Nestor Primecare Services Limited

Allied Healthcare Cambridge

Inspection report

First Floor
9a The Pavement
St Ives
Cambridgeshire
PE27 5AD

Tel: 01480464445
Website: www.nestor-healthcare.co.uk

Date of inspection visit:
06 April 2016

Date of publication:
05 May 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 6 and 7 April 2016 and was announced. We gave the service 48 hours' notice of our inspection. This was because management and staff could be out. We wanted to make sure they were in. This was the first inspection of this service with this provider.

Allied Healthcare Cambridge is a domiciliary care and supported living service that is registered to provide personal care to people living in their own homes. At the time of our inspection there were 89 people using the service. Some people also used the supported living service. In supported living services, people live in their own home usually under a tenancy or licence agreement. They often receive personal care and/or social support in order to promote their independence.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 recruitment was undertaken to help ensure all staff were recruited in a safe way. Only those staff who were deemed suitable to work with people using the service were offered employment. People's assessed care needs were met by suitably trained and qualified staff in a timely manner.

Medicines administration was completed by staff whose role required this. Their competency to do this safely was regularly assessed. Safe medicines administration and management practice was adhered to.

Staff's knowledge and understanding of safeguarding procedures helped ensure that any suspected incident of harm would be acted upon and reported to the appropriate authorities. including their manager, the local safe guarding authority or the Care Quality Commission.

The registered manager was aware of the process to be followed should any person have a need to be lawfully deprived of their liberty. They and staff were knowledgeable about the situations where an assessment of people's mental capacity was required. The service was working within the principles of the Mental Capacity Act 2005. No person using the service had been deemed to lack mental capacity to make some or all decisions about their care.

People's privacy and dignity was respected by staff who knew people's needs, and their levels of independence, well. People were supported to take risks in a safe way. Appropriate risk management strategies and records were in place for subjects such as falls, supporting people out in the community and medicines administration. Checks were completed to help ensure that people's homes were a safe place for staff to work in.

People's needs were assessed by staff using a formal process and information from the local authority which

helped ensure that the service was able to safely meet these needs People were involved in this process in defining and agreeing their care needs.

People were supported to see or be seen by a range of health care professionals including a dietician, their GP or a community nurse.

Sufficient quantities of people's preferred food and drinks were made available. People were supported with their independence to live in their own home as long as they wanted to.

Staff were provided with regular support, mentoring and training for their roles. This was through an effective programme of induction, meetings, coaching, supervision and yearly appraisals.

People were provided with information, guidance and support on how to report any concerns, compliments or suggestions for improvement. The provider took appropriate action to ensure any complaints were addressed to the complainant's satisfaction.

A range of effective audit and quality assurance procedures were in place. The provider had processes in place to help ensure that the CQC is notified about events that they are required, by law, to do so.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had a good understanding in the application of safeguarding procedures and these were implemented when required.

People's assessed needs, including medicines administration, were met by a sufficient number of suitably qualified staff.

The provider's recruitment process helped ensure that only suitable staff were offered employment.

Is the service effective?

Good

The service was effective.

People were supported to make and be involved in the decisions about their care. People's social interests and hobbies were encouraged and supported by staff.

People were supported to eat and drink sufficient quantities of the foods they preferred.

People were supported to see appropriate health care professionals when required.

Is the service caring?

Good

The service was caring.

People's care was provided by staff who showed compassion, respect for people's privacy and dignity with an understanding of the meaningful aspects of people's lives.

Staff listened and acted upon the views of people in regards to their care and support.

People were supported to maintain relationships with family and friends' that were important to them.

Is the service responsive?

Good

The service was responsive.

Peoples care records were detailed and provided staff with sufficient guidance to provide consistent, individualised care to each person.

People were supported to actively follow a wide variety of their hobbies, interests and pastimes.

Concerns, suggestions and compliments were used as a way of recognising what worked well and what did not work quite so well.

Is the service well-led?

Good

The service was well-led.

The provider had, from information viewed, notified us about events they are required, by law, to do so.

Effective audits and systems to measure the quality of the service were in place and actions identified were acted upon.

The registered manager and the management team fostered an open and honest culture to ensure that people received a good quality of care from all staff.

Allied Healthcare Cambridge

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 announced inspection took place on 6 and 7 April 2016. Part of our inspection included telephone calls to people. The inspection was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 this and information we hold about the service. This included the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

We also looked at the results of the questionnaire we sent to people, staff and community professionals prior to our inspection.

During the inspection we visited and spoke with two people in their homes and spoke with 11 people and three relatives by telephone. We also spoke with the registered manager, two field care supervisors, and four care staff. We also asked for, and received, information about the service from the local authority contracts team. This is the service responsible for commissioning care for people who use services.

We looked at five people's care records, managers' and staff meeting minutes. We looked at medicine administration records and records in relation to the management of the service such as checks regarding

people's homes environmental safety. We also looked at staff recruitment, supervision and appraisal process records, training records, complaints, quality assurance and audit records.

Good

Is the service safe?

Our findings

Where staff identified any concerns they had about peoples welfare such as self-neglect, falls or refusing to take their medication. They documented it in an Early Warning Signs [EWS] record. Actions were then taken to help ensure that the people's safety was maintained. This was confirmed in the provider's PIR they sent us. People also had access to an emergency call system which was manned 24 hours a day to respond to any unplanned emergency situations. One person told us, "The care staff are very good and they are reliable."

Staff were confident in their knowledge about the different types of abuse and how these were recognised such as if a person had become withdrawn. They also knew to whom they could report any suspicions of harm or poor care practice including the local safeguarding authority.

All of the people we spoke with confirmed that the office staff always explained the reason for any delays in calls and when assistance would be provided. One person said, "Knowing that at 7am they [staff] are going to walk in my door to help me means the world to me." Another person told us, "Yes, approximately on time. If they are going to be late for any length of time you get a phone call and when they ring they always check you're OK." A third person told us, "They [staff] always stay their allotted time, sometimes longer." A relative said, "My [family member] is safe as care staff treat [family member] very well and are careful when moving them to have a wash."

Risk assessments were in place for subjects including those for people with behaviours which challenged others, accessing the community and moving and handling. These risk assessments were reviewed regularly to ensure that people were supported to be as safe as practicable. People were supported to take risks in a safe way and staff had access to the detailed information about the control measures that were in place to support people with their safety. For example, where people's behaviours challenged others it stated, what the triggers were and what calming measures worked best for each known situation. One member of care staff said, "Knowing the action to take to prevent people becoming distressed or anxious really makes a difference. No two days or care calls are ever exactly the same. The guidance we have helps us especially if it is updated." Other risk assessments included checks that were completed to help ensure that people's homes were a safe place for staff to work in which included the safe storage of people's medicines. This was to assist staff in providing care in a safe way. One person told us, "They [staff] always make sure my door is locked when they leave. They leave my home tidy."

People and relatives confirmed to us, that there were sufficient staff in place to meet people's assessed care needs. We also saw that there was sufficient staff to meet people's needs. The provider used an electronic call monitoring system. This identified the time staff arrived and when they left each person. This checked that staff stayed to provide people's care for the required and agreed time. One person said, "I need two staff in the morning and there is always two of them." One relative told us, "I feel confident that when I am not there that my [family member] is safe." The registered manager told us that as far as possible the same regular care staff supported people. If the regular care staff were ill or unable to cover a care call then another staff member who knew the person would normally be used. People we spoke with confirmed to us

that this happened.

Arrangements were in in place for unplanned absences such as staff calling in sick. Care and management staff told us that permanent staff covered extra shifts. They added that agency staff had been used but that this was a rare occurrence. Management staff also carried out care visits to help cover staff absences. All 14 people who responded to our questionnaire confirmed that they felt safe from harm. We found that this was due to several factors including staff who arrived on, and stayed for the required, time.

Accidents and incidents such as when people had experienced a fall or had behaviours which could challenge others were recorded. Care staff discussed specific triggers for people's behaviours and the calming techniques and measures such as seeking family members' interventions. We found that staff knew what calming measures worked for the person. We saw that actions had been taken to prevent the potential for any recurrences. This included liaison with the person's GP for alternative medication options as well as mental health team interventions. However, we found that not all incidents had been recorded correctly. This put some people at risk of not being supported as safely as they could have been. We also found that appropriate steps had been taking to reduce people's further risk of falls such as referrals to the falls team and the use of walking aids. One person told us, "Oh yes, they [staff] always make sure I have my walking frame and that I use it."

The registered manager told us, "We only recruit staff who are suitable and not just to have the right number of staff." Staff told us that before they were offered employment they had to produce a specific set of documents and records. Examples of these included a satisfactory Disclosure and Barring Service [DBS] check, [This check is to ensure that staff are suitable to work with people who use this service]. The provider's PIR also confirmed, "after four to six weeks of being out on their own each care staff is spot checked to ensure the safety of people at all times". This was confirmed to us by the staff we spoke with. Other records required included a full employment history, photographic identity and proof of eligibility to work in the United Kingdom. These checks were planned to help ensure that staff were only employed when they were deemed to be suitable to look after people.

We saw and records viewed confirmed that people were supported to take their medicines in a safe way. This included those people with allergies to certain medicines and medicines that had to be taken at, specific time of day. One person said, "They [care staff] remind and help me take my medicines and fill out the sheet [Medicines Administration Records] when I take them." Each person's medicines administration records (MAR) contained the level of support, dosage and timings specified by the prescriber. Records and staff confirmed that they had been trained and assessed as being competent in the safe administration of medicines. Staff were able to tell us the support each person required with their medicines. Medicines were recorded accurately and secured appropriately in people's homes.

Good

Is the service effective?

Our findings

People were supported by care staff who had the necessary skills and knew the people they cared for well. One person told us "They [staff] are good at their job. When they do bring someone [a member of staff] who is under training, they are very thorough." The registered manager explained the various programmes in place to support staff in their role. For example after induction staff were supported with a 'Carer Coach'. This is a member of staff with specific skills in mentoring staff to become confident in their role. Staff were supported for eight weeks with their coach and then they could ask for any additional support if they needed this. This was also related to the Care Certificate [a nationally recognised training standard for social care]. The provider used this as a benchmark that staff were expected to achieve. One staff told us, "I was really well supported with my induction. I had to complete a workbook of my training which included lone working and health and safety. I now do some calls on my own and double ups [where two members of staff are required to support people] to help me gain confidence." One person said, "They [staff] do know what they are doing I don't have to tell them what to do."

All staff had received training and regular updates in subjects such as but not limited to, infection control, dementia care, food hygiene, supporting people who had behaviours which could challenge others and the Mental Capacity Act 2005 (MCA). The registered manager's training matrix showed that all staff training were up-to-date. One member of staff said, "We are reminded when our training is due and this gives us time to schedule this in between our main care role."

Staff told us and we saw that after at least three months in post staff were supported and encouraged to undertake recognised diplomas in care to better develop their care skills. The registered manager had ensured that the majority of staff had received an update in this subject with plans in place to ensure that all staff received this training. This helped staff to identify and implement additional opportunities for each person to become more involved with their care on a day to day basis. For example, with the decisions staff supported people with such as the time they liked to get up and the type of soap they preferred.

Staff also attended training provided by the local authority and examples of this was the 'Trusted Assessor's' course which had been made available in assistive technology [This is equipment that helps people communicate who are not able to verbally communicate]. This had given field care supervisors the opportunity to gain a better understanding of the equipment available for people to improve their independence. Another staff member told us that as well as mandatory training they had undertaken training on the ways equipment was provided for people from the NHS such hoists and walking aids.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this must be made through the Court of Protection for people living in the community. We checked whether the service was working

within the principles of the MCA. One person told us "I'll tell them what I want and they do it like I want." Another said, "They [staff] always ask my permission or tell me what they're going to do".

We found that the registered manager and all staff had an understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests and in the least restrictive manner.

We saw that each specific decision a person could make had been determined and what information the person could retain. For example, the type of clothes the person liked. Staff understood people's needs well. This was by ensuring that the care provided was only with the person's agreement and in line with the MCA code of practice. For example, staff described the risk people had chosen to take such as not putting on the safety belt when using the stair lift. One staff said, "Although we always help people as much as possible to be careful we can't make them do things. It's their choice." This showed us that staff knew what protection the MCA offered people and also to protect themselves.

People were enabled to choose their preferred meal options. We saw that people were supported to eat and drank sufficient quantities. This included the foods people liked, how and where they liked to eat them and any particular dietary needs. One person said, "I am having my favourite sandwich today." We observed staff ask if people had eaten and drank enough as well as making sure there was plenty for later in the day until staff came back for their next visit. Staff had an understanding of each person's nutritional needs. Another person told us, "They help me serve the meals and then cut my meat up."

Care staff told us and records confirmed that they supported people to access health care professionals including a dietician, tissue viability and community nurses. One person said, "I did have [an accident] which was my own fault. The staff found me and called 999 for an ambulance." The person was confirmed as having only minor injuries. Another person said, "[Staff name] called to check on me. I didn't feel this was needed but I feel safer now." A relative said, "They [care staff] are very good. Even when I am not there staff have contacted the GP when this was needed for [family member]." This showed us that people's healthcare needs were responded to.

Good

Is the service caring?

Our findings

Staff respected people's privacy and dignity and spoke with them in a way that was respectful and compassionate. One person said, "We have a good chat with each other and we do have a laugh." Another person said, "They [staff] mean the world to me. I don't know what I would do without them. They are all wonderful." People confirmed that staff always knocked on their door, made people aware of their presence and gained permission before entering their home. A third person said, "They [staff] do say can I help you or something like that if I'm getting dressed or undressed. They ask what you need before they do it." Staff were seen to take the opportunity to engage in conversation with the person and make them laugh. The person confirmed that their preference of staff was always respected. Staff were attentive to people's requests for assistance, referring to people by their preferred name and talking politely and respectfully with people. A relative said, "Oh they [staff] definitely have a caring attitude. They have a chat about our wellbeing. They ask about who's been (to see them) and about the TV. They look after [family member] very well. They make sure [they are] clean and tidy. They are very respectful. They're all good girls."

Staff described to us people's independent living skills and the care needs people required with their support. One care staff said, "What I like most about my job is the difference I make to people's lives. When I walk in their home and get such a lovely smile it means a lot." Our observations and people confirmed that this was the case. A person told us, "Couldn't wish for anything better, that goes for all of them [staff]. They always stay and chat. I'm very lucky to have such good [care staff]. They respect me and I respect them. Most certainly I couldn't have anyone kinder."

The PIR confirmed that new format care plans had been introduced in February 2015 and these had brought about a more person centred approach. We saw that these new care plans looked at the finer details of the care each person was provided. This had helped people's personalities and preferences to be more clearly identified and met.

Staff responded to people needs, as well as those people who were not able to communicate in a verbal way. This was in recognition of what the person was saying or communicating. For example, by the person writing their choices down. One person said, "I am cared for really well by all of them [staff]. We get on really well." Another person told us, "When they [staff] are going to help me onto my stair lift they count "one-two-three" and then I know I have to move with their help. They always help me do this in a dignified way." It was obvious by staff interactions that staff enjoyed being with people and that this was reciprocated. When staff met with people they spoke with them of their achievements and asked if they had been alright over the weekend.

Care staff described and people confirmed various methods they used to help support people with their privacy and dignity. This included letting people be as independent as possible such as washing their own face. One person told us, "It's just so nice to have someone to say good morning and goodnight to." Examples staff used to engage with people included having a general conversation and explaining each aspect of the person's care. This was by offering reassurance as well as respecting people's independence. Another person told us, "They [staff] make a big difference to my life. They are real value to me. It's like

having a friend coming. My [family member] has been ill for two weeks and if it hadn't been for my [care staff] I wouldn't have seen anyone. I look forward to seeing them."

One person said, "I had a visit from [name field care supervisor] last week. They listen to what I have to say and that's what I like." Another person told us that staff were compassionate and caring and that they knew and liked all their care staff. Care staff told us and we found that where people experienced a family bereavement they would support the person with in an understanding and sympathetic manner that was tailored to each individual circumstance.

We saw and people told us that they were supported in a way which meant the risk of social isolation was minimised. For example, with visits from relatives, friends, community volunteer and religious groups. The registered manager also encouraged people to get out into the community with a taxi or public transport as well as going to a day centre. Other ways people kept in contact with family members was by letter, e-mail and post cards.

The guide book people were provided with when they started to use the service contained information on advocacy. The registered manager confirmed the advocacy arrangements people had in place such as lasting power of attorney for people's financial affairs. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes.

Good

Is the service responsive?

Our findings

People had regular care staff and all reported that they received a weekly staff rota so that they always knew who was coming. Care that was given was recorded in the daily notes. These were used by other care staff who referred to this information to ensure they were up to date with any changes. People's care plans contained detailed information based upon each person's needs for example, if people liked to have a light left on and the type of soap they preferred to use. These plans ensured staff, especially new staff, only gave the required assistance for people to maintain their independence to live in their own home. Staff told us that they found the new format care plans easy to follow and that these could be referred to at any time. This also helped staff identify people's interests and hobbies and how these could be maintained. For example, going to the bank or a day/community centre. People or their authorised representative had signed their agreement to their individualised care.

Care staff were knowledgeable about the individual needs of each person. People, their relatives and care staff confirmed that people were involved in, and as far as possible, determining the person's care needs and wishes. Care plans were completed using an assessment as well as information from the local authority's records. This was to identify what was important to people such as their preferences, values and beliefs. Staff asked people, "would you like a coffee - is that your sachet type or instant?" We observed how people were able to make a choice based on their preference. This also included the staff available to support people to go to church on a Sunday if they wanted to. Where people had communication skills other than verbal, staff were able to communicate through an electronic device which converted text into speech. This supported people with additional independence. Other ways used by staff to improve communication was by speaking to people slowly and clearly or writing things down where people had a hearing impairment. Each situation was centred upon the person and what communication benefited the person the most.

The field care supervisors were responsible for working with a group of staff within the different village areas. We found that as a result of this they had built good working relationships with each person. This helped ensure that any issues that developed were acted upon by the relevant staff. The provider's PIR and staff confirmed to us that referrals had been made and emergency nutritional support had been provided. One relative told us, "They [management staff] come here from the office and discuss the care plan with both me and [family member] usually a couple of times a year."

One person told us that they had been supported by the service for several years. They said, "They [staff] know me so well that I rarely have to tell them anything unless the staff are very new and then I help them a bit. They have to learn somehow." Another person explained to us, "If I ever need to alter my care (call) which I sometime do for weekends, I just need to call the office and they [staff] make the changes in my care call timings. It's never a problem." This showed us that the provider and its staff considered the aspects of people's care that were important to them.

Another way the service responded to people's needs was a system known as 'pass the baton'. This was a system for when people returned home from hospital. Staff obtained important information as to what had

happened to the person whilst in hospital. This system described how people's needs had changed. This helped determine any new equipment requirements and if any additional training was required for staff. For example when a person returned and they required oxygen. Training had been provided and that the appropriate equipment had been put in place. One person said, "If they [office staff] need to call me they use my [preferred means of communication] as I can't get up as quick as I used to." A relative told us, "Oh yes, [my family member and I were both involved in writing the care plan they [staff] come and review it about every six months."

Staff supported people with their pastimes including doing a jig saw, knitting, reading a newspaper or talking and reminiscing about people's favourite memories. One person said, "I wasn't always old and staff are always saying things positively about what I can still do and what I can do with some support." A relative said, "She [staff] encourages and supports [family member] to walk around the flat. That's what I like. She chats with [family member] and knows what she's doing." This meant that people were supported as far as practicable to maintain and improve their levels of independence.

The service had up-to-date complaints policies and procedures in the form of a service user booklet, which each person had been provided with a copy. This included details on how to contact other organisations such as the CQC and the Local Government Ombudsman. People told us that staff provided support where needed and gave them opportunities to raise concerns about their care and that action was taken where required. Each complaint was logged on the provider's system for monitoring any concerns. These were given a priority rating according to the concerns raised. For any serious concerns only an area manager was able to close the complaint once they were satisfied that any actions taken had been effective. For example, in the way people were supported if they became anxious and exhibited behaviours which could challenge others and that the calming measures were effective. A relative told us that there had been various problems, including not getting on with one member of staff and them being late. However, they had spoken with the office staff and changes had been made. They said, "We now have one [care staff] who has been very good. We're moving forward now. They listened and now it's so much better." Reviews of complaints were undertaken to help identify any potential trends. We saw that people's concerns were specific and not of a general nature. The record of complaints we viewed demonstrated that people's concerns and complaints were investigated and responded to.

Good

Is the service well-led?

Our findings

Ways in which people were involved in improving and developing the service was through the EWS system. This system gave the registered manager information more quickly than waiting for people's daily notes to be audited. The EWS was having a positive impact on subjects such as people's nutritional needs and how these were best met. The office staff liaised with third parties such as family members, dieticians or a social worker to resolve the issue. For example, one person told us, "I was unwell a few weeks ago and the staff sorted me out straight away. I now have the [equipment] I need." Another person told us. "They [office staff] called me last week to make sure I was happy with my care and if there was anything else I needed." This showed us that the provider considered ways to identify what worked well for people and where changes were needed. The service's commissioners commented that this service was the first to have achieved a 100% score against the standards that were assessed by them.

The registered manager had completed a strategic review following the result of the six monthly quality assurance survey. This looked at where people who used the service and the staff lived and how to most effectively ensure that as far as practicable people's needs were reliably met and that staff weren't travelling long distances. Staff commented that they now found it easier to get to each person's home as well as feeling less pressured and having time to support people to access the community. This was also supported with access to the Community Navigators. [Community Navigators are local volunteers who help people access activities or services which they would enjoy or find useful]. For example, car schemes to take people to health care appointments. The registered manager showed us an example of a person who previously had not wanted to go out but now attended a community centre with the support of the community navigators.

Strong links were maintained with the local community and this included assisting people to attend a day centre, volunteer organizations such as community church support groups, visit relatives and friends. The registered manager and staff confirmed that people were supported to access and use public transport where appropriate and through people's choice. This showed us that there were measures in place to reduce the risk of people's social isolation.

The registered manager told us and we saw that staff were rewarded and recognised for their achievements. For example, having awards for their standards of work and the differences they had made to people's lives. Care staff told us about the values of the service. These included treating people as an individual. Examples given included supporting people and their relatives with a special birthday party. One relative said, "The staff do things in their own time and without them I couldn't organise [special occasions]." One person told us, "I don't think there is anything they could do better for me. The staff all work well together and do my [housework]."

Staff were supported with supervisions, appraisals and on the job mentoring. Staff team meetings were held regularly and staff were expected to attend one of the two dates offered. Staff discussed general themes such as the sharing of good practice such as understanding of events in the local area and any new training courses that domiciliary care agencies could access. For example, the local authorities MCA and end of life

care training. One staff member said, "Yes, we get given information at meetings but we can also raise any aspects that we feel could be improved." All staff commented very positively about the support that management provided. One member of staff said, "[Name of registered manager] is always asking how I am and I know I can ring them at any time. We have an out of hours' service but if the issue is complicated I can call them [registered manager]. Another told us, "If I ever need support their door is truly always open. I can share ideas or concerns with them even my personal life if it affects my work and [registered manager] listens and acts to help me and my work."

The service had three staff 'care champions' who acted on the behalf of all staff and met with the registered manager regularly. This was to identify any issues that may have arisen and to discuss ways in which they could be resolved. For example, where people's behaviours which could challenge others had escalated due to the person's health and new strategies had been put in place to calm the person.

The provider was in the process of introducing new staff to complete the Care Certificate 2014 as well as other staff completing aspects of their training that was based on this Act. The service and registered manager were also supported by the provider's representatives who visited the service regularly. This was to update staff on any new procedures or documentation as well as where the provider's other services had been merged.

Spot checks on staff's performance were undertaken frequently and these were planned for the whole year. We saw that these checks were to keep in touch with people and also to make sure staff were working to the right standards. They also included staff's adherence to any changes such as those to people's prescribed medicines as well as ensuring staff correctly completed documentation. The registered manager and office based staff also completed some care calls with staff. This was to monitor the day to day culture of staff and offer any advice and guidance needed as well as providing praise on the things staff did well.

Staff were confident and described the circumstances they needed to be aware of if they became aware of any poor standards of care. One care staff said they would "definitely" have no hesitation in reporting unacceptable care. Another member of care staff said, "I feel very confident that [name of registered manager] would take swift action to protect me and the person I care for. They would always support me."

The service had a registered manager. The provider is required, by law, to notify the CQC of certain important events that occur at the service and in people's homes. From records viewed we found that they and the registered manager had notified us about these events where required.

People were at ease with all staff. We heard office staff speak with people in a sensitive and understanding manner. It was clear that people knew the registered manager and the staff team. The registered manager told us that they knew each person by name and made sure they visited people in their homes. All of the people described the management of the service in a positive way. One said, "A very good [registered] manager. They [office based staff] always inquire about me and give me information. I tell them I'm very happy and perfectly satisfied with how they [care staff] look after me." Another person told us, "They [office staff] do a very brief survey by phone, occasionally [if required] they come out to do one. The [registered] manager is very responsive. We have a very good relationship with them." A third person told us, "The [registered] manager's very good. If we need any changes we ring the office." This showed us that the provider considered the continuity of people's care.

People, and their relatives, told us what the provider did well with regard to their care needs. One person said, "There is always going to be the odd little thing to improve. I have never had any issues and I can't think of anything they could do better for me." A relative told us, "Staff going the extra mile by helping in their own

time and being there for my [family member]. I don't know how they have such patience." This helped confirm that the provider and its staff considered and acted upon what people told them.