Eleanor Nursing and Social Care Limited

Eleanor Nursing & Social Care Ltd - Lewisham Office

Inspection report

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20 November 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We conducted an inspection of Eleanor Nursing & Social Care Ltd - Lewisham Office on 16, 19 and 20 November 2018. This was our first inspection of this service.

This service is a domiciliary care agency. It provides personal care for people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of the inspection they were supporting 420 people. Not everyone using Eleanor Nursing & Social Care Ltd - Lewisham Office receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager at the service. 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 were given appropriate support with their physical healthcare needs, but care records did not contain enough information about people's mental health histories where there had been issues in the past.

Risk assessments identified risks to people's care and contained clear guidelines to care staff about how they were required to mitigate these. However, care records did not contain enough information for care staff where risks had been identified in relation to their nutritional intake.

The provider was not consistently meeting the requirements of the Mental Capacity Act 2005 (MCA) as care records did not always contain clear details about people's capacity and were sometimes signed by people's next of kin without clear evidence that they were authorised to do so.

The provider assessed the quality of the service, but these checks did not identify the issues we found in relation to people's mental health records and ensuring their care was delivered in line with their valid consent.

The provider had suitable safeguarding systems in place for the prevention of abuse. Care staff had received safeguarding training and understood the usual signs of abuse and what to do if these occurred.

Recruitment procedures helped ensure candidates were safe to work with people. The provider conducted appropriate pre- employment checks to assess candidate's suitability for employment within the service.

Medicines were managed safely and people received support with their medicines where needed. The provider conducted checks of medicines administration and took action to rectify issues where needed.

Care workers received an appropriate induction and ongoing training, supervisions and appraisals of their performance.

Care staff had a good understanding about people's preferences in the way they wanted their care delivered. Care staff supported people to be as independent as they wanted to be.

Care workers ensured that people's privacy and dignity was respected and promoted.

The provider had an effective complaints procedure and people told us they would raise a complaint if needed.

The provider met the Accessible Communications Standard and communicated with people in person and in writing in a manner that suited their needs.

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.

The provider assessed and appropriately mitigated risks to people's safety. Care workers had a good understanding of the risks involved in people's care.

The provider had appropriate systems to help protect people from the risk of abuse. Care staff had received training in safeguarding people and were aware of what actions they were required to take if they suspected someone was being abused.

People were supported to receive their medicines safely where they required support. Where issues were identified, the provider took reasonable action to rectify this.

The provider conducted safer recruitment practices to help ensure candidates were safe to work with people.

Care staff understood how to provide hygienic care to minimise the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People gave good feedback about the abilities of their regular care workers, but were not as positive about newer care workers.

Care records contained useful information for care workers about people's physical health needs, but did not always contain enough information about people's mental health histories. There was not always enough useful information about how care staff could mitigate risks associated with people's nutritional intake.

The provider was not always working in line with the Mental Capacity Act 2005 (MCA).

Staff received an induction, training and supervision of their performance.

Is the service caring?

Good

The service was caring.

People gave positive feedback about their care workers and told us they were kind and treated them well.

People's privacy and dignity was respected and promoted and care workers gave us examples of how they did this. People were supported to be as independent as they could be.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning of their care and people's care records contained information about different areas of their care needs.

People's care records included details of their recreational interests. The provider communicated with people in a way that they could understand, according to people's needs.

Is the service well-led?

Good

The service was well-led.

The provider conducted quality monitoring, but this did not identify the issues we found in relation to people's mental health records, their nutritional needs and delivering care in line with people's valid consent.

Care workers gave good feedback about the registered manager.

The provider sought feedback from people using the service and took action to resolve any issues identified.

Eleanor Nursing & Social Care Ltd - Lewisham Office

Detailed findings

Background to this inspection

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

We visited the office location on 16, 19 and 20 November 2018 to see the registered manager, office staff and to review care records and policies and procedures. After the site visit was completed we then made calls to people who used the service and their relatives.

Prior to the inspection we reviewed the information we held about the service which included notifications that the provider is required to send to the Care Quality Commission (CQC).

We spoke with 27 people using the service and 13 of their relatives on the telephone. We spoke with 10 care workers after our inspection over the telephone. We spoke with the registered manager of the service and other senior members of the management team. We also spoke with two care coordinators who were responsible for the rotas and line managed care workers. We also looked at a sample of 25 people's care records, 10 staff records and records related to the management of the service.

Good

Is the service safe?

Our findings

Our discussions with people using the service identified no safety concerns. People told us they felt safe when using the service. Comments from people included, "I feel safe" and "I trust them."

The provider had effective systems and processes in place to safeguard people from abuse. Care workers were able to explain the signs of abuse and what they were supposed to do to help prevent abuse. One care worker told us "If we think someone is being abused we would definitely report it to the manager" and another care worker said "I wouldn't just report things and leave it there. I would make sure something was done about it and the client was safe."

The provider had an appropriate safeguarding policy and procedure in place which included the procedure to be followed in reporting a concern as well as the contact details of local authority safeguarding teams. We reviewed the provider's safeguarding records and saw that concerns were recorded and appropriately reported.

There were appropriate systems in place to enable staff to whistleblow. Whistleblowing is when a staff member reports suspected wrongdoing at work. Staff can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

Risks to people's safety were assessed and managed appropriately. People's care records included risk assessments for known risks associated with their care as well as guidance for care workers about how they were expected to manage risks. For example, we saw one person's record stated that they were at high risk of falls due to having problems with balance. Their care record specified what they were able to do themselves as well as what assistance they required. For example, the person needed assistance to get out of bed. The person's moving and handling risk assessment stated that they could mobilise independently with the use of grab rails as well as a walking stick. They had a separate falls risk assessment in place which included guidance for care staff about monitoring the person while they were moving, ensuring their environment had no tripping hazards and ensuring that they were wearing appropriate footwear. Another person's care record included a skin integrity risk assessment relating to leg ulcers. The assessment was detailed and included advice for care workers about managing the person's sensitive skin, how to differentiate between their leg ulcers and bruising which they were particularly susceptible to, as well as a body map which identified the specific areas of the body that the person's ulcers covered.

Care workers also demonstrated a good understanding about the risks involved in caring for people. Care workers explained that one of the most common risks people faced was falling. One care worker told us "The main risk is the risk of falls… we do things like making sure there are no wires or things to trip on and we watch people carefully to make sure they are moving around ok."

Appropriate investigations were conducted into accidents and incidents and other concerns. We saw records of investigations that had been conducted and saw that these contained details of the concerns raised and action taken to rectify these. This included taking statements from all parties concerned as well

as exploring any lessons learned. For example, we saw one concern raised by a clinical nurse specialist who visited one person and saw that their flat was untidy and there was no medicines administration record (MAR) chart in place. The person's field care supervisor visited the person in the presence of their social worker and found at the time of their visit that issues had been rectified, but also spoke with the care worker involved to make sure they were aware of the concerns and what they were expected to do. We saw that one of the learning points from this investigation included improving communication between the care worker and office based staff. As a result, a reminder was sent to all care workers via a newsletter to ensure that care workers reported any issues to their care coordinator when needed.

Care staff received training in safety systems and practices. For example, all care workers received training in emergency first aid. When we spoke with care workers, they had a good understanding about how they were supposed to respond in the event of an accident or other medical emergency. For example, one care worker told us "If something happened I would assess the situation, call an ambulance straight away if I had to or maybe the GP if it wasn't an emergency. I'd remove any hazards depending on what happened and always report it to the office."

The provider effectively managed risks within people's homes to ensure their living environments were safe. Each person had an environmental risk assessment conducted as part of their initial assessment prior to using the service. We saw this included details of any concerns about their gas and electricity, whether there were any tripping hazards within their home or any other environmental issues that needed consideration. The assessments we saw did not identify any issues and there was confirmation that people's home environments were appropriate to their needs. For example, those people with moving and handling needs had corresponding occupational therapist visits with any adaptations made as required.

The provider ensured that there were a sufficient number of suitable staff deployed to meet people's needs. Care workers confirmed that their skills and availability was ascertained when they first joined the service. Care workers confirmed that they were matched to people based on their skills and experience and felt enough of them were sent for an appropriate length of time based on people's needs. We reviewed six care workers rotas and these consisted of 289 calls. We found that the provider allowed enough time for over 95% of people to receive their care call within 15 minutes of the scheduled start time. Care workers confirmed that they were given sufficient travel time to do their work. One care worker told us "We do get enough travel time and if there was a problem, I would report this."

The provider practised safer recruitment practices to help ensure candidates were safe to work with people using the service. We looked at 10 care worker's files and saw these included evidence of application forms with their previous employment history, identification as well as criminal record checks, evidence of their right to work in the UK and two references from their most recent employers.

Medicines were managed safely. People's care records specified the level of support they required with their medicines. Some people required no support and were able to take their medicines independently. However, some people required care workers to prompt them to take their medicine or to administer their medicine for them. Where care workers were responsible for administering people's medicines, they were required to fill in MAR charts to document that this had happened. Office based staff known as care coordinators were required to check completed MAR charts monthly to ensure that care workers were administering people's medicines properly. People's medicines were also checked during spot check visits. We saw one example where concerns had been identified with the recording of one's person's medicines as their MAR chart contained gaps and errors. Records indicated that the care worker responsible was spoken to and given a warning. This demonstrated that issues were identified and action taken to remedy these. We also saw that people's care plans were not consistently updated with their most recent medicines list. We

spoke with the registered manager about this and she confirmed that the most recent information about what medicines people were taking was contained within their MAR chart and this is what care workers accessed when administering medicines to people. Care workers also confirmed they relied on people's MAR charts for up to date information about which medicines people were supposed to be taking.

Care workers had a good understanding of their role and responsibilities with regard to infection control. We spoke with care workers about how they protected people from the risk of infection and comments included "I always make sure I wash my hands first thing, before I do anything" and "We use aprons and gloves. This is really important."

The provider had an appropriate infection control policy and procedure in place. This included details of care workers responsibilities as well as guidance in best practice such as hand washing techniques. We also saw that care records included personalised guidance in infection control where needed. For example, one person's care record stated that they had a stoma bag fitted. Care workers were required to ensure that the person's wound site was kept clean to minimise the risk of infection. There was also a risk assessment in place regarding the risk of infection from having a stoma bag in place and it included details of signs of infection for care workers to be aware of. For example, redness and swelling. The risk assessment included guidance for care workers to contact the person's district nurse or GP in the event of an infection as well as reporting this to their care coordinator.

Requires Improvement

Is the service effective?

Our findings

People's needs were not effectively met as the provider did not always ensure care was provided in line with people's valid consent. 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, and found that the provider was not always meeting the requirements of the MCA. We identified one person whose mental capacity assessment confirmed that they did not have capacity to make decisions, however, there was no corresponding best interests documentation to demonstrate that the decision to provide the person with care had been taken in their best interests and in consultation with any other relevant parties. We saw another person's care record stated that they experienced confusion and were at risk of self-neglect. However, there was no mental capacity assessment in place to determine whether or not they had capacity. . We also saw examples of people's care plans being signed by relatives without any information about whether they had the authority to do so.

We recommend that the provider seeks advice from a reputable source to ensure that they fully meet their responsibilities under the MCA and clearly demonstrate that decisions are only made on people's behalf by those with the legal authority to do so.

Care workers had a good level of knowledge of the MCA and understood the importance of assessing whether people had capacity to make decisions. Care workers confirmed they had received training in the MCA and if they had any concerns about people's capacity, they would report this. One care worker told us "If someone didn't have capacity I'd make sure the office was aware."

People gave good feedback about their regular care workers ability to do their jobs effectively, but told us that this was not always the case with care workers who were not familiar with their needs.. People's comments included "Regular support workers are consistent and know what they are doing but others who aren't as regular have to be told what and how to do things. Training wise, we think they are well trained, they are polite, courteous and show a lot of respect." Another person told us "My two main carers are delightful and competent; some are not up to scratch, they are muddled and need more training."

People received appropriate support with their physical health needs, but did not always receive appropriate support with their mental health needs. We saw people's care records included details about their vision, their foot care and dental care. However, we identified two examples of people with a serious mental health history which was not included in their care plan. For example, we identified one person who previously had 'suicidal ideation' which was confirmed within an assessment that had been completed within the last two years. The person had a history of self- harming which was recorded in the rota that staff received. However, we saw their care plan stated that 'I am feeling alright, not bad' and the mental health

section of their care plan stated that the 'client does not have any mental health issues'. We spoke with the registered manager about this person and she confirmed that the person had been discharged from mental health services and that there were no longer any risks associated with their mental health. However, we noted that the person's mental health history and signs of relapse were not recorded within their care plan for care workers to recognise and appropriately manage any potential future change in their mental health condition. Following the inspection the provider sent us documentation stating that care workers were to report any concerns regarding change of mood or risk of self-harm.

Likewise, we saw another person's rota stated that the person had a depressive illness, low mood and negative thinking. They were identified as having recurrent depression with a high risk of self- harm and had previously been sectioned under the Mental Health Act. We spoke with the registered manager about this person and they confirmed that they had also been recently discharged from mental health services. Once again, we found there was no recorded information within the person's care plan about their mental health history along with any potential signs of relapse for care workers. Following the inspection the provider submitted documentation stating that care workers should report any concerns indicating a deterioration in the person's mental health.

People's care records did not always contain sufficient information for the management of their nutritional needs. We saw some people's care records included specific information about their likes and dislikes in relation to food and whether they had any particular nutritional requirements. For example, one person's care record gave details such as the breakfast cereal they enjoyed and that care workers were to ensure that the cereal did not go soft before giving it to them. There were details recorded such as how they took their hot drinks. Their record included details about their eating and drinking skills and stated that they were able to use a cup as long as the cup was only half filled. However, we identified two care records for people who were at risk of malnutrition and dehydration that did not contain enough advice for care workers. One person's rota which was given to care workers, included some information that they had reduced food and fluid intake which had previously resulted in weight loss. However, their care plan did not contain information for care workers about how they were supposed to manage this risk should it reoccur. We spoke with the registered manager about this and they confirmed that the person was no longer at risk, but they amended the person's care plan to include this history. We saw another person's rota included details of a risk of malnutrition and dehydration and also stated that they had diabetes. However, their care plan did not include any details of this risk or that they had diabetes. We spoke with the registered manager and they confirmed that the person had not been using the service since August 2018 and were therefore no longer at any risk.

Care workers were provided with an appropriate induction, training and ongoing supervisions and appraisals to perform their roles. The induction consisted of a five day training programme which covered all 15 standards of the Care Certificate as well as practical training with moving and handling and medicines administration. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of job roles in the health and social care sectors. Care workers confirmed they had received an induction prior to starting work and that they found this useful. One care worker told us "The induction was good and I felt ready to start work at the end".

Records indicated that care workers received appropriate training in mandatory subjects on an annual basis. This included safeguarding adults, medicines administration and moving and handling training. Care workers confirmed they received this training and that they felt they received enough training to do their jobs. One care worker told us "They give us a lot of training and you can always ask for more if you need it".

Care workers received quarterly supervisions and annual appraisals of their work. Records indicated that

care workers received these and they told us they found these useful to their roles. One care worker told us "We get supervisions and appraisals and they're definitely useful" and another care worker told us "We get spot checks and they are unannounced… It's always useful to get feedback." Records confirmed that spot checks were conducted every three months.

People's needs and choices were delivered in line with current legislation and guidance. We spoke with the registered manager about how she ensured that people's needs were met in accordance with best practice and she stated that care workers were given up to date training every year, and policies and procedures were reviewed annually to ensure they were current. We reviewed some of the policies and procedures used within the service and found that these were in line with legislation and guidance. For example, we saw the provider's safeguarding policy and procedure included reference to the Counterterrorism and Security Act 2015 and the Modern Slavery Act 2015 among others.

Good

Is the service caring?

Our findings

People told us their care workers were kind and treated them well. People's comments included "They are very nice, if I am depressed they will chat and cheer me up" and "I'm very happy and pleased to have them; they are like a family to me, we have nice chats."

Care workers demonstrated that they understood the people they were caring for and had taken the time to develop an understanding of their needs. Care workers gave us examples of how people liked to have their care delivered, their routines and particular rules they wanted them to adhere to when coming into their homes. One care worker told us "I try to remember how people like things done in their homes. It's important to follow people's rules."

Care workers also gave other examples about people's life history or their families to demonstrate that they knew the people they were caring for. One care worker told us "When you're caring for people you get to know their families as well as you get to know them" and another care worker told us "I get to know the people I'm caring for and try to remember things they're interested in. If I know someone is watching something on tv, I might ask about it, or if they support a team, I might talk to them about that."

People told us that care workers safeguarded their privacy and dignity and treated them with respect. People's comments included "they know how to treat me with respect," and "They are very respectful, they help me with personal care but allow me to be as independent as I can be." Care workers gave us examples of how they respected people's privacy and dignity, particularly in relation to personal care. One care worker told us "When I'm giving personal care, I make sure everything is done in private" and another care worker said "I try to make people feel at ease when I'm giving personal care. It's not easy for someone to ask for this kind of help." We saw care records included details about whether they preferred a male or female care worker and people's daily notes demonstrated that their wishes were being adhered to.

People's care records included some details which assisted care workers in helping people to be as independent as they wanted to be. Care records included some information about what activities of daily living people could perform independently as well as what care workers were supposed to do to support people. For example, we saw that people's moving and handling records contained specific details about which movements people could perform alone, such as moving from a sitting to standing position or changing position or getting out of their bed. We also saw people's nutritional information contained specific details about whether they could prepare any meals for themselves or whether they were able to hold their cutlery. Care workers had a good understanding about how they should support people to be as independent as possible. For example, one care worker told us "You don't want to take people's independence away, so it's important to encourage them to do as much as they can by themselves".

Good

Is the service responsive?

Our findings

People were involved in formulating their care plans. We spoke with the registered manager and she confirmed that people's initial assessments were conducted with them and their families and that their plan of care was based upon these. We saw people's care records included some personalised details which demonstrated that they had been involved in formulating these. For example, we saw records of people's and likes and dislikes in relation to the food they ate as well as some other information about their personal lives and relatives and friends important to them.

People's care records covered a range of different areas of their needs. The care plan template included sections that covered people's physical health as well as their social and nutritional needs. People's care records also included a 'One page profile'. This was a personalised account of different areas of the person's individual needs and the questions asked were 'what is important to the person', 'how best to support them' and 'what those who like me say they like and admire about me'. We saw varying levels of detail within the one page profile that was completed for different people. However, we found this document assisted in providing the care worker with a concise summary of the person, their personality and their needs. The type of information included ranged from details about the person's family and friends, their pets and healthcare needs. Care workers told us they found the document useful. One care worker told us "It's a good summary."

People's care records included some detail about their social interests and whether care staff could support them in these. The care plan template form which was used included a specific section about people's recreational needs. Where care workers were not required to assist people outside their home, we found the records included information about what people enjoyed doing within their own homes. For example, we found this stated whether people liked to watch tv, to read or to do any other activity such as listening to music. Care workers told us they used this information as well as people's specific instructions to assist them. For example, one care worker told us "You try to be useful before you leave people to go to the next call. I might say if a programme is coming on TV that I know the person likes or I might find the remote. I like to leave people with something to do that I know they like."

People were assisted with their communication in accordance with their needs. We saw people's care plans contained a communication section which specified whether people had any particular needs such as any hearing problems or difficulty verbalising. For example, we saw one person's care record stated that they spoke slowly as a result of their physical condition, but that their cognition was sound. Care workers were therefore instructed to allow the person time to verbalise their response to any questions staff might ask. We saw another person's care record notified care workers that they were occasionally confused and care workers were required to speak slowly and clearly with the person. We spoke with care workers about how they met people's communication needs and they demonstrated a good understanding about people's individual requirements. For example, one care worker said "You have to talk to people in a way they understand. If someone has hearing problems, talk louder and more slowly."

The provider met the Accessible Information Standard (AIS) through providing information to people in a format that they were able to access and understand. The AIS is a national standard that all organisations

providing NHS or adult social care are required to implement. The AIS ensures that people using services who have a disability or sensory loss receive information they can access and understand. For example, we found the provider's complaints policy was available in an easy read format and the registered manager confirmed that other information such as policies and procedures could be made available in either different languages or an easy read format on request.

People told us they would feel comfortable raising a complaint if needed. One person told us "I don't have to moan about anything, but would if I had to" and another person said, "I am very happy and am sure there won't be problems, but I can deal with them if I do. I will contact the office." The provider had a complaints policy and procedure which stated how formal complaints were supposed to be dealt with. This included stipulating a timeframe for an acknowledgment and response to complaints. We looked at complaints records and saw records of investigations and appropriate follow up actions that were taken as a result. For example, we saw one record which involved a complaint about a missed call. Records indicated that the provider had taken statements from all parties, had identified that the root cause of the missed call was miscommunication between the care worker and office based staff, and discussed the matter with all involved so as to avoid a repetition of the incident.

Good

Is the service well-led?

Our findings

The provider did not always effectively monitor the quality of the service. Auditing systems were in place, but we found these did not identify the issues we found in relation to ensuring care was delivered in line with people's valid consent and people's mental health needs. Care records in relation to people's mental health needs did not always provide an accurate and contemporaneous record detailing their needs as these had not always been updated when their needs changed or did not always reflect important historical information about their mental health.
We recommend that the provider reviews systems to ensure that each person's care records are up to date and provide a contemporaneous and accurate record.

The provider conducted a monthly analysis of people's daily logs, medicine administration records (MAR) charts and spot checks that had been conducted. Where issues had been identified we found the provider had devised action plans to remedy any issues.

The provider conducted annual surveys and monitoring visits to people using the service to obtain feedback. Monitoring visits were conducted every six months and were conducted by field care supervisors to ensure care packages were being delivered in accordance with people's needs. We saw copies of these within people's care files and found these were generally positive. We also read a copy of the most recent survey conducted. We found the survey was comprehensive in scope and asked particular questions about the service and people's views on their care workers. Responses to questions were also positive and indicated that people were happy with the service being delivered. We spoke with the registered manager and she confirmed that where individual issues were identified, these would be addressed individually. We saw an action plan had been developed into areas that could require improvement and these included timeframes for completion.

Care workers gave good feedback about the registered manager and told us they were happy to work for the service. Their comments included "This is a good place to work" and "You can talk to the manager- she listens to you and wants to help."

Care staff had a good understanding of their roles and responsibilities and told us this was made clear to them when they applied for their roles. We saw copies of care workers job descriptions and found these tallied with care workers understanding of their jobs.

The registered manager confirmed that she communicated with care staff through supervision meetings and spot checks and also delivered wider messages about the organisation through monthly newsletters and regular team meetings. We saw a copy of the provider's individual branch newsletter for August and September 2018. We saw this included information on various subjects such as inspirational stories from care workers about their experiences of working with people using the service, a reminder about care workers' responsibilities to whistle blow about concerns and introductions to new staff members. There were also details about the 'carer of the month' which was awarded to a care worker who had performed exceptionally well and deserved recognition.

Various team meetings were held between different team members. For example, care workers located within individual 'zones' held monthly team meetings to discuss organisational matters within the geographical area they operated in. These were led by their Care Coordinator who was based in the office and organised their rota. Further meetings of all care coordinators were held every six months and a full team meeting was also held every six months. Care workers told us they found team meetings to be a useful means of communication with management. One care worker told us "They're really good. You can get together and talk about things with other carers and find out what's going on with everyone else".

The provider kept the day to day culture of the service under review. Care workers told us the registered manager was approachable and they felt comfortable raising any issues with her. One care worker told us "She's really nice. She listens and wants to help" and another care worker said "She's a very good manager."

The provider worked in partnership with other agencies where needed. For example, we saw minutes of team meetings where district nurses had been invited to speak with care workers directly. We also saw correspondence to demonstrate that the provider was working with healthcare professionals such as occupational therapists, GPs, social workers and district nursing teams in relation to individual people's needs.