Hull Churches Housing Association limited

St Giles Court

Inspection report

19 St Giles Court
Hull
North Humberside
HU9 5AR

Tel: 01482788330

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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

St Giles Court is the location hub for a number of flats and houses owned by Hull Churches Housing Association. The service is registered to provide personal care to people who live in their own houses or with their family to enable them to live as independent a life as possible; not everyone who received a service from St Giles's Court staff required personal care. In addition to personal care, the service provided practical parenting support to families and personal assistant support to enable people to access social and leisure facilities. Currently within the location hub there are nine houses used for assessment for family parenting skills, 10 flats for adults with a learning disability and mental health needs, 10 houses for people with general support needs and five people who live in their own houses in the wider community. St Giles Court is situated in a busy part of Hull close to local amenities and transport networks.

The service had a registered manager in post as required by a condition of their registration. 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.

We undertook this unannounced inspection on the 15 April 2016. At the time of the inspection there were a total of 28 people receiving a service, however only five of them had recently been commissioned to receive the regulated activity of personal care; the remaining people were in receipt of social care and support. The Care Quality Commission had considered the service was dormant until staff started to provide personal care to people again. At the last inspection on 8 November 2013, the registered provider was compliant with all areas assessed.

We found staff knew how to keep people safe from the risk of harm and abuse. There were policies and procedures to guide staff and they had also completed safeguarding training. This provided them with knowledge about how to raise safeguarding concerns and which agencies to inform. Staff had completed assessments for activities of daily living which posed a risk for people; there was guidance for staff in care plans regarding how to help minimise risk.

We found staff had been recruited safely and full employment checks were in place prior to them starting work. There was sufficient staff employed and they had access to a range of training and supervision to ensure they felt confident and skilled when supporting people in their own homes and in the community.

We found people's health was monitored and they were supported to access health professionals when required. Staff had assisted people to make appointments to see their GPs and had contacted paramedics when required. Staff had a good understanding of people's health care needs and could recognise the signs of when they required additional support or treatment. Staff supported people to take their medicines safely when this was part of their package of care. Staff also monitored people's stock of medicines to ensure these did not run out.

We saw some people had support to shop for food and prepare meals as part of their care package. Guidance about this was provided in people's care plans.

We saw people had assessments of their needs and care plans were in place which described to staff how each person preferred care to be delivered. The care delivered to people was person-centred and in line with their preferences. We found staff had obtained information from health and social care professionals involved in people's care to ensure a full picture of their needs was available.

The daily notes written by staff of the care and support provided to people were detailed and evidenced they were provided with choices about aspects of their lives; staff described how they ensured people gave consent prior to care and support tasks being carried out. Staff understood the need for best interest meetings if people lacked capacity and major decisions were required about their care.

We found people were treated with respect and their dignity maintained; staff encouraged people to develop new skills. People we spoke with described staff as having a caring and positive attitude. We found people were supported to access community facilities when this was part of their care package. People were encouraged to use the community facilities at St Giles and we saw people popping in and out of the office chatting to staff. Staff maintained confidentiality and ensured personal information was stored securely.

We saw there was a complaints policy and procedure and people told us they felt able to raise concerns in the belief they would be addressed by the registered manager.

We found there was an open culture and one that listened to people. Quality monitoring took place where the registered manager completed spot checks of staff practices and sent out surveys to seek people's views. We saw the registered provider had been successful in a recent tendering exercise; there had been a smooth transition of services, and staff worked well with other agencies, during the transfer of support from other providers.

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 were recruited safely and in sufficient numbers to meet the needs of people receiving care and support in their own homes.

Staff knew how to keep people safe from harm and abuse. They received safeguarding training and knew how to raise concerns.

People were supported to manage their medicines when required and to take them as prescribed.

Is the service effective?

Good

The service was effective.

Staff monitored people's health during visits to them and contacted health professionals when required.

People were supported to maintain their nutritional needs when this was part of the care package commissioned from the service.

Staff supported people to make their own decisions and choices and were aware of what to do if they believed they could not consent to care.

Staff had access to training suitable for their role in supporting people in their own home. They received supervision and support from management.

Is the service caring?

Good

The service was caring.

People told us the staff approach was kind and caring; they treated people with respect and helped them maintain their dignity.

People were provided with information about the service to help them with decision-making.

Staff maintained confidentiality. Personal information was

stored securely.

Is the service responsive?

Good

The service was responsive.

People received care and support that was person-centred and which met their needs in an individual way.

Staff supported people to access community facilities when this was part of the care package commissioned from the service.

The service had a complaints procedure which was available in accessible formats for people. We were told by a person who used the service and two relatives that they would feel able to complain.

Is the service well-led?

Good

The service was well-led.

The service had a quality monitoring system which consisted of audits and seeking people's views so that improvements could be made.

The culture of the organisation was open and staff felt able to raise concerns and express their views.

The registered manager and staff had worked with other agencies to ensure a recent transition of services went smoothly.

St Giles Court

Detailed findings

Background to this inspection

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

This inspection took place on 15 April 2016 and we gave 24 hours' notice. This was because the service was small and we wanted to make sure staff were available to speak with us.

Prior to the inspection, we looked at the registered provider's '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. We also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority contracts and commissioning teams about their views of the service. There were no concerns expressed by these agencies.

During the inspection, we observed how the registered manager and staff interacted with people who used the service when they approached them at the main office. We obtained verbal consent from one person to visit them at their home and talk to them about the service they received. We spoke with two people's relatives, the registered manager and four care support workers. Following the inspection, we spoke with a social care professional who was involved in supporting some of the people who received a service.

We looked at three care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as their medication administration records (MARs) and daily recording records. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These

included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Good

Is the service safe?

Our findings

The one person we visited told us the staff came on time to support him. He was very emphatic when asked if staff treated him well and said, "Oh yes, definitely". The person also said, "They show me their identity card" and "I'm over the moon with the service."

A social care professional told us, "I have had no concerns raised so far; the care provided is going well."

There was a policy and procedure to guide staff in how to safeguard people from the risk of harm and abuse. The registered manager had access to the local authority risk matrix tool which they could use in assessing risk and whether to report any concerns. The registered manager told us they would contact the local children's and adults safeguarding team if required for advice and guidance. In discussions, staff were able to describe the different types of abuse, the signs and symptoms which may alert them to concerns and how to report issues. Risk assessments were completed to guide staff in minimising the risk to people. These included moving and handling, skin integrity, personal care, road safety awareness, finances, health issues, nutrition and falls.

Staff were recruited safely and full employment checks were carried out prior to new staff starting work. These included application forms to assess gaps in employment, obtaining references, an interview process and a disclosure and barring service (DBS) check. A DBS check was a way of obtaining information about any previous criminal convictions so that employers could assess the suitability of potential staff for working with vulnerable people. We saw on one occasion that a member of staff had been employed with a DBS check from a previous employer. The registered manager told us a new DBS was always completed within six weeks of employment if a member of staff came with an existing DBS; they said they wanted to make sure information was up to date.

We found there were sufficient staff employed for the current needs of people who used the service. The registered manager told us they had only recently won a local authority 'tender' to provide personal care to people in the community. They had tendered for a set amount of hours and told us they were careful about ensuring the right staff were in place before the start of any service. Recruitment was underway and interviews were taking place on the day of the inspection. The registered manager told us there were day by day checks on people's needs to ensure they continued to be met with the current levels of allocated hours. They said, "The staffing numbers are identified for each service user and planned in a person-centred way. I always ensure we have enough staff for capacity." They also said there was a current phased increase in staffing levels to ensure the obligations of the 'tender hours' were met. There was a bank of staff to cover shortfalls. We saw there was a matching process in place to help ensure there were commonalities of characters between staff and the people they supported.

We saw staff had received training in how to safely manage people's medicines. There were care plans to guide staff when people required support with their medicines. These detailed where medicines were located and how often people were to be supported to take them. We saw one person had a protocol in place to guide staff when administering rescue medicine 'when required' to them. There were completed

medication administration records (MARs) held in the location hub office and current MARs held in people's homes. The daily records for one person showed staff had been proactive in managing a situation when a person was prescribed additional medicines following tests; they double-checked the person was to have the medicines. They had also noted the MAR had been taken to hospital with the person when they were admitted but had not been returned; staff contacted the pharmacy for another one for the person. Staff also arranged for the pharmacy to cut specific tablets in half to reflect an accurate dose.

The local hub office was clean and tidy and had suitable facilities for staff. Equipment used such as computers, gas appliances and fire fighting had been tested for safety. There was a business contingency plan in place for emergency situations which had been updated in December 2015. We saw there was evidence of staff highlighting potential safety issues with the hub location, for example uneven paving stones outside the building; these were reported to maintenance and we saw the issue had been addressed.

The registered manager had systems in place to support staff when lone working. Each member of staff had a mobile phone and a specific 'app' to use which included a start 'protect me' facility. Staff described this as being able to activate the 'protect me' when they left a person's house at night. This sent an alert to the registered manager on call and if after a specific length of time the 'protect me' wasn't deactivated by the member of staff, they would be contacted to check they were alright. The mobile phone was also used for staff to initiate the time of their arrival at a person's house and when they left. This enabled the registered manager to be sure staff had attended the person and the length of time they had stayed for the call.

Staff had access to personal, protective equipment such as hand sanitiser, gloves, aprons and sleeve covers for use when required. We saw staff had completed training in infection prevention and control.

Good

Is the service effective?

Our findings

The person we spoke with who used the service told us staff would support them to access their GP if required. When asked if they thought staff knew what they were supposed to do, they replied, "Yes, I would like to buy them a trophy."

A relative told us staff had received training in how to support their family member prior to the start of the service and they had shadowed other staff to ensure they knew how to meet their needs.

A social care professional told us, "They [registered manager] ensure staff develop skills with each service user care package."

We saw from records staff supported people to maintain their health when required. One person's care records showed staff supported a person with their health condition, monitored how this progressed, contacted health professionals when the situation became an emergency and stayed with the person throughout.

In discussions, staff described how they would deal with medical emergencies and how they recognised when people were unwell. They told us they would always pass on information to the parents or carers of the people they supported or to health care professionals. Staff said, "One service user's mental health recently started to go down, you could tell because they stopped keeping their home and themselves clean. I spoke to them and checked out what was worrying them and realised they were depressed. I went with them to their GP and they received a prescription to help them." Staff described how they prevented pressure ulcers from occurring and were knowledgeable about the signs and symptoms of chest infections, urinary infections and deteriorating mental health. They said, "It's about getting to know the person and monitoring them and also about good communication with each other and other people" and "I've supported [person's name] to ring their GP for an appointment and written it down for them so they wouldn't forget."

We saw staff supported people to maintain their nutritional needs when this was part of their care package. For example, they supported people to shop for their meals and helped them to prepare them. Staff documented what support they had provided with preparing meals and made a record of what food and fluids the person had eaten and drank during each visit. We saw some people had special diets. Staff were aware of them and knew how to make sure people were not placed at risk when eating their meals.

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. Most people who used the service were able to make day to day decisions about their care. Staff were aware that some people lacked capacity to make their own decisions and that these had to be made in best interest meetings with relevant people such as relatives and health and social care professionals

involved in their care.

Staff described how they ensured people provided consent prior to completing care tasks. Comments included, "We spoke with [person's name]'s mum about this [consent]. We found [person's name] could communicate by making eye contact and hand movements. It's about getting to know them. They will push you away and make loud noises if they are not happy with something. We use MCA and best interest meetings for major decisions" and "We gain consent all the time by asking people and getting their permission; that's how we are encouraged to work. We talk about this all the time in team meetings and the manager says whatever we do we must ask consent. We are reminded about other forms of consent for people who can't give it verbally." We saw staff supported people to make their own choices and decisions.

In discussions, care support staff confirmed they completed training prior to supporting people. They said they received the right amount of training at the right time. One member of staff said, "Yes, we get enough training and if there is ever anything I need, they would provide it." The training record showed staff completed training in a range of areas. These included health and safety, infection control, first aid, safeguarding children and adults, moving and handling, food safety, MCA and DoLS, equality and diversity, person-centred thinking skills and medication handling. Staff also had the opportunity to complete nationally recognised qualifications in health and social care. Staff had training to help them support people's individual health needs, for example epilepsy and management of equipment for one person who received their nutrition and medicines in a specific way. The registered manager had completed a leadership and management course. Staff told us some of them had completed training in managing behaviour in people with a learning disability but it was unclear if they had received any specific training in mental health and learning disability conditions. This was mentioned to the registered manager to check out and address. Staff told us there was a range of methods used for training. These included, face to face sessions, work books and on-line computer based training.

Staff confirmed they had supervision meetings where issues such as training needs were discussed. Staff said, "It [supervision] can be about anything, clients you are working with, any issues, training and anything we feel we are not so good at; they ask us that in supervision" and "We have supervision every few months." They also confirmed they had annual appraisal where their personal development was discussed.

We saw new staff had an orientation style induction which was recorded and held in the files. This was a tick box form which showed staff were made aware of health and safety issues. Staff confirmed their induction consisted of shadowing staff to ensure they were fully aware of people's needs, discussions with the registered manager and completion of specific training.

Good

Is the service caring?

Our findings

One person we spoke with who used the service was complimentary about the staff team and they confirmed their privacy and dignity was respected. Comments included, "The staff are so useful and so kind; I could blow a trumpet and put the red carpet down for them", "I know all their faces if not their names yet", "They always knock on my door" and "They really are marvellous."

Two relatives spoken with said, "Their attitude is good and they are very willing to take on things, small bits at a time", "They are a nice group of staff", "The service has been really great", "I know she is very happy with the new service" and "I think it's a good service." When asked if staff respected core values such as privacy, dignity and obtaining consent, one relative told us, "Yes, they tick all those boxes."

A social care professional told us, "The manager gave staff profiles to people which was a good thing. Sharing details about staff in this way was important as relatives then had information about them."

We observed positive relationships had been built up with people who used the service. This included people who received social support and lived within the main complex of St Giles Court. It also included the person we visited who received personal care support in their own home in the community. We observed staff spoke to people in a kind, patient and caring way. They provided information to people, offered them refreshments when they visited the office, offered choices and ensured they made their own decisions and had friendly banter with them.

We saw care plans and task sheets prompted staff to respect privacy and dignity and also encouraged people's independence skills. They were detailed and gave staff full guidance in how to support people in ways that met their needs and preferences for how care should be carried out. The care plans detailed scripts for staff to use to offer encouragement and to be sure people were included in decisions about their care.

The care files included 'communication passports' for those people who needed them. These gave staff instructions and guidance in how best to meet people's communication needs and which methods to use to achieve this.

The registered manager told us they tried to keep teams of staff to a minimum for each person who used the service. Staff confirmed this in discussions with them. They said, "We try to keep to a minimum of four staff for each person."

In discussions, staff described how they respected people's privacy and dignity and promoted choice and independence. Comments included, "When showering [person's name] they use the shower chair and is able to do most themselves. It's important to let them do as much as possible, give them privacy by closing the door", "[Person's name] is very specific with who they like to support them. The care plan tells us to wait outside the bathroom whilst they are having a bath to give them privacy; we can prompt them through the door", "We check their preference for gender of carer", "I put myself in their shoes and wouldn't want to be

laid out on a bed uncovered. Keep people covered up, explain things and treat people as you would want to be treated" and "It's important to make sure they get to know me and my voice before I complete personal and intimate tasks; I help people to be as comfortable as possible."

We saw people had been provided with information prior to the start of the service and on a day to day basis. Each person was provided with a care file. This included their assessment, any risk assessments, care plans and task sheets, medication administration records if required, a service user guide and a complaints procedure. Some people also had a communication book for staff to record messages. Staff also held the daily records they made about care provision in the care file until the end of each month and then these were taken to the main office for archive. The person we visited told us they received information about which staff were visiting them at each call.

People who used the service were involved in a 'Care Services Steering Group'. This was facilitated by a member of staff but the group was run by the people themselves. We saw the minutes of the last meeting held in March 2016 and these reflected issues such as improving the satisfaction survey and getting more people to complete it, reducing the number of staff supporting families to lessen the impact on children, staff rota issues and involvement in staff recruitment. The registered manager told us some people who used the service were involved in the interview panels to recruit care support staff, which were taking place on the day of inspection.

The registered manager and staff were aware of the need to maintain confidentiality and to keep personal information secure. Information regarding people who used the service was held securely in lockable cabinets in one of the offices. Staff personnel files were held at head office. The registered manager told us computers were password protected. The registered provider was registered with the Information Commissioners Office (ICO) which was a requirement when computerised records were held.

Good

Is the service responsive?

Our findings

The person we spoke with told us staff supported them in the way they wanted them to. The person told us they would feel able to make a complaint if required. Comments included, "I would tell [registered manager's name]; I've got his number."

Relatives told us, "[Person's name] has complex needs and they have put a good team together to meet her needs quickly; I give them the thumbs up", "The arrive on time and the length of time they stay varies depending on her needs; they stay until her needs are met" and "I think this service is better than the last one." Relatives also told us they would feel comfortable making a complaint and named the registered manager as the person they would raise concerns with.

We saw people had assessments of their needs prior to the start of the service. The registered manager had also received information from health and social care professionals who were involved in specific people's care and treatment. We saw risk assessments were completed which were brought together in a 'risk overview' document. Care plans and task sheets were completed from the information gathered at the assessment stage. The care plans called 'care plan issues forms' identified the issue, goals and intervention required. They were signed and dated by staff. The tasks sheets broke down the care to be provided into components that were very detailed.

The registered manager told us they had just started a contract to assist a person with support during the week of the inspection. Most of the documentation was in place and the registered manager told us the main care worker had met with the family to go through information from various health professionals and was in the process of formulating care plans that would meet the person's needs.

We saw some people had information in their care file which had been transferred from their previous local authority provider. This was person-centred and included information about what was important to the person, how best to support them and what others liked and admired about them. In one of the care files we looked at, we saw the information was very clear about their personal possessions and how they preferred to keep these private. We saw this information had been transferred to care plans produced by staff at St Giles Court.

We saw some task sheets were very detailed and gave staff full and up to date information about how to meet people's needs and routines in a person-centred way. For example, one task sheet described how staff were to support a person with bathing. It described how the person preferred this to take place, how staff should offer support, where they should position themselves whilst the person was bathing and how they should prompt and encourage the person whilst maintaining privacy for them. We saw one person had an epilepsy management plan which had been produced by health professionals to provide staff with guidance. The care plan and task sheets for this person were detailed in how staff would manage their medication and what safety measures were in place to support them to minimise the effects of epileptic seizures. It was also person-centred in describing how they preferred to take their medicines. Another person's care and support assessment identified communication needs and stated, "Workers to break down

information into simple terms" and "Use person-centred tools to describe risks and life events."

In discussions, staff were clear about how they provided people with person-centred care that met their preferences. They told us they had completed training in using 'person-centred tools'. Comments included, "Allowing service users to take control and encouraging them; this is their life", "Check out what is best for them, how did their day go and how could we make it better" and "One person doesn't like to be told what to do. I ask the question and give four possible answers written down. They are able to read and we talk about each answer and the consequences of each action. This enables the person to make the actual choice themselves taking into consideration the risks."

The daily records completed by staff reflected their person-centred approach to care. These covered personal care tasks, social care activities, domestic support, diet and nutrition provided, any medical concerns and any additional risks or problems staff had encountered during each visit to the person. The records evidenced staff encouraged and supported people to gain new skills. For example, in person's records staff had recorded, "She is learning to imitate the action I do with cream [for the person's hands]; well done [person's name]. We noted in one person's daily records that an episode of self-harm had occurred. Staff had managed this calmly and professionally and supported the person throughout. However, when we checked the person's risk management and care plans this had not been added to them as a future potential risk and how staff were to manage it. This was mentioned to the registered manager to address.

We saw staff supported people to be part of their local community and to access facilities when required. Staff told us about a card system that certain shops and cafes had signed up to and displayed in their windows. This alerted people who could be potentially vulnerable that staff within the facilities could provide support in emergencies such as contacting a worker on their behalf. One member of staff described how they facilitated an adults club one evening a week. The club was held in the meeting room in the main office building of St Giles Court. The club was used to support people to share experiences, develop skills, be part of the community and prevent isolation. The member of staff said they were organising a police community support officer to attend one of the meetings to talk about how people could keep themselves safe. There was a laundry on site which people could use and the price had been included in their package of care.

The registered manager told us about transition arrangements that were put in place to transfer people's care and support from their previous care support agency to provision from St Giles Court. They said this had been planned carefully to ensure people's needs continued to be met throughout the transfer process. Members of staff from St Giles Court shadowed staff from the previous agency, training was carried out by health professionals to ensure they had the right skills, introductions were made with people and their relatives and staff read care plans and task sheets. Relatives spoken with confirmed this process. They said, "The transition went well. She was nervous about the change but is very happy" and "I can say the transition to Hull Churches Housing went very well. The manager visited us and we have been impressed by their whole attitude." A person who used the service said, "The change was alright; it's a better service and they listen to me" and "The workers came together, the old ones and the new, to introduce the new one."

We saw people had information in their care files called, 'Patient passports' which were used in readiness to support any hospital admission for them. The information was to provide nursing and medical staff with a quick reference guide to the person's needs.

There was a complaints procedure on display in the service. This described how people could make a complaint and how to escalate it if required. People who used the service were provided with a copy of the

complaints procedure in a welcome pack at the start of the service. The complaints procedure was supplied to people in easy read format. Staff spoken with were clear about how to manage complaints. The service user guide, also provided in the welcome pack, stated "We will learn from every complaint, to help you and future service users. All comments and complaints will be taken seriously, investigated thoroughly and confidentially, and resolved as quickly as possible. We will be open and honest. Apologies will be given when appropriate." People who used the service and staff told us they felt able to raise concerns.

Good

Is the service well-led?

Our findings

The person we spoke with and relatives all knew the registered manager's name. This told us they had made themselves known to people. A relative told us the registered manager had visited them at the start of the service and they had been impressed with their attitude.

A social care professional told us, "[Registered manager's name] was really good. He met with people [before the start of the service] and was good at gathering information; very thorough" and "People were anxious about the change in service but he reassured them and wanted to make the transition go well, which it did."

We looked at the registered providers 'statement of purpose' and spoke with the registered manager about the culture and values of the organisation and their own personal management style. The aims and objectives as laid out in the registered provider's statement of purpose included staff delivering person-centred care with 'high quality care practices', being flexible, respecting people's rights and ensuring their inclusion in all areas. The registered manager spoke about the service user being at the core and the service being 'person-centred driven'. They also said, "Our mission statement is not just about maintaining people but developing them", "We have to advocate on service users behalf so they get the service they need and deserve" and "I have an open door and people can come to me at any time. I'm open and flexible and find the carrot works better than the stick and fits naturally with my character." The registered manager also spoke about their policy of not having zero contract hours for staff as they felt it was important to value staff. They said, "How can we expect staff to treat service users with respect and dignity if we don't treat them [staff] with respect? We do our best to develop staff for their future work." We saw these values were reflected in practice.

The registered manager was aware of their responsibilities in reporting incidents which affected the safety and welfare of people who used the service. There were very few incidents which had occurred in the service but when they had, we received a notification in a timely way.

We found the registered manager had developed working relationships with health and social care professionals from other agencies. During the transition period, following the registered provider's successful tendering exercise for specific care support hours, the registered manager and staff worked with other agencies. These included commissioning officers, specialist nurses, social workers and other health care professionals to ensure the transfer of care and support from one agency to the registered provider went smoothly. There was a period when staff from St Giles Court shadowed local authority staff on visits to people and received training from community nurses. We saw staff were proactive in liaising with professionals when required such as paramedics, GPs, community nurses, pharmacists, social workers and police community support officers.

We saw staff were provided with a handbook. This detailed what was expected of them and what they could expect from the registered provider. There were policies and procedures to guide them in ways of working.

In discussions, staff described the organisation in a positive way and said it was a good place to work. Comments included, "I love it here and there is so much support. I don't ever feel alone and there is always someone at the end of the phone", "He [registered manager] is very approachable", "The company is good and the manager is very fair; I feel supported", "I think the company is very good and I have been well-supported on a personal level", "I have felt very welcomed especially by the manager. He has an open door and has told me to ring him if I have any problems" and "You can go to [person's name and senior manager] anytime if you have any concerns. We have a whistle blowing policy which we are given with our contract." The deputy manager and the senior care and support worker completed staff welfare checks on a weekly basis to ensure they did not have any concerns.

Staff confirmed communication within the service was good. They had regular monthly staff meetings and received messages on a daily basis when required. They said they felt able to raise issues at meetings.

There was a quality monitoring system in place which consisted of audits, spot checks, meetings and surveys to ensure people who used the service, their relatives and staff could express their views about the running of it. The registered manager had developed a new annual task calendar which identified areas for auditing at specific intervals. Currently the audits were ad hoc and the new calendar gave it structure. We saw audits had been completed on how staff managed medicines in people's homes; these included an observation of their practice in administering medicines, how staff followed good hand hygiene and how they interacted with the person. There had been audits on infection prevention and control, the equipment used in people's homes and how staff recorded people's nutritional intake. There were action plans when shortfalls were identified and a revisit of the audit to check actions had been completed. A member of staff said, "We have spot checks from [registered manager's name]. My last one was just before Christmas. He pops in, completes an audit and talks to the service user and relatives."

We saw satisfaction surveys for people who used the service had been carried out in July 2015. There were some minor issues identified on the surveys and it was difficult to locate an action plan to see if these had been addressed. The registered manager told us the new survey was about to be sent out to people and they would ensure any shortfalls had a clear action plan. We saw people who used the service ran a steering group and discussed areas of the service they wanted to improve; they raised the suggestions with the registered manager. The steering group had developed the new survey to be sent to people who used the service.