Essex Cares Limited

ECL Regaining Independence Service

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 9 February 2016 and was announced.

ECL Regaining Independence Service provides structured support for people living in their own homes across West Sussex. At the time of our inspection, approximately 124 people were using the service. People are referred to the service following hospital discharge or through social services. They follow a time limited, 're-enablement' programme of support which helps them to attain planned goals and regain their independence.

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.

People and their relatives felt safe using the service and staff were trustworthy. People's risks were identified and assessed appropriately and guidance was provided to staff on how to manage people's risks. Staff had been trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place. Safe recruitment practices were in place so that suitable staff were engaged to work in the care profession. Staff were not always prompt in arriving at people's homes at the stipulated time, but it was recognised that some people needed additional support which varied from day to day. Accidents and incidents were reported and managed appropriately. People's medicines were managed safely by trained staff.

Staff were trained in a range of areas to support people effectively and new staff followed the Care Certificate, a universally recognised qualification. The majority of staff were up to date in their training, but the registered manager had identified this was an area for improvement and had plans in place to address this. Weekly staff meetings enabled staff and other professionals to discuss people's care needs and progress. Staff had regular supervision meetings and observations were undertaken of staff as they supported people at home. Staff had received training on the Mental Capacity Act 2005, but some staff did not have a thorough understanding of the requirements of this legislation. This did not impact on people's care as staff gained people's consent before delivering care and providing support. Care plans recorded that people gave consent to their care and treatment. People were supported by staff to have access to a range of healthcare professionals.

People were supported by kind, caring and friendly staff who knew them well. People spoke highly of the staff and the care they received. There was a high turnover of people who used the service because people received planned support in a structured, time limited programme of care lasting, on average, six weeks. People were involved in their care as much as they wanted to be and were treated with dignity and respect.

People received personalised care that supported them to regain the independence they had lost as the

result of a specific event, such as an accident or through illness. People helped to set goals they aimed to achieve and were supported by staff in this. Complaints were managed and responded to appropriately in line with the provider's policy.

People were asked for their views about the service through surveys sent by the provider. A large majority stated they were happy with the service and were likely to recommend it to friends or family. The service demonstrated good management and leadership and staff felt supported to raise any concerns they had. There was a range of audits in place to measure the quality of the service overall and the care delivered.

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.

People and their relatives felt safe; staff were trained to recognise the signs of potential abuse and knew what action to take.

Risks to people were managed appropriately and were identified and assessed as needed. Guidance was provided to staff on how to mitigate risks.

People felt happy with the time staff spent with them, but some felt staff did not always arrive at the stipulated time. People and community professionals recognised that, because of the nature of support provided, it was not always possible for staff to keep to timed visits.

People's medicines were managed safely and staff trained in the administration of medicines.

Is the service effective?

Good

The service was effective.

Staff were trained in a range of areas, received regular supervisions and attended weekly staff meetings.

Whilst not all staff had a thorough understanding of the Mental Capacity Act 2005 and its implications, they did seek people's consent when providing care and support.

People had access to a range of healthcare professionals and staff supported them to attend healthcare appointments.

Is the service caring?

Good

The service was caring.

People felt they were cared for and supported by warm, kind and friendly staff. They were involved in all aspects of their care.

People were treated with dignity and respect and had the privacy they needed.

Is the service responsive?

Good

The service was responsive.

People received personalised care and helped to plan goals they needed to achieve in order to regain their independence.

People's complaints were responded to in a timely manner and actions taken to address any complaints raised.

Is the service well-led?

Good

The service was well led.

The provider asked for people's views about the service. Staff were also asked for their feedback.

Staff felt supported and that they could raise any concerns they had.

A range of audit systems measured the quality of the service overall.

ECL Regaining Independence Service

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 9 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. Two inspectors undertook this inspection.

Before the inspection, we examined the previous inspection report and information we had received. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. 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 any improvements they plan to make. We used all this information to decide which areas to focus on during our inspection.

Before the inspection, the Commission sent out questionnaires to obtain feedback from 50 people who used the service, their relatives and friends and 15 community professionals. We received 13 responses from people who used the service, one response from a relative and six responses from community professionals.

We observed care and spoke with people and staff. We spent time looking at records including 12 care plans and daily records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with two people who were receiving care at home and two relatives.

We spoke with the provider's head of quality and corporate governance, the regional manager, registered manager and three care staff. After the inspection, we contacted three people by telephone to obtain their feedback about the service they received.

The service was last inspected in February 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe using the service. One person said, "I've seen a few of the staff over the last few weeks. They're lovely and very trustworthy". Another person referred to staff and said, "I like them all. I definitely feel safe". A third person said, "I felt very safe with both workers, they were absolutely super". A relative told us, "They've been really helpful since [named family member] came out of hospital. I come as often as I can, but the carers have helped a lot. I really trust them". Another relative said, "They're like friends, so we do feel safe". One hundred per cent of people who responded to our questionnaires said they felt safe from abuse and/or harm from their care workers.

Staff were trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place. One member of staff told us that if they had any concerns relating to safeguarding, "I would speak to my senior and they would refer on". Another member of staff said, "I'd record and report to the office and fill in the safeguarding form". When any concerns were raised, the registered manager and other representatives of the provider would investigate and liaise with the local authority safeguarding team. Staff told us the different types of abuse they might encounter, such as financial, sexual or self-neglect. A copy of the West Sussex Adults Policies and Procedures – April 2015, was available for staff to reference.

Risks to people were managed appropriately. When people started to be supported by the service, their risks were identified, assessed and guidance was provided to staff on how to mitigate risks. We asked staff about the management of risk working in people's homes. Care plans included environmental risk assessments that had been undertaken, in each case, outlining possible risks to people and staff. Risk assessments had been drawn up in areas such as bathing and the use of hoists and included the steps staff should take to minimise risk. Staff told us about the procedure they would follow if they were unable to gain access to people's homes. We were told that many people had 'keysafe' devices fitted to exterior walls, which enabled staff to access house keys in a secure manner via a combination locked metal box. Staff kept the codes for individual keysafe boxes on adapted smartphone devices issued by the provider, which were PIN protected. Staff also told us of procedures for contacting relatives, or the police if necessary, in order to gain access and ensure people's safety at home.

Guidance for staff was provided on the reporting of accidents, incidents and near-misses. Staff would record any accident or incident and these were then investigated by the provider. The guidance stated that a 'competent person' would undertake the investigation and, 'They will ensure that the required action has been taken in order to reduce the risk of reoccurrence'. All incidents and accidents had a target date for closure within 20 days of the incident occurring. The provider would decide whether any incident or accident needed to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Records confirmed that when an accident or incident was reported, appropriate follow-up action was taken and the risk assessment for the relevant activity was reviewed or drawn-up. Six incidents or accidents had been recorded for 2016 and appropriate action had been taken. A member of staff explained how they would complete an incident form and the risk assessment reviewed. They told us, "We're the first to pick up on things, good or bad".

We asked people and their relatives about staff and the amount of time they had to spend with them. One person said, "They [staff] always seem to have the time to spend". A relative told us, "I've no complaints at all. If they need to spend the time here, they spend it and if they're running late, they let us know".

We asked staff about the amount of time they spent with people using the service. One staff member told us, "If we need to spend extra time with a customer, then we do. And if we think someone is going to need extra time in the future, we can talk about it at the weekly meeting. We'll get the extra time. The management are really good". Another member of staff explained, "It is task orientated, but it's not time specific. It can take longer for example to have someone wash themselves, rather than us washing them. There is a certain amount of leeway, we can swap clients around. If a client has a hospital appointment, then the phone signals the carer as the call can't be changed because time is needed to prepare for the hospital appointment". Recently completed customer satisfaction questionnaires showed that 4% of people's visits were late or cancelled, although this was from a relatively small sample of people. Another member of staff felt they had time to chat with people in the time allocated. They added that if they were going to be late, "Say 45 minutes or more, I would ring the person to explain". One person told us, "Staff are not very often late. I never get worried. Someone else may have had a fall. They [staff] let me know usually if they're going to be late". We asked another person whether staff were punctual when they visited and they told us, "They can't be specific about time. I'm aware the staff can't arrive on the dot". Staffing levels were sufficient to meet people's needs, but support provided by care staff to people could vary on a day to day basis. This meant that timings allocated to care visits were not always adhered to and there were occasions when staff spent additional time with people that might result in them being late for the next call(s).

In response to our questionnaire, one person stated, 'I never know now what time to expect them. Only the local chap who makes me his first call'. Of 12 responses, 58% of people stated that their care worker arrived on time. A community professional commented, 'Care call times vary and cannot be set so this sometimes upsets customers. We continue to try to improve the service'. Another community professional stated, 'Some of the issues raised by customers that I visit that are receiving this service are that they do not feel that consistent times and care staff are provided to them at calls. I am aware, however, that the remit of the service is one that is unable to provide regular call times or care staff due to its variability based on changing according to the needs of the customers in the service at that particular time. Where customers have a genuine need for a regular call time, I do feel that this service does attempt to provide this regularity more where possible'. The registered manager said that, "Most of our staff are very flexible" and that they were in the process of recruiting additional staff. In the Provider Information Return (PIR), the registered manager stated, 'Recruiting additional staff over and above establishment requirement will allow more flexibility to deliver the service effectively and efficiently'. Overall, people were happy with their call times and acknowledged that staff could sometimes be late arriving if another person had needed additional support or time spent with them. Statistics were not kept and analysed relating to staff punctuality in call times. A member of the management team explained, "We try and fit with customer's preferred times" and that call times were "constantly rejigged" because of the type of service provided.

People's medicines were managed so they received them safely. There was a medicines policy in place which defined the support that staff might provide to people in the administration of medicines. The policy stated, 'Prompt – remind customer (who has mental capacity), Assist – physically help customer, remove tablets from pack and Administer – staff select, measure and give appropriate meds to customer and ensure it is taken and/or applied as prescribed. This can happen when the person has been assessed as lacking mental capacity'. The policy contained guidance for staff on the need to gain people's consent and capability, fridge storage, medicines to be taken as needed (PRN) and what to do if people refused to take their medicine. Staff had signed to say they had read the medicines policy, confirmed they had received

training in the administration of medicines and that Medication Administration Records (MAR) had been improved. One member of staff referred to the changes in MAR and said, "Now a lot better. You can see what time the medicine was given".

Safe recruitment procedures were in place. Before staff commenced employment, appropriate checks were undertaken to ensure they were safe to support people in their homes. Staff files showed that checks had been undertaken with the Disclosure and Barring Service (DBS) and that two references had been obtained for each new member of staff.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Induction training was provided for new staff in a range of areas including dignity and values, moving and handling, lone working, basic life support, mental capacity, safeguarding, administration of medicines, health and safety, equality and diversity. New staff undertook the Skills for Life Care Certificate covering 15 standards of health and social care. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. In the PIR, the registered manager stated, 'A training passport has been introduced. These have been issued to all staff who are expected to bring the passport with them to all training events to be signed. This will evidence an immediate record of training completed and the date and gives the individual their own personal record'. New staff shadowed experienced staff until they were confident to work alone and were assessed as competent to do so.

According to the responses from our questionnaire, 92% of people asked felt that care staff had the skills and knowledge they needed. We asked staff about the training opportunities on offer. One staff member said, "There is always training on offer. We deal with a wide variety of issues so we need it". Another member of staff told us they had completed a vocational qualification in health and social care and a diploma in dementia care. They said, "Everybody is as informed as they possibly can be". A third member of staff told us about recent training they had received in medicines administration, moving and handling and safeguarding. They said that some training was delivered as e-learning and other training was face-to-face. The staff training plan included the mandatory training that all staff had to complete in a range of areas such as medicines, health and safety, safeguarding, mental capacity, food hygiene and infection control. Some training was updated annually, for example, medicines administration, whilst other training was refreshed every two or three years. The training plan indicated which staff training was up to date, which needed to be refreshed or was booked and which was out of date, using the colour codes of green, blue or red respectively. In the main, staff training was up to date; the registered manager said, "I know some training is out of date, but we've worked really hard on the training".

The provider organised weekly staff meetings. Minutes from recent meetings showed that staff contributed to the meeting and made suggestions of importance to them. The meetings were primarily used to discuss developments and changes regarding people who used the service. Topics such as safeguarding issues, medicines management and staff training were discussed. However, the minutes did not contain a review of the minutes of the previous meeting. In addition, the record did not contain a plan to decide what action would be taken as a result of the current meeting, by when and by whom. Consequently, it was not possible to judge the effectiveness of staff meetings or to know if staff's concerns or requests had been dealt with. We brought this to the attention of the registered manager who stated they would record any actions arising from staff meetings in future minutes.

Staff confirmed they received regular supervisions with their managers at least three times a year and two observations when delivering care to people in their homes, one announced and one unannounced. Staff told us they felt their supervision meetings were productive and helpful and one said, "If I have any concerns

about anything I can have a supervision if I need to". Staff files showed that staff received at least two supervision meetings every year, in addition to observations of their work. In the PIR, the registered manager stated, 'ECL is currently introducing an employee wellbeing package which is being rolled out to all staff. This will be part of a programme which offers expert advice and specialist counselling service to support ECL staff with unexpected events'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and staff understanding of the requirements of the MCA. Staff had undertaken recent training in this area, but three staff we spoke with did not have a good understanding of the implications of the MCA. One staff member told us, "Getting people to do things for themselves is part of what we do. We always ask for consent before we do things". Another member of staff was asked whether they had received training on the MCA and said, "I'm sure I would have, but not recently. When you first meet somebody, you pick up whether they have capacity or not" and added they would assess this by talking with people and from the information in their care plan. However, one member of staff confirmed they had received training on the MCA and said, "It's about people's capacity to make their own decisions". They provided an example of people making choices about taking their medicines, what to eat or getting dressed and said, "You have to go with that". The lack of understanding by some staff on the MCA did not appear to have any negative impact on the care and support that people received.

The provider's Customer Risk Enablement Policy included information for staff on the MCA and the assumption that people have capacity. The policy stated, 'Ensure that a clear distinction is drawn between putting a person at risk and enabling them to manage risks appropriately. Ensure that customers can take informed and reasonable risks insofar as this is consistent with meeting the outcomes of the service that is being commissioned'. When asked about issues of consent, people confirmed that care staff always sought their permission before delivering care or providing support.

Care plans showed that consent was sought from people or their representatives on a variety of issues, including sharing of information with health and social care professionals. There were no mental capacity assessments in the care plans we looked at. However, all the people concerned had been referred to the service by local authority agencies, such as occupational therapy or social services departments and had been assessed before referral. As the maximum length of input provided by the service was approximately six weeks, this did not represent a risk to people.

People were supported to maintain good health and had access to healthcare services and professionals and care plans confirmed this. The provider involved a wide range of external professionals in the care of people. These included social workers, GPs and community nurses. Advice and guidance given by these professionals was followed by staff and documented.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and care staff. We asked people and their relatives about the caring approach of staff. One person said, "The staff are very kind, yes. I don't feel uncomfortable at all". Another person told us, "They do care, all of them. They're a lovely bunch!" Telephone interviews conducted with people confirmed that they thought highly of the staff who supported them at home. One person said, "I broke my left arm and they were wonderful. They did everything I wanted and they're very charming". They added, "We'd have a laugh and we just had a lovely relationship and that's very important. They did everything they could to alleviate my problems. I've already told my friends how good they are". A relative told us, "Their approach is really good. They're very caring, but they are here to help [named family member] improve, so they do push, which is right". Responses to our questionnaire showed that 92% of people were happy with the care and support they received from the service and 100% of people stated that the care staff were caring and kind.

We accompanied one care assistant on two home visits. We observed excellent interaction between the staff member and the people they were visiting. The staff member was respectful and mindful they were a guest in people's homes. They took the time to explain procedures and to listen to people and relatives' issues and concerns. For example, during one visit, an occupational therapy technician arrived to fit a shower seat and grab rail in the person's bathroom. The staff member involved the person in the process and listened to their concerns. At one point, a relative was concerned that an item had not been delivered; the staff member was able to reassure them that it had and was being fitted. We asked staff about their work and one said, "I love it, it's very rewarding" and added that it could be a challenge supporting people living with dementia, but that they enjoyed it and had taken a diploma in dementia care.

The care plans we looked at did not contain detailed life histories and social assessments. There was information concerning next of kin details and contact numbers, in addition to the person's requirements from the service. However, staff displayed a good knowledge of the people they were caring for. In addition, as the service is time limited for people, the lack of detailed life history did not have an impact on people using the service. According to the PIR, 1,318 people had used the service within the last 12 months.

We asked people if they were involved with their care as much as they wanted to be. One person said, "Yes, I am. They always ask me before they do anything". We also asked relatives about their involvement with their family member's care. One relative referred to staff and said, "They will always get in contact if there's been a change or they need information". Staff told us they tried to support people to regain their independence, if possible at the level they had enjoyed before they required the service. One staff member said, "Every person's different. Every day can be a challenge". The registered manager said they tried to match people with staff and said, "Staff are always much better at doing one thing than another. We try and match staff with people, for example, some staff may support people really well who live with dementia".

We looked at care plans and daily records. All care plans and risk assessments were signed by staff and reviewed weekly at staff meetings. There was evidence that people and their representatives had formal involvement in care planning and risk assessment. People's views were sought on their care plans and there

were opportunities to alter the care plans if the person did not feel they reflected their care needs accurately.

We asked people if they were treated with dignity and respect. One person told us, "Yes of course. They're very respectful. They don't rush me and they're never rude". Another person said, "They're lovely, that's all I can say". A third person agreed that staff treated them with respect and said, "Definitely, most of them are very kind. One male carer is so gentle and kind". Results from our questionnaire indicated that 94% of people felt they were treated with respect and dignity by care staff. A relative told us, "We haven't known them for long, but they're very good. They treat [named family member] very well". Staff described how they would treat people to give them the privacy they needed when delivering personal care. One staff member said, "I shut the curtains, shut the doors and cover them with a towel. In some cases, it's just confidence building and you just stand outside the door. You build up to getting them to have a shower on their own. You step back and in the end, they're doing it themselves".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People were referred to the service either when they were discharged from hospital or through an assessed need via a social worker. An occupational therapist would visit people to assess their needs and to establish whether 're-enablement' was appropriate. Re-enablement is a programme that is personalised to the individual and seeks to support them, through a range of goals and targets, to regain their former level of independence before a specific event occurred to them, for example, an accident or through illness. The programme would be planned with people and/or their representatives and their agreement gained in setting a range of goals and outcomes that were achievable. For example, one person had developed mobility problems following a recent hospital stay. Their medicines had also been reviewed and changed. The person's 'customer service delivery agreement' stated the aims of the service's input and the plan to achieve it. This was signed by the person using the service. Assessments had been made about their ability to manage their own medicines. The care plan also included an assessment by an occupational therapist, outlining staff actions required to ensure as full a recovery as possible was achieved.

Normally people received support that lasted between four to six weeks and comprised up to four calls a day from care staff. An occupational therapist told us that after about three weeks, they had a good idea whether a person was responding well to the support they received from care staff. The occupational therapist decided initially how many calls were required by people and the time allocated and then the number of calls/time allocated could be increased or decreased over time, depending on people's progress. Weekly team meetings were convened at which community professionals and staff discussed people's care and support, whether people were likely to regain their independence with support or whether they might need permanent support from a care agency. An occupational therapist told us they would support people, when they left the service, either to source ongoing support from a care agency or to be referred back to social services, if it was felt the person could not live long term without 24 hour care.

A member of staff explained how they supported people when they were referred to the service. They said, "On the first visit, you can see what they can and can't do" and explained that they had all the information about the person's needs beforehand, saying, "There's quite a lot of information. It's very varied". Another member of staff said, "I love it. Just the fact you're going in and helping people to gain independence". The same member of staff talked about helping people to achieve the goals that had been agreed with them. They said, "If somebody sets their goal to be able to cook their own lunch, then we go in and help them to work the microwave. We gradually drop back and correct them if they're wrong, eventually they cook their own meal". Another example provided was that of a person who wanted to go on the bus to do their shopping and how staff would first accompany the person on the bus, then progress to seeing them on to the bus and meeting them at the destination. Eventually, over time, calls would be reduced until the person would be able to catch the bus and do their shopping on their own. The registered manager explained, "Goals might be small in the first week, then increase week on week".

Care plans and daily records were legible, relevant and up to date. They contained detailed information about people's care needs, for example, in the management of risks associated with environmental hazards

and food preparation. People's choices and preferences were documented. The daily records showed that these were taken into account when people received care, for example, in their choice of a male or female carer. Care planning and individual risk assessments were reviewed weekly during the duration of the service delivered. In the PIR, the registered manager stated, 'ECL are planning to introduce a more effective IT system that will allow for the required documentation which is completed with the customer to be sent electronically back to the office immediately. This will allow for any changes to support plans to be carried out with immediate effect'.

People's concerns and complaints were encouraged, explored and responded to promptly. The provider's complaints policy stated that a formal complaint may be made verbally by a person or in writing and that complaints were acknowledged within three working days. The expectation was that complaints would be investigated and responded to fully within 28 working days. The policy provided contact details for the local government ombudsman and for the Care Quality Commission should the complainant feel that their concerns had not been addressed appropriately by the provider. Three complaints had been recorded since September 2015 and had been managed appropriately to the satisfaction of the complainants. For example, one complaint related to the use of keysafes by staff and documented what action had been taken in response.

Good

Is the service well-led?

Our findings

The service promoted a positive culture that was person-centred, open, inclusive and empowering. People were asked for their views about the service in a survey organised by the provider. Feedback from a survey in February 2016 included the following comments from people, 'All carers were very nice and polite at all times' and 'The carers have been excellent, professional and courteous, as well as patient and caring. They have been friendly and a pleasure to have in my home. I shall miss them in every way'. In total, 47 positive comments had been received.

We looked at the provider's previous satisfaction questionnaire survey which had been compiled following the completion and return of forms by people using the service in November and December 2015. The questionnaires covered areas such as the quality of information received prior to using the service, staff attitudes and whether staff actively promoted people's independence. Forty people had returned forms over the two months. There was a high degree of satisfaction in all areas examined. Over 90% of people were likely or highly likely to recommend the service to friends and family. We noted that 13% of respondents had stated their wellbeing was poor following input from the service. We discussed this with the registered manager. As the question did not specifically ask people if there was a link between poor wellbeing and service input, it was not possible to establish a causal link. That is, people's perception of poor wellbeing may have been caused by an event completely unrelated to input from the service, for example, a bereavement or acute illness. The registered manager stated the question would be re-visited and re-phrased.

The service demonstrated good management and leadership. There was a whistleblowing policy in place and staff told us they felt supported to raise any concerns they had. When asked what they felt was 'good' about the service, one member of staff told us, "Everything really, I just love it. Some if it's challenging, but it's good fun". In the PIR, the registered manager stated, 'Staff surveys provided via survey monkey are conducted annually and staff are invited to comment on the support they receive, development opportunities, environment that they work in and training provided'. The registered manager talked about the adjustment that had been made when the service transferred from being managed by the local authority to a private provider and felt positive about the move. They told us that they felt supported by the new provider and said, "It just feels like we're in a better place". The registered manager felt improvements had been made under the management of the new provider and said, "Where we are with staff and recruiting staff, it's much better now". They added, "I would like to think that six months from now we have the staff we need and are providing a good quality service".

We asked the registered manager about 'duty of candour' and its relevance to the care and support of people using the service. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant person's' when things go wrong with care and treatment. Providers must have an open and honest culture at all levels within the organisation and have systems in place for knowing about notifiable safety incidents. The registered manager was able to describe the relevance of duty of candour and its application. They explained, "Duty of candour is about being open and transparent. You're not trying to hide things. If you do

something wrong, admit to it. And it's about apologising as well".

There was a range of audits in place to monitor the quality of the care delivered. Accidents and incidents were analysed by the provider, any patterns or trends identified and action plans put in place to prevent reoccurrence, together with lessons learned. The provider monitored a range of quality 'performance indicators' across its services including safety, customer experience, effectiveness, staffing, learning and development, governance and compliance and external assessments. The quarterly report from July – September 2015 rated various aspects of the service and included comparison of statistics and forecasts to include 2015/16. Quality assurance was also discussed at team meetings and the registered manager said it was important to involve staff as they would, "Often come up with ideas and how things could work better". Where improvements had been identified through the auditing process, plans were put in place and action taken.

We asked the registered manager how they felt they delivered high quality care. They said, "It's all about people regaining as much independence as they can, giving them confidence, trying to get them back to where they were before they were poorly and in a safe way".