Alexander's Care & Support Limited

ACASA

Inspection report

101 Alexandra Road
Farnborough
Hampshire
GU14 6BN

Tel: 01252540277
Website: www.parkgroupcare.co.uk

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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 23 April 2018 and was announced to ensure staff we needed to speak with were available. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults, in addition to people living with dementia, sensory impairment, people who misuse substances, people with a learning disability or mental health diagnosis.

CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. On the day of the inspection, 130 people were being supported with the regulated activity of personal care.

The service had a 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.

People were safeguarded from the risk of abuse; staff understood both their role and duty to protect people and had access to relevant guidance. A range of risks to people had been assessed in relation to their moving and re-positioning needs, falls, skin care and environment, and measures were in place to manage them. People received their medicines safely from trained and competent staff. People were protected from the spread of infection as staff had undertaken relevant training, which they applied during the course of their work. Processes were in place to investigate incidents and to ensure any relevant learning took place in order to reduce the likelihood of repetition.

Where people's care had been commissioned by a statutory authority instead of privately purchased, the provider had applied the commissioner's capacity planning tool to determine the timing of people's calls. They also took into account their preferences where possible and any identified risks, that impacted upon the required timing of their call. Appropriate pre-employment checks had been completed for new staff.

People's needs had been assessed with them. The delivery of their care and treatment took into account legislation and good practice guidelines, in order to ensure people received effective care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff received an appropriate induction to their role, on-going training, professional development opportunities and supervision. Staff supported people appropriately to ensure their food and drink needs were met. Staff worked well together, both within the service and with external agencies, to ensure people received effective care. Staff supported people to access healthcare services as required.

People and their relatives reported staff were kind and caring, which we observed. We heard staff as they

involved people in decisions about their care and treatment which was also confirmed by people and records. The provider consulted people about their preferences for male or female staff at their initial assessment and endeavoured where practicable to meet their requirements. Staff upheld people's privacy and dignity during the provision of their personal care.

People received care that was responsive to their needs. Their care planning took into account their strengths and levels of independence. People's information needs had been identified and met.

People's complaints had been noted and actions taken, the registered manager hadtaken action to ensure verbal complaints received and the actions taken are added to the central complaints log to enable effective monitoring.

At the end of their lives people received appropriate support from staff and their preferences were clearly documented.

People, although satisfied with the service overall, felt there could be better communication from office staff. The registered manager was aware of this issue and actions were already underway to address this for people. There was a clear strategy for the delivery of people's care.

Staff and professionals provided positive feedback about the management of the service. There was a clear management structure to ensure the delivery of people's care. The registered manager understood their legal responsibilities.

Processes were in place to audit and monitor the quality of the service provided. People's views on the service and those of staff and professionals were regularly sought.

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 were safeguarded from the risk of abuse through the processes and staff training, which were in place to protect them.

Risks to people had been identified and managed to promote their safety.

There were sufficient staff to complete people's calls. Appropriate pre-employment checks had been completed for new staff.

Processes and procedures were in place to manage people's medicines safely.

Processes, policies and staff training were in place to ensure people were protected from the potential risk of acquiring an infection.

Processes were in place to investigate incidents and to ensure any required learning took place.

Is the service effective?

Good

The service was effective.

People's needs were assessed and their care was delivered in accordance with best practice standards.

Processes were in place to ensure staff were adequately trained and supported within their role.

People were supported to eat and drink enough to meet their needs.

Staff worked both together within the service and with external agencies to ensure people received effective care.

Staff supported people to ensure their healthcare needs were met.

People's consent to their care and treatment was sought and legal requirements met.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff.

Staff involved people in making decisions about their care.

Staff upheld people's privacy and dignity during the provision of their personal care.

Is the service responsive?

Good

The service was responsive.

People received care that was planned with them and was responsive to their needs.

People's complaints had been noted and actions taken. The registered manager has taken action to improve the monitoring of any verbal complaints received.

People were appropriately supported with their end of life care.

Is the service well-led?

Good

The service was well-led

There was a clear strategy for the provision of people's care. Staff were observed to be committed and keen. They enjoyed working with people.

There was a clear management framework, which ensured the service was well managed.

Processes were in place to seek the views of people, staff and professionals about the service provided.

Processes were in place to audit and monitor the quality of the service provided and to drive service improvements for people.

The service proactively worked with other agencies to deliver people's care.

ACASA

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 23 April 2018 and was announced. We gave the service 48 hours' notice of the inspection activity to ensure staff we needed to speak with were available and to enable the service to inform people the inspection was taking place and that they may be contacted. Inspection site visit activity started on 19 April 2018 and ended on 23 April 2018. We made telephone calls to people on 19 and 20 April 2018 and visited the office location on 23 April 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection team included two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people.

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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

Prior to the inspection, we received written information about the service from three social workers and spoke with a specialist nurse. During the inspection, we spoke with 15 people and five people's relatives. We also visited four people at home to observe how staff interacted with people during the provision of their care. We spoke with two care supervisors, two senior care staff, two care staff, the operations manager, the team manager and the registered manager.

We reviewed records that included eight people's care plans, six staff recruitment and supervision records and records relating to the management of the service.

This was the first inspection of this service under this legal entity.

Good

Is the service safe?

Our findings

People said they felt safe. A relative told us, "We have a lovely girl and I can leave her with my relative without getting worried. They are all excellent, worth their weight in gold. [Name of carer] is my anchor." A person said, "Absolutely, ACASA has made a big difference to me. I've got some sort of order in my life now- my tablets are organised and they make sure I eat." Another person commented, "I feel very safe because they know me, they help me and do what I like." People said the care staff wore gloves and aprons where necessary.

Staff told us they had undertaken face-to-face safeguarding training, which records confirmed and relevant policies were available. Policies and processes were in place to ensure that where staff supported people with their finances, this was done safely and there was a clear audit trail. We saw in people's homes completed financial sheets with receipts were in place where shopping was provided by care staff. These had been jointly signed by the person and staff for their safety.

Staff were provided with information about how to enter people's property, for example, with a key safe and how to leave the property securely. Staff were observed to wear their uniform and identity badge to ensure people could see who they were and that they had been sent by ACASA.

The service had submitted 14 safeguarding notifications to the Care Quality Commission (CQC) within the past year. Many of these were actually medicine recording incidents or missed calls where no one had experienced any harm. Actions had been taken to reduce the risk of repetition for people. These notifications had been made to CQC, as they had correctly informed us of any safeguarding referral they had made to the local authority, as the lead agency for safeguarding.

A range of risks to people had been assessed in relation to their moving and re-positioning needs, falls, skin care and environment. Risks had been rated as low, medium or high, depending on their severity and likelihood of occurrence. This ensured risks were prioritised and addressed accordingly for the person. Where people required more than one staff to support them, this had been noted and there was a record of any equipment the person used to mobilise. Staff had been instructed in people's care plans to check the safety of equipment prior to using it to transfer a person, for example. Where fire risks had been identified, people had been referred to the fire service for a home safety assessment. Staff had been instructed in people's care plans to observe people's health and or behaviours and to report any concerns to the office. A person told us, "They check my skin over every day and let the district nurse know if there's any problems." People's records documented staff's contact with the office raising issues and the action taken. A person told us the office staff had arranged for them to have a lifeline and people's care plans instructed staff to ensure people wore them, so they could call for assistance if required. There were instructions for staff about what items a person needed to have to hand to ensure their safety between calls. Risks to people had been identified and managed safely.

The service had a Business Continuity Plan, which outlined how the service would be delivered in the event of a major disruption to the business, such as for example, due to bad weather or staff sickness, to ensure

those at most risk received a service.

People's preferred times of care calls had been identified at their initial assessment. The provider had been required to apply the commissioning authority's recently introduced 'Capacity Triangle,' in conjunction with any identified risks to people when determining the time care was to be provided to those whose care was commissioned. This meant that people's care calls were now booked according to whether the timing of the call had been assessed using the tool as high, medium or low. This had resulted in some existing people's care calls having to be re-scheduled. The provider had taken into account people's preferences where possible within this process. For example, two people had their calls scheduled at different times on the days they needed to be ready at a different time to attend activities. The model had resulted in a change of time for some people, which not everyone was happy with, however, where possible people's call time preferences had been accommodated.

Staff told us and records confirmed that appropriate pre-employment checks had been completed. Applicant's identity had been checked, references provided and full employment histories were in place and a Disclosure and Barring Service (DBS) check, to ensure people's safety.

Staff told us they had undertaken medicines training and had their competency to administer people's medicines assessed, which records confirmed. Medication policies and guidance were available to staff, to instruct them in their safe management.

People had received a medicines risk assessment, to enable staff to identify their medication needs, wishes and preferences, storage and ordering arrangements. A person said, "I had a medication change this week and the carers were quick to report it into the office." People who took 'PRN' medicines (which are those taken 'as required') had protocols in place to provide staff with guidance on their safe use. If people required staff to apply topical creams then there was a body map and clear directions for staff about how the cream was to be applied. Where staff applied medicine 'patches' to people's skin, there was guidance to ensure their safe application on alternate sites on the person's body. People's medicine administration records (MARs) were reviewed both in the office and in people's homes and had been correctly completed by staff and robust processes were in place to identify any gaps in MARs and to address them with the relevant staff.

Staff had undertaken training in both infection control and food hygiene, as they often prepared people's food for them. Infection control policies and guidance were available to staff, to instruct them in safe infection control practice. Records demonstrated that staff were issued with appropriate personal protective equipment (PPE) when they started working for the provider. This included a uniform, gloves, aprons, and hand gel. Staff confirmed PPE was provided and easily accessible from the office when more was required. During home visits, we observed staff used appropriate PPE when providing personal care and washed their hands both before and after contact with the person, to minimise the risk of cross-contamination.

Processes were in place to record and review incidents. Following a recent incident, we saw evidence that staff had been reminded of the relevant policy in the staff meetings as one of the agreed actions from the incident review. This ensured that staff had been reminded of their duties and responsibilities. When audit processes had identified issues such as having staff forgotten to sign the person's MAR record, an incident record was completed and relevant action taken to reduce the likelihood of repetition, both through discussions with individual staff and group discussions at staff meetings.

Good

Is the service effective?

Our findings

People and their relatives reported that the service was effective. Their comments included, "They know their job and they know what they are doing." People said care staff usually made drinks for them to have between visits. Fourteen people felt the carers communicated well and worked with each other. A person commented, "The carers always seem to know what is going on. They often phone the district nurse and they have called the GP on my behalf." People said they were verbally asked for their consent to care when the care staff provided their personal care.

People's needs had been assessed by the supervisors or senior care staff prior to the commencement of their service and noted who had been involved. Six people confirmed they were involved in their or their relative's care planning.

The provider's policies referenced relevant legislation to ensure legal requirements were understood and followed by staff. The registered manager showed us the memory aide they had created for staff to embed their medicines knowledge, to ensure people received their medicines safely.

If people lived with chronic conditions such as diabetes, then there was clear guidance in their care records provided by the diabetes nurse about their care needs in relation to their diabetes. There was also information for care staff to inform them when they should be concerned about the person's welfare and alert healthcare services. Only staff who had undertaken appropriate training were able to support people with their blood glucose monitoring. Where speech and language therapists had provided guidance about people's thickened fluids requirements, the guidance was both made available to staff and incorporated into people's care plans.

Staff who were new to care underwent the 'Skills for Care,' 'Care Certificate' as part of their five day taught induction. This is a set of standards that social care staff work towards in their daily working life. It is the minimum standards that should be covered as part of induction training of new staff. Eleven of the 32 care staff held a professional qualification in social care. Staff confirmed that they had been supported by the provider with their professional development.

Staff told us, there was a three monthly supervision cycle of a practical observation, medicines observation and a face-to-face supervision. A person confirmed, "Once a month a senior staff comes out to make sure all the carers are wearing their gloves and doing everything right." Staff told us they received regular supervision, which records confirmed. The team manager was in the process of booking appraisals for staff, to give them the opportunity to reflect upon their performance over the past year and to identify goals for the forthcoming year. The provider had a training matrix for staff's on-going mandatory training, which demonstrated that overall staff were up to date with their required training. Staff were appropriately supported within their role.

People's care plans clearly instructed staff what support they were to provide for the person with eating and drinking. For example, whether they were to prepare the meal. If the meal needed to be fork mashable or

pureed, the person's preferred foods and drinks, any physical support they required with eating and any specific positioning requirements to enable the person to eat and drink safely were all included. If the person could not eat any particular foods that might interfere with their medicines then this had been noted for care staff. Where required, staff documented the food and drink people had consumed. Staff had been instructed in people's care plans to ensure they were left with fluids accessible between care calls, to ensure they could access a drink. Staff supported people appropriately to ensure their food and drink needs were met.

A person told us, "If there is any problem or uncertainty when the carers are here, they will always pick up the phone to clarify it [with the office]. They have made things better for me. Sometimes I forgot to take my tablets before bed so they organized an extra call for me before bed. I used to fall asleep in my chair sometimes; they now make sure I get into bed for the night." Staff told us they had good working relationships with external agencies, which social workers confirmed and records demonstrated there was regular communication for people.

There was evidence that staff had worked with a variety of health and social care professionals to promote people's well-being, such as GPs, district nurses, specialist nurses, occupational therapists, speech and language therapists and social workers. A person told us, "If they think I need a doctor, they just call one. My morning carer came in and said I looked unwell. She called an ambulance and I went to hospital. The office arranged my teatime call for an hour later than usual so they came when I returned from hospital." Staff supported people to access healthcare services as required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People had signed their consent to the care provided where they had the capacity to do so. Staff told us they had undertaken training in the MCA 2005, and understood its application to their role. There was evidence that where health care professionals had made a mental capacity act assessment and best interest decision about how an aspect of a person's care was to be provided, the provider had obtained a copy of the assessment to ensure the person's care was provided in accordance with legal requirements.

The service sought information at people's initial assessment regards whether they had a Lasting Power of Attorney (LPoA) in place and whether this was for health and welfare or finances or both. A LPoA is a legal document that enables a person to appoint one or more people to help them to make decisions in the event they can no longer make decisions for themselves. However, they had not always managed to obtain a copy from the person, despite requesting it, as is good practice, in order to be able to assure themselves of its existence. We discussed this with the registered manager who during the course of the inspection identified the process whereby they could complete these checks for themselves and they have assured us they are in the process of completing this work. This will ensure they have satisfied themselves of attorney's powers to act on the person's behalf.

Good

Is the service caring?

Our findings

People and their relatives reported staff were kind and caring. A person said, "The agency I've got now by far exceeds the others I've had- the kindness of the girls, they cheer you up, involve me, talk to me." Other comments included, "Excellent care, very kind and caring people." "They're a good bunch. They have a very good rapport with me, they say a little bit more than 'are you alright?' "The carers have a very polite attitude. We talk to each other just like family coming round. I get them on a one to one basis." "I feel as if I get a good, thorough job. They don't rush me." "They are absolutely smashing carers, very friendly and caring." People said care staff showed respect to them and helped them to maintain their dignity by closing bathroom/bedroom doors if possible. A person said, "They treat me with respect – it makes all the difference."

People's care plans contained information about their personal history and background, what was important to them and what was not working so well for them in their life. There was a record of people's interests and hobbies to provide staff with information about topics that interested people, which they could use as a basis for discussion. People's care plans noted if they experienced low mood or anxiety and care staff were instructed to be 'friendly and approachable, with a positive attitude.'

People's care plans instructed staff to ensure people were comfortable. For example, when seated in their wheelchair and provided guidance about how to achieve this for the person and made staff aware if the person experienced any chronic pain, for example, which might affect their comfort. It was also documented if people became anxious about any aspect of their care and how staff should support them to allay their concerns.

We observed care staff demonstrated compassion to people and were very caring in their approach. It was evident that care staff knew the people well and were able to talk to them about their families. A person told us, "The girls come and sit and talk to me after they have finished their jobs. It has made so much difference to me." People were treated with kindness and compassion by staff.

Staff had undertaken training in equality and diversity. People's records noted their communication needs and how staff should interact with them, for example whether the person needed them to speak slowly. Where people could not communicate verbally, there was guidance for staff to observe the person's facial expressions and body language in order to gauge their response.

People's care plans instructed staff to consult people about their care, for example, a person's care plan stated 'Ask if I would like my hair washed.' Staff were instructed to promote and offer a choice of breakfast to people. People confirmed they were involved in decisions about care and treatment. A staff member told us, "I give choices in everything." We observed people were offered choices by staff, for example, people were asked what meals they wanted for lunch and what they wanted in their sandwiches. Staff involved people in making decisions about their day-to-day care.

If people required female staff on religious grounds, then this requirement had been met, in accordance

with the requirements of the Equalities Act 2010. Three people told us they did not have a choice of male or female carers. We shared this information with the registered manager. They advised that the agency employed both male and female care staff and that the possibility of male care staff being rostered was discussed with people at their initial assessment, which records confirmed. They also advised that, wherever practicable, people's wishes were accommodated. We noted at a person's review in 2017, they had stated they did not want male care staff, when we checked their rosters we saw they were now only allocated female care staff, as per their wishes. The provider consulted people about their preferences at the initial assessment and endeavoured to meet their requirements where possible.

We observed people were treated with dignity and respect by staff. People's care records informed staff they should leave people in private, where safe to do so, in the bathroom and wait to be called, to uphold the person's privacy. There were instructions for staff to ensure blinds, for example, were closed during the provision of personal care. A person confirmed, "They respect my privacy and dignity- they cover me with a towel when washing one half of my body." Staff were able to tell us how they ensured people's privacy and dignity were maintained during the provision of their personal care. Staff upheld people's privacy and dignity during the provision of their personal care.

Good

Is the service responsive?

Our findings

People spoken with knew how to raise a concern or complaint.

The provision of people's care was related to six outcomes, which encompassed all aspects of people's lives, such as health and well-being, personal care, daily living, environment and mobility, social and emotional well-being. People's care plans addressed how their support was to be managed, any potential barriers were identified and addressed and there were agreed actions. If people required support, for example with completing physiotherapy exercise, then this was built into their care plan. People's care plans addressed all aspects of their care needs.

Where people had protected characteristics under the Equalities Act 2010, for example, due to their religion, staff had been provided with additional information to educate them and inform the sensitive and respectful delivery of the person's care.

People's care was regularly reviewed, which resulted in updates to their care plans as required. A person confirmed, "My care plan is reviewed every 12 weeks. For example, now I need my kitchen window blind pulled down at teatime. It was added to my care plan straight away. Any new girls have to look at it first to see what they should be doing." Another person had raised an issue at their review and this had been addressed for them.

Records showed that people's care had been increased in agreement with the commissioning authority where their needs had increased. A person confirmed, "They organized an extra call for me before bed."

The service was commissioned to support people with their shopping where needed. A person confirmed, "Usually the same carer takes me shopping." Staff supported people with community activities where commissioned to do so.

People's care plans identified their 'Circle of Support,' which documented who was in the person's life in relation to their family, friends and professionals, in addition to any work or social activities that they attended. This ensured staff were aware of people's contacts and helped with the planning of their care. For example, one person's 'Sitting service,' that was provided to enable their main carer to have breaks, had been booked at a specific time to enable the carer to attend an activity.

Care plans noted what aspects of people's care they wished to be independent with and how staff should support them. For example, one person's records noted how staff were to ensure they were positioned so that they could shower themselves. A person told us, "Carers are very good; they leave me to do things when I can. They try to encourage me to do what I can do. I hook the straps on my hoist and feed them through the sides." Another said, "They ask me to try and do what I can. I sit to peel my potatoes and they put them in a saucepan to cook. We work together."

Staff had undertaken training in managing behaviours which could challenge them. People's care plans

provided staff with guidance about the actions to take if people were resistant to receiving care, such as to give them time, divert their attention and to be conscious of how they approached certain topics with people.

The service ensured that people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

People's information needs had been assessed as part of their initial assessment. Where people required information in an alternative format, this was available for them. For example, the provider's safeguarding and complaints policies were available in an 'easy read' version for people with a learning disability. If people needed their letters, for example, read to them then this had been noted in their care plan to ensure people received the required level of assistance.

The provider had a policy for dealing with written and verbal complaints which staff had received training on. Several people told us they had voiced concerns over the telephone, mainly about visit times, lateness of calls, and not knowing who would arrive. Most people said office staff were apologetic, but felt nothing was followed up. Records demonstrated that if people had raised issues by telephone, these were documented on their individual electronic care notes and the actions taken. As the complaints log only contained written complaints, and not a central log of verbal complaints received, we could not readily check all verbal complaints and actions taken. We shared people's feedback with the registered manager who took immediate action to address this. They spoke with relevant staff and are reviewing the processes and training in place to ensure that telephone complaints received are now added to the central complaints log. Four written complaints had been received since January 2018. All complaints had been investigated and responded to within a four or five day timescale. Action plans were in place where needed which included learning for the staff concerned.

Staff had not undertaken specific training in palliative care. However, the district nursing team had responsibility for meeting people's clinical needs at the end of their life. Where people had been identified by their GP as approaching the end of their life, this had been documented, along with the person's wishes about their care and staff had been informed. Relevant medicines were in place for people to ensure their comfort when required. Staff spoken with felt confident in their ability to support people approaching the end of their lives and had provided this care to people. Where people had decided to have a do not attempt cardio-pulmonary resuscitation (DNACPR) form in place, the provider had ensured there was a copy on people's records to inform staff. There was guidance for staff to ensure they were supported, as well as families, at the end of a person's life. People received appropriate support from staff.

Good

Is the service well-led?

Our findings

People had varying views about the culture of the service, their comments ranged from, "Very reliable indeed," to "I don't run into management" and "I don't know." Most people said the office staff did not communicate well. However, people reported good communication generally from the care staff. The majority of people were happy overall with the service received. One person commented, "If I have any problems, I phone them and they sort it. They do make errors but they do make a big effort to correct them."

Although people reported there had been issues with communication from the office staff, we noted that at the last two care co-ordinators meetings held in February and March 2018, office staff had been reminded of the importance of informing people of any changes to the timing of their care calls. A relative confirmed staff had been in touch to advise when a care call was running late. The registered manager also took further action to reinforce this with staff when we spoke to them about people's feedback. The registered manager was already aware of this issue; they had taken action and continued to take action to address this for people.

The provider's beliefs, purpose, objectives and the service they could offer to people were set out in their statement of purpose. This ensured there was a clear vision for the delivery of the service, which underpinned the provision of people's care. Staff were observed to be committed and keen. They clearly enjoyed working with people.

A social worker told us, 'I have nothing but good things to say about this service. Management works well with us and they work collaboratively to keep clients safe.' Another social worker confirmed, 'The service is well- led.'

Staff provided positive feedback about the management of the service. A staff member said, "Management has improved massively." They told us that with the new registered manager and team manager there had been an improvement in both the level of communication and direction in relation to what was expected of staff. Staff felt management were approachable, one staff member told us, "I can talk to them." They also told us, "Things get dealt with."

There was a registered manager in post, who also had responsibility for three of the provider's extra care services. At the service, there was also an on-site team manager, who had recently commenced the process of making an application to the Care Quality Commission (CQC) to become the joint registered manager for the service. The operations manager supported both of these managers in their role. In addition to the registered manager, the team manager and office staff, there were supervisors and senior care staff based in the field, to support staff and to have oversight of the care provided to people. There was a senior on-call staff member out of hours for people or staff to contact if required. There was a clear management structure to ensure the safe delivery of people's care.

Records demonstrated that when incidents had occurred, relevant notifications had been completed for CQC and people and their families updated as required by the 'Duty of Candour.' This requires the provider

and the registered manager to be open and honest with people when something goes wrong. The registered manager understood their legal responsibilities.

The views of people, their relatives, staff and professionals had been sought, both through their regular reviews and quality assurance surveys, which demonstrated a high level of satisfaction with the service. Staff told us that within their geographical 'teams' staff meetings were held, which records confirmed. This was both a practical way of holding staff meetings with a large staff group and ensuring the information discussed related to the people to whom staff provided care.

The registered manager completed a bi-monthly audit of the service. Each audit reviewed people's care plans and medicine administration records (MARs). Then different additional areas of the service were included in the audit across the year such as, medicines, dignity and respect, consent, nutrition, complaints and recruitment, for example. This ensured all aspects of the service were audited. Any issues identified were added to the action plan for the service. For example, the need to improve MARs recording by staff had been identified in February 2018. As a result, changes had been made to both the process and staff's responsibility for auditing MAR sheets and people's log books.

Although this was an on-going issue, we saw progress had been made and there had been a large reduction in recording errors, since the introduction of these changes. The team manager also completed a monthly audit of the service, reviewing areas such as, MARs, care plans, incidents, safeguarding alerts or concerns, complaints and staffing. An action from the January 2018 audit was for all care plans to be brought up to date by 1 March 2018. The care plans we reviewed were up to date and provided detailed information about the provision of people's care.

Information from these audits was reviewed at the provider's managers' meetings to enable the identification and analysis of any trends that required action for people. An action from the managers' meeting in January 2018 had been for people living with diabetes to have relevant support plans and we saw that these were in place to provide staff with relevant information and guidance.

The registered manager told us the service had been working with the local pharmacies to ensure they had clear instructions for the administration of people's medicines, especially topical creams that often only stated, 'apply as directed.' This was confirmed by staff and records; this piece of work had led to clearer administration instructions for staff and therefore reduced the likelihood of errors in their administration.

There was evidence that staff had attended multi-disciplinary meetings with both people and professionals. A person's records showed such a meeting had taken place, to discuss how the ACASA service fitted in with the person's care provided by other services. Another person told us, "They all came out and had a meeting about how best they could manage and make sure my visits were so many hours apart. The plan is working." The service was proactive at working with other agencies to provide people's care effectively.