Alina Homecare Ltd

Alina Homecare Ringwood

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

About the service
Alina Homecare Ringwood is a domiciliary care service. They provide personal care to people living in their own homes in the community. At the time of our inspection, 36 people were receiving personal care from the service.
Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were protected from harm by staff trained in safeguarding and a robust risk assessment and care planning process ensured that people were kept safe while enjoying fulfilling lives.
Staff were safely recruited and sufficiently deployed to provide unrushed care to people.
Staff were trained in administering medicines and were regularly checked for competency. Medicines were audited by the registered manager and a clear procedure was in place in the event of medicines errors or omissions.
Staff understood the importance of infection control procedures and were clear in their approach to use of protective equipment and hygiene.
The provider had a robust system of sharing learning from incidents and learning from all services would be shared to ensure that best practice was constantly updated.

Peoples assessments and care plans were person centred and the provider asked the question, "What can Alina make easier for you?" to identify the supports that people needed.
Staff completed an in-depth five-day induction before commencing their caring duties and were assessed to ensure they were competent in some areas such as medicines. Staff were supported to complete their care Certificate then progress to qualifications such as diplomas in social care. A training academy provided other training and could source additional training that was required.
Staff participated in six weekly supervision meetings and found the process useful.
The provider supported people with meals and if someone needed additional support referred to appropriate healthcare professionals. They also used less formal approaches to stimulate people's appetites such as buying one person fish and chips to tempt them to eat more.

Peoples care needs had been assessed and detailed assessments and care plans were found in all care records. Protected characteristics under the Equality Act 2010 had been identified and measured were in place to ensure any associated needs were met. We received extensive positive feedback from people and their relatives about the approach taken by staff and the management team.

Staff were able to get to know the people they supported well, and the provider had a policy of limiting the amount of staff providing support to people enabled people to become familiar with staff. Regular reviews both face to face and by telephone ensured that the care delivered was delivered as the person preferred and staff were aware that a 'one size fits all' approach to care was not acceptable.
People felt respected by staff and staff respected people's privacy and dignity and encouraged them to complete tasks that would retain their independence.

Staff understood the principles of providing person centred care and care plans reflected that the person was consistently considered.
Peoples communication needs were met, and the provider could source a variety of different formats when standard written information was unsuitable.
The provider supported people to access their local community and planned some events for people to attend to reduce social isolation. Staff took time to ensure they were familiar with peoples interests and life, so they could tailor conversations and develop rapport with people.
A great deal of positive feedback had been received from people, relatives and social care professionals about staff and the service they provided and just one complaint, likely due to a miscommunication had been received in the first year of the service.
When we inspected, no-one was being supported with end of life care. The provider had previously supported people at the end of life and provided training and support to staff in this area.

We received positive feedback about the management team and the registered manager. Staff and people found them to be approachable and open to suggestions.
The provider's values were evident in the care provided, the conduct of staff and in the day to day running of the service.
There was an open and honest culture with information being shared with staff and people as appropriate.
The registered manager was clear about their responsibilities under the duty of candour.
Regular quality assurance surveys provided feedback and people were encouraged to provide feedback at point of review. Audits were completed at intervals and a provider led quality team completed a robust audit every six months which produced and action plan for the registered manager to complete.
The registered manager had forged positive links with commissioners, healthcare professionals and the public and was working in partnership with them whenever possible.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 27 April 2018 and this is the first inspection.

Why we inspected
This was a planned inspection based on our requirement to inspect within 12 months of registration.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our safe findings below

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Alina Homecare Ringwood

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.
Inspection activity started on 14 May 2019 and ended on 15 May 2019. We visited the office location on 14 May 2019.

What we did before the inspection
Before we inspected Alina Homecare Ringwood, we reviewed the information we already held about the service. We looked at notifications. Notifications are sent to us by the service to tell us about significant events.
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with, one senior carer, two care workers, one quality manager, an area manager and the registered manager. We also spoke with seven people who use the service and five relatives of people that use the service about their experience of the care provided.
We reviewed a range of records maintained by the service including records of accidents, incidents and complaints, audits and quality assurance reports, health and safety monitoring, three peoples care records, three staff recruitment and supervision files, and policies and procedures.

After the inspection
The provider sent all requested information and clarified any additional queries.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse by staff who had participated in face to face training in safeguarding.
• Staff could describe scenarios that would cause them concern and told us they would always record and report their concerns to senior staff.
• The provider had a whistleblowing policy and procedure and once trained in this area, staff were issued with copies. Staff were confident that if they raised issues concerning the conduct of a colleague that the registered manager would deal with the matter. If it was not suitably dealt with, staff told us they would not hesitate to approach more senior management within the provider or approach external agencies such as Care Quality Commission. Staff also stressed to us that this situation had never arisen.

Assessing risk, safety monitoring and management
• Risks to people were assessed, hazards identified, and actions put in place to mitigate risks while not restricting people's ability to enjoy living fulfilling lives. For example, people were, when possible, taken out into the community. Other people were encouraged to complete activities such as cooking which was higher risk than someone doing it for them. This gave people a sense of achievement and helped to maintain their independence.
• Peoples care files contained a wide range of different risk assessments. The home environment was risk assessed to ensure that staff could access the home, provide care, be aware of possible hazards such as pets or loose floor coverings and have a plan in the event of an emergency such as fire. Environmental risk assessments identified the hazards and documented a plan to minimise risks to the person and staff delivering care.
• Care records also held risk assessments concerning people's needs and care delivery. These included risk assessments to mitigate risk in the areas of mobility, moving and assisting, nutrition and all aspects of peoples care as required. Risk assessments were also held in files in people's homes. Care staff told us they would read risk assessments when they arrived in people's homes and when they had been updated.
• Records were maintained in people's files of equipment maintenance. If someone required a hoist and slings during their care, dates when services had taken place or were due were maintained to ensure that staff were only using safe equipment thus minimising risks to people and themselves.

Staffing and recruitment
• All staff recruited to Alina Homecare Ringwood were subject to checks before they could commence their duties. We saw recruitment files containing all the necessary pre-employment checks including, for example, four references to evidence conduct in previous social care roles, full employment histories and appropriate proofs of identity.
• All staff had a Disclosure and Barring Service, (DBS), check before commencing in post. The Disclosure and

Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults, to help employers make safer recruitment decisions.
• Staff recruitment files were well organised, and all expected documents were in place. More confidential items such as copies of peoples DBS checks were stored in a separate file only accessed by the registered manager, and documents such as copies of passports had been annotated to show when the original had been seen and by whom.
• Sufficient staff were deployed to meet the needs of people. One staff member said, "It's not too busy, it is well balanced with people to staff numbers. Everyone works together as a team and everyone helps each other out… I love it".
• There were plans to continue to grow the business however this was being done in line with recruitment so as not to overstretch existing staff. The quality manager told us, "We want to grow, but grow safely. Customers will recommend us if the quality is right. We will recruit at the right rate to support the registered manager and will ask to stop or reduce if needed to ensure that quality is retained. Our ethos is quality, not quantity".

Using medicines safely
• Staff were trained in giving medicines and completed a competency check before being able to give medicines unsupervised. Competency was also checked during spot checks of staff when senior staff observed practice.
• We saw that sample staff signatures were retained on file and that medicines administration records, (MAR), were correctly completed with no unexplained gaps in recording. All medicines contained in multi-dose systems were signed for and PRN, or when required medicines were offered at each visit if appropriate.
• Staff knew what actions to take if there was a medicines error or if someone refused to take their medicines. One staff member said, "I would report and record, contact the office, the pharmacy and the GP to find out if there may be any side effects, would it be OK if they (medicines) were missed and what action I should take".
• In the event of a medicines error, staff would undergo retraining and a series of competency checks before being able to administer medicines without supervision again.

Preventing and controlling infection
• Staff participated in training in infection prevention and control during their induction and when asked could tell us how they would prevent the potential spread of infection. One staff member told us, "We use the right PPE, (personal protective equipment). We wash our hands during and after calls and before and after tasks such as food preparation and personal care. We are provided with gloves and aprons but if we needed anything else, like booties for our shoes, they (provider) would get it for us".

Learning lessons when things go wrong
• Staff informed the registered manager when accidents or incidents happened and documented incidents in both care records and on specific incident forms.
• The registered manager told us that accidents and incidents were now recorded on an online system that enabled easy analysis and prompted notifications to Care Quality Commission and Health and Safety Executive for example.
• When incidents occurred, the provider ensured that, as necessary, GP's were informed and relatives and other involved care providers.
• Lessons learned were shared immediately with staff via a weekly email or, if staff would be working with that person, by phone to ensure that measures were taken to reduce future risks immediately.
• We spoke with the provider's quality manager who told us that when things went wrong across the whole company, lessons learned were shared with every branch. For example, one service had needed to adapt their approach to covert medicines. That learning had been shared across the company.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments were holistic, and person centred. Peoples assessments contained the question, 'How can Alina Homecare make life easier for you?' This was answered with general statements of what the person wanted to achieve with support. One person's response was, 'to allow me to be at home and to be independent'.
• People were assessed before receiving care to ensure that the service could fully support their needs. Assessments were extensive and included, for example, assessment of medicines, health conditions, nutrition and hydration, social and emotional wellbeing and moving and assisting.
• People, whenever possible were encouraged to be independent and care plans showed that staff would support when needed and would not do things for people that they could do for themselves. For example, one person could be more independent if corridors were kept clear of obstacles, if things they may need were kept at low level within their reach and if their medicines were opened for them.
• Peoples care plans were regularly reviewed. When someone started to receive care from the service their package would be reviewed at two weeks, one month, three months, six months, nine months and a year. Reviews were a mix of phone calls and face to face meetings and aimed to ensure that peoples care was delivered as they wanted.

Staff support: induction, training, skills and experience
• Staff participated in an in-depth induction when they commenced in post. The induction training was in line with the Care Certificate. The Care Certificate is an agreed set of 15 standards that define the knowledge, skills and behaviours expected of staff working in roles in the social care sector. Standards include understanding their role, safeguarding, equality and diversity and effective communication.
• Training was both classroom based and with senior staff in the community. One staff member told us, "the training was fine, it covered everything I needed to know. After two days shadowing I felt ready to start working alone". Another staff member said, "I did my Care Certificate and NVQ 2, the shadowing helped me complete my certificate". They added that if there was any area that they needed additional training in they could request it.
• There was a provider training academy that oversaw training needs of staff and if there were new areas of training needed such as around the specific needs of people the academy would source suitable courses. More in-depth courses such as advances dementia and stoma care were provided in-house through classroom-based training. Qualification training courses were also available to staff through the training academy.
• People told us they thought staff were suitably trained. One relative told us, "They seem well trained and if there is anyone new then they are shadowed until they get the hang of it". A person receiving a service said, "They seem well trained. I look forward to seeing them. We sit together in the conservatory and have a chat,

which I really enjoy".
• Staff told us they received regular supervision, approximately every six weeks. One staff member told us, "Yes, it's good, you come into the office and you can get things off your chest, reflect and hear them say that you are doing well".
• One staff member told us that they had official supervisions and could also speak with the registered manager informally for support. "You can phone in, they (registered manager) are really approachable. It's the best place I have worked in terms of them (provider) trying to do right for you, it is really good".

Supporting people to eat and drink enough to maintain a balanced diet
• Staff received training in fluids and nutrition and told us they would alert the registered manager if they were concerned that a person was not eating. One person they supported was causing some concerns about food intake and the provider was looking to increase the call time to ensure that staff could remain with them while they ate their meal. Until this was arranged, staff were staying as long as possible and checking to see if food had been left from the previous call when they next visited.
• One person was being supported to develop skills in food preparation as part of increasing their independence.
• Information about peoples likes and dislikes was held in peoples care plans. If someone was reluctant to eat, staff tried different approaches and meals to try to tempt them to eat. One person who was living with dementia had been very reluctant to eat and staff found that taking them food from the local fish and chip shop once per week had been a great success. The sensory aspect of the smell of the food and the wrapping had contributed to them enjoying food again.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff worked closely with health and social care professionals such as GP's, social workers and district nurses. When health concerns had been noted, appropriate relatives and medical professionals had been involved and care packages were regularly reviewed with commissioners.
• People were supported to access services such as dentists and chiropodists in the community if they were unable to do so without support.
• The provider supported people to maintain their wellbeing by arranging trips out with them. One person who had been feeling quite low had improved greatly following a trip to the New Forest. Another person had enjoyed some art books supplied by the service. People's wellbeing was constantly considered by the provider.
• The registered manager told us they were proud to be recommended by district nurses and a GP surgery locally.

Ensuring consent to care and treatment in line with law and guidance
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.
Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.
• Mental Capacity Assessments had been completed and were retained on people's care records. These covered all aspects of care including medication and personal care. If a person lacked the capacity to make choices, decisions had been made in consultation with relevant parties in their best interests or a person who held a Lasting Power of Attorney, (LPA) for them had made the decision. An LPA is a legal document allowing the holder to make decisions on your behalf when you lack the capacity to do so yourself. There are two types of LPA, health and welfare and property and financial affairs.
• We found that in one person's care record, documents such as consents for medicines, personal care and use of a reclining chair had been signed for on behalf of the person based on the signatory holding an LPA for health and welfare. We were unable to find a copy of the LPA on file, there was a copy of a property and financial affairs LPA. We asked the registered manager to investigate this and they found that an error had been made at point of initial assessment and both LPA's had been recorded as in place as this is what the relative believed to be the case. Within 24 hours of discovering this error, the provider had held a best interest meeting involving the persons relatives, social worker and GP and had formulated a care plan as in line with the persons best interests as possible.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• Care Files contained details of peoples protected characteristics under the Equality Act 2010. These were retained confidentially, and people's needs were met according to their preferences.
• We asked the registered manager how they ensured that the service supported equality and diversity. They told us, "The service is person centred, that is the main thing, we promote people's individuality".
• People and their relatives told us they felt that care staff were kind and caring. A relative told us, "They are all very pleasant and nice. They take (person) down to the river which (person) really enjoys". Another relative said, "They are caring, and they understand (persons) mobility problems". A person using the service told us, "They are very caring, efficient and professional", a second person told us, "They are very caring; all I would ask for".
• Staff told us they would not hesitate to use the service to provide care to a family member. One staff member told us, "Yes, I would use the service, the carers care and that goes a long way, I would be happy with any of the staff".

Supporting people to express their views and be involved in making decisions about their care
• People and their relatives told us they felt supported and included in decisions. One relative praised staff for supporting someone who had been reluctant to maintain their personal hygiene. They said, "[Person] doesn't like to have a shower, but they always manage to persuade them to have one. They work things out".
• Staff were keen to know the people they cared for well and made efforts to get to know them. One staff member told us, "I know people very well, it helps that I sometimes assess them, but I make a real effort to get to know them. With some people, we keep going back to their files and add more information. We will send a message to staff with little key likes and preferences such as what to talk about and what not to discuss, things to help people feel involved".
• The provider limited the staff supporting people to six different staff per month and if there were two person calls this would be up to twelve staff per month. This enabled staff and people to forge relationships and support people in making decisions and choices about their care with staff they were familiar with.
• Reviews were held regularly both in person and by telephone. People receiving a service were spoken with as well as relatives as appropriate. Care plans were person centred and staff told us, "They (care plans) are about the person, what they want and what is best for them, not about fitting them into a box of one sized care".
• People felt able to speak out to staff. One person told us, "I know I can tell them if I have a problem – I feel confident I can. They are very caring and helpful – no complaints".

Respecting and promoting people's privacy, dignity and independence
• Staff were mindful of maintaining people's dignity, privacy and independence. One staff member told us, "When we support with personal care we will close the doors, unless someone says they want to have the door open. We make sure we keep them covered with towels and we get them to do as much as they can do for themselves. We give them the flannel to wash their face and then support them with the rest. This is especially important after a hospital stay, it is important for them to get back to doing this".
• A relative was impressed with the respect that staff showed her family member saying, "dignity is always preserved – the lower half is always covered".

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Peoples care plans were person centred and described how they wanted to receive support. Care plans also contained information about people's lives, likes, dislikes and any family involvements.
• Peoples preferences of male or female carers were recorded and whenever possible adhered to and any changes to peoples care needs, wishes and preferences are immediately added to care plans and communicated to staff to ensure the plan remains current.
• If a person does not respond well to the staff members allocated to them, the provider ensures that staff are changed at the earliest opportunity.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• The registered manager told us that there were options for people as to how information was presented to them. They could provide large print options, a neighbouring office had facilities to produce easy read formats using symbols and the provider could also offer information in braille. Most information was read through with people and there was no-one receiving support requiring information in accessible formats when we inspected.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.
• Though the provider does not provide activities during most care calls, some people had longer calls which included personal care and a sitting service. One person had thanked staff for painting their relatives' toenails for the first time in their life in time for their 89th birthday. Another relative had been pleased that staff made an effort and spoke with their family member about things they were interested in which had caused a positive change in the person, even after the staff member left.
• The PIR contained information about support provided to ensure that people were included in their community. It stated, 'We take people shopping, escort a lady to a local care home to visit her husband and take a customer out to the hairdressers regularly. We ensure [people] have calls in place that allow them to regularly have their care needs delivered in order for them to attend day centres. We walk with one of our [people] down to the local coffee shop, this also allows them the opportunity to get some money out at the cash point. We provide sitting services for family members, so they, as the full-time carer, can have a break for a few hours each week'.
• A first anniversary of the service party was planned when we inspected. After the event we received an

update from the registered manager. People receiving a service had been invited to a tea in a local community venue. Over 40 people had attended and had enjoyed a fun afternoon with staff from the service.

Improving care quality in response to complaints or concerns

• People and their relatives know how to complain, one person told us, "If I needed to complain at any time I could easily. There is a complaint form in the back of the file". People and their relatives were given a copy of the complaint's procedure at the start of their care package and at each review feedback was sought by the provider.

• The provider had a robust complaints procedure however only one complaint had been dealt with. Complaints, when received, would be dealt with promptly and audited monthly by both the registered manager and the quality assurance manager. Any themes and learning would be shared both with the service and throughout the provider organisation to ensure that practice was changed to improve the service provided. We also saw feedback from people and their relatives about the service which was positive.

End of life care and support

• Staff could access training in supporting end of life care through the Alina Academy. When we inspected there was no-one receiving end of life care however this had been provided regularly by the service.

• One staff member spoke with us about end of life care, "It was a shock to the system, but I felt well supported and worked with senior staff. The registered manager was comfortable and confident in what she did and that really helped, it was sensitively done". They also told us that the office-based staff would regularly contact them to offer support, to ask them to visit the office for a chat and to check on their wellbeing.

• The registered manager told us that staff would be supported throughout the end of life care delivery and that a care ambassador from the provider would always be present to support staff, the person and any relatives.

• We saw thanks received by the provider from families whose relatives had been supported by the service to, as per their wishes, die at home.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People were happy with the service they received. One person told us, "The management are good. Any comments are acted on. They are a very good team".
• The registered manager told us they aimed to make life easier for the people they supported and to enable them to remain at home. The provider had an ethos of quality over quantity and this was reflected in the quality of care provided and the steady increase in care hours over the first year. Staff were recruited before hours were increased to maintain standards at all times. We received no negative feedback from people or their relatives about their care.
• The PIR stated, 'We monitor and support staff to deliver clear vision and a set of values that includes involvement, compassion, independence, dignity, respect, equality and safety to which Alina Homecare aspires". Feedback we received from people, relatives and staff evidenced that the registered manager was enabling their team to deliver care in line with the visions and values of the provider.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• There had been only one complaint in the year the service was operational. This was likely due to a miscommunication however the registered manager had provided an apology and had strengthened procedures to ensure that the concern did not arise again.
• The registered manager had a clear understanding of their responsibility under the duty of candour. Throughout our inspection the themes of honesty and integrity were mentioned by staff at all levels and were clearly values that were promoted as vital to the service provided.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The registered manager had a clear understanding of their responsibilities as a registered person to submit notifications of significant events that happened within the service.
• Policies and procedures were in place and available to all staff to ensure that care provided was done in a manner reflecting legal requirements and best practice evidence.
• People told us the registered manager and more senior managers in the organisation were approachable. One person told us, "As far as the management is concerned, I am 101% happy with them", another said, "The Manager is lovely and sometimes comes in. I would say they are 99% excellent. They are like friends to me".
• The registered manager completed audits of the service on a monthly basis and a quality manager

completed a more in-depth audit of the service on a six-monthly basis. This ensured clear oversight of the service and would identify if improvements were needed in a timely manner.
• A robust audit by the provider's quality assurance team was completed regularly and identified actions for the registered manager to take to improve service delivery.
• Regular spot checks of staff performance took place and feedback was given immediately. Retraining was provided in any areas that were not to standard and praise given to staff providing quality care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider issued an annual quality assurance questionnaire to people receiving a service to obtain feedback about their performance. The responses would be analysed to inform the provider of what they were doing well, and if any improvements were needed.
• People were encouraged to give feedback about staff and we saw 17 compliments received from social care professionals, people and their relatives about care workers and care provided, that they considered to be exceptional.
• Staff meetings were held every six weeks and arranged to enable staff to attend. Staff told us they found these useful as they provided an update and an opportunity to discuss people they provided care for.
• The service had a presence in the local community. They had been involved in community events including a carnival and had been the sponsor for a raffle in a local school.

Working in partnership with others
• The provider had good working relationships with local commissioners, social workers, GP surgeries, occupational therapists and district nurses. The provider was frequently recommended by a local GP surgery and district nurses.
• Meetings were held with health professionals to ensure that care delivered was appropriate and if someone's needs had changed and they needed to have a reassessment for equipment such as stand aids and hoists, the provider arranged to meet the person and their occupational therapist to ensure the correct items were supplied.