New Concept Care . Nursing . Training Limited

New Concept Care Market Weighton

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

This inspection took place on 19 and 26 April 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location office when we visited.

New Concept Care Market Weighton is a domiciliary care agency that provides support to people who live in their own home, both younger adults with disabilities and older people. They provide a service throughout the East Riding of Yorkshire to people who have a service commissioned via the local authority and to people who are privately funded. The office is in Market Weighton. At the time of our inspection 299 people were receiving support from the service. Some of the people using the service had complex support needs and received 24 hour support from the service. Others only required time-limited care calls each day.

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

The provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns.

We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm. There were some historical inconsistencies in paper copies of risk assessments held in the office, but the care documentation and risk assessments that staff used in people's homes and the computer records held at the office were consistent and up to date.

The provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers.

Most people that we spoke with told us that staff usually arrived on time, or within the 20 minute timeframe allowed for the start of the care call. On occasions when there was staff sickness other care staff covered

their calls, which resulted in some calls running late. However, we were told this was not often, and nobody we spoke with told us that any of their care calls had ever been missed.

Where staff supported people with their medication, we found that this was accurately recorded on Medication Administration Records. Staff had received training in administering medication and the provider completed audits of medication records and staff competency assessments. This showed that there were systems in place to ensure people received their medication safely.

Staff completed a range of training to help them carry out their roles effectively, and there was a schedule for refreshing this training when it was required. Staff received supervision and appraisal.

The registered provider sought consent to provide care in line with legislation and guidance. We saw that care plans were signed by the people using the service where they had the capacity to do so. Staff had completed Mental Capacity Act (MCA) workbooks and were able to demonstrate an understanding of the principles of the MCA.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as community learning disability services and district nurses. People were also supported with their nutritional needs, where this was part of their care plan.

People told us that the staff who supported them were caring and that they felt involved in decision making about their care. People also reported that they felt their privacy and dignity were respected. Staff we spoke with demonstrated a caring and empathic approach towards the people they supported.

All of the people whose care files we reviewed had an up to date care plan. We found that care files contained information about people's needs, routines and preferences. Staff also demonstrated an understanding of people's needs and preferences.

There was a complaints procedure in place and people using the service told us they knew how they could raise a complaint if they needed to, and that they would feel comfortable doing so.

There was a quality assurance system in place, which included user and staff satisfaction surveys, medication audits and care reviews. This enabled the registered manager to identify issues and measure the delivery of care.

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.

There were systems in place to protect people from avoidable harm. Staff had been trained in safeguarding vulnerable adults and knew how to report any concerns.

Risks to people were appropriately assessed and managed.

Robust recruitment processes and appropriate checks were completed before staff started work.

There were systems in place to ensure that people received their medication safely.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction and regular refresher training. Staff felt confident they had the training they needed to carry out their roles, and could request additional training if they needed it.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care to someone.

People were supported with their nutritional needs where this was required. They also had access to healthcare services.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and they had positive caring relationships with the staff that supported them.

People we spoke with felt that staff involved them in decisions about their care, and that staff respected their privacy and dignity

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place to enable staff to provide personalised care. Staff demonstrated an understanding of people's individual needs and preferences.

There were systems in place to manage and respond to complaints and concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a positive and person-centred culture by providing opportunities for people and staff to feedback on the service.

Staff were provided with the support they needed to deliver the service.

There were effective quality assurance systems in place.

New Concept Care Market Weighton

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.

This inspection took place on 19 and 26 April 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from the East Riding of Yorkshire Council's contract monitoring team.

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

As part of this inspection we spoke with thirteen people who used the service, a relative of someone using the service, four care workers, the deputy manager and the registered manager. We looked at six people's care records, four care worker recruitment and training files and a selection of records used to monitor the

quality of the service. We visited the agency office, and following this we spoke on the telephone with people who used the service. We also made a home visit to speak with someone who used the service and their relative, and to look at the information available to care staff.

Good

Our findings

We asked people using the service if they felt safe with the staff and the support provided by the service, and everyone we spoke with said they did. People told us, "I know most of them [staff] as they have been coming for a while" and "I feel very safe with them [staff] in my home."

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. There was also a copy of the Local Authority's easy read guide to understanding and reporting abuse, which was available for staff to refer to. All staff received training in safeguarding vulnerable adults from abuse as part of their induction training, then regular refresher training thereafter. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. One staff member told us, "I would report any concerns to the office straightaway and they would take appropriate action." They continued, "If I had any concerns about a member of staff who was senior to me, such as a manager, I would report it to someone higher than them."

The safeguarding records we looked at recorded when a referral had been made to the local authority and what actions had been taken. The registered provider also had a whistleblowing policy, which was available for staff to refer to in a staff handbook. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

People also had appropriate risk assessments in place, in relation to their individual needs. These included moving and handling assessments, medication and environmental risks. Risk assessments were up to date in all the files we reviewed. We noted however, that in some files there appeared to be some historical gaps in the regular reviews of risk assessments. On exploring this further, and discussing this with the manager, it was noted that on occasions the paper copy of the risk assessment in people's care files in the office had not been updated in line with the up to date version held on the computer and in the person's own home. The registered manager agreed to issue a reminder to staff to always ensure the paper copy of the care record in the office was consistent with the up to date version held in people's home.

We saw that records of any accidents or incident were stored in individual files, and a copy passed on to the office, in order to ensure appropriate action had been taken in response to any incidents.

The registered provider had a business continuity plan which was reviewed annually. This detailed how the provider would respond, and minimise the impact to people using the service, in the event of an emergency

such as a fire, flood or electrical failing at the service.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for four staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references and identification checks. We saw that the provider also verified the references provided, by telephoning the referee. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The first date that staff started lone working was not always recorded in the recruitment checklist on staff files, so the registered manager agreed to add these, to ensure that they were consistently recorded on all files. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We talked to the registered manager and staff about the availability of sufficient staffing to meet the needs of people using the service. The registered provider completed an initial assessment of people's needs, prior to providing support to them. The registered manager told us that where someone was funded by the Local Authority the service received information about the person's needs from their Social Care Assessment, which enabled them to plan the staffing required. We were told staff rotas were planned around care packages organised in 'runs' on a geographical basis. Where there was any sickness or unplanned absences other care staff were asked to stand in. The deputy manager showed us the computer programme they used to plan the call times and staff rotas. Staff told us, "By and large we get to all our calls on time. Occasionally if someone is off sick and we have to pick up extra calls we may get a bit behind, but we call the office so they can let people know. This isn't often though."

The registered manager told us that the finance team checked all the planned call times on their computer system against the actual call times recorded on the monitoring sheets completed by staff, and that they reported any discrepancies to the care coordinator to investigate. We looked at a sample of time monitoring sheets and these were reflective of the planned call times. The registered provider also told us they were considering introducing an electronic call monitoring system, so that they would be able to more promptly identify if a call was late, without having to rely on staff calling in to update them.

Of the 13 people we spoke with who used the service, three people commented that occasionally staff were late arriving. One of these people told us they telephoned the office when this had occurred and that they had been provided with an explanation that they were satisfied with. Other people that used the service said that care staff arrived on time, or within the twenty minute timeframe allowed for the start of the call. They also told us that staff stayed the right length of time.

There was an 'on-call' system; staff or people could call the office if there were any problems, or could call for support 'out of hours' if there was an urgent issue outside normal office hours.

This showed us that the provider had a system in place for ensuring there were sufficient numbers of staff to meet peoples' needs.

The registered provider had a medication policy in place, and this was given to staff as part of their induction. Staff had received training in medication management and a competency assessment after their training. Their medication training was refreshed annually. Care coordinators checked all Medication Administration Records (MARs) when they were returned to the office, to identify any gaps or issues. We saw that monthly medication audits were also completed; these were done on a selection of approximately five

people's medication records each month. This included a check of the records and medication at the person's home. Any issues or actions required were recorded in these audits.

People's individual care files contained details of any support required with medication, including who was responsible for ordering medication, where it was stored and any specific requirements. In some instances, the registered provider shared responsibility for medication with people's families, and where this was the case, families completed medication records too, so that there was clear communication between both parties to ensure they each knew when medication had been given. We looked at a selection of MAR charts. Where there were any gaps on these records we were provided with an appropriate explanation.

This showed us that there were systems in place to ensure people received their medication safely.

Good

Our findings

We asked people using the service if staff had the right skills and experience to do the job; people told us they did. One person said, "Even though I've only been supported by them for short while, I cannot fault them."

We saw that all staff completed an induction when they started in post. They completed a five day induction course, which covered topics such as; confidentiality, equality and diversity, dealing with emergencies, safe working practices, risk assessments, moving and handling, the Mental Capacity Act, first aid and safeguarding. Staff also completed a Care Certificate induction workbook if they did not already have an NVQ in Care. The sections in this workbook were checked and signed off by a manager once the staff member had successfully completed them. The Care Certificate is a set of standards that social care and health workers work to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. Staff also completed a medication training workbook, and other specific training workbooks where these were relevant to the people they were supporting. For example, a 'complex care home ventilation' workbook was seen for one staff member. New care staff also shadowed other staff prior to working on their own.

Staff completed refresher training annually where this was required. The registered provider was able to monitor when staff were due to complete refresher training, as records were held electronically. The registered provider also had a training plan detailing the training available in the forthcoming year. Staff told us, "We get enough training, and you can ask them for more if you need anything." Another told us, "They will put extra support and training on if there is anything we are struggling with, or that is new to us. For instance, someone came out to show us how to use a four way slide sheet properly. We also got training about sheath catheters."

We saw evidence of staff supervision and team meetings; both covering a range of appropriate topics. This all showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the registered provider was working within the principles of the MCA. We saw evidence that people had been involved in decisions about their care and had signed to consent to their care plan, where they had the capacity to do so. People had also signed forms to consent to staff supporting them with their prescribed medications were this was applicable.

Staff had completed Mental Capacity Act workbooks. They were also able to demonstrate an understanding of the principles of the MCA, and the importance of gaining consent before providing care to someone. This showed us that staff sought consent to provide care in line with legislation and guidance.

We looked at the support people received with their nutritional needs. Some people who received 24 hour support from the service required significant assistance with their dietary needs; including support with meal planning, shopping for food, meal preparation, and encouragement to follow a healthy balanced diet. Other people using the service required less support with their nutrition and hydration needs, because they were able to prepare their own meals and drinks independently and did not require mealtime calls. Each person's care file contained a section about their dietary needs and the specific support required from staff. Where relevant, this section also included clear information about where responsibility for meal preparation was shared with others; for example, where the service provided to support to a person with their breakfast and their family supported them with other meals.

Where people had specific needs, such as PEG feeds or low calorie diets, this was detailed in the person's care file. PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach. Staff demonstrated an understanding of people's needs, and were also able to tell us how they recorded the fluid balance for someone with a catheter for instance, in order to monitor any issues with their hydration levels.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as community learning disability services and district nurses. Most people we spoke with said that if they were unwell or needed to see a GP they had family who would contact the GP on their behalf. They also said that, if needed, they would be able to ask care staff to do this for them. There were also instructions in care files where people needed more specific assistance to maintain good health, such as support with catheter care.

Good

Our findings

We asked people using the service if staff were caring; the feedback we received was positive. People told us, "They [staff] are always kind" and "I have my favourites; they are very special to me." Others told us, "They are caring and stick to what they are going to do" and "They [staff] love me; they think a lot of me and I do them." Other comments included, "I talk to my carer; it is usually the same person. This helps to lift my spirits" and "I chat with my regular carer; we have a great working relationship."

Staff we spoke with all demonstrated a caring and empathic approach towards the people they supported. One told us, "We do 'double up' runs alongside other carers so I get to see how other staff work too, and I think they are all very good; they care a lot and I feel we always give people the best we can." Another told us, "It's the little things that I feel show how caring all the staff are; for instance, we have one lady we support who needs a hug for reassurance sometimes, and we know how to reassure her. I have never had any concerns about any of the other carers." Another staff member told us, "I do feel staff really care. I know we're supposed to remain detached but it's hard when you're providing such a personal service. We care for people in more ways than one. One person we support for instance is not able to communicate with us in words, but we have lots of interaction and have a laugh, so they are still able to tell us in their own way that they are happy. There is a real rapport there."

We observed staff supporting someone in their own home, and interactions were positive and friendly. The staff member intervened appropriately to offer explanations and assistance where required. A relative we spoke with was very positive about the consistency of staffing, and how this had enabled their relative to build positive relationships with staff. They said, "90 percent of the time it is one of the same four regular carers that come, so that's great." This showed us that people using the service had positive caring relationships with staff.

People had choice and control about their care and most people felt their views were acted on. One person told us, "I make decisions and they do it; [staff are] very good." Others told us that staff talked to them and involved them in decisions, and said "I'm able to express myself; they listen and do what I ask" and "I couldn't wish for better dealings with them; they are very good." One person did however say that they didn't feel in control because they did not always know which member of staff would be coming. Staff were able to describe how they offered choice, and said often this could be with simple things such as showing the person two different jumpers so that they could choose between them. It was evident from people's care files that people had been involved in decisions about their care and what support they wanted. Staff were also able to describe to us how they promoted people's independence wherever possible; this included

breaking down tasks such as getting dressed or preparing a meal, and encouraging the person to do as much of the task for themselves as they could.

Some people using the service used different methods of communication, such as British Sign Language (BSL), Makaton (a form of communication, using signs and symbols in order to support spoken word) and Eye gaze communication. Eye gaze is a way of accessing your computer or communication aid using a mouse that you control with your eyes. Where this was the case, we were told that staff working with these individuals received specific training to enable them to understand and interact using the person's preferred communication methods. We saw evidence in one care file that the registered provider had given instruction to staff about where they could locate specific information about the Makaton signs that the person used. Staff also told us about the importance of understanding body language and gestures for one person they supported who did not communicate verbally.

Discussion with staff indicated that there were no people using the service that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

People told us that staff maintained their privacy and dignity, especially when providing support with personal care, such as bathing and washing. One person told us, "I don't like new carers supporting me with showers; I prefer my favourites to do this until I've got to know someone." They said that this was respected, and that staff always maintained their dignity. Staff we spoke with understood the importance of respecting people's privacy and dignity and were able to explain how they put this in to practice. They gave examples such as ensuring curtains were closed and using a towel to cover people when providing support with washing.

The registered provider had a Dignity in Care policy, a Human Rights Act policy and an End of Life Care policy and these were all shared with staff as part of their staff handbook.

Good

Our findings

All of the people using the service had a care plan, which they had been involved in developing. One person using the service told us they had been involved in developing their care plan and that "The manager attends twice a year to review the care plan with help." Another told us, "I have a file here at my home."

The registered provider completed an initial assessment of people's needs, prior to supporting them. This assessment covered; a life experience pen picture of the person, medication needs, support received from other services including district nurses, dietary needs, bathing needs, sensory requirements and activities, along with a description of what the person wanted help with. We saw that these assessments were signed by the person, where they were able to do so.

We saw that care plans were developed when people started to use the service. These were detailed and person centred. The format of the care plans for people with complex care needs who required 24 hour support from the service, was slightly different to those who required time limited care calls each day. Those people requiring 24 hour support had detailed information about their full daily routines. All care plans did however include key information about people's needs in relation to the areas identified in the initial assessment. They also contained more information about communication, mobility, dietary needs, any behavioural needs and daily routines. For people who required time limited care calls each day there were clear details in the care plan about whether the call was time critical and why; for example, to support with medication. We found that there was comprehensive information about people's needs, the support required from staff, and people's individual preferences, likes and dislikes. For instance, we saw examples of preferences in care plans such as 'I like to have my tea in a tea pot, not strong, and I will pour it myself' and 'I can manage to make my bed, but please ask if I would like some help with this'. Instructions to staff were also tailored to the needs of the individual; for example, 'Please give [Name] time to answer when speaking…can get confused with their words at times' and '[Name] is cautious of the new wet room floor and does not like to be rushed.'

When we spoke to staff about what personalised care meant to them they were able to tell us in detail about how important it was to understand and respect people's preferences. They told us, "We always encourage people to tell us their preferences, so that we can put together a routine that allows them to have their choices. Understanding the small details, such as whether someone likes to wear a petticoat or not, helps to dictate what order you support someone to put their clothes on, and it is these details that make it personal for someone." They continued, "I always say to people 'It's your care, which way do you want us to do it?' This can be little things like, do you like both sides of the bread toasted when you have cheese on toast,

through to bigger decisions and preferences."

People were involved in reviews of their care plans and we could see from the records held that care plans were reviewed and updated. Whilst all of the care files we looked at were up to date at the time of our inspection, we did note that not all of them appeared to have been consistently reviewed and updated every 6 months, which would have been in line with the registered provider's policy.

Where it was part of someone's agreed care plan, staff provided social support and activities. We saw evidence in care files that people were able to use these support hours flexibly if they wished; for instance, rather than receiving three hours social support each week, they could choose to save their hours one week and use them for a full day out with staff the following week. Where people received 24 hour support from the service, people were supported to take part in a variety of activities of their choice, such as swimming, walking, dancing, the cinema and bowling.

Daily logs were completed by staff with information about the support provided during each visit, and communication for other staff or relatives. These daily logs and staff timesheets were regularly returned to the office, along with MAR charts and financial transaction records. This enabled the care coordinators in the office to identify any issues and check the support provided was in accordance with people's care plans.

This all showed us that people received personalised care that was responsive to their needs.

There was a complaints procedure in place and a system to record and respond to complaints. The complaints procedure and compliments procedure were available to people using the service, within their Service User Guide. There was also a copy of the complaints form in each person's file in their home, so they had one available to use should they wish to raise a complaint. Records showed that five complaints had been received in 2015 and one complaint in 2016. We looked at the records in relation to the most recent complaint and this showed that the provider had responded promptly to address the concern. We also saw records of verbal compliments and cards received.

People we spoke with told us they knew how to raise a complaint. Most told us they would ring the office themselves and others told us their relative would ring and sort it for them. One person gave an example of when they had raised a complaint with the registered manager about their care staff being late, and they told us this issue had been resolved. A relative also told us, "We had an issue with the service once and they dealt with it straight away. I feel confident they would do something about it if we had any problems."

This showed us that concerns and complaints were encouraged and that there was a system in place to respond to complaints.

Good

Our findings

When we spoke with people about the management of the service the feedback was positive. A relative also told us, "I feel I can speak to [the management]. It's a good facility they've got." People also told us they were asked for their opinion about the service they received.

The service had a registered manager in post. They were also registered as the manager for a service provided in another area. However, they told us they split their time evenly between the two services, and were able to access the same computer system at both locations. The registered manager understood their role and responsibilities. There was also a deputy manager based at the service. The deputy manager, alongside two other care-coordinators, organised the co-ordination of the care packages and rotas. They also supervised carers and conducted observations and home visits to monitor the quality of service delivered. The registered provider also employed a registered nurse to oversee the complex support packages, and to provide support with any clinical matters. There were dedicated staff members to manage the support packages for people with a learning disability.

The registered manager told us they kept up to date with best practice and legislation via updates from CQC, Healthwatch publications, regular training and health and safety updates from the organisation. They told us they disseminated key information about best practice and any legislative changes to staff in team meetings.

Staff received regular supervision and team meetings. We looked at evidence of recent team meeting minutes and saw that various practice issues were discussed. There were also presentations on particular topics, such as dementia care. Staff were clear what was expected of them, and told us they were supported. One said, "We can walk in the office at any time and talk to managers, or we can ring to speak to someone and they will make time for you." Another staff member told us that the registered manager had been particularly supportive in a period of personal difficulties and that had really helped them. The registered provider also recognised each staff member's birthday each year, as they told us they were keen to ensure staff felt valued.

The registered provider conducted satisfaction surveys every three months. They sampled a random selection of people who used the service and relatives each quarter, so that everyone using the service got an opportunity to respond to the survey over the course of the year. We saw copies of these surveys, including one conducted in August 2015. Questions were asked about whether people were treated with respect and dignity, whether staff wore uniform and personal protective equipment, such as disposable

gloves, and whether staff arrived on time. There were also questions about whether people had a regular team of carers and about whether people had had cause to make a complaint and if so, whether this was resolved. 20 people had responded to this survey in August 2015. The registered manager collated these into a chart to identify themes from the responses. Most responses were positive but there were some individual comments about call times and training for one carer. The registered manager acknowledged that it had been difficult to resolve some of these individual points because the surveys were submitted anonymously. They told us they would encourage people to put their names on surveys where there were individual issues they wished the provider to address.

Staff surveys were also conducted. We looked at a staff survey that had been conducted in August 2015, and 36 staff had responded to this. The survey asked for responses on whether staff were happy with the support they received, along with questions about their induction and training. There was mainly positive feedback in these surveys. There were some comments however about office staff not always passing on to people when their care staff were running late. Some staff also commented they had not had a recent supervision. The registered manager told us that the issue about supervisions had now been addressed and they showed us recent supervision records to evidence this.

The registered provider had information about the aims and objectives of the service in their Statement of Purpose. Their mission statement described the values of the service. Staff told us that the values of the organisation were about "Putting the client first and foremost, along with ensuring dignity and respect." Staff were positive about the culture of the organisation and one commented that the fact that they had worked for the organisation for a number of years "Speaks for itself." They continued, "If the culture didn't feel right, I wouldn't still want to be here." Staff we spoke with also told us they would feel comfortable raising a concern.

This showed us that the service promoted a positive and person-centred culture.

The service had systems in place to audit the quality of the care they provided to people. As well as the satisfaction surveys conducted, the registered provider completed audits of medication and care reviews. They also monitored call log books to ensure care was being delivered in line with the person's care plan. All archived records were logged on the computer system, so there was an organised system to locate any information required. Policies and procedures were in place, and based on up to date legislation and guidance.

We asked for a variety of records and documents during our inspection. Overall we found these were well kept, easily accessible and stored securely.