MiHomecare Limited

MiHomecare - Huntingdon

Inspection report

Ground Floor Windsor House, The Anderson Centre
Ermine Business Park
Huntingdon
Cambridgeshire
PE29 6XY

Tel: 01480418890
Website: www.mihomecare.com

Date of inspection visit:
05 May 2016

Date of publication:
31 May 2016

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 5 May 2016 and was announced.

MiHomecare - Huntingdon is a domiciliary care service that is registered to provide personal care to people living in their own homes. Their office is based on the outskirts of Huntingdon. The service provided included that for older people and people with a physical disability as well as people living with dementia. The service is provided in Huntingdon and the surrounding towns and villages. At the time of our inspection there were 60 people using the service.

The service did not have a registered manager. They left in December 2014. There had been two other interim managers prior to the current manager who had been in post since November 2015. A registered manager is a person who has registered with the Care Quality Commission (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.

Staff were recruited in a safe way and checks were in place to confirm this People's assessed care needs were met in a timely manner by suitably trained and qualified staff.

Staff were trained and knowledgeable about the procedures to ensure people were kept safe from harm. This included a thorough understanding of organisations with responsibilities for investigating any or potential concerns such as the local safe guarding authority.

Medicines management and administration was undertaken in a safe way. This was by staff whose competency to do this safely was regularly assessed.

The manager was aware of the process to be followed should any person have a need to be lawfully deprived of their liberty. They and staff were knowledgeable about the situations where an assessment of people's mental capacity was required. The service was working within the Mental Capacity Act 2005 code of practice.

Staff had a good knowledge of the people they cared for and what people's level of independence was. Care was provided with privacy and dignity. Appropriate risk management strategies and records were in place for emergency events and subjects including falls and medicines administration.

People were provided with various opportunities to be involved in their care needs assessment

People's health and nutritional care needs were identified by staff and met by staff and through a range of health care professionals including a GP occupational therapist or GP. Staff ensured people ate and drank sufficient quantities.

People were supported with their independence to live in their own home as long as they wanted to.

Staff were provided with a formal induction, regular and effective training, supervision and mentoring that was appropriate to the staff's roles.

People were provided with information as to how to make and raise suggestion and improvements to their care. The provider took appropriate action to ensure any complaints were addressed to the complainant's satisfaction.

A range of effective audit and quality assurance procedures were in place. The provider had processes in place to help ensure that the CQC is notified about events that they are required, by law, to do so.

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 had been trained in, and they were, knowledgeable about how to keep people safe from potential harm.

People's medicines were managed and administered in a safe way by staff who were trained and assessed as being competent.

The provider's recruitment process helped ensure that staff's suitability to work with people using the service was safely determined.

Is the service effective?

Good

The service was effective.

People were supported to make and be involved in the decisions about their care. People were supported by staff who had the right skills and knowledge about each person they cared for.

People were supported to drink and eat sufficient quantities of the foods they preferred.

Staff supported people to access and be seen by health care professionals when required.

Is the service caring?

Good

The service was caring.

People were cared for with dignity, compassion and respect. Staff understood the finer points in people's lives and supported people with those aspects which were meaningful.

Staff knew what people's human rights were and supported people with these.

People were supported to see their families and friends and maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

Staff met people's assessed needs in an individualised way.

Social stimulation was provided to people to support them with a range of hobbies, interests and pastimes.

Compliments, suggestions and concerns, were used as a way of recognising what worked well and if improvements were required.

Is the service well-led?

Good

The service was well-led.

The manager undertook their role with an emphasis on transparent support to all staff.

Effective audits and systems to measure the quality of the service were in place and actions identified were acted upon.

The manager and staff with management responsibilities knew their role and responsibilities in ensuring a high standard of care.

MiHomecare - Huntingdon

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 5 May 2016 and was announced. This was because staff and manager could be out. We wanted to make sure they were in. The inspection was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and information we hold about the service. This included the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we visited and spoke with two people in their homes and spoke with six people and four relatives by telephone. We also spoke with the manager, an operations' manager, a quality manager, a field care supervisor and care co - ordinator, one senior care worker and two care staff.

We looked at five people's care records, managers' and staff meeting minutes. We looked at medicine administration records and records in relation to the management of the service such as checks regarding people's homes environmental safety. We also looked at staff recruitment, supervision and appraisal process records, training records, complaint, quality assurance and audit records.

Good

Is the service safe?

Our findings

At our comprehensive inspection of MiHomecare - Huntingdon on 10 and 11 August 2015 we found that people who use services were put at risk because not all staff had received medicines administration training or had their competency regularly assessed to do this safely. Not all risk assessments were in place. This put people at risk of receiving unsafe or inappropriate care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection on 10 and 11 August 2015, we asked the provider to take action to make improvements to staff training on safeguarding, risk assessments and medicines administration and competency assessments. During our comprehensive inspection of 5 May 2016 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above.

Staff told us that they had received medicines administration training and that they had had their competency to do this safely, assessed regularly. One care staff told us, "Since my induction I am now confident in administering medications as I have been trained and shown how to administer medicines correctly. One relative told us that their family member received assistance with the application of topical skin creams and that they had never ran out of medicines. One person confirmed, "The girls [staff] always make sure I take my medicines. They never forget." Another person told us, "They [staff] came the other day and took my old medicines away and left me with the new ones." Training records showed us that staff who administered medicines were up to date with their training. The manager showed us how their monitoring system alerted them to any staff whose medicines administration training was due refreshing. We found that people's medicines were managed and administered in a safe way. Examples included accurate recording, prompt disposal of unused medicines and audits to ensure that safe standards of administration were adhered to.

We found that there was a process in place to identify and ensure risks to people were regularly reviewed. This was to provide people's care in the safest way practicable such as ensuring that people's homes were a safe place for care to be provided in. These included risks for people at risk of falls, being out in the community and moving and handling. One senior staff told us, "I have had risk assessment training and this has helped me understand risk and how to manage them. People can take risks and we make sure that it is safe for them to do this." One person said, "I need lots of help and equipment and they [staff] always make sure my walking frame is right by my side." We observed that this was the case.

Everyone indicated that they felt safe with the staff and the service they received. Comments from people included, "Yes. All the carers [staff] I've got. I wouldn't let them in if I didn't." And, "Yes, I trust them (indicated that they usually had the same care staff)." Another person told us, "I don't mind if they [staff] are a bit late it is the care that matters to me. I need two staff and I always get them." A field care supervisor told us that they made sure that each person's care was covered by the right staff with the right skills as well as letting staff know their rosters in advance. The manager confirmed that an electronic call monitoring was now in place and that this was a way to identify if staff had arrived and left the person's home at the correct time

frames. People's general experience of care staff's timekeeping was a positive one and people indicated that staff were now using the recently adopted call monitoring system.

Staff had a good understanding of how to ensure people were protected from the risk of this harm occurring. The manager had developed and trained their staff to understand and use appropriate policies and procedures and where circumstances required it they had followed local safeguarding protocols. One staff told us, "If a person is not their usual selves or is very quiet I would ask them what the matter was. If I had any concerns I would report them to the manager, Care Quality Commission or if required the police." One person said, "I most definitely feel safe here. Staff are always careful with my moving and handling." People were supported to access information about being safe through a service user guide with contact details for the relevant authorities. This showed us that there were processes in place to reduce and help prevent any risk of people experiencing harm.

The provider in their PIR told us that they had a dedicated recruitment team who were responsible for every aspect of the recruitment process apart for the interview which was conducted in branch by the manager or care coordinator). If the candidate was successful at that stage then a robust recruitment process followed. We saw that checks were in place to help ensure that staff recruitment was undertaken in a safe way. These checks included those for a satisfactory Disclosure and Barring Service [DBS] check, [This check is to ensure that staff are suitable to work with people who use this service] and evidence of previous employment history with any gaps explained.

The manager explained to us that they were recruiting additional staff as well as increasing the staff with management responsibilities in the service's office. They were also considering combining this role to cover several areas of responsibility such as field care supervisor and care co-ordinator. We found, that there were sufficient numbers of staff in place to meet people's assessed care needs. This was confirmed by staff and people we spoke with. We saw that staff had been trained and were appropriately qualified to meet the needs of the people they cared for. All people we spoke with told us that staff always attended to the person's needs for the specified time period that had been agreed.

Staff told us that there had been a massive difference in their workload as more new staff had been recruited as well as only taking on people's care where this could be met reliably. One care staff told us, "The difference now is that I no longer feel pressured to get from one person to another as I know other staff are going to pull their weight and not let anyone down." Other plans were in in place if staff rang in sick. The manager, office based staff and care staff told us that they covered extra shifts as well as cover for when staff were on annual leave.

Accidents and incidents such as when people had experienced a fall, injury or potential neglect were recorded. The manager and staff discussed the measures required to help prevent the potential for any recurrence. For example, referrals to the local falls team or provision of additional staff to support people whose moving and handling needs had changed. This included liaison with occupational therapist, social workers or the person's GP for alternative medication options. One person told us, "Yes, I am always moved and handled in a safe way."

Good

Is the service effective?

Our findings

At our comprehensive inspection of MiHomecare – Huntingdon on 10 and 11 August 2015 we found that people who use services were put at risk. This was because not all staff had been supported with regular supervision, training or annually appraised of their performance. This meant that staff were not as well supported as they should have been.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection on 10 and 11 August 2015, we asked the provider to take action to make improvements to staff support and supervision, and this action has been completed. During our comprehensive inspection of 5 May 2016 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 18 described above.

We found and staff confirmed that there was now a robust supervision and appraisal programme in place. All staff told us that they now had regular supervision, training and support from the manager or senior care staff. An in house trainer provided training to support staff such as hands on moving and handling training using equipment at the branch. All staff had received training in subjects including dementia care, health and safety, infection prevention and control and the Mental Capacity Act 2005 (MCA). The manager's training matrix showed that all staff training was up-to-date or planned. People indicated that their care provision was up to date and staff were fully conversant with their needs. For example, one person said, "They [staff] know what they are doing" and they told us that a new member of staff would ask them how they liked things to be done. Another person told us, "They [staff] check things out [with me]." One member of staff said, "I have just completed my MCA training which has been really helpful for me in understanding what mental capacity is and what a lack of this could mean for people." Another staff confirmed that where specific equipment had been provided that they had training on its use as well as a practical assessment. They added, "The video of the [Name of equipment] was helpful." Other specific training included subjects such as Alzheimer's and dementia care as well as diabetes awareness.

People were supported by care staff who had the necessary skills and knew the people they cared for well. The manager explained the various procedures and processes that were in place to support staff in their role. For example, following staff's initial induction training they were supported with shadow shifts [working with a more experienced member of staff] until they were confident to their job independently. One newer member of staff told us, "I had a really good induction. I was under no illusion that this job was about people's lives and that it is my responsibility [with training] to meet their needs." New staff were enrolled in the Care Certificate [a nationally recognised training standard for social care] and several staff were just awaiting sign off for this. One staff told us, "Training is now much better. I am doing my [Qualifications and Credit Framework] level three and part of this includes the MCA [Mental Capacity Act 2005]." One person said, "They [staff] know me like I know them. It is great to get the same regular care staff, which I now do." People indicated that staff offered them appropriate choices. Comments included, "We talk to each other"; "they've [staff] got to know me'; and "we talk things through".

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. 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. The application procedures for this must be made through the Court of Protection for people living in the community. We checked whether the service was working within the principles of the MCA.

We found that the manager and all staff had an understanding of the MCA and Deprivation of Liberty Safeguards (DoLS) codes of practice. For example, assuming in the first instance that people could make their own choices. One person said, "I can do what I want. It's my choice." The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests and in the least restrictive manner. A member of staff told us that the MCA was, "People can decide what they want to do and we are there to try and make sure they are safe but ultimately it's their choice." Another person told us, "I can go out when I want and I do." A senior care staff added, "If people can't always remember things we can help them by offering a choice and if they still can't decide we need to ensure that it is in their best interest. Examples they gave of this included contacting the person's GP, social worker as well as the family members and relatives who understood the person's needs well.

People had access to appropriate hot or cold refreshments throughout the day. One person told us, "They [staff] always leave me a drink and if it's hot [the weather] I have squash." We found that people were supported to ensure they ate and drank sufficient quantities. This included the foods people needed to avoid such as a low sugar content diet. Staff told us that they always encouraged people to eat and also to eat as healthily as possible. Where people were at a nutritional risk measures were in place which included food and fluid assessments and guidelines to help ensure people's eating and drinking was undertaken safely. The timing of care visits to people's homes also ensured that people's meals were evenly spaced throughout the day.

Staff told us, and we found, that they supported people to access health care professionals including a GP, dietician and community nurses. One member of staff said, "If ever people are not well I ring the office and they call the most appropriate [health care] professional." One person told us, "I have no worries whatsoever that they [staff] would call a doctor for me. My [family member] does this if I need one." We saw that various referrals had been made to community nurses, occupational therapist and that changes to the equipment people had been provided had occurred and that this had helped improved or maintain people's independence. This showed us that people's healthcare needs were responded to.

Good

Is the service caring?

Our findings

Our conversations with people as well as visits to people in their home showed us that staff were considerate of each person's care needs. All people and their relatives had only positive comments about the care staff and spoke highly about them. Comments included, "The carers [staff] are very good." And, "We're very happy with it [the care provided]." As well as one relative saying, "We'd give it excellent as a rating." Other examples included, "They [staff] do make me feel that I matter. And "They [staff] are very kind and like a friend [to me]." As well as, "They always ask me if I need anything else (before they go). I can't fault them."

Staff gave us examples of how they engaged with each person and explained how they promoted respectful and compassionate care. One staff member told us, "If I visit when relatives are there I ask if they could go to another room as the person preferred this." One person said, "I don't mind female carers [care staff] but it would be nice if I could have a male care staff." Senior care staff told us that they would look into the possibility of this for the person. We found that staff respected people's privacy and dignity using various means. For example, letting people wash their own face and other areas. Another person said, "The girls [care staff] care for me in the way I want them to. They are fantastic. They help me with the things I can't do and do this sensitively." One relative told us, "They [staff] are very caring and are kind and respectful, giving [family member] choices and doing whatever we ask of them." Another relative added, "They really do care and wash [family member] so carefully."

Staff confirmed to people when they arrived at the person's house and did this in a way the person wanted. For example by knocking on the door, using a key safe and then introducing themselves. Where people had a visual or hearing impairment staff made sure that the person knew that staff had arrived. One person said, "They [staff] are all good. They do a grand job with me." People's care plans clearly identified the guidance on how each individual person liked to be contacted, either during a care visit or, when required, by telephone. This was for situations of severe weather where a person may have needed prompting to take their medications. We saw that staff took the opportunity to engage in conversation with the person they were supporting. For example, whilst visiting people in their homes we observed that staff asked the person "would you like a coffee and is it with your usual two and a half spoonful's of sugar"? The person responded, with a smile, that they did like it that way.

Staff described to us what people could independently do for themselves as well as how to provide other aspects of their care. We saw people's care plans were detailed and provided staff with guidance on the finer points of people's care. This was to make sure that the person's drink was on the right or left hand side according to the person's needs. One care staff said, "I love my job as we are sometimes the only people that the person's sees throughout the day." People indicated that staff knew how people preferred their care to be provided. Our observations and people we spoke with confirmed that this was the case. One person said, "We chat to each other." Another told us, "They've got to know me and are very polite."

Staff responded to people needs. For example, by staff speaking slowly, clearly and with respect to the person's health condition. One person said, "The staff are very respectful all the time and they do listen to

me. They are all lovely." Another person told us, "I know when I tell staff things that they keep it between me and them. It's confidential." It was clear to us by staff interactions that they really enjoyed being with people and that this was reciprocated. Staff spoke of people's aspirations and what the person had planned for the coming week. Examples of this included going out for ride in a car, seeing families and relatives as well as having a fish and chip supper.

Other involvement people had in their care planning included a face to face visit when the person started to use the service. Examples we saw included staff's day to day conversations as well as more formal six weekly, three and six monthly review of the person's care needs. On these occasions staff took the opportunity to give people the explanations they needed such as how their personal care was to be provided. One person told us, "The office girls [staff] came to see me the other week and went through everything with me and my [family member]. Nothing needed changing as it was right in the first place."

We saw and people told us that as far as possible they were supported in a way which meant the risk of social isolation was minimised. For example, with visits from relatives, friends or community volunteer organisations [Community Navigators]. The manager and staff also encouraged people to get out into the community with friends and relatives and also going for a walk outside for some fresh air.

People were provided with a service user guide book when they started to use the service. This included any advocacy support as well as any advanced decisions people could make. The manager and people's care plans confirmed the advocacy arrangements people had such as advanced directives and lasting power of attorney for people's health and wellbeing. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes.

Good

Is the service responsive?

Our findings

People's care needs were assessed using a combination of methods. These included the local authority's and provider's assessment process. This was to identify what was important to the person and how their individual needs were to be met. For example, if they preferred a bath or a shower and what their favourite foods and drinks were. We found that the provider accurately assessed people's needs. Where people's needs changed such as an improvement in the person's independence than this was considered. One person said, "I spilt my drinks the other day so I rang the office and they came straight away." Another person told us that they felt confident using their mobility equipment and that on some occasions' only one staff would be needed. In care records we saw that changes had been made. For example, when two staff were required on a regular and consistent basis where the person's previous care arrangements had changed.

Each member of staff was knowledgeable about the people they cared for. Examples we saw were staff's knowledge about the person's previous work and life experiences as well as hobbies and interests such as watching football on TV or going swimming. People's care plans prompted staff as to how best meet each person's expectations in maintaining their independence. This was to live in their own home, going out to a day centre or shopping with relatives. Staff told us that they found the care plans easy to follow and that these could be referred to at any time. The manager had introduced better care plans which included much more detail about each person. For example, if family members or relatives assisted with any aspect of the person's care and exactly what level of support this was.

We found that staffing to support people was more consistent. One senior care staff said, "It used to be chaos. I never knew who I could be caring for next but now with [name of manager] at the helm it is just so much better. I know exactly when and where I need to be and also the names of the people I care for." Staff were also asked for their views at staff meetings as well as when they visited the provider's office. This gave staff the opportunity to comment on what worked well and where changes were needed such as more staff. Information gathered by the manager had resulted in the need for an additional office based staff to work over several areas of the service. This was to help better manage people's expectations and the staff required to do this.

People confirmed that they had various opportunities to provide feedback and that they had good ongoing relationships with their care staff and the service. This was so that the service was aware of how people were. For example, one person talked about "an active dialogue" with the provider. Another person explained to us, "If I need more or less staff or change my care times I just have to ask and it happens." Staff confirmed that each request, even if this was at short notice, was considered and if there was staff available or staff had capacity for additional work then this was always considered.

Staff supported people with their pastimes including talking about what the person had done such as having a meal out, visit by relatives or talking and reminiscing about people's favourite memories. One person said, "I am absolutely happy with everything. I have never needed to complain. I am always thanking the girls [staff]."

The service had up-to-date complaints policies and procedures in the form of a service user guide. This included details on how to contact the manager as well as other organisations such as the Local Government Ombudsman. People confirmed to us that management and care staff gave them opportunities to make suggestions, compliments or if required concerns about their care. We saw that the provider had followed its complaints procedure and responded to each concern to the satisfaction, as far as practicable, of the complainant. We saw that action had been taken or plans were in place to address concerns raised.

People told us that that they knew how to make a complaint but had not made a complaint as such. Any contact they had with the service had usually been positive. For example, one person had contacted the service in February 2016 as there had been a missed call on a Sunday. They said, "I received a really nice letter of apology" and they were very happy with how the situation had been dealt with and nothing of this nature had happened since. They indicated that they had real confidence in the service. Reviews of complaints were undertaken to help identify any potential trends. This was completed at a provider level to help ensure that any potential for recurrence was minimised as well as sharing what worked well.

Good

Is the service well-led?

Our findings

People and staff were involved in improving and developing the service. This was through a quality assurance monitoring survey as well as formal staff meetings and supervision sessions. One person said, "I had a call from the girls in the office. They ask me lots of questions about my care [plan] but I am very pleased with things as they are." One relative told us about their family member, "We have provided feedback and we've found them [MiHomecare - Huntingdon] to be a very good service which we would recommend based on our experiences." People confirmed to us that they felt the provider did take things on board and 'listened' to them. For example, one person added, "I get an assessment and a form to provide feedback."

All people and their relatives told us that they had received opportunities to provide feedback, be it via surveys and quality assurance questionnaires, phone calls or face to face visits. People knew a senior member of staff and informed us that they knew that there had been changes to the management of the service. One person told us that although they didn't know the manager's name they had had contact with "someone senior" and added, "Yes. I feel [that I am] kept up to date." Other methods to help drive improvement included a weekly newsletter for staff. This was to share information on those areas where improvement was required such as ensuring that any training or refreshers for this were completed on time.

Changes to make the service better included spot checks regarding the quality of staff's work by senior care staff or the manager. This was to help ensure that the care staff were working to the right standards as well as exhibiting the provider's values of putting people first and foremost. Processes were in place to make sure that staff adhered to these requests. The manager used the information from senior care staff and quality managers to assess the day to day culture of staff. This showed us that the provider considered what worked well for people and where changes were needed.

The provider is required, by law, to notify the CQC of certain important events that occur at the service and in people's homes. From records viewed we found that they and the manager had notified us about these events where required. In addition, the provider was correctly displaying their published inspection rating.

The service did not have a registered manager. They had left in December 2014. Various temporary managers had been in post in the interim period. The current manager had been in post since November 2015 and was in the process of applying to become the registered manager. They had, since taking up post, identified where the improvements were needed and they told us, "It has not been easy. I am not the only one who had to improve the situation. All staff have a responsibility. We have all worked together to make the necessary changes." One staff told us, "I come to work now and the atmosphere is so much more relaxed and happy. It's like one big family as we share things when it's busy as well as stepping up to the mark if any staff or managers are off work," People indicated that their contact with management had been positive and they had usually had been able to get through to someone. For example, One person added that they would have no hesitation in phoning the office staff up if they wished to discuss any issue or concern.

The regional manager, quality manager and manager had compiled an action plan based on the

information gathered from surveys, audits and spot checks. These included reviews of risk assessments, staff training, care plans, supervision and medicines administration. All staff were very complimentary about the changes that had been made by the manager. One told us, "It's [their work] now so much better organized." Another care staff said, "It's [the service] more organized now than perhaps at any time in the last four years. I now love coming to work rather than worrying about it." Another member of staff said, "I can call the manager at any time even for the littlest of things [to me]. It's nice sometimes just to have their assurance that I am doing the right thing."

Links were maintained with the local community and this included assisting people to attend a day centre, see relatives and friends and go out for a walk or swimming. One person told us, "I don't need help in this area but I am sure that if I asked they [staff] would help me. I am still very mobile for my age." The manager and staff confirmed that people were supported to access the community where this was safe as well as if the person needed some gentle encouragement. One senior care staff said, "We have one person who without a little [persuasion] would not go out much but when they do they really like it."

The manager and regional manager told us and we found that staff were rewarded and recognised for their achievements. For example, having awards for their standards of work and the differences they had made to people's lives. This had included supporting people in recently flooded areas, with the fire service, to receive their care and prescribed medicines. This had been confirmed in local newspapers covering the event in the Huntingdon area. The manager added that they wanted the service in the Huntingdon branch to be the provider's best and that this was now the next step on improving the service people and staff received.

Staff team meetings were held regularly, staff were expected to attend either a morning or afternoon meeting and they were encouraged to discuss general themes such as the timely and accurate completion of MAR sheets and how independent each person was. For example, one staff told us, "My supervision is definitely a two way process. I can discuss any issues, even my private life, that could affect or impact on my work. As long as I apply in time the manager supports me." The provider had commenced a programme of introducing new staff to complete the Care Certificate 2014. Several staff had completed all the required units and were just awaiting this to be signed off in the next few weeks.

Staff were confident and described the circumstances they needed to be aware of if they became aware of any poor standards of care. One care staff said, "Being responsible for the quality of people's lives and their life is not to be underestimated. If ever I saw or became aware of any unacceptable care I would report to my manager or the owner [provider] straight away. I feel very confident that I would be supported. All staff we spoke with commented that they would feel confident raising any or suspected concerns and that there would be a fair and appropriate response.

People, and their relatives, told us what the provider did well with regard to the service they received. People told us that that they felt the service and its staff listened to them and worked with them and provided the following comments. "They [management] now seemed to learn from experience. And, "They deliver an efficient service and do it well." Another person told us, 'It has improved. We have the same girl [staff] mostly and there is better continuity."