Coastal Homecare (Hove) 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

We inspected this service on 17 February 2016 and the inspection was announced. This was to make sure there would be someone available in the office to facilitate our inspection.

Coastal Homecare (Hove) Limited is a domiciliary care service that provides personal care and support services for people living in their own homes. These included older people, people living with dementia and people with a physical disability. At the time of our inspection 116 people were receiving a personal care service.

The service had a registered manager. 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

People were supported by kind, caring staff who knew them well. Staff had a good understanding of people's care needs. Staff received the training and support they needed to undertake their role and were skilled in caring for people to maintain their independence. Risks to people were identified and managed in the least restrictive way and people's independence was promoted. One person told us, "I'm arthritic but I like to get myself dressed as much as possible, it's only the fastenings I need help with. I like to do as much as I can myself."

There were systems and processes in place to keep people safe. Assessments of risk had been undertaken. One person said, "Oh yes, very safe and absolutely no concerns about my things. I'm happy for them to let themselves in with the key safe. I'm happy about that." The provider had arrangements in place for the safe administration of medicines. People were supported to receive their medicine when they needed it. People were supported to maintain good health and had assistance to access to health care services when needed. A person told us, "I was having problems breathing so my carer rang my care link and advised to ring for an ambulance and then she stayed with me until the ambulance came. Wasn't that wonderful that I wasn't left alone?" The service followed safe recruitment practices.

People's needs had been assessed and planned for with the person. Plans took into account people's preferences, likes and dislikes and were reviewed on a regular basis. Staff worked in accordance with the Mental Capacity Act (MCA) and associated legislation. Staff observed the key principles in their day to day work checking with people that they were happy for them to undertake care tasks before they proceeded. People were supported to make their own decisions. One person told us "I recently asked for them to give me another call so someone could take me to the bank and help me with my shopping and it's all sorted I only had to mention it."

People confirmed staff respected their privacy and dignity. Staff understood the special responsibility of caring for people within their own home and providing them with choice and control. A member of staff told

us, "We are visiting people in their own homes and we need to be aware of that. I think it's about respecting their right to live as they want".

People and staff spoke highly of the management. One person told us "[Named provider], the main chap, is ever so good, they all are." A member of staff told us, "The management are good and supportive and have time if you need to speak with them about anything." The management of the service was open and transparent and a culture of continuous learning and improvement was promoted. The provider had ensured there were robust processes in place for auditing and monitoring the quality of the service. Feedback was sought by the provider through the use of questionnaires that were sent to people, their relatives and staff. Survey results were positive. People and relatives we spoke with were aware of how to make a complaint and the provider responded to complaints in a timely manner with details of any action taken.

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

Coastal Homecare (Hove) Limited was safe.

Staff were trained to recognise abuse and knew what action to take if they suspected abuse had taken place.

Risks were assessed and there were robust plans in place to protect people, while promoting their independence and choice. We saw that appropriate action was taken in response to incidents to maintain the safety of people.

Safe recruitment practices were in place and there were enough staff deployed to meet people's needs safely.

People were supported to receive their medicines safely.

Is the service effective?

Good

Coastal Homecare (Hove) Limited was effective.

People were cared for by staff who had the skills and experience needed to meet their needs.

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

Staff understood the requirements of the Mental Capacity Act 2005 and put this into practice when gaining people's consent.

People's health care needs were monitored and they had access to a range of healthcare professionals.

Is the service caring?

Good

Coastal Homecare (Hove) Limited 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

Coastal Homecare (Hove) Limited was responsive.

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

People knew how to make a complaint and complaints were dealt with in line with the provider's policy.

Is the service well-led?

Good

Coastal Homecare (Hove) Limited was well led.

People and staff we spoke with felt the provider was approachable and helpful.

The management team looked for ways to drive improvement in the service by seeking feedback.

The provider had systems in place to monitor the quality of the service and identify shortfalls in service provision.

Coastal Homecare (Hove) 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.

The inspection was undertaken on 17 February 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 with experience in adult social care. 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 about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also asked for feedback from professionals involved in delivering people's care.

The provider had completed 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.

During our inspection we spoke with eight people and a relative of a person, three care staff, workforce supervisor, care coordinator, urgent homecare manager, registered manager and the provider. We observed staff working in the office dealing with issues and speaking with people who used the service over the telephone.

We reviewed a range of records about people's care and how the service was managed. These included the care records for four people, staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe using the service. They said they felt safe with the carers that came to visit them, that they were honest, trustworthy and respectful of being in someone's home. One person said, "Oh yes, very safe and absolutely no concerns about my things. I'm happy for them to let themselves in with the key safe. I'm happy about that." Another person told us, "I was having problems breathing so my carer rang my care link and advised to ring for an ambulance and then she stayed with me until the ambulance came. Wasn't that wonderful that I wasn't left alone?"

Staff demonstrated a clear understanding of the types of abuse that could occur, the signs they would look for and what they would do if they thought someone was at risk of abuse. They gave us examples of poor or abusive care to look out for and were able to talk about the steps they would take to respond to it. Staff training records and staff themselves confirmed they had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. Staff were also aware of the whistle blowing policy and when to take concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. One staff member told us, "I would let my manager know if I suspected abuse. I know they would deal with it but if not, I would come to you [Care Quality Commission]". Another staff member said, "We get training in this so we are aware of what we need to do". Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns in confidence. The contact details for people to report concerns externally were made available to staff and displayed in the office. The registered manager told us there were opportunities for staff to discuss any concerns at meetings or on a one to one basis. Policies and procedures on safeguarding were available for staff to refer to if needed.

We saw the service had skilled and experienced staff to ensure people were safe and cared for on visits. We looked at the staff rotas and saw there were sufficient numbers of staff employed to ensure visits were covered and to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased if required. We noted that the recruitment of staff was ongoing and that they had recently employed extra care staff who were undertaking their induction and training period.

Recruitment procedures were in place to ensure that only suitable staff were employed. Records showed staff had completed an application form and interview and the provider had obtained written references from previous employers. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff.

Individual risk assessments were reviewed and updated to provide guidance and support for staff to provide safe care in people's homes. Risk assessments identified the level of risks and the measures taken to minimise risk. These covered a range of possible risks such as nutrition, skin integrity, falls and mobility. For example, where there was a risk to a person regarding falling in their own home, clear measures were in place to ensure risks were minimalised. These included for staff to ensure clear pathways around the home.

In one care plan it detailed the risk of a person choking. It detailed staff to ensure the person was given enough time to chew and swallow when supporting them and to ensure the person had a straw with all their drinks. Staff could tell us the measures required to maintain safety for people in their homes. One member of staff described a situation when a person they were supporting had a fall. They showed good knowledge on how to manage the incident safely and told us how they dealt with the emergency services, informing the office and the person's family.

Staff were asked about the amount of time they had to spend with individuals at each visit. One staff member said, "Yes, it's fine. I have my own group of people that I visit and I manage in the time given. I don't feel rushed." Another staff member told us, "I used to work for another care agency which was nowhere near as good. This is much better and I have much more time." A third staff member said, "We can sometimes find that the fifteen minute appointments are a problem as they can run over. It's enough time to do what we need to do normally, like prompting medicines but you never know what you'll find when you get there. It doesn't happen very often though".

People were supported to receive their medicines safely. We saw policies and procedures had been drawn up by the provider to ensure medicines was managed and administered safely. Staff were able to describe how they completed the medication administration records in people's homes and the process they would undertake. Staff received a medicines competency assessment on a regular basis. We looked at completed assessments which were found to be comprehensive to ensure staff were safely administering or prompting medicines. Any errors or concerns were investigated and discussed with the member of staff.

We examined the provider's incident and accident records. We noted there had been seven accidents or incidents involving people or staff in the previous twelve months. We looked at the most recent records and noted action was taken to minimise the chance of a re-occurrence. For example, we noted one person presented with behaviour that may challenge the service. The provider had undertaken a risk assessment of the dangers posed to staff and the person and put in place measures to minimise the risk. The manager reviewed the incident or accident in a timely manner and outcomes were shared for further learning.

All accident and incident records contained a clear description of the event and indicated whether it should be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1995). These regulations state that employers and those in control of premises are required by law to report specified workplace incidents, such as work-related deaths, major injuries, seven day injuries, that is those causing more than seven day's inability to carry out normal duties, work related diseases and near miss accidents.

Good

Is the service effective?

Our findings

People and relatives said staff were skilled to meet the needs of people and spoke positively about the care and support they received. One person told us, "They're excellent. They always do a good proper job for me here". Another person told us, "This is how it works, you tell them what you want, they provide a care plan together with you and then they provide it to a high standard."

People were supported by staff who had the knowledge and skills required to meet their needs. Training and updates were mandatory for all staff in infection control, health and safety, moving and handling people, fire awareness, safeguarding, first aid, food hygiene and the management of medicine. Other training undertaken by staff included the care of people with dementia, The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. A training plan documented when training had been completed and when it would expire. We spoke with the provider about staff training and they told us about the value they placed in having a trained and skilled workforce. For example, the Skills for Life Care Certificate training was rolled out so that it was undertaken by all care staff. The certificate set the standard for health and adult social care staff to adhere to in their daily working life. The provider gave regular one-to-one support to staff in order to ensure its completion. We heard about future plans that included the provision of nutrition training to be undertaken at a local college and the employment of a staff trainer.

People were cared for by skilled staff trained to meet their care needs and were subject to regular, unannounced spot checks during the course of their duties. New staff received four spot checks in their first month of employment. This ensured that the quality of care delivered was in line with best practice and reflected the person's care plan. Staff were questioned on their level of knowledge of the people they were caring for and the rationale for the care they were providing. Staff were assessed on manual handling and medicines management. They were given feedback concerning their performance. This helped staff to discuss any concerns or ideas. Staff told us they found these were useful.

Staff received supervision every three months and new staff received it twice in the first three months. Staff had a planned annual appraisal. These meetings gave them an opportunity to discuss how they felt they were getting on and identified any development needs. Staff had contact regularly with the registered manager and supervisors, via a phone call or by visiting the office. This ensured staff received support and guidance about their work and discussed training and development needs. The staff we spoke with confirmed this. One staff member told us, "I can say what I want in supervision. Everybody is really friendly". Another staff member told us, "If I have a problem, I know I can speak to the manager at any time but the supervisions are good".

We were told the provider organised regular staff meetings every three months. We examined the minutes from last meeting. We noted that staff were able to contribute to the meeting and to make suggestions of importance to them and the people they were caring for. We were told by the provider that staff were required to attend a minimum of three out of every four meetings. The minutes did not contain a review of the minutes of the previous meeting and did not contain a plan to decide and follow through on actions that arose from the discussion.

People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments so staff knew the level of support they may need to make decisions for themselves. Where it was appropriate, if people did not have the capacity to make specific decisions around their care, the provider involved their family or other healthcare professionals as required to make a decision in their best interest as required by the MCA. Best interest meetings considered both the current and future interests of the person who lacked capacity and decided the course of action will best met their needs and kept them safe. Staff told us how people chose how they would like to be cared for. For example, they always asked permission before starting a task and sought to gain consent and gave choices to people. One member of staff told us, "You have to respect people's choices and gain their consent before starting any care for them". As a reminder for staff, displayed in the training room at the office were key details, hints and tips around the MCA. Staff fed back that the guidelines were useful and proved a reference point for them around the issue.

We asked staff about issues of consent and about their understanding of the Mental Capacity Act (MCA) (2005). We also looked at the staff training record in this area. All of the staff we spoke with had undertaken recent training in this area and were able to tell us about their understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff could tell us the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. DoLS is part of the Mental Capacity Act. The purpose of DoLS is to ensure that someone is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by key people, including, where appropriate, families and professionals, and there is no other way to safely care for them. One staff member told us, "I think it's (the MCA) about letting people take risks if they understand them. They're in their own homes and they will anyway." Another staff member told us, "We have to try to keep people safe and we work with others if they can't make decisions for themselves".

People were supported at mealtimes to access food and drink of their choice. Where it was delivered as part of the package of care, people were happy with the meals that were prepared for them. Some of the food preparation at mealtimes had been completed by family members or people themselves and staff were required to reheat and ensure meals were accessible to people. Where appropriate, people's nutritional preferences were detailed in their care plans. For example, a person's care plan detailed their food likes and dislikes and preference for a particular drink with their meal. One person told us, "I'm diabetic and my carer is very good. At diabetic clinic they said to me I have been looked after very well."

People's health care needs were met. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included occupational therapists, community nurses and general practitioners. We noted that advice and guidance given by these professionals was followed and documented. People told us they felt confident their carers would respond if there was an emergency or if they needed medical attention. One person said, ""I was having problems breathing so my carer rang my care link and advised to ring for an ambulance and then she stayed with me until the ambulance came. Wasn't that wonderful that I wasn't left alone" They told us most of their health care appointments were looked after by themselves or their relatives. They felt confident that their carers would respond if there was an emergency or needed medical attention. However, staff were available to support people to access healthcare appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed.

Good

Is the service caring?

Our findings

Staff had a caring and compassionate approach to their work with people. They had developed caring relationships with people who they grew to know well. They demonstrated understanding of the preferences and personalities of the people they supported. People we spoke with were happy and comfortable with staff. One person told us, "My carer gives me a purpose to get out of bed, she's very encouraging and goes the extra mile. [My relative] passed away last week and [staff member] only had to make a call to the office and they gave her permission to come with me to the home where they were as I couldn't face it alone."

Staff had a detailed understanding of people's needs and were proactive in ensuring people received good quality care and support that promoted independence. People told us they could do things for themselves and that they were as independent as they could be in their circumstances. A person told us, "I recently asked for them to give me another call so someone could take me to the bank and help me with my shopping and it's all sorted I only had to mention it" Another person said, "I'm arthritic but I like to get myself dressed as much as possible, it's only the fastenings I need help with. I like to do as much as I can myself."

People were supported to maintain relationships with people that mattered to them. Care plans contained information about people's wider circle of support, including family, friends, health and social care services. Care plans contained both a life history and social assessment. They were completed with people and their families where possible and contained information staff could use to help build relationships. For example, they held key information about people's previous occupations and hobbies. Some people told us staff supported them to meet family and friends and to arrange to spend time together. A person talked of their faith and was supported to consider options to attend synagogue. One person said, "It's the small things. They notice if you need letters posting that sort of thing, it all helps you out."

People's well-being and happiness was promoted. Staff told us they had formed good relationships with people and had become skilled in recognising when people were not their usual selves. The risk to some people of experiencing social isolation was recognised by staff and addressed where it could be. Another person who was housebound told us, "It's lovely to be able to chat with someone when you never go out. My carer makes me laugh and brings the outside world in."

Staff were respectful of people's privacy and maintained their dignity. Staff told us they respected personal space while they undertook aspects of personal care. A member of staff told us, "We are visiting people in their own homes and we need to be aware of that. I think it's about respecting their right to live as they want". People described carers as polite, courteous and that they treated them with respect. One person told us, "Even though [my relative] can be very sleepy, the two staff always chat to them and include him." People had regular carers that they knew and who knew them. People, staff and the provider all described how consistency and regularity of carers was key to achieving and maintaining respectful relationships. One person said, "They are lovely girls. Someone comes every morning. I see the same girl every day except for her days off."

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

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. People and their relatives where appropriate, told us they were involved in writing and reviewing care plans and had signed records to show this. Staff told us they had read people's assessments and plans and told us that people were able to tell them how they wanted to be supported and when.

The urgent homecare manager looked after a small specialist team of staff who cared for people discharged from hospital or at risk of needing hospital admission. We were told by one staff member, "We work with people, for example, who may be receiving end of life care and want to die in their own home. We get so much positive feedback about the care we give." Because of the complexity of the care needs of some people, packages of care were only accepted when they were confident they could be met. Assessment followed a rigorous process. The registered manager told us, "We sit down with the client and talk with them about what they want from the call. We want the client to be in control of their care."

People were supported to make decisions about how they best used the time of the call. For example, where and when they chose to eat their meal. We asked staff what they understood by the term 'person centred care'. One staff member told us, "It's about caring for people as individuals. What works for me might not work for you". Another staff member said, "It's giving care that's right for that person; the care that they want. It's not about us". A third staff member told us, "We make a point of promoting people's independence. That's what we are here for and that means working with people, not just doing things to them".

Staff kept daily records of people's care that included their personal care and activities undertaken, meals prepared or taken and demeanour. This enabled staff to easily see the care the person had needed. We examined people's care plans and daily records. They were legible, relevant and up to date. They contained information about people's care needs, for example, in the management of the risks associated with poor mobility and environmental hazards. People's choices and preferences were documented. The daily records showed that these were taken into account when people received care, for example, in their preference for shopping items brought to them by care staff. Care planning and individual risk assessments were reviewed monthly; we found evidence of people or their representatives' involvement in this.

People were well informed on how to contact the office about any concerns or wishes for change and the service was responsive to these requests. For example, we spoke with people 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 on each call. These were sent out weekly. One person said, "If you don't get one in the post, and I'm having lots of problems with my post, I just ring the office and they'll even hand deliver it to me." 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. They were able to feedback on the travel times they required between calls. Feedback from people consistently indicated that calls were on time, within reason, and that in the main, communication was good if there were to be delays.

People told us they knew how to make a complaint and who to speak with. They explained that they felt they would be listened to if they did need to complain. One person reflected on their recent experience, "I had a bad experience with a different agency previously and I can assure you I'd be straight onto them but they're nothing like the other lot." Another person said, "They really listen to you and change things to make it better for me." Staff told us that the people they supported would be able to make it known if they were unhappy with something and that they would act on this.

We looked at the provider's complaints policy and procedures, which were displayed in the provider's office. We also looked at the complaints log. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission.

There had been two formal complaints made in the past year. We looked at documentation related to these. The complaints had been resolved in a timely and satisfactory manner. The registered manager had written to the relevant parties with an action plan, where necessary, to prevent further issues. We noted in the same time period that there had been four complimentary letters received and seven cards of thanks.

Good

Is the service well-led?

Our findings

People and staff spoke highly of the care and support people received and commented they felt Coastal Homecare (Hove) Limited was well managed. One person told us "[Named provider], the main chap, is ever so good, they all are." A member of staff told us "The management are good and supportive and have time if you need to speak with them about anything."

The management of Coastal Homecare (Hove) Limited was effective. Staff described an open and transparent culture and told us they felt able to raise concerns or make suggestions. Everyone we spoke with confirmed they felt the management was approachable. People told us they would have no hesitation in raising any concerns with any of the management team. Staff had access to an on-call system to ensure management support could be accessed whenever it was required.

The provider had systems in place to assess and monitor the quality of the service. For example, care plans were reviewed to ensure that they continued to reflect people's needs. Health and safety audits were completed on a regular basis. There were quality assurance and governance systems in place to drive continuous improvement. These included provider visits to people who received care visits. Where shortfalls were identified, an action plan was devised specifying what action had to be taken. The completion of the action plan was overseen by a manager and checked after a reasonable period of time had elapsed. There were processes in place for regular audits to assess the quality of care provided. These included audits of people's care records, health and safety and medication records. Where any issues were identified by audits or brought to the attention of the management, plans were initiated for these issues to be dealt with and resolved promptly.

We looked at the provider's latest client satisfaction survey, which had been compiled following the completion and return of 37 questionnaires by people using the service throughout the year. The questionnaires covered areas such as staff attitudes, the maintenance of people's dignity and privacy and whether staff actively promoted people's independence. We noted a high degree of satisfaction in all areas examined. No-one had rated the service as 'poor' in any category and 31 people rated it as 'good' or 'very good'. The provider also conducted an employee job satisfaction survey. Ten staff members had returned questionnaires in 2015. All staff rated the provider highly in areas of staff motivation and job satisfaction. All staff would either 'definitely' or 'probably' recommend a friend to apply to work at the service.

The provider was deeply committed to the service and was proactive in considering ways of improving it further. For example, we heard how they had worked closely with health care professionals such as GP's and district nurses to provide the most joined up and seamless package of care. The registered manager had also sought specialist training and told us how the management and staff used a variety of methods to learn about good practice and new ideas. Management attended regular external meetings and events, for example with the local authority or with local voluntary organisations such as the Befriending Service to share issues, new ideas and ways of working and learn about new legislation or guidance affecting their service. The information and learning was then cascaded down, for example through the newsletter circulated to people and staff.

Staff told us they were motivated and enjoyed their work. They told us they were involved in developing the service and encouraged to contribute to discussions about what was working well and what could be improved. Where staff performance had been identified this had been discussed in supervision and action had been taken to ensure that the standards the provider required of their staff were met.

Staff reflected on accidents and incidents that had occurred and discussed how improvements could be made and what could be done differently to prevent them reoccurring. This was also a topic within staff supervision meetings. Incidents and accidents were appropriately documented and investigated. Systems for the recording of incidents were in place and staff were aware of what needed to be recorded. Learning was taken from incidents and accidents. Records of all occurrences were audited to make sure the providers' policies and procedures had been followed and the appropriate action had been taken. They used this information to help identify and, where appropriate, make changes to people's care plans to help reduce the likelihood of the incidents reoccurring.

The provider and staff were asked to describe the 'duty of candour' and its relevance to the care and support of people. Duty of candour forms part of a regulation which came into force in April 2015. It required providers to be open and honest with people and others acting lawfully on their behalf. It required that when things go wrong with care and treatment, people were given reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to the person in relation to the incident. Though staff we spoke with struggled to describe its relevance and application, the provider was able to demonstrate knowledge of their duty and implication for the management of the service.