Transformaction Consultancy Limited

Brighter Care

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 December 2017 and was announced. Brighter Care Limited is a domiciliary care service that provides care to people in their own home. It provides a service to older adults. At the time of the inspection the service was providing personal care to 60 people in their homes.

At the last inspection of July 2016, we asked the provider to take action to make improvements to the way they managed risks to people. The service sent us an action plan on how they would make the required improvements. At this inspection, we found the action plan had been completed.

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

The leadership and management of the service was good. The person-centred approach and care people received was evident in all aspects of the service. Staff were passionate about providing high quality support to people and felt that managers listened to and acted upon their ideas and suggestions. Staff spoke highly of the managers and providers. Staff were motivated and empowered to develop professionally and in their careers. The provider rigorously assessed and monitored the quality of the service. They put steps in place to constantly improve quality.

The service responded to people's needs in a very personalised way. Care plans were person-centred and focused on achieving the best possible outcomes for people in an individualised manner. The service adopted an individualised approach and focused on building positive relationship with people. The service actively involved and consulted with people and their relatives in planning and developing their care plan. The views of people and their relatives were considered and used.

Care records reflected people's personal histories and backgrounds. Staff were matched with people taking into accounts their interests, culture and personalities. Staff were encouraged to report every incident and accident. The registered manager reviewed them and took actions to address them and reduce reoccurrence. Lessons were shared with staff.

Staff were trained to keep people safe and report any concern of abuse. The likelihood of people experiencing avoidable harm was therefore reduced. Senior staff members carried out an assessment of people's needs and risks and developed plans to alleviate them. The service followed best practice guidelines in assessing people's needs and risks.

There were sufficient numbers of experienced staff to support people. Staff recruited were vetted to ensure they were suitable to deliver care and support to people. Staff provided people with the support they required to take their medicines safely.

People received care and support from trained, skilled and knowledgeable staff. People received the support they required to eat and drink. Staff supported people to maintain their health and access healthcare professionals as their needs required. The service had system in place to ensure they continued to receive the support they needed when they moved between services.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People consented to their care before they were delivered. People and their relatives were involved in making decisions about their care. Staff and the registered manager understood their roles and responsibilities under the Mental Capacity Act (MCA) 2005.

People received care from staff who were compassionate and caring. Staff supported people to make day to day decisions about their care. People were involved in planning and delivering their care. People were encouraged to maintain their independence. People's privacy was respected and their dignity was promoted. Staff knew people well and had developed positive relationship with them.

People's care was delivered in a flexible manner and met their preferences and requirements. People knew how to complain if the wished. The registered manager investigated and addressed each complaint received about the service. Staff were trained to deliver end-of-life care if needed.

People, relatives, professionals and staff told us the organisation was well managed. The service operated an open and transparent culture. The service worked jointly with other agencies including social services, commissioning teams and training providers to improve the service.

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 trained in safeguarding procedures and knew how to identify signs of abuse and the procedure for reporting their concerns.
People's risks were assessed and plans were in place to reduce them which staff understood.

People were supported by staff who had been recruited through a robust process. People told us there were enough staff available to meet people's needs.
Staff were trained in medicines administration and supported people to receive their medicines safely.

Staff were trained and followed infection control procedures.

Staff were encouraged to report incidents and accidents. The registered manager reviewed records of these and shared learning with staff.

Is the service effective?

Good

The service was effective.

The service assessed people's needs in line with best practice guidelines. Staff were trained in how to support people effectively.

People and their relatives were involved in making decisions about their care. Staff and the registered manager understood their roles and responsibilities under the Mental Capacity Act (MCA) 2005.

People were supported to meet their nutritional and hydration needs. Staff supported people where needed to access healthcare services. The service had systems in place to ensure they continued to receive the support they needed when they moved between services.

Is the service caring?

Good

The service was caring. Staff focused on building positive relationships with people. Staff were matched with people taking

into accounts their interests, culture and personalities. Staff knew people and understood their needs.

Care records reflected people's personal histories and backgrounds. Staff were understanding, compassionate and sensitive towards people.

The service provided care and support to people in a way that promoted their independence. Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Staff responded to people's needs well. The service actively involved and consulted with people and their relatives in planning and developing their care plan. The views of people and their relatives were considered and used.

Care plans were person-centred and focused on achieving the best possible outcomes.

People were supported to do the things they enjoyed and participate in activities. The service assessed people's cultural and religious needs and supported them to maintain these.

The service used suitable technology to respond to people's needs in a timely way.

People knew how to complain about the service and the registered manager investigated and responded to each complaint about the service.

Staff were trained to provide end of life care.

Is the service well-led?

Good

The service was well-led.

The leadership and management of the service was good. The person-centred approach and care people received was apparent in all aspects of the service.

Staff were passionate about providing high quality support to people and felt that managers listened to and acted upon their ideas and suggestions.

The managers and providers were held in very high esteem by

staff. Staff felt supported and encouraged to improve their practice and the support they provided people. Staff were motivated and empowered to develop professionally and in their careers.

The provider had robust systems to assess and monitor the quality of the service.

The provider worked collaboratively with other organisations and professionals to ensure the best outcomes for people.

Brighter Care

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.

The inspection was prompted in part by concerns we received about the care provided to people. The concerns ranged from risk management, staff competence and management support. We carried out a comprehensive inspection and we checked all the issues as part of our inspection.

This announced inspection took place on 22 December 2017. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager and director would be available. It was undertaken 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.

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Prior to the inspection we reviewed the information we held about Brighter Care Limited including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We also reviewed the Provider Information Return (PIR) we received from the provider. PIR 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 used this information in the planning of the inspection.

During the inspection, we spoke with 11 people and five relatives about the care they received from Brighter Care. We spoke with the registered manager and the director, five care staff, the care supervisor, care coordinator and the duty care manager. We reviewed eight people's care records including risk assessments and medicines administration record charts. We looked at seven staff files which included recruitment checks, training records and supervision notes. We looked at other records relating to the management and running of the service; such as the provider's quality assurance systems, complaints and compliments.

Following the inspection we received feedback from six professionals involved in people's care about the

service provided by Brighter Care.

Good

Is the service safe?

Our findings

People told us they felt safe with staff in their homes. One person said, "Yes, totally safe with them and in the way they do their jobs." Another person told us, "I feel safe with [staff] in the house." Relatives concurred with what people told us. One relative said, "We have no safety concerns." Another relative said, "Yes, I think [my loved one] is safe and comfortable with the staff." A third relative commented that, "I have not seen anything unusual or heard [my loved one] say anything negative at all."

At our last inspection we found that risk assessments were not always undertaken by appropriately trained staff to ensure they were adequate. At this inspection we found people were protected from risk of harm associated with their physical, mental health and care and support. Senior staff carried out assessments to identify risks to people. This covered areas such as pressure sores, choking, moving and handling, nutrition and the home environment. Management plans were developed for staff to help to reduce any risks identified. Where necessary, a relevant health professional was involved in developing the risk management plans to give staff guidance to be able to support people safely. For example, we saw that moving and handling plans in place for people at risk of falls and with reduced mobility. A professional manual and handling risk assessor was involved in developing moving and handling plans where required. A speech and language therapist had developed guidance for staff to follow to reduce choking risk for one person. The plan included the food texture allowed, sitting position and action to take if a person was choking. Staff we spoke with understood the risk management plans for people and they followed them to minimise risks to people. This meant people's risks were identified and mitigated.

People's safety was promoted by making sure staff who delivered care and support were trained to identify and respond to alleged abuse. All staff had completed safeguarding training and understood the provider's safeguarding procedures. They were clear about the various types of abuse, possible signs to look for and actions they would take. One staff member said, "If I suspect abuse I will call one of the managers. It will be documented. The managers will investigate it, I trust them. If at any point I feel I can't trust them, I will go to CQC." Another staff member told us, "If I think abuse has occurred or happening, I will report it. I don't have to be certain. I will make a report of the signs I have seen in writing. The managers here will do everything to get to the bottom of it. I surely trust they will take action." Staff also knew how to whistleblow. They told us they were encouraged by their managers to do so if they felt it was needed to protect people. One member of staff said, "I can whistleblow if needed. They [managers] always encourage us to feel free to contact other authorities if we feel we cannot speak to them but there has not been any need for that."

The registered manager knew their responsibilities to protect people and aware of their duty to respond to alleged abuse. This includes alerting the local safeguarding authority, carrying out investigation and notifying the Care Quality Commission (CQC). Record showed that they had followed their procedure in addressing safeguarding concerns and had taken steps to protect people.

There were enough staff available to deliver care to people. People told us they always had a staff member to support. They confirmed they had never had a missed visit. One person said, "I have not had a missed visit. Sometimes they have terrible difficulty in getting here but they always do come." Another person told

us, "As far as I know staff always come." One relative said, "They have come, but they have come later. Often it's because the previous person has to go to hospital. There are always feasible excuses for not coming [on time]." Another relative told us, "No missed visits. Not with Brighter Care."

The service used an electronic monitoring system to schedule care visits and reduce the risk of missed or late visits. Staff knew what care visits they were scheduled to do in advance. The system required staff to log in and out when they arrived and left a visit. That way the office knew when there was a potential late or missed visit. The office then followed up with the staff scheduled to undertake the visit or arranged immediate cover. We reviewed a three months report of scheduled visits and there had not been any missed visits recorded. This confirmed what people told us.

Staff told us they had sufficient time allocated to them to care for people. One staff member said, "We have sufficient time but if we don't we let the managers know. They are always happy to review the time and increase it if needed. It's not a problem at all." In general, it is sufficient. Most times it is fine. Of course, sometimes things happen outside your control like an emergency but the time itself is enough."

Care records provided staff with details of people's preferences for how staff should gain entry into their homes. For example, one person's care records informed staff that the person would use an intercom system to let staff in to provide care. Another person's care records detailed staff should use the key safe. Where people were able to open their doors to let in staff this was recorded in their care records.

Staff knew how to respond to emergency situations. If a person was unwell they would arrange for them to be seen by their GP. If it was an urgent medical emergency, they would contact the ambulance service. If people did not respond as planned to their arrival at their homes, they would contact the office staff for advice and who would then phone family members to check. The registered manager explained that 'no response' procedure would be instigated if there were concerns about a person's safety. The registered manager and office-based staff were all trained and could provide cover to respond in an emergency if needed.

Staff were recruited safely. Prospective staff submitted applications and were interviewed as part of the process. The service explored gaps in applicants employment histories if any was identified. All staff we spoke with told us references, proof of identify, right to work in the UK and criminal records checks were obtained before they were allowed to start work. Records we checked confirmed what staff had told us. This meant staff were suitable to work in a caring role.

People received their medicines as required. One person told us, "Yes. [Staff] issues that in the evening, about 5.30-6 p.m." Another person said, "They sometimes will remind me of the night time medication I take. Apart from that I try to manage myself. They don't help me because it's my wish." A relative told us, "They have a blister pack. The carers give [my loved one] medication in the morning and I give in the evening. They ensure my loved one has taken them and it's marked down in the book." Another relative said, "Yes, the medicines come in blister packs. [Staff] always make sure they have taken it."

The registered manager assessed the support people needed to manage their medicines. Support provided included ordering repeat prescriptions, collecting medicines, administering and returning unused medicines. People told us and records confirmed that staff provided the appropriate level of support to take their prescribed medicines. Staff had completed training in medicine management and their competency had been assessed. Medicines administration records [MAR] sheets we checked showed people received their medicines as prescribed by their GPs. Staff knew what actions to take if a medicine error occurred. They said they would contact the GP and pharmacist for advice and would complete an incident form.

People were protected from the risk of infection because staff were trained in infection control. People and their relatives told us staff followed infection control practices. They confirmed staff always wore protective gloves when attending to their personal care and administering medicines; to reduce the risks of infection. One person said, "They wear gloves. Its one thing I do look for. I am very aware – I don't want to get any infections. They do change gloves." Staff we spoke with told us of measures they used to prevent and reduce the risk of infection which included effective and frequent hand washing, using personal protective equipment (PPE) and disposing of waste appropriately. The registered manager monitored staff practices during spot checks and they discussed infection control procedures with staff during supervision and team meetings.

The service managed incidents and accidents to reduce a reoccurrence and to keep people safe. Staff told us they were encouraged to report every incident and near miss. All staff understood their reporting procedures, the importance of reporting and told us they were committed to it. One staff member said, "We are told to report everything. No matter how small the concern or incident or even if it almost happened but didn't. They [the management] said reporting it will help prevent it from happening. It is for our health and safety and the customer's as well." Another staff told us, "We have to record and let the managers know of medicine errors, incidents of challenging and aggressive behaviour, falls, no entry and things like that. Managers will then look into it."

Record of incidents and accidents were maintained. The registered manager and director investigated each incident or near miss thoroughly and put actions in place to reduce reoccurrence. For example, where people had frequent falls, they were referred to the falls clinic for support. The registered manager discussed incidents with staff so lessons could be learned from them. For example, following a medicine error caused by a dispensing error from the pharmacy, staff had been retrained and reminded to always check labels and MAR charts to make sure they matched.

The registered manager also analysed incidents and near misses to establish patterns and trends to enable learning. For example, from an analysis of incidents they established that there was frequent medicine error relating to one person. After investigation it was found that the relative was unable to manage the person's medicines. This was reported to social services who found the relative needed extra support to cope with caring for their loved.

Good

Is the service effective?

Our findings

People's care was planned and delivered to meet their needs. The service conducted an initial assessment with people and their relatives to discuss their care requirements, needs, and goals. The assessment was done either in people's homes or in the hospital. People also had a choice to visit the office location if they wanted. The assessment covered people's physical health, mental health, personal care, nutrition, behaviour, and social activities. The assessment was used to establish if the service could safely meet people needs and goals. The registered manager used tools recommended such as Malnutrition Universal Screening Tool (MUST) and waterlow assessment to assess people's nutritional and skin integrity needs.

The registered manager liaised with other professionals where required to gather advice and support on how they can support people with their needs in line with the National Institute of Clinical Excellence (NICE) best practice guidance. For example, they had worked with district nurses and GPs to develop guidelines for staff to follow to support one person who was diabetic. Staff had received training and support on how to monitor the person's glucose levels, and what actions to take if their blood sugar reading was outside normal range. This meant the service followed best practice guidelines to ensure people's needs were met.

People received care and support from staff that had the skills and knowledge to do so. One person said, "[Staff] know what they are doing." Another person told us staff felt confident in delivering their roles. One relative told us, "Yes, they all know what to do. If they are new they don't mind me telling them how the others do it." Another relative said, "Generally, they all know how to provide care to [my loved one]. In the past carers have come who were not up to speed on dementia care. My loved one's main carers are dementia experts and I have noticed a difference."

People were supported by staff who had been through a thorough induction. Record showed and staff told us they received an induction when they started work. One staff member said, "I had an induction and training before I went out to work on my own. I also shadowed experienced carers for days. They asked me how I felt, if I had any concerns or needed more training." Another staff member told us, "My induction covered reading policies and procedures, care plans, training and shadowing. I shadowed for three days. They made sure I was comfortable before I went out to work on my own. They asked me if I needed more training but I felt confident so didn't need it."

Staff received training to meet people's needs. Training completed included medicine management, safeguarding, health and safety, manual handling, infection control and first aid. Staff had also received training in specialist areas such as dementia care, diabetes, stoma bag care and catheter care. One staff told us, "I feel confident in my role. I have done so many training. If I need more, they are always happy to organise it." Another said, "The training here is very good. We have online, and classroom. Sometimes we attend training organised by the council." Staff also had opportunities to reflect on their practices in a group or one-to-one as a way of further developing their knowledge and experience.

Records showed and all the staff we spoke with confirmed they were supported to be effective in their roles. One staff member said, "I feel supported. They always give us the support that is needed. It does not matter

who I call. They will listen and support you. I get supervision quite regularly. They come out to assess that we are providing best care to customers." Another member of staff told us, "[Management] support us very well. They do observations and feedback to us how we are doing. They send you on training if they feel you need to improve." Staff also received annual appraisals where their objectives were reviewed and any training needs identified.

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. If the service wished to restrict the liberty of any person for their safety an application would have to be made to the Court of Protection. We checked whether the service was working within the principles of the MCA. At the time of inspection the registered manager told us they were not providing care or support to any people who required an application to the Court of Protection.

People, where required, gave their consent before care and support was delivered. Care records contained signed copies of consent to deliver care and support including managing medicines. People and their relatives confirmed staff obtained approval from them before undertaking any tasks. One relative said, "Yes. They always tell her what they are going to do, they are careful to do that." Another said, "Some are slightly better than others. They have different methods. [My loved one] has a tendency to say they don't want this or that. Some persuade gently, some ask."

The registered manager, senior staff and care staff members understood the MCA principles and their responsibilities to promote it and ensure people consented to their care and support. One member of staff told us, "We don't force people to do anything if they don't want it. We try different approaches, explain to them the risks and benefits, give them time and then involve their family." Another member of staff said, "If a person is continuously refusing care and I am concerned about their mental capacity. I will inform my managers and they will arrange a meeting with the person's family and GP." Records showed that people and their relatives were involved in deciding their care and support needs. Where there were doubts about a person's capacity meetings took place to ensure decisions were in their best interest. People also had appointees in place where required, to manage their care and financial needs when required.

People received the support they required to meet their nutritional and hydration requirements. One person told us, "Yes, they will ask what I want; they will tell me what's available and they will cook it." A relative said, "I buy the stuff and they feed [my loved one] they have blended meals, and pureed meals. Staff keep my loved one hydrated." Care plans indicated what support people needed to meet their nutritional needs and how staff should support them with this. Staff supported people to shop, prepare meals in line with their requirements and preferences and maintain a healthy balanced diet. Records also showed where required, people were supported to meet their hydration needs. A food and fluid chart was completed to monitor one person's intake where this was considered necessary.

People were supported to maintain their health. One relative told us, "The carer discovered an infection and stayed with her, made a doctor's appointment and took her to the doctor." People were supported to make and attend appointments with healthcare professionals and recorded outcomes as required. Records showed a range of health professionals were involved in meeting people's health and social care needs.

People needs were met appropriately when they used other services. For example, when a person was admitted to hospital, staff ensured they took a copy of their information sheet which contained details of their medical history, care and support needs, communication requirements, allergies, list of medicines, next of kin and GP details. Staff liaised with hospital staff to provide any information or support. Before a person was discharged from hospital, staff visited to reassess their needs and for a handover from the hospital about their. Staff also reviewed the discharge summary and updated their care plan as required. This ensured people received consistent and on-going care and support in line with their needs.

Good

Is the service caring?

Our findings

People were supported by caring staff. One person told us, "Yes. [Staff] are just kind, nice, and chatty. I feel totally comfortable with them." Another person said, "[Staff] are very good. I haven't had any problem with them. They will sit and chat. Always very kind." Relatives also commented about how caring staff were. One relative told us, "Yes, they don't lose their temper; they are very nice to [loved one] and treat them well. If [loved one] is not in such a good mood they always treat them nicely and get their spirit up. They all have a laugh."

Staff focused on building and maintaining positive relationships with people and their relatives that achieved best outcomes for them. They explored people's personal histories and cultural backgrounds as part of the assessment process and these were reflected in their care plans. People likes, dislikes and preferences were also detailed in their care plans. Staff told us information in care plans enabled them to understand people and their behaviours so they could care for them as they preferred.

Staff understood the needs of people they supported. Staff told us about what people liked and how they preferred to be supported. Staff gave us examples of what people liked and disliked and how they preferred to be cared for. For example, one person liked a particular TV programme turned on and they chatted with staff about it. Another person prefers to have a cup of tea before having a wash. Staff followed people's care plans and instructions given to them. One staff member said, "You need to try communicate with people well on everything you are doing. It helps build a relationship so they can trust you and share their worries. That way you can support them appropriately."

Staff were understanding and compassionate towards people and showed them empathy. Care plans detailed people's emotional need. For example, one person's care plan stated they had mood swings whilst another could be confused and anxious. Staff told us they provided people with emotional support when they were distressed or unhappy. Staff said people could show sign of distress or anxiety by withdrawing, or becoming quiet or restless. Staff explained they knew people they supported and reassured them if they were feeling low. One member of staff said, "Listening to people with genuine interest is very important. You need to be understanding of their situation and show them empathy and care. You don't have to pity them but empathise." People confirmed staff spent time chatting with them and made sure they were comfortable.

Staff maintained people's dignity and treated them with respect. One person told us, "Yes, they will turn their backs if I am washing. If I have visitors, they will take the [log] book in the kitchen where they are away from company." Another person said, "Yes, they do. If I am using [the toilet they go out of the room. I feel very comfortable with them." Relatives also commented, "Yes. They always close the door when they are washing [loved one] and when they take them to the toilet they leave them to finish their business. They never make them feel ashamed or humiliated." Another said, "Yes, they do. They always make sure [my loved one] has their eye glasses on in the morning, well dressed and coordinated. The door is shut when changing." Staff had received training in dignity in care and showed they understood how to promote this in practice. They gave us various examples which people and their relatives confirmed in their comments.

People were supported, to maintain their independence. "Yes. They might stand back and wait to see how much I can do. They watch me all the time to make sure I am okay. I am really pleased with them." Care records stated what people could do for themselves. For example, one person could dress themselves but required help to bath. Staff understood the importance of enabling people their independence as much as possible. One staff member told us, "We encourage them to do things for themselves. The more they can do the more independent they are. It gives them value and preserves their self-worth." Another staff member said, "To promote independence, you as a staff member need to learn to take a step back and let the person lead. Encourage them to be involved. Giving them praise is good too; it makes them want to try."

Good

Is the service responsive?

Our findings

Brighter Care Agency adopted a personalised approach in the way they designed and delivered people's care and support. They tailored care and support provided to meet people's individual needs in a way that achieved the best possible outcomes for them. For example, one person was supported back from a care home to live at home with their family. This had been their wish and that of their family. As a result of their conditions they had refused to engage with services to assess their needs. Brighter Care Agency consulted a health professional and devised a plan with the person's family on how to engage them for an assessment.

Staff carried out several visits to the person in the care home and established a relationship. They involved occupational therapists to provide equipment needed at home and ensured the home environment was safe for them to return. The person was supported to return home for a visit and while at home a care plan was put in place based on their needs. Staff liaised with care home staff for a period to enable a smooth transition so the person's needs were met appropriately and provided regular and consistent care staff to support them. This meant the person was settled into their home environment, living with their family as they wished and taking control of their lives.

The service had worked with an occupational therapist and a physiotherapist to improve a person's mobility and functional abilities. Staff had followed the programme and supported the person with exercises and routines that were put in place. This achieved a positive outcome which enabled the person to live at home with minimal support instead of living in a care home. The person's care package was also gradually reduced as their functional abilities and mobility improved. Their relative fedback "Unlike the other providers, [Brighter Care] did not jump immediately to a 'three-visits-a-day' solution, and the draft care plan was developed flexibly with experience over the next few weeks. The meticulous assessment of the house, facilities, equipment, safety, and [person's name] expectations about food and personal care were particularly impressive at this early stage, and every attempt was made to choose carers with the experience and personality they would be comfortable with. Changes in the roles and duties and timings have continued gradually as they have recovered and regained more control over her home, possessions, and daily routine." A professional also commented, "Brighter Care are pro-active in identifying the changing needs of their clients and will adapt support plans to meet those needs in consultation with the commissioning team. They will regularly provide us with unsolicited feedback on the welfare and changing circumstances of clients in order that their needs can be addressed in an appropriate and timely way."

We tracked two other examples of how Brighter Care Agency had responded to people's needs in a personalised manner. The service had specifically recruited a staff member who spoke Turkish and had particular religious beliefs to support one person. The person had lost the ability to communicate in other languages due to their dementia. The person had also become very religious. They refused to engage with services or staff members that could not understand and shared the same religious beliefs as them. The person also expressed behaviours that challenged others. The person's relatives struggled to meet the person's needs effectively due to their personal, work and family commitments. They also struggled to cope with the behaviour the person expressed. This caused difficulty in the relationship between this person and their relatives which made the person withdrawn and isolated. The staff member recruited was able to

communicate with them in their own language, understood their background, culture and religious beliefs and so was able to build a positive relationship with them. This person became comfortable and accepted help with personal care as a result. The staff supported them to attend places of worship which was important to them. They also engaged them in activities they enjoyed such as visiting community centres and shopping malls. This thereby reduced the risk of isolation.

In another example, the service had retained a staff member so they can continue to support one person. The person had a strong personality and was particular about what they wanted and how they wanted things done. The person had turned down staff from working with them and staff had also refused to work with this person. The service eventually matched a staff member to this person putting in consideration experience, personalities, backgrounds and qualities. The person and staff developed a positive working relationship and the staff supported them with their needs effectively. The staff member had travel difficulties due to distance and was considering resigning but the service agreed a working arrangement which met the needs of the person and suited the staff member. They also covered agreed to cover the extra cost of travel to ensure they continue to provide a consistent and effective support to the person.

People received care and support tailored to meet their individual needs and requirements. People and their relatives were actively involved in their needs assessment and care planning process. One person told us, "Staff constantly discuss with me any changes. There's good communication with the back office." Another person said, "When they first came, the manager came round on the first visit and worked out the care plan with me." One relative told us, "They [Staff] have been coming for quite a while, so the care plan it's all accepted…They know exactly what to do. It puts my mind at rest to know they are coming in and know what they are doing." Another relative said, "Staff always check with me about every decision. For example, when they have to take [my loved one] to the doctors. They give me an update."

Care plans detailed people's physical, mental, emotional and social needs, personal history, individual preferences, interests and aspirations. It also contained their preferred visit times, tasks to be undertaken, how they preferred these be completed and key people involved in delivering aspects of their care. We saw some people had live-in care staff who delivered aspects of care as agreed such as night time care. The number of daily visits, duration of visits and time of visits was dependant on people's needs and preferences. People received support as required with their personal care, meal preparation, mobilising, transferring, medicine management; socialising, managing and maintaining health. For example, one person who suffered recurring infections was supported to keep up with fluid intake and to have regular blood tests.

The service was flexible in the way they operated and responded appropriately to people's requirements and choices. One person told us, "I requested the visits increased from three to four. I have changed times when I have got to go somewhere, and they will oblige by changing the times. I have extra time for a shower." A relative commented, "They checked with me about Christmas hours and they seem to be very accommodating. They seem to be really on it. I was impressed by that." We saw people amended and adjusted the service required based on their needs. One person had a live-in carer in place to help them settle back home after discharge from hospital. The service adjusted the care arrangement in line with their needs. The live-in arrangement was cancelled when it was no longer needed. We also saw people could change the times of their care visits based on need. For example, they could request for an earlier visit if they had hospital appointments or were travelling.

Care plans were regularly reviewed and updated to reflect changes in people's needs and requirements. When people's needs changed they had a reassessment to establish the support they needed. For example, if a person had a fall or hospital admission. Staff confirmed they were informed about changes in people's

care by reading through the care plans, and phone calls from management staff. Changes were also discusses at team meetings.

Daily care logs showed care was delivered in line with people's needs. Staff we spoke with understood people's care needs as detailed on their care plans. They also showed they understood the importance of following the care plan. One staff member told us, "Care plans help me provide people the care they need."

The service enabled people to maintain their cultural and religious beliefs. Care records noted what mattered to people including relationship with family, faith and culture. One person's care record noted how seriously they took their religion. We saw staff regularly supported them to attend church and practice their faith. Another person was supported by staff to observe their prayer times by reminding them and participating in the prayers. Another person was supported to maintain and follow their cultural and religion's way of dressing and their food requirements. Staff had completed training in equality and diversity and knew to be sensitive and respect people's protected characteristics.

People were supported to do the things they enjoyed, maintain relationships and their lifestyles. One person enjoyed going out to shopping centres and to cafes. Staff supported them with this. Another person was supported regularly to visit family and friends in the community whilst another person was supported to the hair salon and banks.

The service used assistive technology to ensure people received timely care and support. They considered appropriate equipment and technology needed to help meet people's needs as part of the initial assessments and when people's needs changed. Technology used to aid and respond to people's care appropriately included pendant and bracelet alarms which people use to call for help emergency. Door alarms were also installed in people's homes that were at risk of leaving the home unaccompanied.

People's concerns and complaints were listened and responded to and used to improve the service. All people and relatives we spoke with told us they knew how to complain. One person told us, "I would go directly on the phone to the person at the other end, possibly the head, and the manager." Another person mentioned, "I would just ring the office to speak to [the manager's name]. I've had no complaints though." One relative told us, "I have the numbers of all of that. I have had some things I have been concerned with, but they were small. It's been resolved to my satisfaction." Another relative said, "I would contact the office. I have their mobile number as well."

People received information about the provider's complaints procedures when they began using the service. The complaint procedure included how to escalate concerns if not resolved internally by the provider. Records we reviewed showed that the registered manager investigated and responded to complaints and concerns raised about the service. They had followed their procedure to resolve issues.

The service provided end-of-life care when needed. Care assessments covered people's end-of-life wishes. Staff were provided training and support to care for people appropriately at this stage of their lives. At the time of our inspection, no person was receiving end-of-life care.

Good

Is the service well-led?

Our findings

There was a registered manager in post who understood the requirements of their CQC registration including submitting notifications of significant incidents. Our records and the incident records we reviewed showed they had complied with these requirements. The registered manager was also one of the two directors of the organisation. Both directors of the service had strategic management experience and understood their role and responsibilities in delivering effective care service. They had a team of office staff who worked with them to ensure the service was well run, people received care and support they needed and staff were supported.

People, their relatives, and professionals we contacted told us the organisation was well run. One person commented, "I have been very impressed by them so far. They are efficient and professional. They are really good." Another person commented, "They are friendly and very helpful. Everything they do for me is lovely." One relative stated, "It's difficult to say how it could improve. They are all very friendly, amenable, very nice with my [loved ones'], very cheery…I could not complain about the care at all. We are very satisfied with Brighter Care." Another relative told us, "My husband and I selected Brighter Care, having visited their office and those of another local care provider. Our immediate impression was of a focused, coherent, and professional organisation with a strong emphasis on high-quality care tailored to particular customers' needs." A professional commented, "We have worked at developing good relationships with Brighter Care management and have no concerns. Brighter Care is considered by the team to be one of the best agencies available to us in the local area."

Staff also spoke positively about the management and vision of the organisation. They told us people were at the centre of the organisation and the providers emphasised this. One member of staff said, "They are very hands-on and get involved in everything. They know all their customers by name, their care needs, and history. They are very interested in the care the customers receive. They are very person-centred. They always say the care provided to people need to be the best quality possible." Another staff member stated, "The registered manager knows the clients, their needs and abilities. They take a keen interest in the people and staff too. It was interesting to see that when I joined."

Staff had the leadership, support and direction they needed to deliver to achieve positive outcomes for people. All the staff we spoke with told us they were well-supported, motivated and felt satisfied working for the organisation. One staff member told us, "Brighter Care is the only company I have worked in my 30 years in the care industry that I feel so well supported by the registered manager and director. It is not just about the money for them. They are truly interested in people – staff and customers." Another staff member commented, "I can't fault them really. They are very supportive, and very accommodating. They are interested in staff welfare. They are really good. I would recommend them to someone I love."

The registered manager and director involved and engaged staff through meetings on how they could improve the service. Team meetings were held regularly to discuss various issues for people using the service, their work, team work and policies and procedures. Staff told us they felt listened to and were able to make suggestions and share ideas on how to improve the service. One member of staff told us, "I feel

listened to. We discuss ideas together and together we come up with a solution." These meetings were also used to share best practice, and training sessions. We saw that meetings had been used as training sessions on procedures and on topics such as diabetes management, infection control, catheter care and dignity in care.

The service supported professional and personal development. Staff were given opportunities and encouragement to develop areas of interests. They were supported to share knowledge and skills with the team in order to improve the care provided to people. One staff member told us, "They [the management] support development. I was interested in dementia care and I discussed it with the providers/registered manager. I was supported and given a lead role in this area. The role involves working with people with dementia and training staff. They supported me with training to be able to do this." Another staff member said, "They give you a chance to do what you want. They encourage you to do training. They help you improve yourself. It makes you feel valued. It means a lot." From our discussion with staff, they felt motivated, enthusiastic and happy working with the organisation. They all told us they would recommend Brighter Care to family and friends who needed a care service or those looking for work. One staff member told us how they travelled a long distance to work and were happy doing so because the service supported them by given them a suitable working arrangement.

Staff understood their roles and responsibilities. Staff were able to discuss with us the expectation of the service which was focused on delivering person-centred care to people. They confirmed they had a copy of the job description, staff handbook which sets out the values and aims of the service, standards expected and key policies and procedures.

The provider gathered the views of people and relatives through annual surveys, quality monitoring visits, phone calls and spot checks. The provider reviewed and evaluated the information it received and used it to improve the service. The last survey result reported 80% satisfaction level. The other 20% commented that the service could improve on attendance and times of visits. Following this the provider arranged a meeting with people who were not satisfied to discuss their views and comments. The provider developed an action plan to improve areas where people felt dissatisfied. For example, they had the call monitoring system to alert on potential late call and responded quickly to avoid it.

The provider continuously tried to improve the service. They reviewed and investigated every complaint, missed or late visits, incidents and accidents and negative feedback about the service. They shared learning from these with staff so lessons can be learned and to drive improvement. For example, as a result of medicine errors reported, the provider had incorporated practical training and competency assessments as part of their medicine management training. As a result of feedback received about the skills and experience of new staff; practical session was included as part of moving and handling training. Staff told us it was very helpful applying learning in practice.

The service had a range of systems to assess the quality of service delivered. They checked documentation such as care plans to ensure it reflected people's needs and was up to date. Medicine management systems, staff records, training records and others records relating to the management of the service were also checked for their accuracy and correctness. The registered manager and care managers did regular spot checks either over the phone or face-to-face to obtain feedback from people about the quality of the service. They used feedback received or findings from their visits to improve the service. For example, staff training had improved.

The provider worked closely with other agencies to improve the service and achieve positive outcomes for people. They liaised with social services and, local commissioning teams about people's care. The local

authority had completed a monitoring visit following concerns received. The concerns related to various issues about the service including staff training, management support and service delivery. The issues were investigated and a report was produced which found no evidence to substantiate the allegations. The registered manager regularly sought advice from health and social care professionals and organisations to ensure people's needs were met. They receive updates and newsletters from National Institute of Clinical Excellence guidelines to improve how they delivered service to people. The providers also worked with training providers and local colleges to source and develop training for staff.