

Habitat Care Limited

# Habitat Care Limited t/a Home Instead Senior 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

The inspection took place on 19 December 2016 and was announced. The service was previously inspected on 8 September 2013 when we found the service was fully compliant with all regulations covered in the inspection. During this inspection we found no breaches of regulations and we found people received a good service.

Home Instead Senior Care is a domiciliary care provider based in North Somerset, providing personal care and support to people in their own homes. Home Instead Senior Care is part of a franchise that delivers care to people in many areas of the United Kingdom. This service supports 100 people in Bristol and North Somerset. The service offered includes personal care, such as assistance with bathing, dressing, eating and medicines. The service also offered home help covering all aspects of day-to-day housework, shopping, meal preparation and household duties; and companionship services such as escorting people on visits or appointments, simple conversation and company. We only looked at the service for people receiving personal care as this is the activity that is registered with Care Quality Commission (CQC). The staff who support people are known as 'caregivers,' and we have called them this in the report.

The person managing the service had been in post since August 2016 and had sent their application to the Care Quality Commission to become the registered manager. 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.'

Staff told us there had been a lot of changes in office staff, and a period of 'disorganisation'. The manager had been proactive in identifying areas for improvement, including the quality of the care plans, the completion of regular spot checks and the provision of consistent support for caregivers, and was taking action to address any failings. Staff commented; "The team has really pulled together in the last three months", "[Manager's name] is really good. It's an enormous responsibility. We are getting there. [Manager's name] has worked really hard with the team".

The manager and provider were 'hands on' and approachable. Caregivers and people who used the service told us how accessible and supportive they were. There were systems in place to monitor the quality of the service, including regular checks, audits and quality assurance surveys completed with people every three months.

The service had an ethos of providing continuity and person centred support to people. People received visits of at least an hour from a staff team of no more than three caregivers, with whom they had been carefully matched. People confirmed staff had a good understanding of their needs and were well informed about the care to be provided. Comments included, "They provide very good support. I have two visits a day. I couldn't manage without them." and, "All the staff are well trained. They have a good understanding of my family member's needs".

People's legal rights were protected. People who used the service and others involved in their care were fully involved and consulted. People were always asked for their consent before caregivers assisted them with any tasks. Caregivers respected people's privacy and people were treated with respect and dignity.

Comprehensive risk assessments had been carried out, in liaison with people, relatives and health and social care professionals where appropriate. This meant that caregivers were well informed about any risks and the action needed to keep people safe, while minimising restrictions on freedom, choice and control. Care plans were reviewed at least every three months and people were fully involved in this process.

People were kept safe and free from harm. Their small, consistent staff team were able to quickly recognise any changes in their physical or emotional presentation, and take any action necessary to safeguard them. The service had policies and procedures in place about working with and protecting vulnerable people and staff received regular training on this issue. In addition recruitment processes meant staff were thoroughly checked to ensure they were safe to work with vulnerable people. People were assured they would receive their care because there were systems in place to minimise any risks caused by late or missed visits.

There were systems in place to ensure people received their medicines safely from staff who were trained and competent to carry out the task. Regular auditing ensured these systems were maintained and action taken to minimise the risk of errors, for example additional training for staff.

Where required people were supported, as part of their care package, to access food and drink and maintain their nutrition and hydration according to their needs and preferences.

People were supported by a well-trained team of staff with the knowledge and skills required to meet their individual needs. The majority of staff, including the manager, told us they were well supported. They were enabled to keep up to date with best practice through a range of forums including an annual Home Instead conference and the Home Instead website, where current policies and procedures, a weekly newsletter and practice updates were posted.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

People's needs were assessed to ensure any risks were identified and safely managed.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training.

People were assured they would receive their care because there were systems in place to minimise any risks caused by late or missed visits.

### Is the service effective?

Good ●

The service was effective.

Staff had the skills and knowledge to meet people's needs and received regular training to ensure their skills and knowledge were maintained.

People's legal rights were respected and protected.

Where required, people were supported, as part of their care package, to access food and drink and maintain their nutrition and hydration.

### Is the service caring?

Good ●

The service was caring.

Staff were respectful of people's privacy and dignity.

Staff were committed to promoting people's independence and supporting them to make choices.

People were asked for their consent before support was provided

### Is the service responsive?

Good ●

The service was responsive.

People were carefully matched with a small team of caregivers, who were able to provide a responsive service to people because they knew them well.

People were fully involved and consulted when care plans were drawn up and reviewed.

There was an effective complaints process which people were encouraged to use if necessary.

### **Is the service well-led?**

**Good** ●

The service was well led.

People were supported by a motivated and dedicated staff team and accessible and approachable management.

The manager was proactive in taking steps to improve the quality of the service.

The provider had a philosophy of person centred care which was communicated effectively across the service, making a positive difference to people's lives.

The provider's quality assurance systems were effective in maintaining and promoting the standards of service provision.

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## **Detailed findings**

### Background to this inspection

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

This inspection took place on 19 December 2016 and was announced. We gave the service short notice because we wanted to meet the manager and needed to be certain they would be available during the inspection. This also gave the manager sufficient time to ask some people if they would be willing for us to visit and speak with them in their homes. The inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During this inspection we went to the provider's office and spoke to staff including the manager, deputy manager, provider, recruiter and client co-ordinator. We also spoke to five caregivers on the telephone. We looked at a range of records the provider is required to maintain. These included four service user support plans, medicine administration records, staff rotas, four staff recruitment files, staff training records and quality monitoring records. We visited three people with their permission in their own homes, and spoke with another four people on the telephone.

# Is the service safe?

## Our findings

People told us they felt safe using the service. Comments included, "They are always so nice. I could trust every one of them" and, "We go into the café and have a cup of tea and cake. They do everything for me. I feel safe with them". The family member of a person living with dementia told us, "[My relative] is safe with them. I feel very safe. I'm happy to leave [my relative] in their care if I'm abroad. They do contact me if any issues crop up".

People told us they received a reliable service. Comments included, "We have never had a missed visit. They will always send a replacement", and, "They are always on time, If there is a problem they will let me know". There were systems in place to minimise any risks caused by late or missed visits. Caregivers 'clocked in' and 'clocked out' on arrival and departure using the telephone. The system alerted the office if a caregiver was more than 15 minutes late arriving for a visit. This allowed office staff to take any action necessary to ensure the safety of people and staff. Management support was available 24 hours a day, via an 'on call system', which provided reassurance to staff, especially if they were working alone in the evenings or at weekends.

Risk assessments covered a range of areas including people's environment, and their physical and mental health. People and their relatives contributed fully to this process which meant the risks were assessed accurately. The information was used to provide caregivers with the guidance they needed to minimise the risk and support the person safely. For example one person's environmental risk assessment found they had two mats on the floor which posed a potential trip hazard. Staff were required to ensure the mats were flat with no raised corners, to minimise the risk of the person tripping over them.

The risk of abuse to people was reduced because there were effective recruitment and selection processes for new staff. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work with vulnerable people. These checks included seeking a telephone and a face to face interview, up to six references including at least two professional references from previous employers, and a disclosure and barring service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Staff disciplinary procedures were in place, and had been used effectively.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. One member of staff told us they would be able to tell if the person was behaving, "a bit differently. For example, if [the person] was more reserved than usual" when they visited because they knew the person so well. Posters about the whistleblowing policy and process were on the wall in the office. The manager told us, "We go over the procedure in induction, everybody is encouraged to report any concerns". A caregiver confirmed this was the case, saying, "I would tell the office straight away. I have confidence they would react quickly". The service worked alongside other agencies to investigate any safeguarding concerns and take any action that might be necessary to keep people safe.

There were strategies in place to minimise the risk of financial abuse. For example, care plans documented

whether the person had appointed a lasting power of attorney for property and finance, which meant caregivers were aware of who was managing the person's money on their behalf. Where staff supported people with shopping there were robust systems in place for recording and monitoring all financial transactions.

The service had systems in place to ensure the safe management of medicines. People signed a form consenting to staff supporting them with their medicines. The service had an effective medication policy which included an assessment of the person's ability to safely self-administer their medicines where appropriate and the level of support the person required. Medicines were clearly documented in care plans and medicine administration records (MAR charts) completed by staff. All staff had completed training and told us this helped them to feel confident to administer medicines. 'Observations' of practice were carried out by senior staff and MAR charts audited, to monitor any issues such as gaps in recording. Where any errors or gaps were identified, the service investigated them with the member of staff and arranged for them to repeat the medicines administration training where necessary. During the inspection we saw some gaps in a person's MAR chart. We discussed the issue with the manager who found the caregiver had documented in the person's daily 'activity record' that they had administered their medicines, but omitted to sign the MAR chart. The manager undertook to follow this up immediately with the caregiver concerned.

All staff received training in infection prevention. PPE (personal protective equipment). Disposable gloves and aprons, was kept in the office for use by staff. We observed this being used appropriately by caregivers when supporting people, to minimise the risk of them spreading infections.

There were clear systems in place for managing and recording accidents and incidents, which meant staff responded appropriately and any actions were documented. Records were audited to identify any patterns and trends, and any wider actions that might be needed to keep people safe.

The agency had a 'disaster plan' covering a range of circumstances which could affect the delivery of care, such as extreme weather conditions, industrial action or mass staff sickness. The plan was reviewed and updated annually to ensure it was accurate and current.



## Is the service effective?

### Our findings

People were supported by a consistent team of no more than three staff, which meant caregivers knew people well and had a good understanding of their needs. One person told us, "They provide very good support. I have two visits a day. I couldn't manage without them." A family carer said, "I can't speak any more highly of them, even in the office people are brilliant".

People told us the staff were well trained. A family carer told us, "All the staff are well trained. They have a good understanding of my family member's needs". All new caregivers completed a comprehensive three month induction and probationary period which provided them with the basic skills and knowledge they needed to provide effective support to people. The deputy manager, who was responsible for the training, ran practical workshops over an initial three day period covering a range of topics including safeguarding, moving and handling, the ageing process and building relationships. This included an experiential exercise where new caregivers wore gloves and glasses, to mimic sensory and visual impairment. The deputy manager said this helped staff to understand that sensory loss and change can be frightening, and they needed to be calm and professional at all times when supporting people. They told us the induction helped caregivers to see they could make a real difference to people's lives. In addition new caregivers undertook the national skills for care certificate, which is a detailed national training programme and qualification for newly recruited staff. The induction required new caregivers to be supervised and observed by more experienced caregivers to ensure they were safe and competent to carry out their roles before working alone. A member of staff told us, "The induction was really thorough, really good!"

All staff received further training and regular updates on essential health and safety topics such as first aid, infection control and medicines management. The manager told us some caregivers were specifically trained to work with people who were living with dementia, and attended the provider's head office for the training. Bespoke training was arranged as required to support staff to meet people's individual care needs, and caregivers could request a reassessment of their skills and refresher training at any time to ensure their knowledge and skills were up to date.

Supervision was an opportunity for staff to be observed, discuss their work with a more senior member of staff, and highlight any training or development needs. At the time of the inspection, although staff told us they had their annual appraisal, not all had received three monthly spot checks and supervision in line with the agencies supervision schedule. Despite this, all the people we spoke to were very positive about the caregivers and the support they provided, and most staff told us they felt well supported. The office had an 'open door' policy. Some of the caregivers told us they often visited for a coffee and felt "very welcome". Comments included, "They've got all the time needed to talk to you, there's no rush. I could talk to them about my personal problems", and, "They think about us [caregivers] as well as the service users. They have looked after me and helped me out, they are very supportive".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity

to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. We found the service was working within the principles of the MCA. Staff had received training and had an understanding of the requirements of the MCA. A family member told us their relative was living with dementia and could become 'quite confused'. They told us, "The caregivers do try and support them to make the decisions. Generally they ask them what their needs are and meet those needs". Care records showed that people's capacity to make particular decisions had been assessed, and a best interest process completed where necessary, to ensure any decision made was the least restrictive and in the person's best interests. For example, best interest decisions had been documented related to daily support with personal care, and eating and drinking regularly. The service ensured this information was discussed with the caregivers supporting the person, so they were fully aware of their capacity to make particular decisions and the support they needed.

Where required people were supported, as part of their care package, to access food and drink and maintain their nutrition and hydration. This was done according to people's individual needs and preferences. One person said, "I've got stuff in I like. I tell them what I want". A relative told us, "Sometimes they persuade [my family member] that they need to eat". One care plan instructed caregivers to promote the person's independence rather than do the meal preparation for them, saying, "Encourage and motivate [person's name] to prepare meal. Caregiver to give minimal support and encourage them to make their meal".

The service was proactive in ensuring people's health and social care needs were met. Staff were available to support people to access healthcare appointments if needed and, where required, liaise with health and social care professionals if their health or support needs changed. Caregivers knew people well, which allowed them to identify any changes in physical or mental health and refer them for additional support where necessary. For example a family member told us the agency had appropriately contacted the GP because the caregiver had noticed their family member was tired and lethargic. The person had subsequently been diagnosed and treated for an infection.

## Is the service caring?

### Our findings

All of the people we spoke with told us the staff were kind and caring, including the office staff. Comments included, "They are so friendly, and they will do everything. Anything that's needed" and, "They are first class. I like the way they act towards us. They are very friendly and they help us in every way they should. They are very kind and so polite; we haven't had a bad one yet!" A member of staff told us, "It's a fantastic company. I've been blown away by everything they do in the community. They employ caring, compassionate people."

People were supported by no more than three caregivers, with visits of at least an hour. This meant caregivers could build trusting relationships with people over time and learn how they wanted their care to be provided. People told us they valued the consistency and relationships they had developed with the caregivers. Comments included, "I have mainly the same carers" and, "I've got to know them so well". One person said, "[Caregivers name] is really lovely. I've had them for about six months. I look forward to them coming. They always ask me, 'What do you want done?' I'm happy as long as I've got [caregiver's name]. They are really nice". The provider told us about a person living with dementia, who had initially refused to be supported with their personal care. After several weeks of building a relationship with the caregiver and developing trust, it had become an accepted part of their routine.

Office staff also visited people and got to know them, which meant they were able to provide cover in an emergency, and people were never supported by staff they did not know. At the time of the inspection the newly recruited 'scheduler', who was responsible for devising the staff rotas, was making arrangements to visit and introduce themselves to people. One person told us, "I go down to see the people in the office. The boss came to see me on Sunday to find out details of the drugs I'm taking. They made a list of what I take and how".

The Provider Information return (PIR), stated, "Part of the quality assurance process includes seeking client feedback on whether they feel they are treated with dignity and respect by their caregivers. Feedback is acted upon accordingly. Dignity awareness and the principles and values of care forms part of the caregiver induction training." During the inspection we observed that staff treated people with dignity and respect, for example, telephoning the person from outside their house to check if it was ok to come in, before using the key pad to enter. A caregiver told us, "If I have to do personal things I am respectful, and try and put myself in their situation. I try and make it as easy for them as I can. One person told us, "The carers listen to me; I like the help they give. They listen to my likes and dislikes and try to treat me accordingly."

The service was committed to promoting people's independence and supporting them to make choices, involving them in decisions about their care as much as possible. Potential caregivers were assessed on their ability to provide person centred, caring support at interview. They were asked, "If you were a client, how would you like to receive care?" The recruiter told us, "This helps to determine their qualities and whether I think they would fit as a care giver." The deputy manager told us that during training staff were instructed to; "Encourage the client to be involved, help them to prepare food. If their vision is going, choose food that's more colourful and involve them in this. Maybe they could come to the shop with you? Treat

them as important and show them respect and dignity".

Care records contained signed forms showing the person, or their attorney, had consented to the support being provided, including the administration of medicines, the sharing of personal information with other professionals involved in the delivery of care, and visits from agency staff for auditing and quality assurance purposes. A caregiver said they asked people for consent before providing support, and did not make assumptions. They introduced themselves and "had a chat" beforehand, to find out whether the person would prefer a wash or a shower, and what they would like to wear. A relative told us their family member "likes all of the caregivers. We are fully consulted in everything, there are no problems whatsoever".

## Is the service responsive?

### Our findings

People received support that was flexible and met their individual needs and wishes. Caregiver visits were not scheduled 'back to back', which gave them the flexibility to stay on if there was a need, rather than rushing to leave on time because they had another visit. One person told us, "They are very accommodating. If I don't want them for a couple of days that's fine. They do what I want, not what they want. It's a very nice, satisfying feeling".

Prior to the service starting, the client co-ordinator met with people, and their relatives where appropriate, to complete a full assessment, risk assessment and care plan. There was also input from health and social care professionals if required. The PIR stated, "All clients have person-centred care plans with specific outcomes stated. Clients are encouraged and enabled to participate in the care assessment process through the assessor adapting communication methods and the assessment being carried out at a location of the person's choice and others being present if the person consents". The client co-ordinator also gathered information about people's background and interests, which allowed the service to match caregivers with the people they would be supporting. For example a member of staff shared the ethnicity of a woman living with dementia. This meant they could cook the person a familiar meal from the country they had grown up in and talk to them in their first language, supporting them to reminisce about their life. The provider told us, "We try and match clients with carers. If the client doesn't like the carer we try as much as possible to match them and try and find someone else. There needs to be a match".

Caregivers were formally introduced to the people they would be working with, and spent at least a week shadowing existing caregivers before working with the person on their own. The manager told us, "We won't send a caregiver into a client that hasn't been shadowed in and formally introduced". This meant people were never supported by people they did not know.

The care plan was kept in a folder in the person's home, with a duplicate in the office for staff to refer to. Care plans were personalised to each individual, helping staff to understand the person and their needs, and how they wanted their care to be provided. They contained information about people's physical, psychological and social support needs and any related risks, including medication, moving and handling, eating and drinking, personal care needs, daily routines and social activities. Medicine administration records (MAR charts) and daily records were also in people's folders for completion by staff. Care plans contained clear guidance for staff about how to meet people's physical and emotional needs. One care plan advised staff to, "Give the person reassurance if they are upset about something. The person is prone to bouts of depression. The caregiver to provide encouragement and reassurance that everything is ok". They also contained information about people's personal preferences. For example, one care plan stated, "Carer to wash dishes and tidy them away. [Person's name] does NOT like the carer to wipe the surfaces with a tea towel. Carer to take meat out of freezer to defrost naturally according to the person's choice".

Care plans were reviewed every three months, and people were fully involved in the process. A family member told us, "I go through the care plan with the care provider once every so often". Care plans were also reviewed if there had been any significant changes, for example a hospital admission. The manager told

us this allowed them to identify any changes in medication or support needs, to ensure the person was still receiving the support they needed. In addition the manager called a meeting of the person's support team in the event of any changes in their health or circumstances, so that caregivers could be informed and updated and any strategies or concerns about the person shared.

People told us they were confident they could speak with a manager or a member of staff if they had any concerns or complaints. Comments included, "If I had a complaint I would tell the person concerned, or care co-ordinator, or somebody in the office" and, "Initially I would contact the office, I would know who to talk to, but I've never had to make a complaint". The agency had a complaints procedure in place and was proactive in inviting people to feedback on the quality of the support they received. Complaints were reviewed by the national office to ensure they had been managed effectively. The provider told us "Complaints are the best thing we can get because they tell us what is happening".

## Is the service well-led?

### Our findings

The manager of the service had been in post since August 2016, and had applied to the Care Quality Commission to become the registered manager for the service. Staff told us there had been a lot of changes in office staff, which had resulted in a period of disorganisation, and care files that 'needed work'. However, they said the manager had been working to achieve a better service and were very positive about the progress that had been made. Comments included, "The team has really pulled together in the last three months". "[Manager's name] is really good. It's an enormous responsibility. We are getting there. [Manager's name] has worked really hard with the team." and, "They do a brilliant job as a manager. They are really thorough."

The manager told us their aim was to, "continue to provide continuity to clients". They wanted to provide a person centred service and told us that "close contact with clients was important" in this respect. They said, "I want to get everything in order first, and then my plan is to spend a lot of time with clients. I would like to meet face to face with clients every six weeks". They planned to re-establish an agency newsletter informing people about changes or developments at the service, and were hoping to organise community coffee mornings where people could socialise.

The manager wanted to ensure that caregivers received the support they needed to work effectively with people. For example, they had recognised that caregivers needed additional support with recording and administration tasks, and had provided them with additional training and time. Four new 'carer co-ordinator' roles had been created, with responsibility for staff supervision, spot checks and general caregiver support. In addition the manager was planning to reinstate quarterly staff meetings, and 'post-code meet ups' where caregivers in a particular area could meet informally for peer support. They told us, "I speak to every new carer that comes in. I build relationships with care staff, so that I become familiar and can make them feel supported. The carers come in regularly to discuss schedules, make a drink and feel welcome."

The provider had systems in place to check the quality of the service. Regular audits were carried out, looking at areas such as the completion of MAR charts, training and recording. Senior staff visited people once a month to audit daily records and MAR charts to ensure they had been completed properly. The quality of the service was also monitored through the completion of unannounced 'spot checks' and observed supervisions in people's homes. Caregivers reported this had been 'sporadic' recently, although the manager told us this would be addressed through the recruitment of the carer co-ordinators. Client co-ordinators completed quality assurance questionnaires with people every three months to check they were happy with the service. This was confirmed by one person who told us, "[Client co-ordinator's name] comes and checks how things are". In addition representatives from the national office visited once a year to complete a comprehensive audit looking at all aspects of the service including care files, recruitment and supervision records, policies and procedures and training. An action plan was then developed in order to address any failings and improve and maintain the support provided to people.

The manager told us they were well supported by the provider and this allowed them to provide effective support to their own staff team. The provider met with staff and the manager every week. They attended the

induction of new staff, introducing the values of the organisation and explaining the importance of providing continuity to people. The manager told us, "I wouldn't be able to achieve what I have without the support of [provider's name] ... I can bring any concerns to them. They never make me feel it's not important enough to discuss". They told us the provider was, "big on making caregivers feel valued, giving them thank you cards, even for things that seem small. It makes them feel appreciated". This was confirmed by a caregiver who told us, "I have worked for several home care companies and this is the best one because they think about the caregivers as well as the service users". They told us the agency was "very thankful all the time, giving you thank you notes and flowers".

The manager was proactive in keeping their knowledge and skills up to date and using what they had learnt to improve the quality of the service being provided. For example, they met every three months with other managers in the region to share ideas and best practice. They accessed the Care Quality Commission, Skills for Care and Social Care Institute for Excellence websites to check for relevant updates. The organisation provided training for managers, to enable them to do their job effectively, which the manager of the service was due to attend.

Home Instead supported staff nationally to maintain their knowledge and skills and ensure they upheld the values of the organisation. They held an annual conference with speakers and workshops on a range of relevant topics. This was an opportunity for staff to network and share ideas with other staff in the same role. One member of staff told us the conference had been very valuable to them, as they had learnt a lot about dementia and the need to provide emotional support to the caregiver when a person dies. The Home Instead national office maintained a website where current policies and procedures, a weekly newsletter and practice updates were posted.

As far as we are aware, the provider met their statutory requirements to inform the relevant authorities of notifiable incidents. They promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.