Care Quality Commission

Accomodating Care (Driffield) Limited

Accommodating Care (Driffield)

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

Overall summary

The inspection of Accommodating Care (Driffield) domiciliary care agency took place on 1 December 2015 and was announced. We gave the service several hours' notice so that the registered manager could meet with us. At the last scheduled inspection on 12 December 2013 the service was not meeting the requirements for quality monitoring systems in place under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At the follow-up visit on 25 March 2014 the service had met these requirements. On 1 April 2015 the 2010 regulations were superseded by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accommodating Care (Driffield) is a domiciliary care agency that provides care and support to approximately 23 older people in their own homes, some of whom may

Summary of findings

be living with dementia. The service operates from an office in the premises of The White House Residential Care Home located on a main road in Driffield, East Yorkshire.

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

We found people that used the service were protected from the risks of harm or abuse, because there were systems in place to ensure that all suspected or actual incidents of abuse were appropriately handled and managed. The provider had ensured staff were appropriately trained in safeguarding adults from abuse and there were systems in place to ensure safeguarding referrals were made to the appropriate local authority safeguarding department.

People were safe because the risks that were presented to them in their homes were reduced by implementing an environmental risk assessment and other risk assessments, for example, on falls, using mobility equipment and eating healthily. They were supported by staff in sufficient numbers to meet people's needs and staff recruitment practices followed safe policies and procedures. There were medication management systems in place to ensure those people without capacity were safe from the risk of receiving the wrong medication.

We found that people were supported by trained and skilled staff who in turn received support and supervision from their registered manager. Communication was important in the service and systems had been improved following an incident, which meant that staff were more vigilant about checking people and sharing information to ensure people's safety.

People were protected by the use of legal systems, where necessary, in cases where they had reduced capacity to make decisions. They received regular and consistent support with their nutrition and maintaining their health and wellbeing.

We found that people were supported by caring and kind staff who knew about people's needs. The staff team explained what they were doing at each stage of providing support to people. Staff respected people's privacy, dignity and independence when carrying out tasks so that their personal wellbeing was assured.

People were cared for according to their assessed needs and personal preferences as written in their support plans. People were encouraged to maintain interests that they may have had in the past or new ones that they had discovered in later years. They were also encouraged by staff to maintain relationships that were important to them and staff were responsive to people's needs for contact.

We found that while our questionnaires to people indicated that some people were unsure of who to complain, people we spoke with told us they knew how to make complaints if needed to. We saw that complaints and compliments were appropriately managed and recorded.

We saw that people benefitted from receiving a service that was led by a conscientious manager who steadily improved the service each day. We saw that staff were guided and supported by the registered manager who 'led by example'.

People were able to make contributions to changes in their individual care by engaging in care reviews. They were able to affect changes in the overall service delivery by engaging in the quality assurance and monitoring systems operated in the service. There were several means of seeking people's views: surveys, visits and phone calls from the registered manager and periodic spot checks carried out on staff performance, at which people were asked to comment on the staff member's ability, skill and caring nature. We saw that the service completed regular audits on many areas of service delivery to identify shortfalls and that all of the information gathered was used to devise action plans for improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People that used the service were protected from the risks of harm or abuse. The provider had ensured staff were appropriately trained in safeguarding adults from abuse and there were systems in place to ensure safeguarding referrals were made to the appropriate department.

People were safe because the risks in their homes were reduced, staffing was in sufficient numbers to meet people's needs, staff recruitment followed safe policies and practices and medication management was safe.

Good

Is the service effective?
The service was effective.

People were supported by trained and skilled staff who in turn received support and supervision from their registered manager. Communication systems had improved following an incident and staff were more vigilant about people's safety.

People were protected by the use of legal systems where necessary. They received support with their nutrition and in maintaining their health and wellbeing.

Good

Is the service caring?
The service was caring.

People were supported by caring and kind staff, who explained what they were doing at every stage and who respected people's privacy, dignity and independence so that their personal wellbeing was assured.

Good

Is the service responsive?
The service was responsive.

People were cared for according to their assessed needs as written in their support plans. People were encouraged to maintain interests and relationships by staff that were responsive to their needs for contact.

People knew how to make complaints if needed to and complaints were appropriately managed.

Good

Is the service well-led?
The service was well led.

People benefitted from receiving a service that was led by a conscientious manager and staff that were guided and supported.

People were able to make contributions to their individual care and to the overall service delivery through a system of quality monitoring and assuring the service.

Good

Accommodating Care (Driffield)

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 of Accommodating Care (Driffield) took place on 1 December 2015 and was announced. The provider was given a few hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the office.

The inspection was carried out by one Adult Social Care inspector. Information had been gathered before the inspection from a 'provider information return' (PIR) that we asked the provider to submit to us. A 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 also gathered information from notifications that had been sent to the Care Quality Commission (CQC), from speaking to local authorities that contracted services with Accommodating Care (Driffield), and from people who had contacted CQC, since the last inspection, to make their views known about the service.

We had also sent out our own questionnaire to 16 people that used the service and 16 relatives before we inspected. We received seven completed by people that used the service and one completed by a relative: 44% and 6% which gave us an average sample of views from people and a low sample of views from relatives.

We visited and interviewed three people that used the service, spoke with two staff and the registered manager. We looked at care files belonging to three people that used the service and at recruitment and training files belonging to four care staff. We looked at records and documentation relating to the running of the service; including the quality assurance and monitoring and medication management systems that were implemented. We looked at other records held in respect of complaints/compliments, safeguarding and risk management systems.

We observed staff providing meal time support to two people in their homes and we observed the interactions between people that used the service and staff.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe when receiving care from staff that worked for Accommodating Care (Driffield) domiciliary care agency. They said, "The girls are marvellous, they provide any care that I ask for and they are so kind", "The staff are lovely and I am highly satisfied with their services" and "If I ever had any problem with staff I would tell my son. Staff wouldn't dare be abusive because I would give as much back and throw them out."

We saw that the service had a safeguarding file in place which contained information on what constituted a safeguarding concern, how to refer issues and what the local authority multi-agency procedure was in respect of handling safeguarding concerns.

Staff we spoke with told us they had completed safeguarding training with East Riding of Yorkshire Council (ERYC) and they demonstrated a good understanding of safeguarding awareness when we asked them to explain their responsibilities. Staff knew the types of abuse, signs and symptoms and knew the procedure for making referrals to ERYC. We saw from the staff training record and individual training certificates that care staff had completed safeguarding training in the last two years.

The information we already held about safeguarding incidents at the service told us there had been one incident where the registered manager had used the ERYC Safeguarding Adult's Team risk tool for determining if a safeguarding referral needed to be made to them. Details of this had been notified to us using the appropriate notification documentation. We judged that the service acted appropriately and quickly in respect of safeguarding referrals. The safeguarding records we saw showed that incidents were recorded properly, investigated and learned from. Systems that were in place to prevent and address safeguarding incidents, and staff having completed appropriate training to manage these issues, meant that people were protected from the risk of abuse.

We saw that all people that used the service had their environments risk assessed for hazards and unsafe equipment, so that staff would be aware of risks to their own safety as well as that of the people they were visiting.

Other risk assessments included those on cross infection when preparing meals, fire safety, taking medicines, falls and moving and handling when transferring, all of which we saw had been regularly reviewed.

Where people had living environments that were assessed as unsafe for people and staff the service manager contacted people to discuss carrying out some work to remove the hazards or to repair the property. This enabled the service to continue safely.

The service had policies and procedures for dealing with accidents and incidents and there were records in place to record when these had occurred. Records included body maps to show where injuries had been sustained and when. We saw that there were systems in place for staff to handle people's finances should this be necessary, for example, when shopping for them. Staff were clear about their responsibilities and the procedures to follow in handling money and recording this. They were aware of the policies that covered finances and handling money, for example, they told us they were forbidden to access rewards such as loyalty points on their own points cards when shopping for people that used the service, they had to ensure every transaction was accompanied by a valid receipt and they had to maintain accurate accounting records.

The provider's PIR stated there was stricter monitoring of rosters taking place to ensure that all calls were covered and a winter plan had been established to identify the vulnerability of people that used the service in the event of severe weather disrupting staff travel arrangements. It also stated that people could make out of hours contact with the service 24 hours a day and seven days a week. It said that staff were allowed travel time between calls and this was allocated on their rosters. It declared that more care staff were to be employed to allow the registered manager and senior carer more administration time for checking allocated calls in order to monitor and prevent missed calls from happening. It said the service was looking into the possibility of purchasing a computerised roster system.

We found that the service employed ten care workers and provided services to 23 people at the time of our inspection and people received support from staff that in most cases worked alone. Staffing levels were determined by the

Good

Is the service safe?

number of people that required visits and by the number of visits those people needed to meet their support needs. The service maintained staffing rosters and staff were informed of their duties each week.

The provider's PIR told us that new carers were allowed to work under supervision after receipt of a 'protection of vulnerable adults' first check with the Disclosure and Barring Service (DBS) and only moved to lone working after receipt of full DBS check. A DBS check is a legal requirement for anyone over the age of 16 applying for a job or to work voluntarily with children or vulnerable adults, which checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

However, the registered manager told us they used thorough recruitment procedures to ensure staff were right for the job. They ensured job applications were completed, references were taken and DBS checks were carried out before staff started working in most cases. We saw this was the case in two of the four staff recruitment files we looked at. We discussed this with the registered manager who explained that one of the staff had been recruited under the previous registered manager and the other had been recruited in a hurry to cover vacancies and was therefore put on shadowing duties until their full DBS check was received. The registered manager agreed that this practice should be kept to a minimum.

We assessed that staff had not begun to work in isolation in the service until all of their recruitment checks had been completed which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable.

All four files we looked at contained evidence of application forms, references and people's identities and there were interview documents, health questionnaires, contracts of employment, job descriptions and correspondence about job offers.

There were systems in place to manage medicines safely. Only those staff trained to do so supported people to take their medicines. Mostly people administered their own medication as they had capacity and were physically able to do so. Where a person lacked capacity their medication was kept safely stored out of their reach and relatives or the service arranged for it to be reordered and collected and relatives or the staff administered it to them. Management systems followed by the service were appropriate and safe for people that used the service.

Medicine administration record (MAR) charts were in place for people that had their medicines administered to them and the ones we saw contained clear details of when and how medicines were to be given. The MAR charts had been completed accurately by staff.

The Care Quality Commission questionnaires we received from people that used the service and one relative were analysed to show that there was 100% satisfaction that the service was safe, with the exception of people receiving care from inconsistent staff: 86%. People expressed that they would have liked more consistency from the same carers allocated to support them. We discussed this with the registered manager who explained that changes in staffing were sometimes difficult to avoid, as it was impossible to predict illness, but every effort was made to assign staff to people and keep the rosters maintained.

Good

Is the service effective?

Our findings

The registered manager informed us that where possible staff completed training provided by East Riding of Yorkshire Council or in combined groups with staff that worked in the White House Residential Care Home, which is a 'sister' service operating at the same location address. We saw the service's training record which showed that staff had completed training in 'protection of vulnerable adults', health and safety, fire safety, infection control, food hygiene, management of medicines and moving and handling with the use of hoists in 2014 and 2015. One staff had completed a 'train the trainer' course in moving and handling. Some staff had copies of certificates for courses they had completed in a previous job, which included dementia care training, dignity and presentation and emergency first aid.

We found that staff had completed various stages of the Care Certificate and had been competence assessed at the appropriate times to compound their learning.

The provider's PIR stated that there was a staff training programme in place and that regular staff monitoring via supervision observations took place, which involved spot checks on staff as well as announced supervision observations. It stated that staff were introduced to people that used the service and monitored more closely during their induction period. During the induction period new staff shadowed experienced members of the team who guided them in learning the preferences and normal routines of people that used the service.

We saw evidence in staff files and staff confirmed when we interviewed them that supervisions took place and an appraisal system, as well as a staff incentive scheme were in operation.

The provider's PIR stated that rigorous communications within the service and particularly about people's care plans were very important to ensure the service maintained up-to-date service delivery. It said that regular communication with social workers and family members was essential to ensure people's needs were met. It also stated that staff communicate with the service via a telephone app (application: a mobile app is a computer programme designed to run on mobile devices such as tablet computers and smartphones) which all staff had access to and therefore could respond to changes in needs and rosters promptly. Communications from social services were also relayed by the registered manager to staff via the same telephone app, and so they were all 'kept in the know'.

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 interest and as least restrictive as possible.

We found that there were no people using the service that had any restrictions placed on them because of incapacity issues. The service would become involved in best interest meetings if necessary and staff would adhere to the codes of the legislation that were in operation if restrictions were found to be required.

We were told by the registered manager that they had completed training in the MCA three to four years ago and that one other staff had completed it in their previous employment, but no one else that worked for Accommodating Care (Driffield) had done so. When we spoke with staff they were aware of the need to obtain people's consent before they carried out any personal care for them or completed any tasks within their homes. Staff said, "Oh we are very aware that people who we visit to support are the 'boss'" and "We would always seek permission before we offered our support. We are entering people's homes after all."

We saw that people had details in their care files about the foods they preferred and liked and what they would like to have for their meals when supported by staff. People chose their own foods and arranged for their own shopping items to be purchased. Staff asked people what they were to prepare for them each day and usually managed to comply with their wishes. Staff would only intervene in encouraging people with food changes if they thought people were eating a detrimentally poor diet or if they were eating foods that were unsuitable for their medical condition or diagnosis, for example, if they were diabetic or had allergies. This would be done via contacting people's GPs.

People were encouraged to ensure they maintained good health by staff that monitored people's general wellbeing. Staff offered support and advice with regard to visiting GPs,

Good

Is the service effective?

hospitals and optical, dental, audio and chiropody appointments. Where possible people attended these appointments independently but staff were available if necessary to accompany them. Care plans had details of people's health diagnoses, their medication needs and the action staff needed to take to support them in maintaining good health.

The Care Quality Commission questionnaires we received from people that used the service and one relative were analysed to show that there was 100% satisfaction that the service was effective.

Good

Is the service caring?

Our findings

The 'provider information return' (PIR) we received stated surveys were used to ask people if they felt that carers were caring and respected their privacy and dignity, if carers respected their homes and possessions and if staff allowed people to make their own choices. It also said surveys asked people if they felt safe and supported by the carers. The PIR recorded that the service intend to improve service delivery in three ways: by having a nominated staff member as dignity champion, as the previously nominated staff member had left their position, by holding awareness sessions with care staff members and by introducing end of life training or awareness into the training programme.

People we spoke with told us they felt staff were "Very caring", "Lovely girls, happy to do anything for you. So good they are brilliant" and "The reason why I am able to walk again today. Staff really encouraged me and gave me the belief I could recover from my operation."

We found that the approach from staff was professional but friendly and caring. Staff were competent in their roles and knowledgeable about the care and support that people required from them. Staff told us they tried to spend a little time chatting to people when they supported them and when they sat down to write people's diary notes, as they said that most people they supported just wanted some company in addition to the care they received.

People we spoke with told us they felt involved in their care, as they made daily decisions about their routines: when and how they got up for the day, what they ate at meal times and how they kept themselves occupied. One person said, "The carers are kind and helpful. I just have to ask them to assist and they do. I know I have a care plan but I am not bothered about it. All that matters is I keep the same agency and staff."

Staff told us how they assisted people by relating some examples to us. They said they sometimes needed to visit people in twos if the person required the use of a hoist to transfer, and explained how they used the equipment, giving instructions to the person all the time and seeking their cooperation if necessary. We observed staff assisting two people with their midday meal and staff gave information and asked questions so that the people were able to make their own decisions. Staff were informative and sought people's cooperation.

The registered manager explained to us that they assisted people to maintain their wellbeing by ensuring people's health care needs were known, understood by staff and addressed with them and their GP if necessary. Staff were willing to support people to appointments if family were unavailable and always tried to be cheerful when supporting people in their daily routines. Staff said, "We pick up on people's traits and assist them accordingly. If we think people are low or unhappy we would report it to the office and the registered manager would come and hold a discussion with them." This meant that people's wellbeing was monitored and addressed if people were found to be unhappy or low in mood.

Staff told us they also assisted people with some shopping tasks and prescription collections, so that they had the groceries they needed and their medication before other stocks ran out. Staff saw these tasks as being just as helpful to people in maintaining their general wellbeing, because while things were running smoothly people had nothing to get distressed about.

We saw that information about people was kept confidential to only staff and stakeholder that needed to know in the service and that information to be passed to us in notifications was held confidentially and separately in a confidential file.

Staff explained to us how they assured people's privacy and dignity when assisting them with personal care and other support: covering people with towels when they were undressed, allowing people time alone in the bathroom, ensuring curtains and doors were closed and being discreet when assisting people whose physical capability was impaired or their mental capacity was diminishing, for example, prompting people to use the toilet in good time so that they didn't get into undignified situations. Staff assured us they found it important to assist people to maintain their independence in all areas of their lives and said, "We encourage people to be independent wherever possible, as we are fully aware that our clients are the 'boss'."

People we spoke with said, "Oh the girls are always good about making me feel comfortable when they help with care. They cover me up and let me have time in the toilet alone. I can't fault them" and "I don't need help with personal care but I can talk to the staff and know they will be discreet about things. And they do try to keep me independent."

Good

Is the service caring?

The Care Quality Commission questionnaires we received from people that used the service and one relative were analysed to show that there was 100% satisfaction that the service was caring.

Good

Is the service responsive?

Our findings

The 'provider information return' we received stated that care plans were in place for all people that used the service and reviews of these were carried out regularly. We saw evidence of this in the files we looked at. We saw that files contained daily diary notes, records of care delivery observed during 'spot checks' completed on staff, satisfaction records, summaries of needs, action plans, accident records, risk assessments, audit forms on management of medication and contracts to provide a service.

We found that the service was not responsible for the entertainment of people that used the service and so they did not especially engage in activities with people. The service provided personal care and support with household chores or shopping in the main. However, one person we spoke with told us they had been assisted by staff to rehabilitate with their mobility following an operation. They said, "If it hadn't been for one particular staff motivating me and the others for helping in that approach I wouldn't have been walking again." They went on to tell us that the staff supported them to get stronger and therefore they were now able to do things in the community again.

Staff recognised the need to enable people to make as many choices as possible for themselves and facilitated this whenever they could. Staff explained that people usually made their own choices because they were living in their own homes, had reasonable capacity to make decisions and really only needed physical support to manage their daily routines and activities. We saw people making choices when we visited them in their homes: about how many more pieces of dessert they wanted to eat, what they talked about to the staff, how they directed staff to items in their kitchen and essentially whether or not they invited us in to their homes to speak with them.

While some people recognised they were much less physically able than they used to be they still exercised their rights to think freely, make choices and decisions and influence how their support was provided to them. One person felt much more empowered for having had the experience of receiving support when they were recovering from surgery and so they had regained their physical ability and their confidence as a result. They felt that their life was completely their own again.

We found that people were encouraged to maintain family and friend relationships by staff talking to people about their family members and assisting people to make contact with family and friends on the telephone if necessary. This showed the care staff were aware of the need for people to maintain important relationships.

The provider's PIR stated that regular calls and visits were made to people by the registered manager and senior carer so that people gained confidence in speaking out if they were unhappy with the service. These calls and visits were recorded and, if necessary, people were invited to complete a complaint form to formally log their concern.

People we spoke with told us they were aware of how to make a complaint. They said, "If I have a problem with any of the staff or the service I can go to the manager or to my son, who will go to the manager for me" and "I have never needed to complain, but I know I could always speak with [Name], the manager. I believe I received information on how to complain in my care pack when I first started to receive the service."

We saw the service's complaint policy and procedure and the records of complaints made. These were readily available to staff and staff told us they also had their own folders containing blank forms to complete for various areas of their roles, including complaint forms, diary sheets and finance records.

The Care Quality Commission questionnaires we received from people that used the service and one relative were analysed to show that there was 100% satisfaction that the service was responsive with the exception of people knowing how to complain and feeling involved in making important decisions: 83% in both areas. People had not all known how to complain and had not all felt involved in making important decisions about their care and the service they received. The registered manager said that they would remind people about the complaint procedure and would ask them how they wanted to be more involved in their care when she next communicated with them.

Good

Is the service well-led?

Our findings

The registration of Accommodating Care (Driffield) domiciliary care agency had transferred to the Care Quality Commission in October 2010 and there had been no changes to the service provided or the registered regulated activities since that time. It continued to provide personal care to people in their own homes, who were elderly and may be living with dementia. There was a registered manager in post who had managed the service for nearly two years. We found that they were conscientious about the role, singularly focussed as they ran the service single-handed and committed to ensuring the service delivery was of a good standard.

Staff we spoke with felt there was a friendly, but industrious culture within the service, which concentrated on keeping people in their own homes as long as possible and on involving family members in all things.

Staff told us they could approach the registered manager any time to discuss any concern or to offer suggestions and that the registered manager was receptive to their views. They spoke about the registered manager positively and felt they were kept well informed in their roles and responsibilities. They explained that staff meetings and supervisions were used to share information about the service.

They also said that to share every-day information they used a well-known media app (application: a mobile app is a computer programme designed to run on mobile devices such as tablet computers and smartphones) to keep each other informed and that this was set up entirely for work purposes and was closed to all but staff that worked at the agency. The app was used to share and change staff rosters, to inform staff of meetings and to inform staff of particular changes in people's needs where urgent action was required.

We found that the service sent us notifications of incidents, accidents and deaths as appropriate and in reasonable timescales, but that there had been very few occurrences over the last year. This also applied to safeguarding referrals that the service had cause to make. They too were reported to us in a timely manner. The registered manager gave us some feedback from a safeguarding incident that had been investigated in July 2015, as the Commission had not received anything in writing so far. The registered manager explained what had been implemented since that incident, to ensure the service would not make the same mistake again.

We found that the service had a 'statement of purpose' in which was written the services aims and objectives and particular values that were followed. The values of the service were 'To operate within legal, ethical guidelines', 'To understand the type of care required by clients', 'To nurture the personnel employed to create a culture of development, commitment and job satisfaction' and 'To ensure client safety and care will always come before profit.'

Staff told us their understanding of the service's visions and values. They said, "We strive to be polite and smart, we care about clients and we are aware that we represent the service whenever we wear the uniform."

The provider's PIR stated there were regular audits carried out on medication systems, rosters and the recording of missed calls to people that used the service. It also stated that the manager and senior carer were involved in the day to day care of people, which allowed for the consistent monitoring of staff and service delivery. It stated that service user questionnaires were sent out periodically with the option to return them anonymously, so people could make their views known and then all service user feedback was relayed back to staff so they could adjust their practice or feel they were doing a good job. It also said that the registered manager planned to spend more time on completing and analysing audits.

We found that there was a quality monitoring and assurance system in operation, which included audits on policies and procedures, missed calls, complaints and compliments. It also included the issuing of satisfaction surveys twice a year, holding regular staff meetings and learning form complaints. One incident was relayed to us that showed the service took comprehensive action to make changes to the service delivery where it was found there had been a shortfall in the quality of the service. This showed that the audits were used as learning tools to provider an improved service delivery.

We saw some of the questionnaire forms that the service had received as part of the last satisfaction survey in October 2015. Some of the comments were mixed and included, 'I know you can't always guarantee all staff are on

Good

Is the service well-led?

time due to what may happen at the call before mine', 'On a staff member's first visit they may not know what to do, so it looks like they may not be trained', 'All carers are fabulous', 'One carer is not as consistent as others', 'One staff is great fun to be with and another really goes that extra mile', 'Some carers are not as efficient as others so small tasks often get overlooked', 'All the helpers have been good', 'Extremely efficient and friendly staff. I'm very satisfied' and 'I am very happy, get all the care that I need and I know that if ever I need more care again in the future, all carers would be just as good.' The registered manager told us they usually addressed any negative comments with people individually and looked at ways of resolving their dissatisfaction.

We found that records we looked at were appropriately and accurately maintained and all confidential information was safely and securely stored. This showed that the registered manager took the handling of private information seriously and so people's personal details were confidentially held by the service.

The Care Quality Commission questionnaires we received from people that used the service and one relative were analysed to show that there was 100% satisfaction that the service was well-led.