Accord Housing Association Limited

Coventry Short Term Home Support

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The office visit of this inspection took place on 31 July 2018 and was announced.

Coventry Short Term Home Service is a domiciliary care agency registered to provide personal care to people in their own homes. It provides a re-enablement service for up to six weeks. This is to support people to regain their independence, following discharge from hospital or to prevent admission. It also provided support to four people who required long term care and support to remain at home. At the time of this inspection the service supported 41 people with personal care and employed 17 care staff.

This was the first inspection of the service since it was registered in August 2017.

A requirement of the provider's registration is that they have a registered manager. There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe using the service and there were enough staff to provide the care and support people required. Staff had completed safeguarding training and understood how to keep people safe from avoidable harm and abuse. Risks to people's safety were identified and assessments completed to guide staff about how to reduce or manage the risk. The provider's recruitment procedures made sure staff were safe to work with people who used the service. People received their prescribed medicines from staff who had completed training to do this safely.

People had an assessment completed at the start of their service. This was to make sure people were suitable for the short-term service and that staff could meet their care and support needs. Staff received an induction when they started working for the service and completed training that provided them with the skills and knowledge to support people's needs. When needed, arrangements were in place to support people to have enough to eat and drink and remain in good health.

The registered manager and staff understood the principles of the Mental Capacity Act. Staff asked for people's consent before they provided care and respected decisions people made about their care and support.

Coventry Short Term Home Service supported people to regain their independence after discharge from hospital. The service was 'non-time specific' which meant care staff did not always have set times to visit people and people's calls were allocated within a two-hour time slot. Not all the people who used the service knew this and expected care staff to arrive at consistent times.

People received care from staff who they considered to be kind and caring, and who stayed long enough to

provide the care and support people required. Staff promoted people's privacy and dignity. People received care and support which was individual to them.

Care plans provided information for staff about people's preferences, their care needs and the support they needed to regain independence. People's needs were kept under review and plans updated as people's independence increased. People knew how to complain, and information about making a complaint was available for people.

Staff understood their roles and responsibilities and had regular individual meetings and observations of their practice to make sure they carried these out safely. There was an 'out of hours' on call system which ensured support and advice was always available for staff when the office was closed. The management team worked well together and the provider had effective and responsive processes for assessing and monitoring the quality of the service.

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 felt safe with staff who visited them and there were enough staff to provide the support people required. Staff understood their responsibility to keep people safe and to report any suspected abuse. Risks identified with people's care had been assessed and staff knew how to manage risks to keep people safe. The provider checked the suitability of staff before they worked in people's homes. People received their prescribed medicines from staff who had completed training to do this safely.

Is the service effective?

Good

The service was effective.

Staff completed training to ensure they had the knowledge and skills to meet people's assessed needs and deliver safe and effective care to people. The registered manager and staff understood the principles of the Mental Capacity Act 2005 and respected decisions people made about their care. Where required, staff made sure people had enough to eat and drink and referred people to healthcare professionals if needed.

Is the service caring?

Good

The service was caring.

People received care and support from staff who they considered kind and caring. Staff understood people's individual need, and respected people's privacy. People felt involved in their care and were supported to regain their independence.

Is the service responsive?

Good

The service was responsive.

Coventry Short Term Home Service provides a re-enablement service and people receive a 'non-time specific' service. Not all the people who used the service were aware of this and expected their care to be provided at consistent times. Care plans

provided staff with the information they needed to meet people's needs. People's care and support needs were kept under review and staff were informed about changes in people's care. People knew how to complain if they needed to.

Is the service well-led?

Good

The service was well led.

People were asked for their opinion of the service and were satisfied with the service they received. Care staff received the support and supervision they needed to carry out their roles and felt confident to raise any concerns with the management team. The provider and registered manager had processes to regularly review the service people received and to implement improvements.

Coventry Short Term Home Support

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 comprehensive 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. The expert by experience made telephone calls to people prior to the office visit.

Inspection activity started on 19 June 2018 and ended on 31 July 2018. This included telephoning people and their relatives to get their views on the care they received. We visited the office location on 31 July 2018 to see the registered manager and office staff; and to review care records and policies and procedures. We told the provider we were coming so they could arrange to be there and arrange for care staff to be available to talk with us about the service.

The provider had completed a Provider Information Collection (PIC) before this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIC during our visit. We found the information reflected how the service operated.

Prior to the office visit we reviewed the information we held about the service. This included statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also reviewed the 'share your experience' information we had received. This is information that people who use the service/ relatives/members of the public or social care professionals want to tell us about. These can be concerns or compliments. We contacted the local authority who arranged placements with the service. Information received was considered as part of our

inspection planning.

The provider sent a list of people who used the service to us; this was so we could contact people by phone to ask them their views of the service. We spoke with ten people, and four relatives of people who used the service. We used this information to help us make a judgement about the service.

During our inspection visit we spoke with the registered manager about their management of the service. We spoke with the care co-ordinator, two team leaders, the administrator and three care staff about their roles, and what it was like to work for Coventry Short Term Home Service.

We reviewed three people's care records to see how their care and support was planned and delivered. We looked at three staff recruitment files, staff training records and records associated with the provider's quality checking systems.

Good

Is the service safe?

Our findings

Everyone we spoke with said they felt safe with the care staff who visited them. People who used the service told us, "I had no worries about feeling safe." Another said, "I've got no reason not to feel safe." A relative told us, "[Person's name] has a key box now so they [staff] let themselves in, but they stand at the bottom and say their name, so [person] knows who has come in the home." People said they would speak to staff in the office or a relative if they had any concerns about feeling safe.

People were supported by staff who understood how to protect them from the risk of abuse. Care staff had completed training on how to recognise abuse and understood the importance of safeguarding people they provided care and support to. They were aware of the different signs of abuse and their responsibilities to report concerns to the registered manager. One told us, "I would report any concerns or suspicions to the manager or staff in the office, they would look into it and report it to social services." The provider had policies and procedures to follow if they identified any safeguarding concerns. The registered manager knew the procedure for reporting concerns to the local authority and to us (CQC).

An assessment of people's care needs was completed at the start of their service. This identified any potential risks to providing their care and support. Staff knew about risks associated with people's care, such as helping people to move and maintaining their health and welfare. For example, people we spoke with told us they or their relative used equipment to help them stand and transfer. This included, hospital beds, hoists, turntables, bath hoists, and walking aids. One person told us they had a chair to help them get into the bath. They said, "It goes up, swivels and (care staff) gently lowers me into the water. People told us staff knew how to use equipment safely and felt confident during the transfers. A relative told us, their family member had a hospital bed and, "They [staff] use it safely, they are very good, they know what they're doing." Staff had completed training to manage people's risks and keep them safe, such as moving and handling training and medication administration.

The registered manager told us that following the initial assessment an occupational therapist from the intermediate care team visited people at home to assess if they needed any equipment to support their re-enablement. This made sure people had the right moving and handling equipment for staff to use.

Where required people had checks on their skin to make sure this remained in good condition. Care plans reminded staff to check people's skin and to report any changes in skin condition to the GP or district nurse. Staff told us, "We check people's skin during personal care. There is a body map in people's folders if we need to record any skin changes." Records confirmed staff carried out these instructions.

The registered manager and the care co-ordinator who scheduled people's calls told us there was enough staff to provide all the visits people required. The registered manager told us to achieve this they used four outside agency staff. They said, "We use the same staff for consistency. They attend team meetings, have spot checks and we check their medication competencies." The registered manager told us that before agency staff visited people they received confirmation from their employer that the required recruitment checks had been completed and that staff had received the training required to work with people safely. The

registered manager went on to say, "We also give agency staff an induction so they know about our policies and procedures." The registered manager told us they were, "Always looking to recruit care staff, but they must have the right values and attitude."

The provider's recruitment process included checks to ensure staff who worked for the service were of a suitable character. The registered manager told us, they made sure staff had Disclosure and Barring Service (DBS) checks and references obtained before they started work. The DBS helps employers to recruit suitable staff by checking people's backgrounds and police records to prevent unsuitable people from working with people who use care services. Care staff confirmed they were not able to start working with people until all pre-employment checks had been received by the registered manager. One care worker told us, "I had to wait for my DBS to come back before I could go out on any calls."

The provider had an out of hour's on-call system to support staff when the office was closed. Staff said there was always someone available if they had any concerns or worries.

We looked at how medicines were managed by the service. Where possible people administered their own medicines, or had relatives that helped them with this. Some people were supported by care staff to take medicines. One person told us, "I have a blister pack. They take them [tablets] out for me, and put them in a pot." Where people had been prescribed creams that staff applied, this was recorded in their care plan and staff completed a medication administration record (MAR) to show this had been applied. A relative told us, "The carers apply cream to [family member's] legs. They are pretty caring and gentle." Records in the office showed medication assistance was recorded in the initial assessment and a record of prescribed medicines were recorded in the care file. The co-ordinator told us where people required support to take medicines, visits to people were prioritised and arranged around the times they needed to take their medicines.

Staff received medication training and had a competency assessment completed before they supported people with their medicines. Staff recorded in people's records when medicines had been given and signed a medicine administration record (MAR) to confirm this. The registered manager said MARs were checked during spot checks on staff and audited every four weeks when they were returned to the office. We sampled a selection of returned MARs. These had been completed accurately and checked when returned to the office.

Staff understood their responsibilities in relation to infection control and had completed training in relation to this. People we spoke with confirmed care staff wore protective gloves and aprons when providing personal care and carrying out other tasks. One person told us, "They [staff] always wear gloves and I've seen them wash their hands. They are good on the hygiene side." Discussions with care staff demonstrated they understood how to reduce the risk of infection and they said they had a regular supply of protective clothing, which they collected from the office. One told us, "We always wear gloves and aprons when we provide personal care or prepare food."

The provider had a system to record and monitor any accidents and incidents that occurred. The registered manager recorded accidents and incidents, which they shared electronically with the provider. The provider analysed records for any trends or patterns of incidents and to see if there was any learning from events and to minimise the risks of re-occurrence. The registered manager told us there had been no patterns or learning from incidents in the past 12 months.

Good

Is the service effective?

Our findings

An assessment was completed at the start of the service so the registered manager knew what care people required and could ensure staff had the skills to meet people's needs. People remembered having an assessment of their needs. One person told us, "I'm sure they did (an assessment) I remember I agreed with most of their suggestions, they were very good." A relative said, "Yes, someone came out, and they discussed [family member's] needs. I think they understood very well what [person] needed, and they made suggestions too."

People told us care staff knew what care and support they needed to meet their needs and maintain their welfare. One person told us, "Staff are trained and competent." Another said, "They were very good, we felt very confident in them." A relative said, "Yes I think the carers are trained. They understand what to do, they know how to use the hospital bed and why [name] has it."

Care staff told us they completed a range of training to make sure they had the right skills to meet the needs of people who used the service. Newly recruited staff undertook induction training when they first started to work for the service that was linked to the Care Certificate. The Care Certificate is a nationally recognised set of standards to ensure staff have the right skills, knowledge and behaviours. The registered manager and staff we spoke with told us they would prefer the induction training to be block' training. The registered manager said, "One thing I have found is that the induction training is a bit random. You have to wait for the training to be available from the provider and then book staff on this. As new staff are unable to go out on their own till all their induction training has been completed, this can cause delays."

Staff spoke positively about the ongoing training they received and were confident this ensured they had the knowledge and skills to meet people's needs. One staff member told us, "Training is really good, it's in-depth and they make sure you understand it." Another said "Training is brilliant here. They test your knowledge and have group chats. If I didn't feel confident I know they would arrange for more training." The registered manager kept a record of staff training, the dates it was completed and when refresher training was due.

Staff received regular supervision meetings to discuss their role, and had spot checks to make sure they put their learning into practice.

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.

We checked whether the service was working within the principles of the MCA. The registered manager understood their responsibilities under the MCA and told us people's capacity was assessed by social services prior to their initial assessment with the service. Due to the nature of the short-term re-enablement service everyone had the capacity to make their own decisions.

Care staff received training to help them understand the MCA. Care staff gained people's consent before they provided care and knew they should assume people had the capacity to make their own decisions. One staff member told us, "The MCA, is about people making decisions, consenting to providing care and being given choices." Staff confirmed people they visited made their own decisions. For example, one said, "Everyone can make decisions about their care as they have agreed to us supporting them to regain their independence." People confirmed staff asked them before they did anything. One person told us, "Some [care staff] are better than others at this. They always go through with me what we're doing, they don't do anything I don't want or if I'm not ready for something, like to move out of bed." A relative said, "I can hear the carers chat to [name] and explain what they have come to do."

We looked at how people's nutritional needs were managed. Most people we spoke with prepared their own food or had relatives who helped them do this. Where people required staff to assist them with meal preparation, this was recorded in their care plan. People who had assistance from staff to prepare their meals indicated they were satisfied with how this was provided. One person told us, "I'm very satisfied. They ask what I would like, then go and get it. They check to see what there is, then I make a choice of what I fancy." Staff knew what people required their meals or drinks to be prepared in a certain way, for example, meals pureed or drinks thickened where people were at risk of choking. A relative told us, "[Family member] had to have crystals (thickener) put in all their drinks. They were very good about it they never forgot." Staff said they left people with a drink before they left to make sure they remained hydrated. People confirmed staff did this. One person told us, "They make me a cup of coffee every morning, and leave me a bottle of water and a cup of coffee before they go."

People who used the service managed their own health care appointments or were supported by family to arrange these. People told us they thought staff would help them with this if they needed help. Care staff told us they liaised with a range of health professionals including, the Speech and Language Team (SALT) and the Intermediate Care Team that consisted of, district nurses, occupational therapists (OT) and physiotherapists. The registered manager told us if staff were concerned about someone's health they would let the person's family know and contact the person's GP.

Good

Is the service caring?

Our findings

We asked people if they thought staff had a caring attitude. People said they did. Comments included, "Yes I do, they're friendly and it's the way they go on, you can tell they have a caring attitude." Another said, "I think they are all very good, they are very caring." Staff we spoke with demonstrated they were caring by the way they spoke about people. For example, "We visit some lovely people. It is so good to see them regain their confidence and independence." Another said, "I do love my job, I look after people the same as I would my family."

People and relatives told us they got on well with their care workers. Relatives told us, "They listen to [name] he tells them about his life and they ask questions. They're absolutely wonderful and [name] really likes them." Another said, "[Name] says they are helpful she said they are always nice to her, and very friendly."

People told us care staff were polite and thoughtful. Person told us, "They are polite, if you want them to do anything it's never any trouble," and, "They are thoughtful and kind, and one or two of them do extra things too. They put the washing out for me if they see it's done." One person told us they had cancelled their calls a few times as they had felt unwell. They added that the care worker had "popped in to see how I was."

We asked people if they were treated with respect by the care staff. People said they were. For example, one person said, "It's the way they speak to you, it's respectful." A relative told us, "Oh yes, the way they speak to him it's lovely. There is respect on both sides."

People confirmed their privacy and dignity was maintained. One person told us, "They make sure the bath is run first, she [care worker] helps me off with my top, then bottoms' and then helps me into the bath. She always puts a towel ready to cover me." Another said, "They close the shower curtains, I carry on and they come back and check I'm alright." A relative told us when staff washed their family member, "The doors are kept closed so no-one can peer in."

Care staff told us they did not have to rush and had time to talk to people as they were allocated sufficient time to carry out the care and support required. People told us how much they enjoyed the time care staff spent with them and how they had built up friendships with the staff that visited them regularly. One person said, "We mostly chat while [care staff] does the tasks, we talk about everything like friends." Most people told us care staff talked while they worked, others said staff had time to sit and talk when they had finished. For example, "We did chat all the time while [care staff] was showering me." A relative told us, "They stay and have a little natter, [family member] tells them about the army and their experiences and they share theirs." One person told us how care staff, "spent time talking to them about anything," and how they had "really started to get to know each other".

People, relatives and staff told us how the service supported people to regain their independence. Comments from people included, "They just let me get on with what I can manage. It gets better every day and they encourage me." A relative told us, "I can hear them talk to her, they encourage her to do things for herself." Another said their family member, "…tells them [care staff] what to do, and what he wants to do,

they find it funny." Staff told us, "This is what the service is all about, supporting people to regain skills and their independence. We might start off providing four calls a day and as people progress calls are reduced until we don't have to go anymore."

The registered manager, and team leaders who completed people's assessments told us, there was no one using the service that had any specific cultural needs, but everyone had diversity needs that were reflected in their individualised care plans. No one we spoke with had any cultural or religious needs they required staff to support them with. The registered manager told us where possible they offered people a preference of gender of care staff.

People told us they were involved in their care decisions. People said, "I told them what I needed and they sorted it. It was me who made the decisions, I suppose I still do, I tell them what I want when they come." And, "We planned it ourselves, we told them we like to go out early so carers must come in the morning." They went on to say they felt in control of their care, "Yes, it was me who decided what I wanted."

Records confirmed people had signed to agree to their care being provided. Although most people could not remember signing plans they all said they had given consent for the care to be provided. One person told us "I can't recall signing anything," but went on to say, "Though I must have, I gave my consent, they wouldn't be here otherwise."

Staff told us they felt valued and supported by the registered manager and the management team. One told us, "The manager and staff in the office provide good support and communication works very well, they keep you informed about everything."

Good

Is the service responsive?

Our findings

People told us the service they received was responsive to their needs. For example, one person said, "You just ask them and they do it."

The team leaders who carried out assessments of people's care needs told us due to the nature of the service they needed to respond quickly to requests for a service. One told us, "Sometimes the assessment can be the same day we receive the referral, this means people are not delayed being discharged." Team leaders told us, where possible they visited people at home so they could carry out, "A realistic assessment of their abilities and support needs." During the assessment visit the team leaders completed a care plan. The provider used a carbon copy booklet for risk assessments and care planning, and a copy of the documents were left in the home for staff to follow.

We reviewed three people's care records kept in the office. All contained an assessment of needs and a care plan that included how any identified risks were to be managed. Plans were individual and provided care staff with information about how people wanted to receive their care and support. There were instructions for staff about what to do on each visit. For example; what personal care people required and how staff should support people who required assistance or equipment to move around.

Care staff we spoke with knew the needs and preferences of people they visited and told us they had time to read care plans in people's homes. They said there was sufficient information in care plans to inform them what to do on each call and about any risks with people's care. One told us," Everything you need to know is in the care plan, and it tells you what you need to do on each call."

People had different expectations when it came to consistency of call times. Some people said they received their care calls around the same time each day, others said their calls could be anytime within a two-hour timeframe. One person told us his care staff, "Arrive at all different times." They went on to say they had not been given a specific time that staff should arrive, only that "they will do their best" to meet his needs, which they said staff did. Another told us their care staff did arrive on time, generally just after 7:00am. They said they had been asked what time they preferred at their initial assessment and was told the agency would do its best, but couldn't guarantee they would get the time they wanted. One person said, "Yes, definitely," staff arrived on time for their morning call. Like others they had not been given an exact time staff would come, but said, "It's close enough to what suits me." They told us they had a regular care worker, "So it's easier to get the same time each day."

We discussed people's comments with the registered manager during our office visit. They told us, as the service provided short term re-enablement it was a 'non-time specific' service. As the service had to be flexible to provide care and support to people being discharged from hospital at short notice they were unable to allocate calls to people at the same time each day. People were allocated a two-hour time slot for their call to be delivered. The care co-ordinator responsible for allocating visits to people confirmed that people who required a time specific call, for example, to give medicines or provide meals, were prioritised to make sure times between calls supported people's needs.

Some people we spoke with expected their calls to be made at the same time each day and were not aware of the remit of the service. We asked the management team how people knew they would not be allocated a certain time for their call. The team leaders told us they discussed this with each person during their initial assessment. We asked if this information was included the service user guide for the service. This is information about how the service operates that is provided to people when the service begins. We looked at a copy of the service user guide that was provided to people. Information was recorded in small print on a purple background which was not easy to read. We were provided with a copy in larger print. There was no information about being a 'non-time specific' service in the guide. The registered manager told us they would speak with the provider and ask for the information provided to people to be revised.

We asked people if care staff stayed long enough to do everything they needed to. People said they did, but they also said they didn't know how long staff were supposed to stay. For example, comments included, "As far as I know they stayed the full length of time. I don't know how long they were meant to be here," and, "I don't know how long they should be here. They do everything so it's alright."

The registered manager told us that people were initially allocated a length of time for their calls. They went on to say, as people became more independent and regained confidence and skills, the times that care staff stayed would fluctuate. They said people received the service for up to six weeks but as people regained independence there would be less for staff to do. They told us some people only required the service for a few days rather than weeks, so they had to be flexible to people's needs.

People's care and support needs, and their progress to regain independence was kept under review. Staff told us people's care plans were reviewed regularly as people's needs were constantly changing as they improved. Due to the short-term nature of the service people did not have formal reviews of their care. The registered manager met with the Intermediate Care Team every week to discuss people's progress and assess if any equipment was needed to assist people's recovery. Staff told us the registered manager contacted them every week for an update on people's progress or if there were any concerns. Staff said they were notified of any changes to people's care by phone and changes were recorded in care plans for them to follow.

We looked at how complaints were managed by the provider. Complaints had been recorded, and investigated in line with the providers policy and procedures. Feedback was recorded from one complainant who wrote, 'actions were timely and comprehensive'.

People we spoke with said they, or their relative would phone the office if they had any concerns about the service. No one we spoke with had made a complaint,. One person told us, "No-one likes complaining but I would if I had to." Another said, "I would if I had to, I just haven't had to." Staff knew how to support people to make a complaint if needed, they told us, "There is complaints information in people's home folders if they want to make a compliant."

Four people we spoke with said they had asked for more consistency in their call times. People said when they phoned the office they had been told the service offered a two-hour time slot for calls. We found these conversations had not been recorded. We discussed this with the registered manager and the administrator who usually answered the phone to people. They told us these concerns would be recorded in future so they could have an overview of people's experiences and to monitor for any trends or patterns.

The Accessible Information Standard (AIS) is a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We looked to see how this standard was being met. The registered manager told us no one using the service required information in

other formats than written English, but information would be made available in other formats by the provider if people required this.

Good

Is the service well-led?

Our findings

There was a registered manager in post who understood their responsibilities and the requirements of their registration. For example, they submitted notifications and completed their Provider Information Collection (PIC) when requested. 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 management team consisted of the registered manager, a care co-ordinator and two team leaders. The registered manager told us the management team worked closely together. They did not have formal management meetings, but discussed issues related to people who used the service and staff as they arose. The registered manager said these discussions were not recorded, and acknowledged there were no records of any decisions made or actions taken. They advised these meetings would be recorded in future.

People thought the service was well managed. People told us, "Yes, it's really good they have good carers who know what they're doing. As far as we're concerned, that's all we want." Another said, "The service is well-managed because if I need anything, they're there. They answer all your questions, and if you ask them to do something, they're onto it." They went on to explain how they had asked for an earlier time to accommodate a hospital appointment and said, "They organised it all so I didn't have to worry."

Staff we spoke with also thought the service was well managed. One staff member told us, "I do like the way it's run. There is an 'open door' and you can call anytime." Another said, "It's a really good place to work we are all supportive of each other and help each other out if needed.

People were happy with the service they received, although some said they would prefer a regular call time. Comments included, "They were very good and helped me through a hard time," and, "I'm very happy with it, the carers are wonderful, especially the regular one I have now." Another told us they had been happy with the service, "Just the arrival times that isn't so good."

The registered manager and team leaders told us they explained the nature of the short-term service to people at their initial assessment. However, they said people were given unrealistic expectations about the service from the discharge team at the hospital. For example, a team leader told us, "The discharge team at the hospital will ask people what time they want their calls, for example 8am and agree to this. We just can't do this. We will try but as people are discharged we have to accommodate their needs. If they have medicines or dietary needs we will prioritise these calls so people are safe. This means people's calls are not always at the same time each day."

Staff we spoke with enjoyed working for the service and felt supported to carry out their role. Comments from staff included, "We have a good team and relationships between staff is very positive. Everyone feels comfortable coming into the office. We get on well together." Staff told us the provider paid them for the time they travelled to people's homes as well as mileage to cover fuel costs. The registered manager held

team meetings with care staff. Staff had regular supervision (individual) meetings to make sure they understood their role and spot checks to make sure they put this into practice safely. One staff member commented, "I really enjoy my job; it's a very good service. The staff in the office are really supportive you can phone anytime if you need any advice or just pop in for a chat." There was an 'on call' system for evenings and nights so that staff working out of office hours always had access to support and advice.

When we asked staff what the service did well, they all said 'communication'. One told us, "Communication is massively important in this job. It's really good here, the office keep you informed about everything we need to know." We asked staff if there was anything that could be improved. They could not think of anything. One told us, "Nothing, I am really happy here. The service does make a difference, it does re-enable people, which is very rewarding."

People told us they could contact the office if they needed to. "One person told us, "I haven't had any problems getting through. I haven't had to ring that much." Another said, "Sometimes I've got the answer phone, particularly at weekends, they've got some sort of system where even if you don't leave a message, it rings you back."

People said they were asked for their opinion of the service. Comments included, "Two senior people came out and asked us what we thought," and, "Someone did ring us, they phoned to ask if it was going well, and if [person] was happy." Another said, "We had a call last week from someone. It was welcome, it shows someone cares."

We asked people if they would recommend the service to others. People told us, "I would recommend the service because they [care staff] are so caring and do what they say and more." Another told us they would recommend the service because "Yes, because I was offered the care I needed at that time." They went on to say they had a regular care worker and, "It worked out very well." Although one relative thought the service was, "Too random, they don't offer a time or regular carers."

There were procedures to monitor the effectiveness and quality of the service. The provider and registered manager undertook regular checks to ensure quality was maintained. This included monthly audits by the provider which looked at different aspects of the service. Any action points were addressed with an improvement plan that the registered manager and provider monitored. The registered manager told us the provider had an 'intranet share point' where all accidents, incidents, safeguarding referrals and complaints were recorded. This was monitored by the providers quality team for any trends and patterns. Records from people's homes were returned to the office for checking. For example, medicines administration records (MARs) to confirm people received their medicines as prescribed

The registered manager worked closely with other professionals including brokerage who arranged placements, the discharge team at the hospital and the Intermediate Care Team that included, physiotherapists, occupational therapists, and social workers. So, they always had access to expertise and could request an assessment for equipment when needed.