Nash Healthcare Ltd

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Inspection report

Kings Chambers
34 Queen Street
Derby
Derbyshire
DE1 3DS

Tel: 01332417977
Website: www.nash-health-care.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place over two days commencing on 5 April 2018. The provider was given 24 hours' notice of our visit. This was so people who used the service could be told of the inspection and asked if they would be happy to speak with us.

Nash Healthcare Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community in Derby and Gloucestershire. At the time of our inspection there were 13 people using the service, which included people receiving end of life care. It provides a service to adults. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating.

Following the last inspection on 17 March 2017 we asked the provider to take action to make improvements in the management of people's medicine and in its staff recruitment practices. The provider submitted an action plan outlining their planned improvements and this action has been completed.

Nash Healthcare Limited 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.

The registered manager did not take part in the inspection as they were on leave.

The overall rating for the service awarded at the previous inspection which took place on 17 March 2017 was requires improvement at which time we identified two breaches of the regulations. This inspection has found improvements have been made and the overall rating for the service to be good.

The provider's recruitment procedures ensured pre-employment checks were carried out on prospective employees to ascertain their suitability to work with people. We found there were sufficient staff employed to meet people's needs, who had the appropriate training and support to delivery good quality care, which included tailored training to meet people's health care needs.

Systems to provide and support people with their medicine safely had been introduced. Medication Administration Records (MAR's) were for a majority of people provided by pharmacists, which meant staff were no longer having to write MAR's, thus reducing the potential for error. We found people were supported by staff that had undergone appropriate training and had their competency assessed to manage people's medication.

An electronic system had been introduced, since the previous inspection. The system supported the management team by monitoring and recording the time of arrival and departure of staff from people's homes. This provided a clear audit trail as to whether staff were providing care and support based on the

times as detailed within people's care plans.

People told us they felt safe when they were supported by staff and trusted them. All staff had undertaken training in safeguarding to enable them to recognise signs and symptoms of abuse and knew how to report them. Potential risks to people were assessed and plans were put into place to minimise risk, which staff understood and followed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's rights were upheld and decisions about their care were sought as part of the assessment process to identify their needs. The management team had focused on improving the involvement of people using the service or family members in the assessment process and development and review of care plans.

People's health and welfare was promoted as staff supported people with the preparation and cooking meals. Staff liaised and worked with health care professionals to promote people's health, which included providing support to people receiving end of life care and the management of individual health needs.

People received care from staff that in many instances had developed positive relationships. This assisted people in maintaining their wish to remain at home at the end of their lives, whilst for others in meant they were supported to take part in everyday activities to promote their quality of life. People's care and support was documented within their care plan and the service was flexible to enable it to react to people's individual needs.

The outcome and action taken in responding to concerns was now documented, along with the initial comment, concern or complaint. People experienced improvements as a result of sharing their concerns. A number of thank you cards had been received from family members, expressing their gratitude of the care provided to their relatives.

Staff were complimentary about the support they received from the management team and told us they were valued. Staff spoke of the visions and values of the service and shared the management teams ethos of wishing to provide good quality care based on people's individual needs.

People's views were sought through questionnaires and individual comments within these were acted upon. However people did not receive an overall analysis and any planned actions that would be taken in response to people's collective comments. The management team had introduced a number of audits to monitor how people's care was recorded. Where shortfalls were noted these were addressed. Quality audits undertaken by commissioners identified the service had responded positively to action plans put in place to continually develop and improve the service. This evidenced positive partnership working between the management team and commissioners.

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 were safeguarded from abuse as systems and processes were in place, which were understood and adhered too by all staff. A system of staff recruitment was in place to ensure people were supported by suitable staff.

People's safety was monitored, with risk assessments and care plans providing clear information for staff as to how people's safety was to be promoted. This included the use of protective equipment to reduce the potential risk of spreading infection.

People's needs with regards to their medicine were identified within their care plans and they received their medicine at prescribed times.

The registered manager learnt from accidents and incidents and implemented systems and processes to reduce the risk of them re-occurring.

Is the service effective?

Good

The service was effective.

People's needs were assessed and were met by staff that were skilled and had completed the training they needed to provide effective care, which included training specific to meet people's individual health care needs.

Staff received regular practical supervision when providing care and support to people and received support through appraisal and attendance at team meetings.

People were supported to maintain, their health and well-being as staff liaised with health care professionals. This included support with the preparation and cooking of meals.

The principles of the Mental Capacity Act 2005, including gaining consent to care and people's right to decline their care was understood.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service was responsive.

People's and family members contributed to the development of care plans. Care plans were followed by staff to promote people's well-being and to achieve their wishes. This included supporting people to remain at home by staff providing End of Life Care.

People and family members were confident to raise concerns. Concerns received had been investigated and used to further develop the quality of the service.

Is the service well-led?

Good

The service was well-led.

Staff expressed confidence in the management of the service and were committed to the visions and values of Nash Healthcare Limited. The leadership of the service was valued by staff, who in some instances worked alongside managers in the delivery of people's care.

People's views were sought and their views acted upon. People did not receive an overall outcome to the consultation process and the proposed response of the service.

The service worked in partnership with commissioners to bring about improvement and to further develop the service in providing good quality care for people.

Nash Healthcare 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This service is a domiciliary care agency. It provides personal care, which included end of life care to people living in their own houses and flats. It provides a service to adults.

The inspection site visit took place on 4 April 2018 and was announced. We gave the service 24 hours' notice of the inspection visit so someone would be available to facilitate the inspection visit.

The inspection was carried out by an 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.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

We contacted commissioners and health care professionals by e-mail requesting feedback about the service.

We spoke with four people who used the service and seven family members by telephone on 5 and 6 April

2018.

We spoke with the director (nominated individual) and the operations manager as part of our site visit to the office on 4 April 2018. We spoke with five health care assistants by telephone on 5 April 2018.

We looked at the records of two people who used the service, which included their plans of care, risk assessments and records detailing the care provided. We looked at the recruitment files of three staff, including their training records. We looked at a range of policies and procedures and documents, including audits and action plans that monitored the quality of the service.

Good

Is the service safe?

Our findings

At our previous inspection of 17 March 2017 we found the provider's recruitment process for staff was not robust. We issued a requirement notice as this was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

We found improvements had been made which meant people receiving a service could be confident that staff underwent a robust recruitment process. Recruitment files contained evidence that necessary employment checks had been completed before staff started to work at the service. These included application forms with a full history of employment, identification documents and a check with the Disclosure and Barring Service (DBS). The DBS carry out criminal record and barring checks on prospective staff who intend to work in care and support services to help employers to make safer recruitment decisions.

People were supported by staff that had the right skills and knowledge to meet their individual needs. Staff were committed to providing the best levels of care for people. A family member said: "They (staff) are very safe and reliable. Well trained….they shadow (working alongside each other) until they really know what they are doing and they are usually alongside me as well."

At our previous inspection of 17 March 2017 we found people's medicines were not always managed safely. We issued a requirement notice as this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

We found improvements had been made, which meant people received their medicine as prescribed, with records kept as to its administration. The provider had liaised with a number of pharmacists to request they supplied medication administration records (MAR's), to reduce the potential risk of staff making an error by having to produce hand writing the records.

We spoke with people about the support they received with their medication. One person said. "They (staff) do the tablets and my [relative] does some as well. It's all written down. And they've had no mishaps." A second person said. "They (staff) help me take my tablets. They have a box with the times and it's like a book, staff bring them and they make a note each time. No mishaps as far as I can tell." A family member told us. "[Relative] doesn't take tablets, they have a patch and I do that, but they remind me, they make a note."

Staff received training on medicine management and were assessed for their competency in its administration. Staff received tailored training where people's medicine was administered via a PEG. (percutaneous endoscopic gastrostomy) which meant their medicine was passed via a tube directly into the stomach. Staff were knowledgeable and told us how the medicine was administered as prescribed via the PEG to promote the person's safety.

People's care plans included an assessment of the support they needed to manage their medicines. Information included when and how medicines were dispensed and how and where medicines were stored

in the person's home. The assessments had been signed by the person or their family member to provide consent to this support.

When a safeguarding concern was identified the registered manager took appropriate action by making a safeguarding referral to the local authority. For example, a safeguarding referral had been made where there were concerns for a person's safety and welfare. This showed that the provider's systems and processes were effective in protecting people from the risk of abuse. The registered manager had also provided information required to the local authority and other agencies involved in the investigation of safeguarding concerns to assist them with their investigations.

Staff had received safeguarding training. When we spoke with staff about people's safety and how to recognise possible signs of abuse, these were clearly understood. Staff were confident about how they would report any suspicions of or allegations of actual abuse. Information in people's care plans included guidance on how people could identify if they were at risk from or experiencing abuse and people/agencies they could contact for support. This showed people were provided with the information and support they needed to raise safeguarding concerns. This helped to ensure people were treated fairly when raising concerns.

People using the service and people's family members told us they felt safe when their care was being provided. A person using the service said. "I feel very safe." A second person told us. "I've got a zimmer frame and they (staff) make sure I'm safe and they take good care of me." A family member told us: "They (staff) are very safe and reliable." A second family member said: "Yes, they are safe with them (staff)." Several family members commented that their relatives were safe as they had not had any falls.

Staff had a clear understanding as to their role and responsibilities in promoting people's safety, by reducing potential risks. They had knowledge about the management of risk tailored to each person's individual need. A person had significant needs to maintain their health and welfare and required the use of specialist equipment. Staff evidenced they had a comprehensive understanding about how and when the equipment was used and followed information as detailed within the person's risk assessments and care plan.

Each person's care plan had an assessment of risks the person may be exposed to. Risk assessments included areas relating to people's care, which included the use of equipment such as a hoist, nutritional risk and pressure area care. Risk assessments identified how risk could be reduced. For example, through the appropriate use of equipment, encouraging people to drink and re-positioning people to reduce the risk of pressure sores developing.

A robust system was in place which identified and assessed potential risks to the external and internal environment of people's homes such as potential trip hazards. For example, by ensuring people's floor space was clear from obstruction before using equipment to move people safely. Consideration was also given to staff safety by identifying where staff should park their car to promote their safety.

The operations manager spoke to us about the business continuity plan developed for the service. This detailed how the service would continue to run effectively should there be an unplanned event such as adverse weather conditions. A 'grab file' was in place, which contained information to be used should the service need to respond to an emergency by ensuring key information was readily available. For example, information included the contact names and details of staff, names of people using the service, information as to their medical conditions, allergies and next of kin and contact details.

The management team understood their responsibilities to review concerns in relation to health and safety

and near misses. For example, a person who had had an unwitnessed fall had their package of care reviewed. This meant the person now received additional support to ensure their safety and welfare. The person's fall had been documented and information to reduce the likelihood of the incident reoccurring had been provided to staff.

Staff told us they had a supply of protective equipment, such as gloves and aprons, and that they would always wash their hands both before and after providing personal care and preparing food. People who used the service and family members confirmed staff always wore the protective equipment when providing personal care. This promoted infection control.

Good

Is the service effective?

Our findings

People's needs were initially assessed by the funding authority, who shared their assessment with the registered manager. The registered manager or a member of the management team upon receipt of the assessment contacted the person or their family member to meet with them, so they could undertake their own assessment and find out what people's wishes were from the service. The operations manager told us they met with people in their own home or in some instances in hospital before being discharged to their home. People we spoke with confirmed they had been involved in the assessment process. A family member said. "We've been very involved in the assessments and they've taken it all on board." A second family member said. "They [registered manager] came on the same day and saw me. We went through it all, I felt involved."

People's assessment identified how many staff the person required to provide their care effectively. For example, people who were supported to move by the use of equipment had two staff to support them, whilst another person who had specific health care needs was supported by three staff at all times. Assessments identified any equipment the person required to provide their care and promote their independence, which included the use of equipment to promote their mobility. Information about the equipment used by each person and how it was to be used was detailed within their care plan, which included photos of and diagrams of instruction.

Staff were supported to complete an induction programme which included initial essential training, such as safeguarding, the moving and handling of people safely, infection control and medicines and included a period of shadowing (working alongside experienced staff) and competency checks. When we asked staff about their induction, staff told us they were introduced to people using the service, initially by a member of the management team. The operations manager informed us of their plan to enrol staff who had no experience in care to attain the Care Certificate. The Care Certificate is a set of nationally recognised standards which supports staff working in care and support to develop the skills, knowledge and behaviours needed in their roles.

Records we looked at showed staff had completed appropriate training and attended courses that gave them the skills to meet people's needs. This included tailored training to meet people's individual needs, where they required the use of specific equipment to meet their health needs. Staff said they had undertaken sufficient training to enable them to provide effective care. Comments from staff included, "I feel I have had enough training." "I attended all the training I was required to do, I believe it reflects what I need, to provide care to people in my role."

A majority of family members prepared meals for their relatives or left meals for staff to heat and serve. People we spoke with shared their views as to the support they received with their meals. A person using the service said; "They (staff) do my meals, they are set out nicely and they ask me first. Another lady gets my shopping so it's all my choice." Information about people's dietary needs and preferences were included within their care plans for staff to follow. Care plans included guidance for staff to ensure people had drinks and snacks close to hand, which they could reach without support.

A person using the service received their nutrition via an alternative method, known as a PEG (percutaneous endoscopic gastrostomy) which meant their nutrition was passed via a tube directly into the stomach. We found comprehensive guidance to be in place to ensure and promote their safety, which took into account best practice guidance. Staff who supported the person spoke to us in detail as to how the person's safety was promoted in relation to the use of the PEG.

People told us staff supported them when they were unwell by liaising with health care professionals. A family member said. "The fall [relative] had was dealt with. They alerted me, after they (staff) had firstly got [relative] an ambulance."

A member of staff informed us they had contacted the doctor on behalf of a person who was unwell. People's care plans included guidance about people's health needs and this information helped staff to provide effective care. For example, about supporting people to remain comfortable when they were cared for in bed. This included liaising with occupational therapists and physiotherapists, who provided individualised guidance tailored to meet the needs of people using the service, which staff followed. For example, to ensure a person was re-positioned regularly to promote the health of their skin and to reduce the risk of choking.

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. Whey 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. People receiving a service were able to make informed decisions for themselves about all aspects of their care and support. The director and operations manager were aware of the MCA and was aware how to implement this should it be required. People we spoke with told us they made decisions about their care, which were respected by staff. Care plans had been signed by the person or a family member.

Good

Is the service caring?

Our findings

Family members we spoke with confirmed their relatives were treated with kindness and respect. A family member told us. "They (staff) really go the extra mile and it's made a total difference to us all. They also keep an eye on my [other relative] ensuring they are safe and comfortable. Staff are here most of the time so I need to have the staff who can cope and deliver this type of care." The family member shared with us how the service their relative received impacted on them. They said. "I can now get out with the confidence that they (staff) know what they are doing and they will alert me if [either relative] are not so good. They know what to do and handle things right." A second family member told us. "Yes, they (staff) are polite and respectful, lovely."

People's care plans provided guidance for staff on the emotional needs of people. For example, a person's records reflected they had recently experienced a bereavement of their spouse. Staff spoke of the person's interests and how they spent time talking about these issues, providing companionship and support.

People were treated as individuals and supported to make decisions and choices about the way they wanted things to be done. For example, what they wanted to wear, and which room of their home they wanted to spent their in.

Staff spoke with commitment and passion about the support provided to a person, with specialised needs. Staff were aware of the person's dependence on them as a core group of staff involved in their care. This had led to the development of understanding, which had a positive impact on the person. A staff member told us. "I feel privileged being able to support [person's name] it's for us (staff) to encourage and enable [person's name] to lead a fulfilled and rewarding life." The person's family member spoke of staff; "You need staff who are really interested in how [relative's name] rather than themselves…it's not for everyone but I've now got a really good team." (of staff).

Family members spoke to us of their involvement in the planning of care of their relative. Their comments included. "We regularly review the care plan with [registered manager]." People's views about the service were regularly sought, and the opportunity was used to ensure people were receiving the care and support they needed.

People who used the service told us their dignity was promoted and that staff were kind and compassionate towards them. A person told us; "The care is done with dignity, they close the door. They (staff) are a nice lot. They are polite and respectful." A second person who used the service told us; "I'm very happy with them, they are excellent. When I was in hospital two of them (staff) came and saw me and they're lovely with me."

People could be assured that information about them was treated confidentially and respected by staff. Information about people was shared on a need to know basis and with their agreement. Records relating to people's care and support were stored securely in filing cabinets. Information as to how information was stored was detailed within the services statement of purpose and service user guide. People were given a copy of this when they started using the service.

Good

Is the service responsive?

Our findings

Staff spoke of the personalised care they provided to people. "We have to adapt on a day to day basis. We respond to [person] providing what they need. We play music, provide them with a massage, and support them to go in the warm swimming pool." They went onto say. "Sometimes we go for a walk or read to them." People spoke about how the service adapted the times of it calls to their home for specific events, which showed the service responded to people's individual needs. A person using the service said. "The carers are flexible. If I have to go to the hospital, they will make changes."

People's care plans provided an overview as to people's lifestyle choices. For example, one person's care plan stated they enjoyed spending time in the garden and taking part in a range of games with family members. A person using the service was supported by staff in all aspects of their life, which included their physical care and their social and emotional support such as swimming, pampering sessions, playing games and listening to music. Staff we spoke with were very knowledgeable about the person's needs and told us how the person's life was enhanced by their involvement in their care.

People's care plans were individualised and reflected the care and support they required, which included the number and duration of visits by health care assistants each day. In some instances people received longer periods of care, such as 24 hour care. Care plans stated how staff were to gain entry to the person's home, and how they were to greet the person. Care plans detailed the specific needs of each person, which included any personal preferences such as the clothes they wore. It provided guidance for staff as to how this was to be achieved. For example, showing the person a number of 'outfits' and encouraging them to choose what they wanted to wear.

The service had not considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People's assessments made reference to people's communication needs, however this information could be used to further develop person centred care plans, detailing people's communication style. The director and operations manager said they would update the people's care plan to provide greater detail, reflective of the knowledge of staff.

Staff who supported a person with communication needs spoke to us about how the person communicated. Staff had a comprehensive understanding as to how the person expressed themselves, which included differentiating between the noises the person made to indicate whether they were in pain. Staff responded to the person, by providing them with a massage to alleviate their pain and discomfort, re-positioned them in their bed or administered medicine to manage the pain.

Staff who were providing end of life care were knowledgeable about people's preferences and used information in an holistic way to support people both with their physical care and their well-being. For example, a member of staff told us how they listened to a person talk about how they were feeling. They told

us the person enjoyed watching television and that they engaged in conversations with them about the programmes the person had watched. A family member told us it was reassuring to know their relative was receiving one to one end of life care, and that their wishes were being respected and they were able to receive care at home, rather than be in hospital. They said. "It was their (relative's) wish and staff make sure they have the palliative care which is now needed."

A complaints policy and procedure was in place. This was included in documents provided to people when they began to use the service. Complaints and comments received were recorded, along with the action taken. For example changes were made to the questions in the feedback questionnaire sent to people who use the service following comments from a person. A number of thank you cards had been received from family members, expressing their gratitude of the care provided to their relatives.

People we spoke with informed us they had raised matters of concerns with the registered manager. A family member told us how the concerns they had raised about time keeping had brought about an improvement. They said; "Time keeping is now better, big bug bare at the start. I did complain after a difficult week. They've listened; they've done something about it." A second family member said; "I have complained about things twice and it was dealt with. Nothing serious but I would have been very much more involved if they did not see to the issues raised."

Good

Is the service well-led?

Our findings

A majority of people we spoke with were positive about the service. A family member told us. "I would rate them overall as nine out of ten, very good. I would recommend them." A second family member said. "I would recommend them."

The registered manager did not take part in the inspection as they were on leave. Staff were respected and valued by the registered manager. Staff were very positive in their views about the support they received from the registered manager and director. Both worked alongside staff in the care of a person who used the service. A member of staff told us. "I do feel valued, the fact that when we have appraisals we get feedback from clients. The 'bosses' (registered manager and director) have time for us. They want us to learn more and do what's best for [name of person using the service]. A second member of staff said. "I feel valued, always supported by [director's name]. We also get positive feedback from the family [relatives of a person using the service.] A third member of staff told us. "Valued…yes. When I phone them [management team] my views are listened too. We asked them to provide an example as to how their views had been listened too and acted upon. They told us they had raised concerns about a specific issue regarding a person using the service. As a result a health care professional became involved, which led to improvements to the person's well-being.

Staff told us they enjoyed working for Nash Healthcare Limited. A member of staff said. "I enjoy it and I feel supported and I feel value in Nash's commitment too and its development." A second member of staff said. "I'm very happy with my job and we work well as a team, we're rewarded and praised."

Staff spoke of the vision and values of the service and their role in achieving these. A member of staff said; "The vision and values are to provide best quality care. To specialise in individuality, tailor our support to each client and do what they need." A second member of staff told us; "The visions and values are to provide safe care to people and end of life care. I think that we do… sometimes we receive positive feedback from clients."

Staff who were based in Gloucestershire told us staff meetings had recently been implemented. We asked staff what meetings meant to them. A member of staff told us. "It gives us an opportunity to raise questions." The staff team based in Derby regularly met to talk specifically about a person they supported. Staff told us this was valuable as they shared any information they had learned about the person and used this to improve their quality of life.

The director (nominated individual), the registered manager and operations manager have responsibility for the monitoring the quality of the service. The director and other members of the management team assured themselves of the quality of the service by working alongside staff in the delivery of personal care. In addition they undertook audits of records, which recorded the support and care provided by staff, these included daily notes and medicine records. Where areas for improvement were identified, this was shared with staff. Staff told us the registered manager or director contacted them regularly to update them on any changes to people's care, which included improvements to how information was recorded.

Staff were provided with a staff handbook, which contained information as to the key policies and procedures for Nash Healthcare Ltd. We found staff were knowledgeable as to key policies and procedures which included whistleblowing. Staff spoke to us of their responsibility to inform a member of the management team, or external organisations such as the CQC or social services, should they have any concerns about people's welfare.

The provider had a business contingency plan in place, which identified how the service would continue to operate. For example, during adverse weather conditions. The provider had implemented this plan when heavy snow had limited staff's ability to travel to people's homes. People's support had been prioritised, by visiting people who lived by themselves and who did not have family members living close by.

The director and operations manager spoke of a planned investment to assist staff in the provision of people's care. Following the recent adverse weather, some packages of care had to be cancelled or were delayed due to travelling conditions on the roads. As a result of this, we were informed that plans were in place to purchase a vehicle appropriate to these conditions. This vehicle would complement the fleet cars already used by many staff to travel to people's homes.

The service had entered into a contract with an external organisation. The role of the organisation was to provide up to date policies and procedures, which reflected good practice guidance and legislation, including their responsibilities as employers. The director informed us any changes were reviewed and where changes were required these were made.

People's views and that of family members were sought. Questionnaires were regularly made available for people to record their views. In addition members of the management team visited people in their home, to speak with them, as part of their review of their needs. This visit provided an opportunity for people to comment on the service. Questionnaires which had been completed were complimentary. Any comments expressed were listened to an acted upon, which had included revising the questions included in the questionnaires. However an analysis of questionnaires did not take place. This meant there was potential that themes or trends would not be identified. The outcome as to the overall view of people and any action the service would be taking in response to people's feedback was not shared. The director and operations manager said they would in the future provide this information.

The director and operations manager spoke positively of their relationship with Gloucester based commissioners and how their quality monitoring of the service had supported them to continually develop the service they provided. The reports produced by Gloucester commissioners recorded their feedback and advice was acted upon. With the support of the commissioners a computer package had been adopted by Nash Healthcare Limited, which enabled the management team to accurately identify the time staff arrived and departed a person's home. The director spoke of their intention to broaden the use of the computer package to assist them further, for example in the production of staff rotas, and records that provide information about people's support, which would include care plans and risk assessments.

The registered manager and member of the management team where appropriate, had worked with partnership agencies, which had included commissioners of social care and health care professionals, to assure people's needs were met and any changes shared to ensure people's support was accurately assessed and planned for.