Newcross Healthcare Solutions Limited

Newcross Healthcare Solutions Limited (Taunton)

Inspection report

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Date of inspection visit:
15 November 2016
18 November 2016

Date of publication:
06 January 2017

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?	Outstanding ☆

Summary of findings

Overall summary

This inspection took place on 15 and 18 November 2016 and was announced. We gave the service 48 hours' notice because we wanted to meet the registered manager and needed to be certain they would be available during the inspection. This also gave the registered manager sufficient time to ask some people if they would be willing for us to visit and speak with them in their homes. During this inspection we found no breaches of regulations and we found people received a good service.

Newcross Healthcare Solutions (Taunton) provides personal care and support to adults and children with complex care needs living in their own homes. This included sitting services, night support and 24 hour care. At the time of this inspection they provided care and support to 16 people.

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

People were kept safe and free from harm. A relative told us, "I don't trust anybody with my child…but I place my trust in Newcross carers over the nurses and consultants". People using the service, and staff, had access to a 24 hour 'on-call' service, which meant they could ask for guidance or additional support at any time. The provider had a robust recruitment process which minimised the risks of abuse to people. Staff had received training and information on how to recognise and report any suspicions of abuse and they were confident any concerns would be acted on promptly.

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

There were appropriate numbers of staff employed to meet people's needs and provide a reliable and safe service. People were confident staff were never rushed and always stayed for the correct length of time. A relative told us, "They arrive on time always. They refuse to leave early; they will say we are here until eight, so we will stay till eight". People had a consistent staff team, with whom they had been carefully matched to facilitate the development of a trusting and comfortable relationship.

People were supported by a well-trained team of staff with the knowledge and skills required to meet their individual needs. All staff, including the registered manager, received regular supervision and support. They were enabled by the provider to keep up to date with best practice through the sharing of information from recognised sources including the Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN) and the Care Quality Commission (CQC) and participation in various networks and specialist forums.

Risk assessments and care plans were comprehensive and developed collaboratively with the person, their relatives and other health and social care professionals. Registered nurses were employed to support the staff to maintain safety for all care packages. Care plans were reviewed regularly which meant staff were able to continue to meet people's needs as they changed. Effective communication systems ensured that this information was shared promptly with the person and the team supporting them, with the person's consent.

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. Staff received specialist training where required, for example, 'peg' training (percutaneous endoscopic gastrostomy), to support people with feeding when oral intake was not adequate.

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 staff assisted them with any tasks. Staff respected people's privacy and people were treated with respect and dignity.

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.

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

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual support needs.

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

The agency worked collaboratively with health and social care professionals to ensure people's health and social needs were met.

Is the service caring?

Good

The service was very caring.

Staff were respectful of people's privacy and dignity.

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

The agency was able to offer effective care to people at the end of their lives.

Is the service responsive?

Good

The service was very responsive

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

Staff training needs were identified, and any specialist training undertaken prior to the care package starting. This meant people's needs were met by staff who were well informed, trained and supported.

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

Is the service well-led?

Outstanding ☆

The service was well led.

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

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

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

The service encouraged continual professional development, making good use of information technology to ensure knowledge and learning about best practice was accessible to all staff.

Newcross Healthcare Solutions Limited (Taunton)

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 15 and 18 November 2016 and was announced. We gave the service 48 hours' notice because the location provides personal care for people who live in their own homes. We needed to make sure the registered manager was available to meet us. We asked them to make arrangements for us to visit people in their own homes. The inspection was carried out by one inspector. We were also supported by an 'expert by experience' who contacted people and/or their relatives by telephone to seek their views on the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we asked the provider to complete 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 the improvements they plan to make. We also looked at other information we had received about the service since the last inspection.

During the inspection we met with the registered manager and four members of staff. We spoke with a further three members of staff on the telephone, including the provider's 'head of clinical excellence'. We visited three people in their homes and spoke with two people on the telephone. We spoke with, or met, eight relatives. We also contacted health and social care professionals to seek their views on the service.

During the inspection we looked at a range of records the provider is required to maintain. These included seven service user support plans, medicine administration records, staff rotas, four staff recruitment files, staff training records, and quality monitoring records. We also looked at records of accidents, incidents,

compliments and complaints and safeguarding investigations.

Good

Is the service safe?

Our findings

People and their relatives told us the service was safe. One person said they felt safe, "…thanks to the little angels looking after me. We spend plenty of time laughing". Another person told us, "I am very happy, totally satisfied with Newcross. My [family member] is 110% safe". Comments from relatives included, "I wouldn't go out unless I trusted the carer implicitly as [family member] can go downhill rapidly", and, "All the carers get on well with my [family members]. It's a massive relief. I know I can go to work and not worry about it".

The agency employed a registered nurse who supported the staff to maintain safety for all care packages. Risks to each person's health and safety had been carefully assessed and were regularly reviewed. Care plans contained up to date information on all risks and provided guidance to staff on how to minimise the risks and respond in an emergency. For example, the care plan of a person who had seizures contained clear information about how to recognise the person was having a seizure and how to support them. It stated, "Always keep [person's name] calm during seizures, talk to them and reassure them during them. Please alert the family carer if the seizure is prolonged and you are at all concerned". The family carer told us staff followed this guidance. They said, "I don't trust anybody with my child…but I place my trust in Newcross carers over the nurses and consultants". They told us all of the person's medical needs were managed well; however they knew staff would alert them appropriately if they were concerned.

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 rigorously checked to make sure they were suitable to work for the agency. Prospective staff were required to have had at least six months of relevant experience in the previous two years. References were sought from previous employers and needed to be from people who had observed the person delivering care and could comment on their clinical skills. In addition disclosure and barring service (DBS) checks were carried out. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Nurses were checked to ensure they had a 'pin' number, to show they were registered with the Nursing and Midwifery Council (NMC), met the required standards, and were legally able to work as a nurse in the UK. Staff records seen confirmed that new staff did not begin work until satisfactory references and checks had been received by the provider. Any concerns raised during the recruitment process were reviewed to ensure the prospective member of staff was safe to practice.

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. 'Safeguarding' was always on the agenda in staff supervision. Staff told us, and records showed, safeguarding concerns had been managed appropriately, with Newcross working effectively with other agencies to ensure the concerns were fully investigated and action taken to keep people safe.

People confirmed the effectiveness of the systems in place to ensure they received their medications safety. A relative told us, "They administer medication, they are very careful with MAR (Medication Administration Records) charts and whether they are current". Care staff completed medicines administration training and any specialist training that might be needed to support people safely, for example in the use of emergency

medication for people having a seizure .Staff told us 'refresher training' was regularly available if they felt it necessary. Registered nurses completed regular observations of staff practice to ensure their competency, including observations of MAR completion and the use of blister packs. MAR charts were audited every month so any errors could be identified and action taken to minimise the risk of recurrence. In the event of a medication error, staff completed a reflective practice statement which they discussed with a nurse to identify how the error had occurred and the appropriate course of action. This might include additional training or support from a trained nurse mentor.

People told us they received a consistent and reliable service, which meant they received the support they needed when they needed it. A relative explained the support they received was, "very consistent". They had received care for the past two years and consistency was something they had wanted. They told us, "They are never late". There had only been one missed call and that was due to a car breakdown". Another relative told us, "They arrive on time always. They refuse to leave early; they will say we are here until eight, so we will stay till eight". A health professional said, "They are very consistent and very accommodating 99% of the time. They manage to cover really quickly if one person is off sick."

There were sufficient staff employed to ensure people received a safe service. For example, the registered manager told us a staff team for a person having support on five days a week from 8am until 8pm, would consist of seven or eight staff over the five days. They told us this number of staff ensured sickness and holidays were covered, and that continuity was maintained. Staff rotas were sent out every four weeks, so people know who was coming well in advance and staff could ensure their availability.

There were systems in place to monitor staff and minimise any risks caused by late or missed visits. Each member of care staff was allocated a 'pin' number which they used to log in via telephone on arrival and when leaving a person's house. If they hadn't logged in 10 minutes after a shift was due to start an email notification was sent to the agency. This allowed office staff to take any action necessary to ensure the safety of both people and staff, and to offer reassurances that the member of staff was on their way. The registered manager told us this system had been particularly helpful when there had been severe flooding in the area two years earlier, which had impacted significantly on staff travel time.

The service had an 'on call system', operated by the provider's 'central support team', which meant staff and people who used the service could contact the service for support at any time, day or night. The central support team had access to all the information they needed to ensure they understood each person's needs and could provide an appropriate response to any issues. This included full copies of each person's care file, emergency plans and staff rotas. In addition the clinical lead was available during working hours for staff to contact for support and advice, as well as people who used the service and their families. A relative commented, "They regularly keep in contact. Any concerns I can call and discuss it with them".

All staff received training in infection control. Newly recruited staff were issued with a 'kit bag' containing personal protection equipment (PPE) such as disposable gloves and aprons to reduce the risk of infection, as well as antibacterial hand gel. Staff meeting minutes contained reminders for staff that it was their responsibility to inform the office when their glove and apron supplies were running low to ensure they had the equipment they needed to minimise infection risks.

Good

Is the service effective?

Our findings

People were supported by staff who had the knowledge and skills required to meet their needs effectively. The agency would not allow them to work with people if this was not the case. For example, during the inspection a relative expressed concern that staff did not have the training to use the specific equipment their family member needed and this had led to a delay in the agency being able to provide this support. We discussed this with the registered manager who told us there had been some difficulty in sourcing appropriate training, and staff could not support the person safely without it.

One person's written feedback to the service stated, "May I just say how brilliant everything has been so far since [person's name] has come back home. I had no idea care could be this good…we haven't been this relaxed and contented in years". A relative told us the nursing staff were, "really, really good. They always ask if there are problems or if we are unsure". Another relative told us, "I know so many families who are not having the care they requested. As this is set up it works really well. There's not a bad thing I can say. I really hope we never get moved away from Newcross".

In the provider information return (PIR) the registered manager stated, "All staff attend an induction program which covers equality & diversity, the Mental Capacity Act 2005 (MCA), challenging behaviour, adult and child safeguarding, infection control, fire safety, health and safety, food hygiene, record keeping, and medication awareness" . Staff were also introduced to the 'staff extranet', where they could access the service's corresponding policy and guidance. Knowledge and understanding was tested following the induction, and prospective staff had to score at least 80% before their employment was confirmed. Staff then completed a six month probationary period which included time shadowing more experienced staff, complex needs training and competency assessment. A member of staff told us the induction was 'thorough' and 'a good experience'. They said, "It gave me a bit more confidence".

The agency had an in house trainer, and ongoing training was provided and available for all staff. One member of staff told us, "Even if something is not directly relevant to the people we are working with, we can still go." A relative told us how the staff were trained and 'constantly' updated to ensure they could continue to meet the changing needs of their family member. The provider's training policy specified that all staff needed to complete regular updates on essential health and safety topics within a specific time frame, and could not work with people unless this had been done. Bespoke training was organised and tailored to individual packages of care. External specialists delivered training if required, for example in tracheotomy or epilepsy management. In addition staff told us they had attended training in hospital settings, in the use of a BiPAP (bi-level positive airway pressure) machine, to support people with breathing. Training was open to people who used the service and their carers. The registered manager told us about a relative who had completed moving and handling training which meant they could safely support their family member alongside agency staff. The expertise of family carers was recognised and utilised to ensure staff had the necessary knowledge and skills. A relative told us, "I do some of the training at home, I run a tight ship, I have to. [Family member] is my absolute world. I have to be sure they are as safe at night as they are in the day when I care for them".

Staff told us they were well supported. They had regular supervision, including clinical supervision with a registered nurse, and an annual appraisal. Supervision provided an opportunity for staff to reflect on their knowledge and skills and consider how they might be developed to improve the care they provided. One member of staff told us, "I can air my views and talk about any concerns, anything at all". Nurses were supported with their 'revalidation', necessary for them to maintain their registration with the Nursing and Midwifery Council (NMC). This required them to demonstrate their ability to practice safely and effectively.

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. During our inspection we saw staff seeking people's consent before providing any support. They also offered choices and respected people's rights to make their own decisions. For example, staff had used their knowledge of the MCA to determine whether a person had the capacity and information required to make a particular decision, even though it was a potentially unwise decision. This had required an assessment of the person's capacity to make the decision and an honest discussion with them about the risks.

Where required people were supported, as part of their care package, to access food and drink and maintain their nutrition and hydration. Care plans contained clear guidance for staff about people's preferences and the support they needed. For example, one person's care plan stated the person, "requires assistance from carers each meal time. Fork mashable diet. Likes bread and jam cut into small squares. Load their spoon for them and they will put it to their mouth. They enjoy a variety of fruit squashes, tea without sugar or weak coffee with a little sugar". Staff received specialist training where required, for example, 'peg' training (percutaneous endoscopic gastrostomy), to support people with feeding when oral intake was not adequate. A relative told us their family member was, "Nil by mouth and peg fed", and confirmed the care staff were fully trained in peg management to meet the person's specific needs.

The service liaised closely with a multi-disciplinary team of health and social care professionals, to ensure they supported people to manage their needs effectively. This was especially important when people had very complex needs. A relative explained their family member had a team of therapists who instigated three programmes to be undertaken with the person every day by the care staff. They said, "Therapists liaise with the agency or undertake joint work at home with the carers. They look at the programme and respond to any changes. The programmes are changed and updated approximately every four months". The registered manager told us email groups were set up, with the person's consent, which included the multi-disciplinary team members. These groups might include; the person themselves and family members, the clinical lead, community nurses, care staff and social workers. This meant communication was 'transparent' and everybody involved was kept up to date. A relative told us, "Because we all communicate so well, it stops something we're concerned about becoming a problem".

Good

Is the service caring?

Our findings

All of the people we spoke with told us the staff, including the registered manager and office staff, were kind and caring. One person told us, "[Staff member's name] makes my life better". They said they valued the; "love and kindness of the carers, the efficiency like I can't tell you, the understanding". A relative commented, "We have really good communication with the carers. They're really, really lovely. We're very lucky". The registered manager told us of an occasion when office and care staff had worked outside of their contracted hours to ensure that a person at the end of their life could die at home as they wished. At Christmas the management team bought each person a present and a box of chocolates for the parents of the children they were supporting. The gift was delivered by one of the management team, who took the opportunity to wish them a merry Christmas.

Staff were committed to promoting people's independence and supporting them to make choices. A member of staff said, "I'm always talking to the person, checking that they are happy with what I am doing". A person told us, "They don't take over. I'm fully compos mentis. I just need them to be with me in case anything does go wrong". Another person told us, "They are very conscious of their ability to overwhelm their charge; they are very aware of my needs and seem to be observant enough to follow change and allow for it…There are always things that can be done to improve care. The big thing in their favour is that they respond to suggestions and are willing to adapt and try".

People told us staff were respectful of their dignity. A relative described how staff treated their family member, "like a human, giving them a choice in how things happen". A member of staff told us how one person always liked to have the curtains open. When they were supporting them with personal care they encouraged them to close the curtains, saying, "You don't want the man from over the road seeing you!" They told us, "I always think about how I would feel if that was me".

People and their relatives confirmed they had been involved in decisions about their care and how the support was provided. Relatives told us that care staff didn't 'take over', but worked alongside them to support the person where appropriate. Comments included, "I dispense medication, give a verbal handover, carers record in the MAR charts and carers administer medication via the peg" and, "I direct decision making about [family members] care". The registered manager told us how the agency had supported a person who was terminally ill, to work through their 'bucket list.' The person had chosen the staff they wanted to support them, and the agency had ensured the staff were insured to drive the person's disability vehicle. Prior to their death the person had enjoyed realising their ambitions of going to a music festival in a nearby city and going to see steam trains.

The agency was able to support people effectively at the end of their lives. In the provider information return (PIR), the registered manager stated, "When undertaking care packages referred to us via the End Of Life Care Co-Ordination Team we work closely with both the service user and the family to ensure final wishes are met and end stages of life meet all expectations." The care plans for people at the end of their lives had recently been redesigned to ensure they were more focussed, with clear information about the person's physical and emotional support needs, choices, spiritual needs and the emotional support needs of their

family members. The objective in one care plan was, "For [person's name] to know they are supported and they have someone to talk to about their fears". Care staff were guided to reassure the person if they were anxious or frightened and to talk to them if they were awake because they found this comforting. The registered manager told us the agency identified staff at the recruitment stage with the skills and experience needed for working with people at the end of their lives. Specialist training was provided, and they were able to access support and guidance from a local hospice at any time, via the provider's 'on call' team.

Good

Is the service responsive?

Our findings

People received a service that was responsive to their individual needs. A relative told us the service had made a "…massive difference. They are really responsive. They understand it's not just six hours of care; it's something so much more valuable. It's building memories because it means we're able to get out". A health professional told us, "They are so client centred. It's not ever about what they can provide, but about what [the person] needs, then they think about how to provide it. There is a shift in focus…They are looking outside the box. The registered manager is excellent at coming up with solutions". They gave an example of how the agency had recruited male care staff with a shared interest in particular computer games to work with one person. They told us this had helped to meet the person's psychological needs. Another person told us how their 'favourite carer' shared a love of Rachmaninov's concerto. They said, "We talk a scintillating conversation".

Each person had their needs assessed by appropriate clinically trained staff before the service began. For example, a person living with dementia had their needs assessed by a nurse specialising in this field, because they had the knowledge and skills to fully understand the support needs of the person and their family. This was an opportunity for training needs to be identified and specialist training arranged, to ensure care staff had the necessary skills and knowledge prior to the care package starting. The registered manager told us, "the package will not go 'live' until it's safe to do so". A health professional described how the agency had visited a person in hospital to meet them and discuss their support needs prior to the person being discharged. There had been some anxiety about returning home. The agency had fully involved the person, their family and relevant professionals in the assessment process, which meant staff were appropriately trained beforehand and the person was now being safely supported at home. The person confirmed, "From the first they were excellent, from the hospital visit through to the set-up after discharge. They've been consistent; have faced the challenges and hiccups (day to day normal operational). Very little gets past [clinical leads' names] ".

A key part of the assessment was talking to the person and their advocates about their likes and dislikes and what they were looking for from the agency. This meant the staff team could then be matched to the person on the basis of their personality and interests, as well as their knowledge and skills. People had the opportunity to see profiles of their potential staff team and to meet those who were shortlisted, to ensure they were happy with them before the care package commenced. Relatives told us the matching process had worked well, and they had appreciated having the opportunity to feedback about whether the member of staff would fit in with the family. For example, a relative told us their family member "…can get anxious and communication can sometimes be difficult". Prior to a visit by a new member of care staff, the person had received a phone call from them. They had talked about things the person was interested in, and the person had got to know them a bit, "making change more seamless". The registered manager told us, "It's not just about hands on care; it's about enablement and quality of life".

The information from the assessment was used to develop the person's care plan. In the provider information return (PIR) the registered manager stated, "Care plans are undertaken by clinically trained staff, completed on site, and are based on the service user's wishes and aspirations working collaboratively with

all members of that service users care team and advocates. All care plans are approved and signed by the service user or their advocate". A portable computer and printer meant that the care plan could be printed out at the time of the assessment visit, and left in the person's home.
Care files contained a crisis plan with contact details for use in emergency, information about risks and how to manage them, people's physical and emotional support needs, communication, social and recreational activities, as well as details about how the person wanted their care provided. For example, one person's care plan said the person, "…likes to have their feet massaged before they go to sleep". A child's care plan contained a booklet entitled, "A book about me", written by their parents to inform staff about their child and their likes and dislikes. A member of staff told us they had suggested to the registered manager that the care plans for adults would be more person centred if a similar document was in place, and this was being followed up. Adult care plans were clear about whether the person was able to make choices and consent to their care. For example one care plan said the person was "…unable to assess basic risks and is dependent on others to anticipate even basic needs". There was clear guidance for staff about how to support the person, for example, "Call [person's name] by name in each interaction in order to reinforce name recognition …Promote a tranquil and calm environment and where possible promote independence in daily choices…If [person's name] shows signs of agitation or is unsettled they may be hungry, thirsty or require the toilet". A relative told us how initially staff referred frequently to the care plan to see how to respond to their family members seizures, and now "most of them read it to 'brush up'".

The care plan was reviewed by the clinical lead at least every three months with the person and their advocates, printed out during the review visit and left with the person. The registered manager told us some people's care plans were being continually reviewed and updated because their support needs were changing rapidly. This meant people could be confident staff had access to accurate and up-to-date information about their health needs at all times. The agency held regular meetings for the individual teams supporting people, where information was shared and staff updated about any changes to the person's support needs. A relative told us, "Newcross registered nurses review my [family members] folder and liaise with the community nurses and ensure it is up to date. They are fab. Out of the agencies I have had they are the most professional and thorough. I appreciate that level of care".

People told us they were confident they could speak with the registered manager or a member of staff if they had any concerns or complaints, and that their concern would be addressed. A relative gave an example of a concern they had raised about a carer. They told us, "We reported it straight away. They dealt with it very professionally and let me know the outcome". The registered manager explained, "As soon as a complaint is logged the information goes through to the quality assurance and audit manager who has an oversight of the process. The concern is fully investigated and a letter goes to the complainant detailing the actions we will be taking. A resolution letter is sent to the complainant describing the action that was taken, the outcomes and further contact details".

Outstanding ☆

Is the service well-led?

Our findings

People, relatives and health professionals told us it was a well led service and they would recommend them. One person told us, "Newcross communicate using business protocols we recognise, they use engaging language and allow the 'customer' to participate and work within the latitude they have within their CHC (continuing health care) defined limits". Comments from relatives included, "From my initial contact they have been very professional. They gave me all the information I needed. [Managers name] and office staff were brilliant", and, "They have high standards and this is reflected by the staff. It is lovely to work with an agency with the same standards that I try to achieve". A health professional described the management of Newcross as 'very slick and responsive', with a 'really good knowledge 'of the people they were supporting.

The agency was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. They had a 'hands on' approach, and, when visiting people during the inspection, we observed they had a positive and warm relationship with the people using the service and their families. A senior member of staff within the organisation commented, "They are a really strong manager. They know what they want and are really in control of the team. They are a real key player and a strong leader".

The registered manager told us their ethos was, "delivering care that would be good enough for my nan". They told us this was always in their mind, whether they were interviewing prospective staff or speaking with people who used the service. "It's not just delivering what's on the care plan; it's delivering a service that makes them feel like an individual, and helps them forget they're receiving care." The agency focussed on supporting people with long term health conditions. At the time of this inspection they were providing care and support to 16 adults and children with complex needs, ranging from 24 hour care packages, overnight support or support for a few hours at a time. Following the inspection they were due to move into new premises, which would allow them to expand, providing enhanced training facilities and recruiting more staff. The registered manager explained it was about "quality, not quantity" however. They were "starting small, and building strong foundations", and would, "increase at a rate that is safe to do so".

The registered manager was very responsive to the needs of staff, for example, recognising the emotional impact on staff when a person they had been working with had died. In the provider information return (PIR) they stated, "When supporting with long term conditions, upon the passing of a service user, we use support available through local hospices and Cruse bereavement to hold team meetings to ensure a support network is available [for staff]". They told us, "This was about ending the care package, not just for [the person who had died], but for staff."

Staff confirmed they felt well supported by the agency and the registered manager. One member of staff told us they often worked with people overnight who were at the end of their lives, and support and guidance had been available to them when they needed it. Another member of staff described how the registered manager and office staff had supported them after they had made a safeguarding allegation. They told us, "[Manager's name] and all of the staff were really good… They were brilliant. I can't fault them at all…I've never worked anywhere this supportive. They've always got your back. They always support you and check

you're ok". Good practice and long service was formally recognised by the provider and certificates and tokens of appreciation were given at an award ceremony.

On the agency website the provider explained their philosophy of care, stating; "Throughout our journey we've developed the skills and experience to set the standard for the provision of first class care. Our Philosophy of Care leads to an approach that is holistic, transparent and person-centred. It is essential that every Newcross employee understands how they fit in and how they can make a difference to the lives of those receiving care, their family and their friends." This was confirmed by a senior member of staff who told us the provider had a "real 'can do' attitude", and were open to considering, "how could we do this differently?"

The registered manager told us they were well supported by the provider and this allowed them to provide effective support to their own staff team, ensuring a high quality service. They had regular telephone and face to face support from their own line manager. Managers meetings were held every six months, to consider best practice, looking at case studies and incidents. An annual manager's conference focussed on learning and development, sharing best practice and developing support networks. The registered manager told us, "You can feedback ideas to the organisation and they are implemented". For example, they had created an information leaflet for parents and professionals explaining how the agency provided individualised packages of care for children. This described how the process worked and contained anonymised case studies to demonstrate how children and their families had been supported in practice.

The provider had a range of checks and monitoring systems to ensure the service was running smoothly. Regular audits were carried out, looking at areas such as complaints, the completion of medicine administration records (MAR), training, supervision and recording. Accidents and incidents were reviewed by the provider's quality assurance team to ensure there had been an appropriate response and to identify any trends and further action that might be needed to keep people safe. The quality of the service was also monitored through the completion of regular unannounced 'spot checks' by members of the management team to ensure staff competency, and to check support was being provided in line with people's agreed care plan and company policy. Regular feedback was sought from people who used the service. One person told us, "Every time I have a new carer, they send a questionnaire asking me how the carer has got on. I'm really rubbish at sending them back; I'm giving verbal feedback anyway". Staff were asked to feedback anonymously via 'engagement questionnaires', which asked for their views about the organisation.

The provider made good use of information technology to facilitate communication between the provider, management and office staff, care staff and people who used the service. For example, care staff had an 'app' on their mobile phones, where they could access the information they needed to support people effectively. This was password protected to ensure confidentiality. The 'app' 'included directions, care plans and emergency plans, as well as staff rotas.

The registered manager and staff team were proactive in keeping their knowledge and skills up to date and using this knowledge to improve the lives of the people they supported. The agency participated in local forums run by the local authority and clinical commissioning group (CCG) where issues and developments in health and social care were discussed. The provider employed a range of information sharing strategies. For example, there was a monthly on-line newsletter and a quarterly magazine for staff, as well as a Facebook page. The head of clinical excellence compiled and issued weekly bulletins for staff from a range of recognised sources of national good practice, including the Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN) and the Care Quality Commission (CQC). Qualified nurses had access to a computer networking system called 'Nurchat' which provided a platform where they discussed relevant nursing and clinical issues, and best practice. Specialists from all over the country were invited to

participate. Recent discussions had looked at issues such as whether nurses would feel confident to raise a complaint while on placement, the role of the carer in supporting people living with dementia, and the importance of communication with people and their families when making decisions about how they want to be supported at the end of their lives.

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.