Safehands Support Services (UK) Limited

Safehands Support Services UK Limited

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 28 and 29 September 2016 and was announced. This meant we gave the provider 48 hours notice of our intended visit to ensure someone would be available in the office to meet us.

We last inspected Safehands Support Service UK Limited on 22 April 2014, at which time it was meeting all our regulatory standards.

Safehands Support is a domiciliary care provider based in Oldham providing personal care to people in their own homes in the local area. At the time of our inspection the service provided personal care to 60 people, the majority of whom required help to maintain their independence at home.

The service had a registered manager in place. 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. The registered manager had extensive experience of working in the social care sector and demonstrated a good knowledge of the needs of people who used the service.

People who used the service, relatives and external healthcare professionals expressed confidence in the ability of staff to keep people safe. No concerns were raised from relatives, external healthcare professionals or local authority commissioning professionals and feedback was positive.

There were effective pre-employment checks of staff in place with a checklist to ensure these procedures were followed.

We found the service had in place risk assessments to ensure people were protected against a range of risks. These risk assessments were regularly reviewed although we saw there was an opportunity to improve the consistency of how risk assessments were documented.

Medicines administration was found to be safe and regularly audited, with people not at risk of unsafe medicines administration.

We found infection control training was in place and evidence people were well protected against the risk of acquired infections.

We found there were adequate staff to ensure people's needs were met safely, with adequate provision of travel time included in the planning of care calls. The electronic call monitoring (ECM) system effectively tracked all care calls and staff ensured any anomalies or late calls were addressed promptly.

Staff were trained in core areas such as safeguarding, first aid and dementia and the registered manager had ensured the Care Certificate had been delivered.

We found staff had a good knowledge of people's likes, dislikes, preferences and communicative needs.

People who used the service were supported to maintain their independence in line with the service's statement of purpose.

We found care plans to be sufficiently detailed so as to give members of staff a range of relevant information when providing care to people who used the service. We saw these care plans were reviewed regularly and with the involvement of people who used the service and their relatives. People's personal histories and preferences could have contained more detailed information and the registered manager undertook to review this.

The registered manager displayed a good understanding of how to have regard to people's varying capacity and the need for consent throughout care practices.

People's changing needs were identified and met through liaison with a range of external health and social care professionals. These interactions were clearly documented in communication books and amendments made to care plans.

People we spoke with and relatives told us they knew how to make a complaint if they needed to, and to whom.

Staff, people who used the service, relatives and other professionals praised the support they received from the registered manager and we found the registered manager and office staff to have a sound oversight of the organisation, as well as knowledge of the needs of people who used the service.

We saw the registered manager and office staff had in place a range of audits and other quality checks to identify errors or inconsistencies and to put in place improvements.

The registered manger had successfully established a service that delivered care in a manner that met people's needs and ensured they received a continuity of care from staff they had formed trusting bonds with.

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.

All people who used the service, relatives and professionals we spoke with expressed confidence in the ability of staff to keep people safe.

Where concerns were identified we saw relevant agencies were involved to keep people safe. Risk assessments contained accurate information to help staff reduce the risks people faced.

A range of pre-employment checks of staff ensured the service reduced the risk of unsuitable people working with vulnerable adults.

Is the service effective?

Good

The service was effective.

People received support from a range of healthcare professionals when needed.

Staff received a range of core training as well as training specific to the needs of people who used the service, such as dementia awareness training and specific training to help support people with eating.

Care calls were well planned and managed by an office staff who communicated well with each other, people who used the service and other staff.

Is the service caring?

Good

The service was caring.

People and their relatives described high levels of compassionate care delivered by staff they knew well. The service successfully delivered a continuity of care.

People were treated with dignity, patience and respect, in line with the standards set out by the service in the company literature.

People were involved in the planning and ongoing review of their own care.

Is the service responsive?

Good

The service was responsive.

Care plans were subject to regular review, as well as being subject to change when the need arose.

Where people's needs changed staff liaised with external care professionals to ensure people's needs were met, incorporating advice into care planning.

People who used the service and others knew how to make a complaint if they needed.

Is the service well-led?

Good

The service was well-led.

People and relatives we spoke with were extremely positive about the approachability and hands-on approach of the registered manager.

Auditing of service provision, undertaken by all office staff, was sound, with discrepancies identified and corrective actions undertaken.

Staff were well supported both in terms of receiving appropriate training and guidance but also in terms of the duty of care the registered manager had towards them.

Safehands Support Services UK Limited

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 service on 28 an 29 September 2016 and our inspection was announced. The members of the inspection team consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who had personal experience of using or caring for someone who used this type of care service. The expert in this case had experience in caring for older people and people living with dementia.

On the day we visited we spoke with the registered manager, the office manager, the care co-ordinator and four care staff. Following the inspection we spoke with five people who used the service and seven relatives. We also spoke with a dietitian and a manual handling assessor who had worked with the service.

During the inspection visit we looked at people's care plans, risk assessments, staff training and recruitment files, a selection of the service's policies and procedures, meeting minutes and maintenance records. We also looked at the service's IT systems.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the Care Quality Commission (CQC). Registered providers must notify CQC of certain events, such as serious incidents or changes to the service. We contacted the local authority safeguarding and commissioning teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This

document sets out what the service feels it does well, the challenges it faces and any improvements they plan to make. We also reviewed responses to questionnaires CQC sent to people who used the service. We used these documents to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service and their relatives consistently told us they felt safely cared for by staff and that they had no concerns regarding their safety. One person said, "I have complete trust in them." One external healthcare professional told us, "I have never had any concerns and have confidence in them," whilst a safeguarding professional confirmed they had, "No concerns" with the service. Similarly, questionnaires returned from people who used the service and relatives showed all respondents agreed or strongly agreed that people were, "Safe from abuse or harm". This demonstrated there was a strong consensus of opinion regarding the ability of staff to keep people safe.

Where safeguarding concerns about a person who used the service had been identified, we saw staff took prompt action to ensure the person was kept safe and the appropriate agencies were alerted. For example, we saw the registered manager had raised a concern about the risks presented to them by their peer group and pursued this concern with agencies until a suitable outcome was achieved for the person. This demonstrated staff were able to put safeguarding principles into practice to ensure people were protected from the risks they faced.

We saw risk assessments were undertaken and that these were subject to regular reviews. Risk assessments identified risks such as environmental hazards, people at heightened risks of falls and the risks of specific conditions people had. When we looked at risk assessments and associated care plans we saw there were instructions to help staff perform people's care safely. For example, where someone required the use of a hoist, we saw instructions regarding how many staff were required and how staff should speak to the person to reduce any anxiety. We saw in some care files that risk assessments were in a general 'risk' section of the care file, whilst in other care files this section was blank and risks were documented in separate sections at the rear of the care file. The registered manager agreed to review care files to ensure there was a consistent approach to how risk assessments were documented. When we spoke with staff they were able to clearly explain the risks people faced and how they helped them reduce these risks. This meant risk assessments were in place and, whilst the formatting of them could be improved, they gave staff the information they needed to keep people safe.

Staff we spoke with displayed a good understanding of how to keep people safe. They were able to tell us what constituted abuse and how they would go about raising any concerns if they thought people were at risk of abuse. We found their responses to be in line with the service's safeguarding policy.

Staff we spoke with were also able to describe how they would whistleblow (tell someone) if they had concerns about the organisation and we saw this topic was part of the learning in the induction process. We also saw the induction introduced staff to the lone worker policy and there were a range of other measures in place to ensure the registered manager was able to keep staff safe, as well as people who used the service. For instance, every new member of staff was given a kitbag containing a torch, personal attack alarm, hand gel and personal protective equipment such as gloves.

We reviewed a range of staff records and saw that all staff underwent pre-employment checks including

enhanced Disclosure and Barring Service (DBS) checks. The DBS restrict people from working with vulnerable groups where they are considered to present a risk and also provide employers with criminal history information. We also saw that the registered manager asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. A checklist was in place to ensure none of these pre-employment procedures were missed. This meant that the service had in place a consistent approach to vetting prospective members of staff and had reduced the risk of unsuitable people being employed to work with vulnerable people.

The service had adequate medicines policies and procedures in place. We saw that appropriate medicine administration training had been delivered and that staff competence with regard to medicines administration was regularly reviewed. When we spoke with staff they were able to discuss the medicines procedures they adhered to in line with the medication policy and people's assessed needs. We spoke with one external healthcare professional who told us, "They're always very careful with medicines. Syringes are always cleaned and stored appropriately." We saw medicines audits were undertaken each month when people's care documentation was renewed and the previous month's information brought to the office. We also saw daily care records had recently been amended to include a tick box to indicate whether medicines had been administered. We saw medication administration records (MARs) were collected each month and audited to identify any errors. We reviewed a sample of MARs and found there to be no errors. This meant that people were more protected against the risk of the unsafe administration of medicines.

With regard to topical medicines (creams), we saw there were descriptions of where on each person's body a cream needed to be applied and staff displayed a good knowledge of this. In one person's file however this information was not sufficiently detailed. We spoke with people who used the service who required creams and all told us they had never experienced concerns in this regard. The registered manager rectified this care file immediately and agreed to consider the use of body maps to make the application of creams safer in future.

We saw that accidents and incidents were recorded and reviewed on a monthly basis by the registered manager to try and identify any common trends or patterns. We saw these instances were infrequent and no trends or patterns were evident that had not been identified.

With regard to infection control we saw staff had been trained appropriately and, when we spoke with people who used the service, they confirmed staff used personal protective equipment (PPE) such as gloves when performing personal care. One external professional also told us how staff maintained good levels of hygiene when visiting people's houses, stating, "The place was always immaculate." Staff had undergone training regarding the Control of Substances Hazardous to Health (COSHH) and risk assessment training, meaning they were given additional training on the hazards they and people they cared for might face before going into people's homes.

We saw there was an 'out of hours' contact number for staff and people who used the service, should they have any concerns outside of office hours. People who used the service told us, "The senior staff are always available – there is a special mobile number to get them on. It's one of the things I like about the service." Staff we spoke with confirmed they always had support if they needed to raise concerns, including outside of office hours.

All staff we spoke to felt staffing levels were sufficient to keep people safe. All relatives of people using the service we spoke with agreed.

When asked whether care workers arrived on time, five out of twenty-one people who used the service who

returned questionnaires to CQC either disagreed or strongly disagreed with this statement. The rest agreed that care workers arrived on time. We followed up this line of enquiry during the inspection and found there was a broad consensus that staff were consistently on time. People told us that, if staff were late on occasion, they were informed and that there had never been any significant delays. One person said, "The care workers are nearly always on time, even with traffic. They always give me my full hour." Another said, "They are very reliable and if they are ever late they have a valid reason." One external healthcare professional said, "There was never any delays with the visits."

We looked at the electronic call monitoring system (ECM) the service used and saw this kept a record of any late calls, with a documented reason, as well as giving office staff a live overview of ongoing calls and whether any care staff were late or not logged onto the system (via work mobile phones). Where staff did not log in to the system within fifteen minutes of being due to arrive, they received a call from office staff to establish their whereabouts.

We saw staff rotas were planned a month in advance, subject to unforeseen changes, and that office staff planned in travel time between calls. The National Institute for Health and Clinical Excellence (NICE) guidance, 'Home care: delivering personal care and practical support to older people living in their own homes (September 2015)' states providers should, "Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments." We found this to be the case, with sufficient travel time factored in to the calls. One person told us, "They do not stint on personal care. They stay that bit longer."

We saw the ECM system allowed for prompt and efficient analysis of any patterns regarding lateness by particular staff, should this occur. We also saw the three office staff were experienced carers and, should the need arise, were able to cover a care call at late notice. One person we spoke with said, "The office staff are carers themselves," and, "Today a senior member of staff turned up to take a girl's place – that's how good the service is." This demonstrated staff were committed to ensuring calls were not missed.

The ECM system had a client log-in facility, whereby people who used the service or their relative could log-in and view the information entered onto the system by care staff. Whilst only one person had started to use this facility, they told us, "We use the log-in system on our computer. It's a good tool so everybody is on the same page." This demonstrated the service was open and accountable in its processes and had begun to use technology to involve people more in their care.

Good

Is the service effective?

Our findings

People who used the service and their relatives were positive about the service. 90% of respondents to CQC questionnaires stated they would recommend the service to others, whilst 92% of respondents agreed or strongly agreed that staff had the skills and knowledge to meet people's needs. When we spoke with people who used the service they said, "I receive an excellent service. The staff all know what they are doing and we work together," and, "They get training in dementia care, lifting and food hygiene." One external healthcare professional we spoke with said, "We work with them quite a bit and staff knowledge seems good."

Training the registered provider considered mandatory included safeguarding, privacy and dignity, equality and diversity, basic life support, health and safety, dementia awareness, infection control, mental capacity and fluids and nutrition. Moving and handling training was delivered by the office manager, who had attended a four-day training course with an external trainer to become the service's facilitator of this training. People who used the service expressed confidence in this regard, stating, "They use a lift to hoist me – they know what they're doing," and, "When they are using the hoist they always listen to me and my word is final, i.e. if I'm in the right position and comfortable." The external assessor who worked with the service told us, "They are quite pro-active in their approach and will get in touch if they're not 100% about something. They make sure staff know how to use the equipment."

Staff were also trained in areas where people's individual needs required, for example percutaneous endoscopic gastrostomy (PEG) feeding training. A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate. This demonstrated the registered provider put in place training to ensure staff had the relevant skills to meet people's individual needs.

The majority of people we spoke with prepared their own food or had help from relatives, but those who relied on staff were complimentary. One said, "They prepare breakfast and are very capable. They know what I like and give it to me in a nice way." Another said, "They make me two good meals. I can help if I want to and the food preparation is good." One person required a pureed diet and we spoke with their relative who confirmed staff were always knowledgeable in this regard and that they, "Complete the job to a high standard – this is the standard I set and expect."

Staff told us they were well supported by their manager, confirming that they had shadowed experienced members of staff prior to beginning care calls, as per the service's induction policy. We saw the experienced member of staff provided written feedback to the registered manager regarding how the new member of staff had conducted themselves with people who used the service, as well as their demonstration of knowledge and skills. This helped the registered manager ensure staff in the probationary period of employment were suited to the role.

All staff had completed or were in the process of completing the Care Certificate. The Care Certificate is the most recent identified set of standards that health and social care workers adhere to in their daily working life. Staff told us, "I'm supported to complete the NVQ, which I appreciate, and I know others get the

support, too," and, "They're always at the end of the phone." We saw staff meetings, supervisions and appraisals took place regularly and staff confirmed they found these meetings helpful in terms of ensuring they had the skills to complete care calls and also to raise any queries they had.

We saw evidence of prompt and effective communication with other healthcare professionals to ensure people's healthcare needs were met, such as GPs, specialists, dentists and opticians. This meant the service recognised people's needs and took action to meet them.

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 saw that members of staff had been trained on the subject of Mental Capacity and were comfortable talking about the subject. The registered manager demonstrated a good understanding of mental capacity considerations, presuming capacity and identifying the need to ensure people were given support to make decisions where they were unable.

Good

Is the service caring?

Our findings

People who used the service were consistent in their positive comments about the caring attitudes of staff. One person said, "They know how I feel and they treat me with kindness and respect." Another said, "The staff are brilliant." Relatives were similarly complimentary about staff, with one saying, "These people are very kind and caring. My relative loves music and sometimes they sing them songs to cheer them up. They are always trying to make [Person] smile and laugh." Another said, "The care staff are definitely in tune with [Person] and their needs. They are always happy and laughing and that is down to the people that care for them."

100% of respondents to CQC questionnaires confirmed, "My carer and support workers are caring and kind." 100% of respondents to CQC questionnaires confirmed they were treated with dignity and respect by care staff and people we spoke with agreed with this. One relative told us, "It's their attention to detail. [Person] has to have their teddy with them in the chair every day and staff never forget this." This demonstrated staff listened to what was important to people and ensured they respected and acted on those wishes. As such, people received support from a group of carers they had formed trusting bonds with.

We saw that people were involved in their care planning, consenting to care where they were able. Where they were not, family members had clearly been involved in the original care plans and subsequent reviews, in line with capacity assessments undertaken. People told us they felt the delivery of care was collaborative in that they were always given advanced notice of any changes and felt part of the decision making and ongoing review process.

The registered manager told us they aimed to provide a continuity of care to people who used the service, whilst the statement of purpose stated, "We know that people can find it hard to have carers coming into their homes and don't want a lot of different carers visiting them – we always do our best to keep the number of carers visiting you to a minimum." We found this to be the case in practise, with people confirming they were introduced to staff in advance and that they generally received the same carers. One person told us, "They came down to my home to set up my care plan and brought some of the staff who were going to look after me so I could meet them." Another said, "They talked to us beforehand. They told us which staff were coming and would we like to meet them beforehand, and did we have any questions." We found people were consistently supported by staff who knew them well.

The importance of maintaining a continuity of care was highlighted as an area of best practice for domiciliary care providers in guidance issued by the National Institute for Health and Clinical Excellence (NICE) in their publication, 'Home care: delivering personal care and practical support to older people living in their own homes' (September 2015). We found the registered manager successfully maintained a level of continuity of care for people in line with this best practice.

People who used the service told us staff communicated well with them, explaining aspects of care before delivering it. One person said, "They always listen." One person whose first language was not English told us, "They were all very patient and I told them I learned my English in my home country and they all

understand. They understand me and compliment me on my English." This meant that staff had regard to people's individual communication needs and adapted their style accordingly. We saw this was reflected in the person's care plan.

When we spoke with staff we found they had a good knowledge of people they cared for, both in terms of medical needs and personal interests, life history, likes and dislikes. Staff we spoke with took pride in the care they delivered to people and valued the relationships they had built with people who used the service. The registered manager had therefore ensured people's needs were met by staff who behaved kindly and compassionately when supporting them.

The registered manager and other office staff also contributed to people's emotional wellbeing through their provision of a meal at Christmas (either on Christmas Eve, Christmas Day or Boxing Day). They did this to ensure people without family members or visitors received a meal and an interaction with people to celebrate Christmas.

We reviewed compliments received by the service, which provided further evidence of the caring approach of staff. Comments included, "I'd like to thank those ladies for being very kind and cooperative with me," and, "Thank you so much for all the care, kindness and help. You made a huge difference to the last few months of [Person's] life with your cheerful manner and capable, experienced ways." This last comment demonstrated that a person who used the service had been supported towards the end of their life and we found other evidence to indicate staff were compassionate and capable in supporting people nearing the end of their lives. We saw the registered manager had responded to an urgent request for support from a local healthcare commissioner regarding a person nearing the end of their life without an adequate care package. The registered manager ensured staff were able to attend and provide discreet personal care for the person. Feedback from the commissioner described the service's actions as, "The most compassionate response."

The statement of purpose described one of the main aims of the service as supporting people to maintain their independence in their home. We found staff successfully met this objective, with one relative stating, "[Person's] wish to remain at home as long as possible could only have happened with the unfailing support of your dedicated and caring team."

Whilst no one using the service had an advocate we saw the service used family members effectively as natural advocates to ensure people's views and needs were fully represented.

We saw people's sensitive personal information was securely held in the office in locked cabinets and password protected computer systems.

Good

Is the service responsive?

Our findings

The majority of changes to people's needs involved unexpected re-arranging of the agreed care calls. People who used the service were confident in the ability of individual staff members and the service generally to respond to their changing needs. One relative told us, "On a number of occasions they have had to change the service they provide for us because GP or hospital appointments can change at short notice. They responded by getting someone to come early so [Person] could be ready for the appointment." Another person said, "If things need to change they will adapt around us."

We found this flexibility and responsiveness was also evident in how staff approached people's medical and health needs. One person who used the service told us how staff responded to their needs as their degenerative disease progressed. They told us, "They knew about some of the help I would need in future," and confirmed staff regularly assessed the support they required. When we spoke with a healthcare professional they told us, "They come to us to ask about anything complex and we discuss it with the office manager, the service user and the family. They involve all the right people in those decisions." Another external professional told us, "They kept reviewing the package in place and they were amenable to re-assessing as regularly as they needed to. At all stages they followed our advice and adapted the care to suit."

We saw evidence in care plans of the registered manager and other staff liaising with external healthcare professionals to ensure people's needs were met. The service regularly assessed a range of input to ensure people's care plans were accurate and responsive to the changing needs of people. For example, we saw advice from a physiotherapy team had been sought by the service and incorporated into care planning. Likewise, we saw advice had been sought from a moving and handling assessor and that this information had been incorporated into the person's care planning documentation. We also saw advice had been sought from the Speech and Language Therapy Team (SALT) regarding one person's dietary needs. Where contact was made with external professionals, this was documented in communication books in the office then updates were incorporated into people's care files. Relatives confirmed the care delivered by staff was in line with this up to date information in the care file. This demonstrated staff acted on recent and accurate information regarding people's changing care needs.

Responses to CQC questionnaires from people who used the service were broadly positive regarding whether they were involved in decision-making about their care, as well as confirming that they knew who to complain to and how to complain if they needed to. We saw this information was in each service user guide.

The majority of calls the service provided were to help with personal care or complete household tasks. Within that context we found evidence that people who used the service were encouraged to develop and maintain levels of social interaction. For instance, one person told us, "I am mobile in my wheelchair so visit my friends and family. When I get visitors the carers are always friendly and helpful." One relative told us, "They take [Person] around the village when they are low in spirit to see her friends." This demonstrated people were supported to maintain connections important to them at their pace, protecting against the risk

of social isolation.

We found care plans generally to be easy to follow, with a range of information from the local authority at the front of the file and the service's own care plans and reviews following on from that.

Care plans were person centred to a degree and contained information that gave staff details that would assist them, such as the person's family background and interests. We found the most informative care plan had been written by a person who used the service, going into a high level of detail about how they wanted their care to be delivered. Whilst this was a good example of people being involved in the planning and delivery of their own care, it also illustrated that other care files could be improved in terms of the amount of background information they contained about people's preferences and personal histories.

When we spoke with staff they displayed a good knowledge of people's preferences and personal histories, whilst people who used the service confirmed this to be the case, saying, for example, "They know what I like and they are my friends." The registered manager agreed to review and improve the 'background' sections of care plans to ensure new staff would have a fuller picture of the people they would be caring for.

We saw the service routinely gathered people's opinions about their care through a range of means. This included regular telephone calls to people who used the service after a care visit, asking questions like, 'Do staff do all tasks that are on your care plan?' We found people who used the service welcomed this level of contact and felt able to raise queries or concerns they had with staff. They confirmed any such queries were promptly addressed. One person said, "The staff in the office got a replacement aid straight away when I asked them for help," and, "I can feel free to ask if things can be done differently and I can ask for advice about problems that come up." This demonstrated the service encouraged people who used the service to raise any queries or concerns, and that staff responded to such queries appropriately.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had extensive experience of working in adult social care and displayed a good knowledge of people who used the service and the systems and processes of the organisation.

People who used the service confirmed they knew who the registered manager was and that they had regular contact with them or a member of the management team. One relative said, "The senior staff visit once a month to make sure the service provides everything we need." Another said, "Senior staff drop into the house and chat to make sure everything is okay." Healthcare professionals we spoke with and evidence in care files confirmed senior members of the office team regularly attended care calls, either to help ensure a planned call was not postponed, or to undertake checks of staff and to ensure care was being delivered to a high standard. One staff member told us, "They help with the calls but take on some of the assessments and dealing with referrals."

People told us they had a good rapport with office staff, as well as carers who regularly visited them. One person said, "I know all their names in the office. I can call if I want and get information. They are nice people."

When we spoke with staff they consistently told us about the, "Hands on" support they received from the registered manager, the office manager and the care co-ordinator. One staff member told us, "It's much more organised than another place I've worked and you are trusted here to get what you need then get out to your calls."

This member of staff acknowledged that this level of trust was balanced by high levels of scrutiny and accountability and we saw evidence of a service that was well managed. One staff member told us, "If we were to find ourselves needing to be in two places at once and struggling to cope we'd draw the line – we won't risk those standards." One member of staff said of the registered manager, "They are very supportive but strict when they need to be. [Registered manager] sets the standard and the expectation is that quality care is delivered." We saw this was monitored and maintained through a range of means.

The registered manager undertook six monthly observations of care staff on a care visit, documenting how they performed in relation to their demeanour with people, their completion of tasks in line with assessed needs, completion of care documentation and use of equipment. Office staff also telephoned people who used the service subsequent to a care visit to ask their opinion of how it went, including whether they were treated in a caring way, and whether staff completed all the tasks they expected. This showed people were encouraged to contribute to how the service reviewed the delivery of care and how and where to make improvements. This also demonstrated the registered manager took responsibility for ensuring people were cared for by staff who were subject to regular scrutiny.

In addition to this the registered manager and office staff also conducted an audit of care records when

these were returned to the office on a monthly basis. These audits identified, for example, when a member of staff had not ticked a box in the daily notes to indicate they had administered medicines. We saw where such an error was made it was communicated to the relevant member of staff to avoid future recurrence. We also saw the registered manager was proactive in seeking ways to improve the service when identifying such errors. In this instance, they had introduced the additional tick box to prompt staff to think about the person's medication needs. We saw they had also planned to develop the mobile phone application staff used to confirm they had completed a call to enhance safety around medicines. A new system was to be trialled whereby the member of care staff would not be able to log out of the visit until they had confirmed they had completed the medicines aspect of the call. The registered manager hoped this would further improve the safe management of medicines.

The registered manager attended provider forums and was keen for the service to provide high standards of care through looking for ways to improve service provision. They were able to demonstrate an awareness of the latest safeguarding policy implemented by the local authority and were responsive to suggestions. Whilst the use of the client log-in aspect of the electronic call monitoring system (ECM) was not widely used as yet, it did demonstrate the registered manager was keen to ensure the service was accountable to those who used the service by making their daily notes accessible to them.

Staff told us the registered manager was responsive to finding ways to support them best. For example, one member of staff told us, "Most days tend to start at 7am but my circumstances changed. They were able to make sure I was moved to an 8am start. They were really good like that."

We found staff morale to be positive and staff told us they felt valued by the organisation. One member of staff told us, "[Registered manager] has an open door policy and they mean it." We found the registered manager had introduced ways of demonstrating their recognition of the efforts of care staff, for example they ensured that each member of staff had the day off on their birthday and were given the equivalent wages of a four hour shift to mark the occasion.

We generally found a consistency between the policies and procedures, which were up to date, and the practices in place, as evidenced through discussions with people who used the service and care documentation. We saw the registered manager also ensured updates to policies were shared with staff and that staff were asked to sign to confirm they understood the updated policies. For example, we saw the social media policy and expectations of behaviours around this had been updated. Staff we spoke with were aware of these changes.

The registered manager had a project delivery plan in place and we saw aspects of this had been achieved. For example, in the health and safety development section we saw the planned action was to ensure all staff had a lone worker risk assessment in place. We saw this had happened. Similarly, we saw one action was to audit all personnel files to provide assurance that no pre-employment checks had been overlooked. We saw this had also been completed. The plan listed the service's four strategic objectives at the outset of the plan and, whilst we saw the plan had ensured a range of action had been or were being undertaken, it did not link those actions to the relevant strategic objectives. There was an opportunity to more closely link the individual actions to the service's strategic objectives.

We found the registered manager, office staff and care staff had successfully delivered the continuity and familiarity of care as set out in the statement of purpose to ensure people who used the service felt at ease and supported by a range of staff who knew them well and valued their individuality.