got to know them". A relative told us, "Yes, we feel safe with them in the house I can just leave them with him. I trust them and have no concerns."

People were protected from the risk of abuse because staff understood how to identify and report safeguarding concerns. Staff had access to guidance to help them identify abuse and respond in line with the policy and procedures. All of the staff members told us they had undertaken adult safeguarding training within the last year. All were able to identify the correct safeguarding procedures should they suspect abuse. Staff described in detail the sequence of actions they would follow if they suspected abuse was taking place and said they would have no hesitation in reporting abuse. One staff member told us, "I think the safeguarding training was good as it refreshed what I need to know." Another staff member said, "It has helped me to recognise things. I have had to deal with a situation where relatives were acting abusively. I spoke to the manager and they referred it to safeguarding." Staff voiced confidence that the management team would act on their concerns. They confirmed the manager operated an 'open door' policy and they felt able to share any concerns they may have.

There were sufficient number of skilled and experienced staff to ensure people were safe and cared for on visits. Rotas for care staff were planned and written until the end of January 2017 to achieve consistency of calls. People and relatives were mostly happy with the consistency of staff to call on them, though one person told us they were not informed in advance of changes of staff so they did not always know who would be coming and at what time, they told us "We don't have a rota so we don't know who is coming". However, the following experience was more representative, "We do have different carers and they are very nice and polite and if there is a new one they are introduced to us," and "We get regular carers and we like the routine so we know them." The number of people using the service and their needs determined staffing levels. Staffing levels were adjusted according to the needs of people. For example, the number of staff supporting a person could be increased from a single to double call, if required. Double calls are when two members of staff attend a person. The provider reviewed staff numbers and recruited staff in response to

future need to ensure all visits were covered.

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for four staff members. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including character references, interview notes and copies of identification documents, such as passports, in staff files. Up to date documentation for staff required to use their cars for work purposes was also present, including copies of drivers' licences, motor insurance and MOT certificates.

Regular, unannounced 'spot checks' were carried out by managers on staff visiting people in their homes. These included checks on such areas as staff attitudes, knowledge of the people they were caring for and awareness of policies and procedures. All of the staff we spoke with confirmed spot checks were regularly carried out.

We asked staff about the amount of time they had to spend with individuals at each visit. One staff member said, "I don't feel rushed. Some days are busier than others but it's okay." Another staff member told us, "I do have a bit of an issue with travel time. Sometimes I get out of a visit and I'm due at the other end of the patch. It all works out though; I try not to arrive late to calls." A third staff member said, "I give people as long as they need .If I'm running fifteen minutes or more late, I ring the next person and let them know". A fourth staff member told us, "We give plenty of time for those needing a lot of care; an hour or more sometimes and if we think someone needs more time because they are unwell, the office do listen." The provider confirmed that before people started to receive care calls they were informed that fifteen minutes leeway time was factored into scheduled call times to allow for extra travelling time or unexpected issues at the staff members previous call.

Risk assessments detailed and identified hazards and how to reduce or eliminate risk. For example, a home risk assessment included an analysis of the condition of flooring, carpets, or rugs and considered whether they presented a risk of trip, slip or fall for either the person or the staff member. Other potential risks included the equipment people used and how staff could ensure they were used correctly. For example, one care plan described how a person used a walking aid around their home, what staff needed to be aware of and the safest way to assist the person around their home. This meant that risks to individuals were identified and managed so staff could provide care in a safe environment. Staff told us that they talked through the risks with the person to ensure that they were happy with any suggested changes that would reduce the risk.

Staff were aware of the appropriate action to take following accidents and incidents to ensure people's safety and this was recorded in the accident and incident records. There were processes in place to enable the management team to monitor accidents, incidents or near misses. This helped ensure that any themes or trends could be identified and investigated further. It also meant that any potential learning from such incidents could be identified and cascaded to the staff team, resulting in continual improvements in safety.

People confirmed care staff supported them to take their medicines, applying creams or patches. One person told us, "I used to be a nurse so I know what needs doing and I have no concerns." Staff demonstrated appropriate knowledge of safe medicine administration. People's individual care plans included information on whether support was required with medicine management. For example, plans noted when the person self-medicated or a family member provided assistance. Medication management included individual risk assessments and guidance on the risks associated with the safe administration of

medicines. For example, the assessment recorded when people or their representatives were able to order, collect and dispose of medicines safely. Staff and the management team were also able to tell us this information.

Good

Is the service effective?

Our findings

People and their relatives felt confident in the skills of the care staff, they commented that care staff, "Are trained, they can use the hoist and do everything we need and ask of them." One relative told us, "They are definitely trained 100% and the new ones shadow the experienced carers who show them what needs doing and how to do it."

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Training records demonstrated that care staff had received essential training on the Act. Care staff understood the importance of gaining consent from people and records demonstrated that training on the MCA 2005 was in place. A member of staff told us, "I think it's about keeping people safe but also letting them live their lives. We're only seeing them for a few hours a week." People and their relatives confirmed that they were always asked for their consent. One person said, "They are very pleasant and helpful and always ask what he wants and he tells them." Consideration was given to whether the individual lacked capacity and required someone to make a decision or sign the consent form on their behalf.

Staff had an induction when they started work and were subject to a probation period. New staff shadowed experienced colleagues until it was judged they were competent to work alone. We spoke with staff about their experiences of induction. One staff member told us, "It was brilliant. I never felt left alone and I shadowed staff until I felt comfortable". Another staff member told us, "The induction was really good. There was a lot of training. I had heard it was good like that before I came to work here."

We spoke with staff about the training offered by the provider. All care staff undertook training that led to the award of the Skills for Life Care Certificate. This familiarised staff with an identified set of standards that health and social care staff follow in their daily working life. One staff member said, "There is training which we do regularly. If you need it, you can do it." Another staff member told us, "I know the office are always looking at new ways to improve the training." We examined the training record for this year and compared these with staff files. Staff were able to access training in subjects relevant to the care needs of the people they were supporting, provided 'in-house' by senior staff. The provider had made training and updates essential for all staff in areas that included; infection control, moving and handling people, safeguarding vulnerable adults, and medicines management. Other training undertaken by staff included; dementia awareness, dementia and mental health, domiciliary duties and working in a person centred way.

Staff were given opportunities to learn and develop and it was acknowledged that this improved the quality and delivery of care and outcomes for people. Formal systems for development included one to one supervisions with members of the management team. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have. Staff confirmed they

had scheduled supervision meetings with the registered manger where they could sit down in private and have a one to one discussion. They told us they had an annual appraisal of their performance and confirmed they felt supported in their role. One staff member said, "We have one to ones. They're very good and the management is very supportive." Another staff member told us, "I come to the office and yes, it's good. I can say what I like and I do." Staff were observed undertaking specific care tasks to ensure that their practice was competent and met the needs of the person supported. Observations enabled the provider to monitor staff performance against areas such as punctuality, their professional and personal presentation.

People were supported to eat and drink and maintain a healthy diet. People were supported at mealtimes to access food and drink of their choice. Care plans included information on people's dietary likes and dislikes and staff told us how they supported people to make their own decisions on what they wished to eat. This was borne out in the comments of people and their relatives, one person told us, "They do it just as I want it. They make my breakfast and do me a sandwich for lunch and they leave me a flask of tea and some juice for the day so I get plenty to eat and drink."

Care plans documented that people's health care needs were being met. The provider involved a wide range of external health and social care professionals in the care of people. These included social workers, GP's and nurses based in the community. Advice and guidance given by these professionals was followed and documented. Care was provided to people who had a range of medical needs and frailties associated with old age. Some people used specialist moving and handling equipment and input and guidance was sought from the occupational therapist (OT) and physiotherapist services to accommodate the needs of people. People and their relatives told how care staff helped to ensure their health and care needs were met. One relative told us, "They will ask [my relative] if they want help with dressing and they have Crohns disease so they will help with cream if they have a tummy upset."

Good

Is the service caring?

Our findings

People's experiences of care were positive. People and their relatives said they were consistently looked after by staff that were caring and compassionate. A person told us, "They are very good they have a laugh and a joke and they really look after me." One relative told us, "They are very kind and caring and when they help, both the men and women know how to treat [my relative] properly."

People and their relatives told us that staff were thoughtful towards their needs and displayed compassion. They ensured that people's needs were met. For example, we spoke with one person who told us, "I have had lots of surgery and my lower body is a mess but I am not self-conscious with them because they are so brilliant and nice with me." People and relatives told us how care staff 'went above and beyond.'

People and their relatives cherished their relationships with staff who made them feel valued. Staff also told us they had formed good relationships with people and had become skilled in recognising when people were not their usual selves. Some people risked experiencing social isolation and this was recognised by staff and addressed where it could be. A person who had limited opportunities to leave their home told us, "My carers make me laugh and brings the outside world in." Another person told us, "We have banter. The carers are brilliant and I have a good relationship with them."

People and their relatives told us they were involved in deciding how care was delivered and were able to give their views on an on-going basis. A relative told us, "They are most kind towards [my relative] and they ask her what she wants and ask me if they can do anymore to help." Care plans were reviewed on a regular basis after the package of care started and changes were updated in the individuals care plan. For example, following one review, a care plan was updated to reflect changes in a person's mobility needs. One person told us, "[Two named care supervisors] have reviewed the care plan and they also do some of the work so they can check on me whilst they are doing the job." Care staff enabled people to be as independent as possible. One relative said, "They encourage [named person] to use the walking frame which she likes to do if she can." Another person said, "I am fiercely independent and anything I can do I like to do myself." We asked staff how they ensured they delivered a caring service while promoting a persons continued independence. A staff member said, "I think it starts with the assessment process at the beginning. We get to find out about people's needs and go from there". The care plans we looked at contained a high degree of detail concerning people's likes and dislikes and the way they preferred to receive care. For example, one person preferred to use a particular bowl for breakfast and would not eat until staff had left, having completed their tasks in a way stipulated by the person. This was documented clearly and concisely in the care plans and followed by staff. One staff member told us, "We're in people's homes so we always have to have that in mind."

People received care that respected their rights and dignity. Staff enabled them to have choice and control whilst promoting their independence. One person told us, "They are friendly, respectful and not rude. I have no issues at all with the carers. I am pleased they help me out." People, staff and the provider all described how consistency and regularity of carers was key to achieving and maintaining respectful relationships. One person said, "Most of them know the routine so they don't need to ask me much but some of the new ones

will ask me questions." Care staff understood how to uphold people's dignity within their own home and could demonstrate these values in their practice. One member of staff told us, "We provide personal care to some people and to some it's important that they like to do as much as they can themselves. I respect that, I give them some privacy and I like people to be independent."

People's confidentiality was respected. Staff had a good understanding of the need to ensure people's confidentiality was maintained. Staff understood not to talk about people outside of their own home or to discuss other people whilst providing care to one person. Issues of confidentiality were covered during staff induction and the provider had a confidentiality policy which was made available to staff. People's and staff records were stored securely within the location office.

Good

Is the service responsive?

Our findings

Staff were knowledgeable about people and responsive to their needs. People and their relatives told us staff were responsive to their needs. One relative said, "The [named manager] comes out to check everything is alright and make sure we have what we need." Another relative told us, "I have no problem with the carers, they don't rush and they are very nice."

People were valued as individuals and their needs were central to the delivery of care. Each person's needs were assessed before they received a service. People's initial assessments and risk assessments were used as the basis for detailed care and support plans. Care plans took as their starting point how the person wanted and needed to be supported. Plans provided comprehensive, detailed information about people, their personal history and individual preferences. Care plans covered areas such as, mobility, continence, eating and drinking, communication, bathing and personal care. Care plans also provided staff with information about the level of support and tasks required at each care call. People had combinations of call times and duration according to need and the care plan provided an outline of the tasks required at each call. For example, a morning call may consist of help with personal care and support with breakfast while later calls may require other intimate personal care or support around the home. Staff told us they found the care plans helpful, informative, and enabled care to be given that was safe, effective and responsive. They told us they had read people's daily records and signed entries at the conclusion of their visit. We examined people's daily records and they were legible, relevant and up to date.

Personalised care planning is an approach aimed at enabling people to influence their own care plans and to get the services that they need. Bespoke Homecare care plans considered the person's past, their wishes and what was important for them when they received care. For example, we heard of one care plan for a person that contained details of a lullaby song that was played as they received their bedtime call. One relative told us, "The senior carers review the care plan, I know it's a lot of paperwork but I get everything I need." We asked staff about person centred care. One staff member told us, "It's about caring for people, as people. Everything should revolve around them." Another staff member told us, "We are guests in people's homes. It's up to us to learn how they want to be cared for."

The delivery of care was personal to each person and responsive to their changing needs. We noted the provider and staff displayed a flexibility and willingness to adapt care calls in order to care for people safely and effectively. Staff told us how they were able to remain at a care call if they had concerns over a person's health presentation. For example, one staff member told us, "If I'm running late and I'm stuck somewhere, I can ring the office and ask someone to cover my next call. That way, I am meeting the client's needs and it means the next client is not hanging around waiting for us". Care staff confirmed they felt they had generally sufficient time at care calls to provide personalised care. A staff member said, "I give people as long as they need .If I'm running fifteen minutes or more late, I ring the next person and let them know." A fourth staff member told us, "I don't like the fifteen minute calls we do. We're not giving personal care or anything, it's usually just to support someone but you never know what you will find. We give plenty of time for those needing a lot of care though, an hour or more sometimes and if we think someone needs more time because they are unwell, the office do listen."

People were informed about methods to contact the office if they had concerns and the service was responsive to these requests. For example, people told us, "I've rung up to complain about timings of calls but they say it's because people were off sick or they've got held up at other jobs," and another person said, "I once complained about an invoice but it did get sorted out." People told us about their experience of staff cover and the rota that told them who was visiting on a call. Rotas were provided so people knew who was attending each call although two people said they had not received a rota. One person told us, "I can't complain we are very grateful but I would like a rota to know who is coming." We spoke with the staff about the rotas. They told us the management tried to ensure they had sufficient time to travel in between calls by keeping their care rounds consistent and based, as far as practical, in the same locality. Staff were able to feedback on the travel times they required between calls. Feedback from people indicated that calls were on time, within reason, and that in the main, communication was good if there were to be delays.

Information on how to make a complaint was provided to people when they first started receiving care and people confirmed they felt any complaint would be dealt with and acted upon. The complaints policy was also accessible to people within their homes, as a copy was available in their care plan. The policy set out the timescales that the organisation would respond, as well as contact details for outside agencies that people could contact if they were unhappy with the response. The information provided to people encouraged them to raise any concerns that they may have. Feedback from satisfaction surveys demonstrated that people felt confident in raising concerns or any complaints. The provider noted compliments as well as complaints, we saw that the relative of a person phoned the provider to request a change of carer as the member of staff physically reminded them of a person from their past, 40 years earlier. The provider said, "We are small enough and flexible enough, so that after only two care calls we can accommodate the request."

Good

Is the service well-led?

Our findings

At our last inspection, there were no records to show that audits of MAR charts had been completed. MAR charts are the formal record of administration of medicine. Therefore, the provider did not have an overview of errors in the recording of medicines and opportunities for corrective action to be taken were missed. Care plans were checked each month to ensure they were up to date but these checks had not always identified shortfalls. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had followed their action plan, this breach had been addressed and the improvements had been sustained.

People and their relatives we spoke with thought the service was well-led. They told us, "I've met [named manager] several times and they are very approachable. Sometimes it can be difficult to get through to them at the busy times but if I leave a message they do get back to me." One staff member said, "I think this is well led. The manager is good." They will always listen." Another said, "Someone from the office is always available when we are out and about."

A quality framework ensured the provider identified how they could continuously improve the running of the service. The development of the quality assurance framework directly fed into the running of Bespoke Homecare. There was an electronic system in place to monitor and identify whether people received their support on time and for the agreed time. The records we looked at confirmed found staff recorded the time they arrived, left the care call, and remained for the allocated time. The management team audited the electronic records to ensure people received their allocated calls. The provider said, "The monitoring system for late calls allows us to work through call times by looking at what time staff checked in and left. It allows us to run off reports and check that people are receiving their calls as scheduled."

There was a mechanism in place to continually audit care plans. We found care plans contained the information required to deliver care and support. For example, for those people at risk of having trouble with hydration or adequate nutrition there was risk assessment in place. Care plans considered the diet and people received input from health and social care professionals in this area. This information was recorded in the individual's care plan and care staff were aware of people's needs.

The registered manager and provider were approachable and supportive and took an active role in the day-to-day running of the service. Staff appeared comfortable and relaxed talking with them in the office. While we were on the inspection we observed positive interactions and conversations were being held with staff and people in the office and on the telephone. Management took time to listen and provide support where needed. Care staff felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns. One staff member said, "I get good support. I can ring the office whenever I need to if I need any help."

Staff understood their roles and responsibilities within the service. They said that communication was good and information was available by telephone and in person. This helped them to keep up date on what was happening within the service or if there were any changes and developments. Efficient communication

meant that issues highlighted by staff were quickly picked up and dealt with by staff in the office. For example, a staff member had talked with office staff to discuss the admission of a person they were supporting into hospital. Staff received spot checks on the way that they completed home visits and were 'signed off' as competent to deliver care. There were periodic checks on the daily records that staff completed about the care they delivered. This ensured they were accurate, clear and appropriate so that shortfalls in expected standards were identified and addressed.

Staff told us about the support they received from the management team. They told us the team was always available and helpful. Staff said that they received good on-going support. One staff member told us, "We work well as a team. You can always get hold of someone and there is a nice atmosphere in the office". Another staff member said, "It feels like a family atmosphere. Everybody gets on really well. I think that comes through in the care we give." Staff were supported when working on their own, particularly during the dark hours. This was included as part of the environmental risk assessments of people's homes.

Systems were in place to obtain feedback from people and their relatives that was used to help drive improvements. Satisfaction surveys were one method used to gain feedback. Feedback from the survey recorded that there were positive comments around the management of the service and people felt staff were kind and caring. Where shortfalls were identified, a service improvement plan was implemented. A person told us, "I have had a survey and I mentioned the timing. [Named manager] is nice and approachable and has been out to the flat to see us."

There was a system in place for reporting accidents and incidents to the provider. Staff logged any accidents or incidents and the registered manager monitored these to identify any patterns or trends. Action was taken to minimise the risks involved or to prevent future occurrences. The management team held management meetings where all complaints, accidents, incidents and risks to people were monitored and discussed. Minutes of these meetings identified actions taken. Systems were in place for the provider to keep up to date with changes in policy and legislation. The provider had taken an active role in a local safeguarding reference group that ensured the service had access to the latest safeguarding guidance from the local authority. This information was shared with staff.

Staff told us they had regular meetings in the service that gave them a chance to share information and discuss any difficulties they may have. Minutes of the meetings were available to staff who were unable to attend. Subjects discussed included people's support and care, new staff and training sessions available. The provider had worked to develop a newsletter that informed people of what was happening in the service. This included the celebrating of staff achievements and future plans.

The registered persons were aware of their responsibility to comply with the CQC registration requirements. They were aware of the importance of notifying us of certain events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions were being taken. They were aware of the requirements following the implementation of the Care Act 2014, such as the requirements under the duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.