A New Angle Ltd

Independent Home Living (Beverley)

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 inspection took place on 3 March 2016. The inspection was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the location offices when we visited.

Independent Home Living Beverley is a domiciliary care agency which is registered to provide personal care to people in their own homes. The service supports people living in Beverley and the surrounding villages and provides assistance with personal care, domestic help and companionship. At the time of our inspection the service supported approximately 100 people with approximately 70 people receiving support with a regulated activity.

The service was last inspected in April 2013 at which time it was compliant with all the regulations we assessed.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes.

We found that people's needs were assessed and risk assessments put in place to keep people using the service and staff safe from avoidable harm. We found that the administration of medicines was being audited appropriately. However we found that some medications were not always accurately recorded. People were happy with the service they received and told us that the staff usually arrived on time. They told us that they generally received support from the same member of staff or group of staff.

We saw that staff completed an induction process and they had received a wide range of training, which covered topics including safeguarding, moving and handling and infection control and also more specific

training such as dementia awareness and pressure area care. Staff told us they felt well supported; they received regular supervision and attended team meetings. Staff were also encouraged to complete an NVQ Level 2 or higher.

People were supported to make decisions and choices. Staff received training on the Mental Capacity Act 2005 and were aware of the importance of using this legislation should any decisions need to be made on behalf of a person who used the service.

Some people told us they received support from staff with shopping, cooking and domestic tasks. They were involved in choosing what items they wanted staff to buy or what they wanted making and were generally satisfied with the meals prepared. People were supported to access healthcare support where necessary.

People told us that staff were caring and that their privacy and dignity was respected by the agencies staff. People told us that they received the support they required from staff and that their care packages were reviewed and updated as required.

We saw that people's needs were assessed and care plans put in place to enable staff to provide responsive care and support. People had been involved in the planning of their care and relevant people were included in reviews.

People were supported to make choices and decisions and to feedback any concerns. There were appropriate complaints procedures in place should people need to raise any issues.

People using the service and agencies staff told us the service was well-led. We could see there were systems in place to monitor the quality of care and support provided and evidence that action was taken to address any concerns.

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.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm. Risk assessments were in place and reviewed regularly which meant they reflected the needs of people receiving a service from the agency.

Recruitment practices were robust and ensured only those people considered suitable to work with vulnerable people were employed. There were sufficient numbers of staff employed to meet people's assessed needs.

Systems were in place to ensure that people received their medication safely and as prescribed by their GP. Staff competencies were checked on a regular basis and medication records were audited monthly to check for accuracy of recording.

Is the service effective?

Good

The service was effective

Records showed that staff completed training that equipped them with the skills they needed to carry out their role.

Staff received training on the Mental Capacity Act 2005 and understood the importance of seeking peoples consent.

People told us that their nutritional needs were assessed and that they were happy with the support they received with meal preparation.

People had their health and social care needs assessed and received additional care and treatment from appropriate health professionals.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. Staff knew people's preferences and they responded to people in a kind and caring manner.

People were supported to make decisions about the care and support they received and their independence was promoted.

People were treated with respect and staff knew the importance of maintaining people's dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs were assessed and continually reviewed which meant that staff were aware of their up to date care and support needs.

People's individual preferences and wishes for care were recorded and these were known and followed by staff.

There was a complaints procedure in place and we saw that formal complaints received had been investigated appropriately. People told us they were happy
to discuss any concerns with the agencies staff and knew how to make a complaint if needed.

Is the service well-led?

Good

The service was well led.

The service had effective systems in place to monitor and improve the quality of the service.

People told us they were happy with the service they received and staff told us they enjoyed their role.

There were opportunities for people who used the service and staff to express their views about the service that was provided by the agency.

Independent Home Living (Beverley)

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 registered 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 inspection took place on 3 March 2016 and was unannounced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in location offices when we visited.

The inspection was carried out by one Adult Social Care inspector.

We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur. The registered provider was not asked to complete a provider information return (PIR) prior to this inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

We also sought relevant information from East Riding of Yorkshire Council quality monitoring team, and a social worker. They told us they did not have any concerns about Independent Home Living Beverley at the time of our inspection.

As part of this inspection we spoke with seven people using the service by telephone and visited three people in their own homes (with permission). We also spoke with two relatives to ask them their views of the service. We visited the registered provider's office and spoke with three members of staff who provide

support in people's homes and two care coordinators who are responsible for arranging rotas. We also spent time with the regional manager. We looked at six people's care records, five staff recruitment and training files and a selection of records used to monitor the quality of the service.

Good

Our findings

The agency had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the registered manager used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We looked at the safeguarding records and found that no concerns had been reported in the past 12 months. We saw from training records that all staff had completed training in safeguarding vulnerable adults from abuse and that the principles of safeguarding were regularly discussed during team meetings.

We spoke to staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. The staff provided us with appropriate responses and told us that they would initially report any incidents to the care coordinators or the registered manager. They also told us they knew how to escalate the concerns if they felt the issue had not been appropriately addressed. Staff told us "If I saw anything that concerned me, I would make sure the person was safe and then report it to the manager straight away and let them deal with it" and "I would speak with either the care coordinators or [Name of manager]. If I wasn't happy with their response I would speak with social services." One member of staff gave an example where they had reported a concern in relation to the medication a person who used the service was receiving. They told us the registered manager had arranged a review to discuss the concern and this ensured that all of the people involved in the persons care had a clear understanding of how the person's medication should be managed.

We found the registered provider had systems in place to ensure that risks were minimised. Care plans contained risk assessments to identify potential risks to people using the service and staff. This included an assessment of environmental risk, risks associated with the location, individual risks to the person using the service and any risks to staff. These assessments listed the type of risk, who was at risk and what actions had been taken to eliminate or reduce the risk. We saw that staff were protected from potential risks associated with lone working. Staff told us that the phone they carried enabled them to send a distress signal to the office if at any time they felt threatened either during or traveling to and from a call. This enabled the office staff to locate them and respond accordingly.

We saw some staff were required to drive between calls and take the people they supported out in their own cars. To ensure that people were protected from any risks associated with being a passenger in a staff member's motor vehicle, the agency had ensured that all staff who were required to drive had a current valid driving licence, a valid MOT certificate and the correct insurance to enable them to transport people as part of their occupation.

The agency had a business continuity plan which recorded how issues such as adverse weather, illness to staff or power failure might impact on the delivery of care and the action to be taken by staff to address this. The plan recorded the need to communicate, assess, consider key resources and evaluate. It gave clear guidance to staff on how to manage in an emergency. On the day of the inspection we found that staff from another of the registered providers services were also utilising the Beverley office as their internet connection had failed. This showed that the contingency plans in place enabled the service to continue to operate effectively in the event of unforeseen circumstances.

We checked the recruitment records for five members of staff. We found an application form was present which recorded the person's qualifications, previous employment history and the names of two employment referees. We saw that a thorough interview process had taken place that included questions that helped the registered provider learn what motivated, influenced and inspired the applicant to apply for a role as a care worker. Applicants provided documents to confirm their identity; these had been retained with personnel records. Two written references and a Disclosure and Barring Service (DBS) check had been obtained by the registered provider. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. It was clear from the records we saw that new staff did not start to work unsupervised until all safety checks had been received by the agency office.

We asked the area manager how they ensured there was sufficient numbers of staff to meet the needs of the people using the service. We were told that the registered provider completed an assessment of people's needs before they started providing a service and this enabled them to determine the number of staff needed to safely deliver the required care and support. We were told that the number of calls required and the number of staff needed at each call were all taken into consideration before the package of care was agreed. The area manager told us "We are a growing company and continually recruit new staff; we currently induct two new staff members every month. If we found we had three staff leaving the company, then we would look to step up recruitment further."

Staff told us their 'runs' were planned on a geographical basis and this helped to ensure that they were usually able to arrive at people's homes on time. One member of staff told us "The care coordinators try and keep my calls all in the same area; this means there isn't much travel time between my calls." Another said "The calls are well organised and this means I can usually get to my next call on time" and "If I feel that I've not been given enough time to get to the next call then I will speak with the care coordinator and they will review it for me."

We found that the registered provider used an electronic call monitoring system that enabled them to track the time the call started and finished. The system was linked via Global Positioning System (GPS) to 'smart phones' that were issued to each member of staff. This enabled staff to check in on arrival and check out at the push of a button. The registered provider was able to set tolerances which would alert the care coordinators in the office if a call was more than five minutes late or had been missed. The care coordinators would then contact the member of staff to establish if they were alright and to ask what time they would be attending the call. If they were going to be more than ten minutes late then the person expecting the call would be contacted to reassure them that the member of staff was on their way.

People who received a service told us that staff were usually on time. Comments included "They are pretty good at getting here on time", "They are generally on time and always call if they are going to be more than ten minutes late", "They are usually on time, but my street is very bad for parking and they only get 5 minutes to travel a mile and a half" and "They are better than they used to be for turning up on time, I just

wish they would always call to let me know if they are going to be late." However, one person told us that their lunchtime call was scheduled for 12pm, but was sometimes moved to 1pm. They told us that they went out on a Wednesday afternoon and if the call was late it meant they had to rush or cut the call short. They told us they had raised this with the office staff and had been told they could not fit them in at the time requested. We discussed this with the regional manager who told us they would us they contact the person to resolve this issue.

The registered provider had a medication policy in place and the regional manager told us that all staff received training in medication management prior to administering any medication in people's homes. The staff we spoke with confirmed they had received training and told us they felt confident with the process. They told us if they had any concerns then they would speak with the care coordinator before giving a person any medication.

The registered manager told us that medication administration records were returned to the office on a monthly basis and were checked by the care coordinators for accuracy. They were also checked during spot checks that took place in people's homes. Any gaps or anomalies were cross referenced against the diary records to identify an appropriate explanation. If an explanation was not identified then the care coordinators were able to identify the staff member who had attended the call and these issues would be addressed. We discussed the process for reducing the number of medication errors with the regional manager. They told us that all medication errors were addressed through supervision. If the same member of staff made two errors then they would be required to retake the medication training. If a third error occurred then the staff member would be 'taken off' all calls that required the administering of medication.

We looked at Medication Administration Record (MARs) for the three people we visited in their homes and found that two of the records had gaps on one occasion without an appropriate explanation. We discussed this with the regional manager who told us that they would address this immediately with the staff involved to identify the reason for these gaps. They stated that they would also increase spot checks on the staff involved to ensure that medication was administered in line with the registered provider's policy.

Good

Our findings

We looked at the induction, training, supervision and appraisal records for five staff. We saw that staff had completed a five day induction which included training in number of key topics, such as the role of a social care worker, communication, reports and record keeping, dementia awareness, medication management, safeguarding, health and safety, food hygiene, infection control, moving and handling, first aid and Cardiopulmonary resuscitation (CPR), equality and diversity and pressure area care. We were told that periodic refresher training was also completed by staff in these topics and this ensured they maintained their level of knowledge and skills. Discussions with staff confirmed this.

All new staff were then required to complete a number of shadow shifts where they observed a more experienced member of staff carrying out their role. This gave them the opportunity to meet people before providing care and allowed them to develop and test their skills and knowledge. One member of staff told us that they were initially a little nervous about working on their own in people's homes. However they told us that they discussed this with the registered manager and it was agreed they could spend additional time shadowing more experienced members of care staff until they felt they had the confidence to work independently. They told us that this approach enabled them to develop the self-assurance required and they were now fully confident in their ability to effectively carry out their role.

Once the induction process was completed all new staff were enrolled on the Care Certificate. The Care Certificate is an identified set of standards which social care and health workers adhere to in their daily working. It covers 15 topics including, for example, understanding your role, duty of care, privacy and dignity and infection control. Following the completion of the Care Certificate staff were then enrolled on the NVQ level 2 or equivalent in care and the registered manager told us staff were then encouraged to complete their Level 3 award.

Staff told us they felt well supported and that they were able to approach the regional manager and office staff if they had any concerns. They told us they had supervision every three months and we saw copies of supervision notes in staff files. Staff told us this was an opportunity to discuss any concerns they may have, identify any training needs and also discuss whether they had any concerns regarding the people they supported. Staff also told us that 'spot checks' were completed by the field supervisor. The field supervisor checked whether they were wearing a uniform, turned up on time, stayed for the required length of time and also how they interacted with the person they were supporting. One member of staff told us "Sometimes the field supervisor will be waiting for you when you arrive at a client's home. They check to see if I am on time, how I am dressed, how I approach people and they give me feedback to tell me how I have done. I've had

good feedback so far, which helps me know I am doing the right things."

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 registered provider was working within the principles of the MCA. We saw that staff completed MCA training as part of their induction and their on-going training. Staff were able to tell us how they requested people's consent before performing any care tasks and enabled people to make their own choices where possible. Care plans contained information relating to people's capacity and advised what decisions people were able to make, when they might require support to make a decision and who the decision maker would be. One person who received a service told us "My son deals with the office and if there are any decisions to be made, we talk it through and he sorts it out." We saw that people using the service or their representative had been asked to sign a consent form agreeing to the care and support provided and that they were involved when the care package was reviewed.

One member of staff told us they had started to develop a better understanding of dementia and that this allowed them to provide better support for people. They told us "One client I visit thinks that every day is a bank holiday Monday, I don't correct them I just go along with it as it makes them happy." We asked the staff member what they would do if they thought a person was putting themselves at risk through their behaviour. The staff member said "I would discuss this with the office and they would arrange a meeting."

Some people who received a service required support with shopping for food and the preparation of meals and drinks. The amount of support required varied from person to person. One member of staff told us "Sometimes all I need to do is put a meal in the microwave. If their family has bought the meals and there is choice then I always ask the client which one they would like. Other times people might ask for sandwich and occasionally I will cook a meal from scratch if they have all the ingredients." People who received a service told us that some of the staff who attended were capable of preparing a variety of meals. One person said "The carers prepare all my meals - they can cook anything but mostly I have spaghetti bolognaise and stew's." We asked if they had a choice of what food was prepared and they told us "Yes, I put all the ingredients out for them and then they cook whatever I ask." However, one person told us that they sometimes had to tell the member of staff how to prepare some foods as they did not always have the necessary culinary skills.

We asked staff how they ensured that people were getting enough to eat and drink. Staff also told us they could monitor people's weight by looking for signs such as whether the person's clothes were becoming looser or too tight. They told us if they had concerns they would start to monitor a person's food intake more closely by checking how much of the meal the person had eaten at each visit. They told us that any meals they prepared were recorded on a weekly food chart and also in the daily diaries. We looked at the food and fluid charts and found that they were not always fully completed; however, we found that this information was available in the daily records. We discussed this with the regional manager and they told us that the food and fluid charts should only be used when people's nutritional status was deemed to be at risk. They told us they would address this with staff. These steps helped ensure that people's nutritional needs were met.

Staff monitored people's health and ensured risks to their health were minimised. Information about each person's physical health needs was recorded in their care plan, including specific details of any known

health care conditions. One person's care plan included information about their restricted mobility and the use of safe moving and handling practices. We saw people had support from GPs, dieticians, district nurses and physiotherapy when needed. One person receiving a service told us "If I am unwell then the carers will speak with my family and they can get in touch with my doctor." The regional manager told us that, if family were unable to provide support then staff would accompany people to health appointments. One person told us they had recently required a member of staff to take them to the hospital. They said "I'd not met her before but they were very, very kind and very good. They supported me out of the car and stayed with me whilst I was in hospital. They really did look after me." This meant people using the agency had their health care needs met and staff had easy access to information

Good

Our findings

All of the people we spoke with told us that the staff that supported them were kind, caring and attentive. Comments included "I usually have the same carer each day, [Name of staff] is very good", "The carer that came this morning was really genuine and thoughtful" and "The carers are clean, tidy and polite. They treat me as if I am one of their parents."

We spoke with one relative whose family member had recently moved into residential care. They told us "I couldn't fault the staff. There was one in particular who was fantastic." They also told us that the office staff were quick to provide additional support in people's homes if necessary. They said "[Name of person] collapsed when they were in the bath and [Name of care coordinator] came out to the home to provide extra support to the carer" and "It was really reassuring to know they would do that."

People told us that having a regular member of staff or group of staff attend to their care needs was important to them and when this was happening their care was generally good. We were told that when a member of staff left or was moved to a different care 'round' that this was unsettling and a period of adjustment followed whilst the new member of staff and the person receiving the service got to know each. One person said "They have a difficult job to do, some are naturals and know what to do instinctively, others come and need telling, but that's just how people are" and "When we have a consistent carer the service is great, they know your likes and dislikes and it's easy. However, it's a high turnover industry and people chop and change jobs. Overall I'd give them nine out of ten."

One relative told us "We've had the same carer for four months and they are absolutely fantastic. My wife passed out and they knew exactly what to do, they stayed and helped when the ambulance arrived" and "They always make sure her nails and hair are done and they used to take her out shopping but she doesn't want to go anymore."

The area manager told us that they tried, where possible, to match people who received a service with the member of staff who they had the best rapport with. If people indicated that they did not want a particular member of staff to attend then they were able to set the call monitoring system to automatically exclude that member of staff from the person's rota. They also told us that, when there was a planned change of staff for a person due to somebody leaving, then they would always make sure the person had met the new member of staff before they started working in their home. However, they acknowledged that when it was extremely short notice due to staff sickness this was not always possible.

Staff told us they encouraged people to be as independent as they could be and offered them choices where possible. One member of staff told us "If I am there to prepare a meal and the person is able to help prepare some of it then I try and get them involved and get them in the kitchen with me." Another told us "If I take a client shopping, then they make the decisions about what they are buying and what food they want for their tea."

Care plans were person centred and included information on people's daily routines and also contained a life story which provided an insight into people's 'early years', 'middle years', 'after retirement' and 'memories of things I enjoyed'. This ensured staff knew about a person's past as well as their present life and needs. The staff we spoke with told us that this information was particularly useful when they were first getting to know people who used the service. We saw in one person's file that there was no life history present. We discussed this with the person's relative and they informed us that they had requested this was not completed as it would be too distressing for their family member. This request had been respected by the staff.

Staff told us the steps they took to ensure that people's privacy and dignity were respected. One member of staff told us "If I am supporting people getting dressed and undressed I always make sure the curtains are drawn so people can't see in. I will also make sure people are given a dressing gown or if they don't have one I'll cover them with a towel", "If somebody wants a bath or a shower I always make sure the room is nice and warm, just like I do for myself at home" and "I ask them to choose what bubble bath they want to use." We saw that staff were required to sign a confidentiality agreement that helped to ensure people's information remained private. We also saw that staff were reminded in team meetings about ensuring they did not discuss client's in front of other people who used the service. These steps helped ensure that people's privacy was maintained.

Good

Our findings

Prior to a person starting to receive a service we saw that detailed assessments were completed. These assessments included information about people's medication, personal care and physical well-being, preferred method of communication, family involvement and social contacts, personal safety and risk, mental health and cognition, continence, sight / hearing and communication and mobility and dexterity. The assessments were then used to develop people's care plans.

Care plans provided guidance for the staff attending on how best to meet the person's needs. People we spoke with told us that a copy of their care plan was held in their home and that the agencies staff also wrote in their daily diary after each visit to record the tasks they had completed. When we visited people in their homes we viewed the care plans and found that they contained information on peoples personal care needs, any specific dietary requirements, pressure care, how they communicated, details of any medication required. In addition to this, people's likes, dislikes, life story and personal preferences about how they would like their care to be delivered were recorded.

We viewed six people's care plans and found that the quality of the information contained was inconsistent. Some care plans were presented in a person centred manner and contained detailed information regarding how a person's care should be delivered. However, one care plan we viewed had little information for the agencies staff to follow and although the person was able to communicate their needs, they also had moments of confusion when they might find this difficult. We discussed this with the area manager who explained the person had only recently started to receive a care package therefore the care plan was still under development. They told us the initial support plan was returned to the office after 6 weeks to be updated and this helped check that any information that had initially been received was correct and also enabled the staff providing the support to comment on whether the care plan was reflective of the person's needs. They also told us that the content of care plans was continually being reviewed and that one of the care coordinators was currently in the process of adding additional information to people's care plans to ensure that all were completed to the same high standard. We saw evidence that this process was underway.

Almost all of the people we spoke with told us that staff had enough time to complete the tasks that were required of them. However one person said they sometimes felt that staff were 'a little rushed'. We asked how this impacted on their care and they told us that all the tasks were completed but it just seemed like 'they could do with a bit more time'. Staff told us that they always had enough time to complete the required tasks and if they felt that a person's needs had changed and they needed more time, or if the

person requested additional services, then they would discuss this with the care coordinators who would arrange a review.

A number of people were still active in the local community and they had care packages in place that enabled them to continue to access the places they liked to visit. One member of staff told us "Some of the people I support still like to go out for a cup of coffee, or to visit some of the garden centres. As I am a driver it means I can take them wherever they fancy."

There was a complaints procedure in place that explained how complaints regarding the agency were received, recorded, investigated and responded to. We saw that a copy of this was included in the persons care file that was located in their home. One of the office staff told us "If people call with a minor complaint then this is recorded on the system. However, more serious complaints are recorded in the complaints file and are fully investigated." We looked at the complaints file and found the last recorded complaint had been received in February 2016. We saw that when complaints had been received they were thoroughly investigated and a written response was sent in a timely manner, usually to the satisfaction of the complainant. The regional manager told us that complaints were audited and this enabled them to check if there were any reoccurring issues that they could then address.

People we spoke with told us they had not needed to make a complaint. However, they said if they needed to they knew they could speak with a member of staff or the regional manager. One person said "I haven't needed to complain but I would speak to the office directly if I had any issues" and "If I was very concerned I have heard of the CQC so could always contact you." One member of staff told us that they had helped a person deal with a complaint they had regarding the time of one of the calls they were receiving. They told us that they discussed this with the care coordinators and that although they had to wait a short time for a call at the desired time to be available, this was soon implemented. This showed that issues of concern were used to improve the service people were receiving.

The agency had received numerous letters of thanks and compliments from the families of people who used the service. The registered manager told us that they shared this information with staff, particularly if they had been mentioned in the compliment.

Good

Our findings

As a condition of their registration, the service is required to have a registered manager in post. We found that there was a registered manager in post and this meant the registered provider was meeting the conditions of their registration.

On the day of the inspection the regional manager was present; they explained the registered manager was based at another location. The regional manager told us that they attended regular manager's meetings within the organisation and additional training workshops, and that this helped them to keep up to date with any changes in legislation and with good practice guidance.

We asked people whether they found the office staff helpful and whether they were able to easily contact them. One relative told us "The office staff are brilliant. I know I can talk directly to them" and "When they were setting the original care package up they knew it needed doing quickly, they moved mountains to ensure that it was in place in time." Another told us "Whenever I've spoken with [Name of manager] they have always seemed to be on the ball." One person who received a service said "I get a timetable through each week which has the name of the carer on which is helpful. It varies slightly but is fine for the most part." Another said "They send me a letter once a week with the timetable on so I know who's coming, but other than that I don't have much to do with the office. When I have called them they've always been fine." However one person said "I have not had my rota for three weeks now so I don't know who is coming or at what time." We asked if they had raised this with the office staff and they told us they had not.

We saw that a call management system was in place and that this not only alerted the care coordinators to any late, short or missed calls but also provided several other key functions. It was able to monitor staff training, staff supervision, calculate staff mileage and alert the care coordinators to when staff's MOT or car insurance was due for renewal. This enabled the care coordinators to focus on ensuring that staff rotas were in place and any sickness or absence was covered.

We asked people about the culture of the agency. The regional manager told us that the retention of staff was important in maintaining a high quality service. They said "We invest a lot of time in staff, ensuring that they receive the appropriate training and skills to carry out the job. Therefore we want to try and keep good quality staff to help the business expand. If staff have any issues then we try and work with them to enable them to stay with the agency. We offer opportunities for them to gain qualifications and apply for internal promotions. One of our care coordinators started off working as a carer."

The staff we spoke with told us that they felt well supported and that they could approach the regional manager or office staff with any concerns or issues they might have. One member of staff told us that they had experienced some personal problems and briefly left the agency. However, through the support they were offered they were able to return to work and were now enjoying their role more than ever. One member of staff said "I enjoy my job. I feel really well supported and am really content at the moment." Another told us "It's a lovely, lovely team, they're really supportive. I love the job."

All of the staff we spoke with told us good communication was key to the success of the agency and ensuring that standards were maintained. Staff told us that although they often worked alone they did not feel isolated as they were in constant contact with the office through their 'smart' phones. They told us these held information about their weekly rota and alerted them to any changes that had been made such as a cancelled call or if they needed to cover a call that was nearby. One staff member told us "It's all about communication; if we talk to each other then we can resolve any problems and really make a difference."

We saw regular staff meetings took place and records of issues discussed were kept in a meetings file. We saw that a variety of issues were discussed pertaining to what was relevant at that particular time. For example, we saw that when a new medication chart was due to be implemented this was discussed in the meeting and staff were given the opportunity to familiarise themselves with this and ask any questions they may have. We saw that the next staff meeting was due to take place the day following our site visit and the agenda included documentation, sickness, holidays and clients. These meeting ensured that staff were kept up to date with any important changes or developments.

We saw that audits were carried out to ensure that the systems in place were effective and that any issues were addressed. These included monthly audits of daily records and medication records. This enabled the care coordinators to check that the information recorded was accurate and take appropriate action should they find any discrepancies.

The area manager told us they sent out satisfaction questionnaires every six months. They told us that they had recently started to include a pre-paid envelope and this had improved the response rate. This meant they received 31 of the 70 they posted out. We found that the feedback was generally positive; however we noted that the number of comments had reduced in comparison to previous years. The regional manager told us that the 2016 questionnaire would place more emphasis on open ended questions to try and encourage more in depth information about what was working and what required improvement. We noted that there was no summary to reflect what the overall findings of the survey were or what actions had taken place as a result of the survey. We discussed this with the regional manager who agreed that this would add value to the process and they would ensure this happened in the future.

The regional manager told us they recognised the cost implications of staff using their own car, therefore they made sure they were paid a fair rate for each mile they travelled. We were also told that staff were paid for attending any training or staff meetings. We found that staff received a pay supplement as an incentive when they completed NVQ Level 2 and a further supplement once NVQ Level 3 was achieved. This rewarded staff for their commitment to continued learning and also helped the registered provider to retain their most qualified staff.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.