ICare Healthcare Limited

Good Oaks Home Care (New Forest)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This announced inspection took place on 25 October 2018. We gave the provider 24 hours' notice that we would be visiting the service. This was because the service provides care to people living in their own homes and we wanted to make sure staff would be available to speak with us

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.

When we inspected, the service was providing personal care to 15 people. In some instances, the home care assistant would be a second carer for people who had an additional live in carer.
People and their relatives told us the service was safe and they felt cared for.

There were sufficient staff deployed to meet the needs of people receiving care. The registered manager recruited additional staff before building her client list to ensure they could always meet needs.

People were cared for by staff who had been trained in safeguarding. Staff knew how to report concerns and who to speak to outside of the service about safeguarding.

Comprehensive risk assessments minimised the potential for harm during care provision and in people's home environments.

Every person had a personal emergency evacuation plan (PEEP) giving details how to evacuate them from their home in an emergency.

The provider responded quickly when accidents or incident happened or there were significant changes to peoples care such as a medicine change.

The provider supplied additional information about how to care for clients who had more complex needs and requirements.

People had an initial assessment completed to ensure the provider could meet their needs, this was comprehensive and involved the person and their relatives.

All staff completed an induction and shadowing shifts before starting in their post, staff told us the training was in-depth and fully prepared them for their work.

Staff received regular supervisions and their practice was assessed during spot checks each month.
Staff had a good working knowledge of the Mental Capacity Act 2005 and told us they would ask for consent

before providing care to people.

The provider had received many compliments and when received they were passed to staff concerned. The impact of the compliment was also recorded.

Care plans contained sufficient information to provide person centred care to people. Life history information enabled staff to start relevant conversations with people.

Staff maintained people's dignity by communicating with them in the most effective way and ensuring their privacy was maintained both during care delivery and by not discussing them with unauthorised persons.

The provider issues regular quality assurance questionnaires to people, the feedback we saw was all positive. Staff also completed a questionnaire with nine of ten responses being very positive.

The registered manager read all care notes completed by home care assistants to ensure they had current knowledge of people. The care coordinators and registered manager also completed care calls to maintain their relationships with people and ensure they were familiar with peoples changing needs.

Complaints were thoroughly investigated and if possible, measures put in place to reduce the risk of similar concerns happening again.

We received positive feedback bout the registered manager from staff and people receiving a service.

Staff morale was very good, staff enjoyed their work and felt well supported by management.

The electronic care system provided real time auditing of the service and a full audit was completed every six months by senior management.

The providers values were evident in the practice of both the management team and the care staff.

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 could recognise the signs and symptoms of abuse and knew who to report their concerns to.

Robust recruitment procedures ensured that only staff suitable to work with people were employed by the service.

Risk assessments minimised risks to people and staff when delivering care.

Is the service effective?

Good

The service was effective.

Staff understood the principles of the Mental Capacity Act 2005, (MCA) and asked people for consent before providing care.

Staff completed an induction and annual updates to training to ensure they were working to current best practice standards. Staff were encouraged to complete qualification training courses to further their careers.

People were assessed and regularly reviewed to ensure their care needs were fully met.

Is the service caring?

Good

The service was caring.

People had small teams of carers so could develop positive relationships with staff.

Staff were caring and worked to maintain people's dignity when providing care.

Peoples confidentiality was maintained, staff only discussed people's care with authorised persons.

Is the service responsive?

Good

The service was responsive.

The provider had a complaints procedure and dealt with complaints within specified time scales.

Peoples care plans were person centred and described how they wanted to receive their care.

The provider had developed the service in line with staff recruitment so they could ensure that care needs could always be met.

Is the service well-led?

Good

The service was well-led.

We received positive feedback from people and staff about the registered manager and their professionalism.

Staff morale was very good and staff told us they felt supported by the registered manager.

There was constant monitoring of the service using electronic systems.

Good Oaks Home Care (New Forest)

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 25 October 2018 and was announced. This was because the service provides care to people living in their own homes and we wanted to make sure staff would be available to speak with us.

This was our first inspection of Good Oaks Home Care since it registered with the Commission in November 2017.

The inspection was completed by one social care inspector and one 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 service.

We visited the providers office and the expert by experience telephoned people to speak with them about their experiences with the service.

Before the inspection we checked information that we already had about the service. We looked at notifications from the provider. Notifications are specific events that the provider is required to tell us by law.

We reviewed the Provider Information Return (PIR) submitted by the registered manager. This told us what the service had achieved and what they intend to develop in future. We require the provider to submit this annually and it provides us with information to plan our inspection.

We contacted health and social care professionals to get their views of the service, checked the providers website and a well-known care review website for additional feedback.

We spoke with four people receiving care and three relatives (listed as next of kin) on the telephone, and with six care staff members in person. We looked at five electronic care records and checked the recruitment and supervision records of five staff members. We spoke with the registered manager who was also the nominated individual and a care coordinator.

Good

Is the service safe?

Our findings

People told us they felt safe being cared for by staff from Good Oaks Home Care. One person told us, "the carers are very good, very attentive". They went on to explain "I fell out of bed last night and they came straight away". We asked how he alerted them and he said he "pressed the alarm. I didn't hurt myself, I feel safe with them". Another person told us she feels, "very well looked after. They are always on time". She explained that they receive a rota which is "very helpful" so they know when to expect the carers. She feels she has got to know carer well and vice versa. A relative told us, "It is excellent care…always on time, always give 150% more than they should. We were very apprehensive at the beginning but are all confident with them now".

People were cared for by staff who had received training in safeguarding. We asked staff what signs and symptoms they may see if people were experiencing different types of abuse, they gave us thorough answers and were very knowledgeable on the subject. We asked what they may notice if someone were being financially abused, one staff member told us, "Their cupboards might be empty, not a lot of food in them and their clothing might be looking worn". Another staff member told us that someone experiencing financial abuse could, "be distressed when dealing with money or say they are worried if they are paying bills when you visit". We were given clear and in-depth answers all our questions about safeguarding indicating that the annual training staff received was effective.

The provider had a robust safeguarding policy and procedure which was closely linked with local multi-agency safeguarding procedures. Staff knew who to contact if they suspected a person was experiencing abuse and what to do if they believed that insufficient action had been taken by the provider. Staff were aware they could contact the local authority safeguarding team directly or approach CQC. This information was found in the providers whistleblowing policy. Staff had monthly spot checks completed by one of the care coordinators and when feedback was being given, both whistleblowing and safeguarding were discussed and staff could comment on care plans and concerns they had.

There had been no safeguarding alerts made by the provider since they registered with the Commission and this was confirmed by the records we held.

When care planning, people were asked if they had preferences as to the gender of the person that provided their care. The provider was keen to ensure people had the right support however ensured that protected characteristics of the Equalities Act 2010 were not marginalised as a result.

Peoples care files contained risk assessments to ensure that care delivered to them was safe and potentially harmful situations were avoided. Risk assessments covered the environment people lived in including the outside area. For example, was it an area of high anti-social behaviour was street lighting sufficient and working, and was there parking available? Internal environmental risk assessments checked for residents that smoked, pets, floor coverings and rugs, accessibility and space to complete care tasks, general hygiene and smoke detectors among many other areas.

Other risks assessed included staff lone working, staff transporting people in their own cars, medicines, moving and assisting as well as risks associated with care provided. When relevant the provider also included additional information to aide staff in keeping people safe. There was an information sheet on first aid to be delivered if someone was choking in a person's care file. This was due to them having a safe swallow plan that they chose not to adhere to and to ensure that if staff felt panicked if the person choked they would have clear instructions how to best support them. People who had a history of falls had factsheets from a local ambulance service giving guidance on the actions needed post fall.

The provider had also considered fire safety and as part of their risk management procedures checked peoples smoke detectors regularly and had completed a personal emergency evacuation plan (PEEP) for each person which held current information about the supports they would need to exit their home in the event of a fire, the least risky route through which to exit and where they should go to ensure they were safe until help arrived.

The provider acknowledged in their 'Care and Support Planning Policy' that risks would still exist even when situations were assessed and in fact were necessary. 'reasonable and responsible risks are inherent to quality of life. For any situation that entails risk which is identified during the creation of the plan, a formal risk assessment will be undertaken. This will list and weigh up the positive benefits against the possible adverse effects of the proposed action". The provider ensured that people were kept safe whilst ensuring calculated risks were taken to ensure people had fulfilling lives.

The provider had expanded the service in line with staff recruitment. Care packages were only taken on if there were sufficient staff in place to deliver that care. The registered manager told us they were turning down new clients regularly however had sufficient staff members employed to cover all calls and were also able to cover staff sickness and holidays with existing staff. The registered manager was also concerned that if they took additional clients then staff would feel pressured to cover more and staff wellbeing was also vital to providing safe care. The provider used a computer package to plan care calls which included time between calls to ensure that staff were not rushed in their care delivery.

There was a wide range of staff, different ages, ethnicities, nationalities and genders, and different backgrounds. For example, one staff member had been a teacher, another had become a carer as their first career. We met with six care staff and looked at five staff recruitment and supervision files. We checked to ensure that the provider had completed appropriate checks of staff before they commenced in post. Each file contained an application form, full work history with any gaps accounted for in writing, two references, interview notes, literacy and numeracy skills tests, health declarations and results of peoples Disclosure and Barring Service checks (DBS). The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable people. This ensures that people employed by the service are suitable to work there. In all staff files we checked, necessary checks had been completed and all clearances received prior to staff working with people.

Staff supported people with their medicines offering different levels of support from prompts through to taking responsibility for administering medicines. Peoples capability to manage their own medicines was assessed by the provider and appropriate support added to the care plan. Staff were trained during their induction and their competence was assessed before they were permitted to support people with medicines. If any errors occurred, staff were retrained and reassessed for competence before supporting people again.

The provider had an electronic care system that help electronic medicine administration records (MAR's). On entering a home to commence a care call, staff had to scan a barcode which recorded when they arrived and opened the care record. Medicines required were recorded on the electronic MAR's and as staff administered the medicines they checked each type to confirm it was checked and given. If there were outstanding medicines to be given and staff scanned the barcode to leave the person, the system would notify them to indicate they had not fully completed their tasks. This minimised the risks of staff forgetting to administer necessary medicines.

When we were inspecting, a home care assistant visited the office with details of a medicines change for a person they had visited that morning. They informed the registered manager who immediately telephoned the person as she recognised there was an urgent concern to ensure that the person did not take both the new and old medicines due to both containing paracetamol. Taking both medicines would have resulted in the person taking double the daily dose of this medicine. Fortunately, the person had been advised by their GP, the provider made contact and ensured the person was safe. They also arranged for the care coordinator to visit the person within an hour and update records in the home and remove the old medicines to return to the pharmacy for disposal. The registered manager is also a registered nurse which proved invaluable in this situation.

One person supported by the service needed to have a pain patch applied. The patch contained controlled medicines and staff did not usually support them with this as the district nurse usually applied it. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation (and subsequent amendments), which are closely monitored. In the event there was no nurse to support the person, the provider had gained a letter of permission from the persons GP to enable care staff to apply the patch for the person. They would apply the patch and record its location in their care notes so the district nurse was aware when to position the next patch.

The provider had a robust infection prevention and control policy and provided staff with personal protective equipment (PPE) to use to help them to minimize the spread of infection. When asked, all staff were aware of PPE and when it should be used. One staff member told, "I wash my hands when I arrive and after completing care tasks", another staff member said, "When you have finished supporting people with personal care, you should remove your gloves, turning them inside out and dispose of them".

Care plans detailed where care items such as gloves and wipes should be disposed of. Staff were also knowledgeable as to how to deal with soiled laundry and one staff member had worked slowly with a person to improve the hygiene in their kitchen as when they first supported them it was not suitably clean for food preparation. Staff were provided with gloves, aprons and hand sanitising gel which they collected from the providers offices affording them an opportunity to informally chat with the registered manager and care coordinator.

The provider maintained detailed records of all accidents, incidents and near misses that took place within the service. These records included details of what had occurred, an investigation if necessary and possible, and a clear outcome. In one record, a person had fallen and had been taken to hospital for a check-up. After they had returned home, the person, their family and the provider discussed actions to take if this happened again as they had not liked attending the hospital. In partnership with the persons GP, an advanced care plan was agreed that stated that no future admissions to hospital should be made.

When we inspected, a person had been found on the floor by the home care assistant having fallen. They had not been injured and with support from the person, using an agreed moving and handling procedure, they had been supported to their feet and checked thoroughly for harm. The staff member stayed longer

than the usual time to monitor the person and ensure they were fine to be left. Details of the fall was immediately added to the electronic care record to ensure that all staff that may visit the person were aware what had happened. The staff member attended the providers office later that day to complete the accident form. The registered manager spoke to them and was most concerned about their wellbeing as the staff members was relatively new to caring and had initially been worried when they found the person. In addition to follow up support, whenever possible a second support worker or a member of the management team would attend the incident to support the person and staff.

Good

Is the service effective?

Our findings

People's care records contained full assessments and detailed care plans. People were assessed to ascertain not only their needs but how they wanted their care to be delivered. Preferences as to the gender of support staff were recorded according to whether people would only accept one gender through to them not having any preferences.

People had an initial assessment to ensure the service could offer suitable support. One person had her assessment in hospital. She felt listened to and the care was set up ready for her when she returned home. A relative told us, they had an assessment which they were all involved in. "My sister and I met with the manager and a carer, with mum too".

Staff participated in an extensive three-day induction training course when they commenced in post. This involved completing training courses and work books, as well as being assessed as to their competency in areas such as administering medicines. One staff member we spoke with had just completed their induction training and told us, "[the training] is very thorough. I'm new to care and feel prepared, so you could say the training is good". The staff member was completing shadowing shifts with other care staff so they could become familiar with peoples care and for people to meet them. We saw the staff member request to meet a home care assistant in addition to their planned shifts as they wanted to meet another person they would be supporting.

Staff received update training each year in six training courses the provider had identified as mandatory. These included moving and assisting, safeguarding, health and safety and medicines administration. The provider was also encouraging staff to enrol on qualification training courses so that they could achieve professional qualifications to enable them to progress in their career. Three staff members were completing a level five qualification and one a level three with more staff due to commence qualifications shortly. Staff members were also able to complete a Dementia Friends information session as the registered manager was a champion and able to deliver the sessions. Most staff were 'Dementia Friends'. People and their relatives told us they thought staff were well trained and skilled at their jobs.

Staff participated in supervision sessions with the registered manager on a three-monthly basis. Appraisals took place annually. One staff member told us, "Supervisions happen every three months and I will have my appraisal when I have worked here for a year. The supervisions are really useful, I feel I improve each time I have one". Another staff member said, "They are always useful and its nice as it helps you to feel a part of the team".

In addition to supervisions and appraisals, staff performance was monitored and improved using spot checks. The Care Coordinator would attend a care call with each staff member every month on an unannounced basis. They would check on practical aspects of the visit such as staff appearance, were they wearing their uniform and identification badge, time keeping, moving and handling and infection control procedures such as use of PPE and hand hygiene. In addition, staff were assessed on their ability to interact with the person and their relatives, their work ethic and whether they promoted the persons dignity.

Following the observation, the care coordinator asked the staff member questions about safeguarding and whistleblowing, moving and assisting, infection control and medicines. The checks were thorough and we saw from an overall spreadsheet and staff files that they were completed every month.

Staff prepared meals for people and offered support for them from heating and serving food to assisting them to eat. Care plans such as safe swallow plans from Speech and Language Therapy (SALT) were available for staff reference. People were offered a choice of meals, and staff ensured that additional drinks were left for people so they could have them between care calls. One relative praised staff for ensuring their family member had sufficient drinks to alleviate symptoms of a medical condition.

Most people had a small team of regular care staff. This enabled people to feel more relaxed about receiving care as they could form a relationship with their care team and had the benefit that staff were very familiar with people and were able to see if they had lost weight or were not well. Concerns were recorded on the care system and shared with the care coordinator or the registered manager so that relevant support could be sought, either through people's relatives or directly to the GP.

The electronic care system provided staff with 'live' information about people's care needs. The care coordinator and registered manager added updates to peoples care files on receipt of new information. When a person's medicine changes were passed on to the registered manager, we saw the old medicines collected and care plans updated in less than an hour of the information being received. The care coordinator sent a weekly update email to all staff members. This had to be read and responded to by all staff. We saw the care coordinator speak with a staff member that had not been responding to the emails. Responses had to be received or the staff member would have to attend the office to read the documents such was the importance of staff receiving current information.

Care files held consent forms that had been signed by people. The forms covered an agreement with the care plan which acknowledged that people had participated in compiling it and agreements for sharing information with regulators, for staff to contact their GP's, for first aid to be given and for emergency medical support to be sought. We also asked staff how they obtained consent to provide care. One staff member told us, "I check their care file and check they understand what we will be doing. I will then ask before, during and after how they feel, if they are OK and comfortable".

Staff members had a clear working knowledge of the Mental Capacity Act 2005. The Mental Capacity Act (MCA) provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions 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. Staff could tell us about the five principles of the MCA and how they used them in practice. Peoples care files also contained copies of lasting powers of attorney documentations. A lasting power of attorney (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lose the mental capacity to do so or if you no longer want to make decisions for yourself. Any consents signed by appointed persons were supported with a relevant LPA.

Good

Is the service caring?

Our findings

People and their relatives told us that they felt cared for. One person told us, "[the staff are] kind. They always have little chats with me while I have my breakfast. I'm on my own you see so it's nice". A relative told us, "[person] is as happy and secure as she can be, thanks to their support. They try the very best they can with her. She feels the staff are all very kind, for example, they will take her to her favourite pub for lunch". Another relative said, "The carers are kind and always do that little bit more like tidying around and things. They treat her with dignity. She has got to know them well now".

We saw many compliments received by the provider about the support and care they had provided. One complimented staff on going the extra mile for a person. The staff member had advised the family to call for the GP as the person was not well. The family were extremely pleased with the constant communication from staff particularly as they were not always around. The compliment was conveyed to staff members and the provider thanked the person for their comments. The provider had also noted that the outcome of the compliment was that staff morale was boosted and the compliment was welcome.

Staff told us they did not need to rush when providing care. Care plans detailed how people wanted to receive their care and once they had completed their allocated tasks, staff would generally offer to complete extra jobs such as washing up or tidying round the home.

The electronic care system allowed for travelling time between care calls. Set times were allowed depending on which area the calls were based. This ensured that staff could spend the full time of the call supporting the person. The electronic care system was also designed to make recording care delivered faster than hand writing notes affording staff more time with people.

Staff told us that peoples care plans were well written and provided them with everything they needed to know to support people. A new staff member had been given their first week's rota and had access to the mobile care system application and had read the care plans for people they would be caring for. "I've checked all the care plans and they have everything you could possibly need to know, I read them in advance. There's a personal history, family information, their interests are listed…. I can go in and ask her about her art, her travels and her children, they are very thorough". Another staff member told us they didn't want to be just the carer visiting but a friendly face.

Staff maintained people's privacy and did not share information about people unless authorised to do so. One staff member told us that there were a lot of friendly neighbours asking about one person they cared for. Though they knew people were genuinely concerned they did not share information with them. Another staff member told us there were often family members visiting a person they cared for. When delivering care, the staff member told us they would ensure the door was secured to prevent anyone walking in on them. They would also only share information that the person permitted with their family as well.

Personal care was provided in a way that promoted people's dignity. Care was taken to keep people covered when they were being washed, to give private time if assisting with the toilet and in one instance a person

needed to be monitored while eating as they had a significant risk of choking. Staff would sit in the next room, the person in constant view as the person also did not like staff to watch them eating. Staff could monitor from this short distance and it was acceptable to the person.

Staff also made sure they communicated with people in the most appropriate way. Some people due to their health conditions did not communicate verbally however staff still asked them questions and spoke to them whether they would be answered or not. One person had no speech and staff would either read messages they wrote or look for other communication methods such as gestures or expressions.

The provider ensured that people felt cared for. They gave cards and cakes to people on their birthdays and other special occasions. They also celebrated their staff team's special events and provided incentives such as team spa days. Team meetings were also followed by a team meal to strengthen team bonds.

Good

Is the service responsive?

Our findings

People and their relatives told us the service responded well to their needs. One relative told us that when looking for a care provider she telephoned three companies before Good Oaks Home Care, but as soon as she spoke with the registered manager it was easy to choose. "[registered manager] called me straight back and could see we were in a predicament as mum had moved into the next stage of her life". The relative had felt that the registered manager understood their situation and acted to support them. Another relative sent in a compliment that read, 'Thank you all so much for what you do with [person]. She seems to have settled well into the new routine and that is very much down to the care you give. We are well aware she is not the easiest person to get along with so thank you again'.

We saw, as previously mentioned in this report, that the provider responded very quickly to changes that needed to be made to peoples care plans. The medicines change that the registered manager was alerted to during the morning had been adjusted on the care system and medicines collected and new MAR's provided in approximately one hour.

The provider issues quality assurance questionnaires to people receiving a service. We saw responses from the last survey. All responses were positive and many contained positive feedback comments. The comments included, "The care plan is flexible and as things change we tweak the plan accordingly. For example, focus on food and cooking for a month might be eased off for a while". "Always punctual, never fail to turn up". "The service is excellent". "The quality of the service I receive is excellent and efficient".

Staff surveys had also been completed. We saw ten staff survey responses, nine of which had scored all areas positively including rota, on-call system, giving and receiving feedback and staff benefits.

Staff knew the people they cared for well. One person told us, "We know each other well now. They know my likes and dislikes". A staff member told us she had been shadowing another staff member that week and met a new person. The other staff member had immediately introduced them and mentioned something that the new staff member and the person had in common. This knowledge of people had stimulated conversation between a person and a new carer which had removed any apprehension from the situation and had started the process of a relationship between the person and their carer.

The provider worked hard to remain current with the needs of everyone they provided with a service. Each day the registered manager would read through everyone's care notes to stay in touch with how they were and changes to their needs. Additionally, both the care coordinators and the registered manager would complete care visits, again keeping them in touch with the person and more able to respond to changes in their needs.

The provider had received a complaint, not about the service but from a member of the public who believed one of the home care assistants may have damaged their car when attending a person's home. The complaint was dealt with efficiently by the registered manager, they spoke to all staff members that had attended the persons home during the specified time and agreed an alternative parking area for staff. There

was a clear process and investigation underway and the provider had sought an agreeable outcome.

The service provided palliative and end of life care to people, caring for them at home as per their wishes which were recorded in their care plan. The registered manager was also a registered nurse and they told us this was useful as they may have different priorities than a carer. The provider had close relationships with three local GP surgeries and the district nursing service and worked alongside them in providing end of life support to people. In addition, the registered manager has applied to become a link person with a local hospice.

Good

Is the service well-led?

Our findings

We received positive feedback about the management of the service. When asked if the service was well led, one relative said, "Yes, very well led. Absolutely amazing, very professional". A person who received a service said, "The office is very easy to contact…. I would contact the manager who is brilliant". Everyone that we spoke to would recommend the service to others.

A healthcare professional told us, "My contact with Good Oaks has also been very positive, [registered manager] is always very prompt to return my calls, arrange meetings and is always helpful and trying to accommodate, even when busy. Therefore, I feel the service is well lead, caring, responsive and effective". Another healthcare professional said, "I don't, or never have had any issues using this service when selecting appropriate service providers for my clients, they are always friendly, receptive, open and honest".

The registered manager and care coordinators were also praised by the staff team. One person said, "They are so good, always texting to ask about the slightest thing and they've never not answered the phone. I feel very supported and they have the staff's best interests in mind".
When we arrived to inspect the service, the registered manager had prepared the relevant documents for us to see. In addition, they had a file with evidence for each of the five domains illustrating good practice in each area.

The management structure of the service was clear. The registered manager who was also the nominated individual was supported in the running of the service by two care coordinators. There were eight home care assistants. All staff had clear roles within the service, for example all supervisions were completed by the registered manager and all spot checks were completed by the care coordinators.

Staff members were extremely enthusiastic in their roles and when asked if they thought staff morale was good they all responded positively. One staff member said, "Yes, they are really lovely people who all enjoy their jobs… they are just amazing and enthusiastic". One of the care coordinators told us, "when we spot check staff and give them feedback and praise them for the care or interactions they are really happy with the results".

Good Oaks Home Care is one if a group of services. A senior manager from the head office completes an audit of each service every six months. We saw the first of the six-monthly audits of the provider, all aspects of the service were checked to ensure they were compliant with policy, procedures and regulations. Minimal actions were needed as a result of this audit, for example, some forms had yet to be added to the electronic care system for a person. This audit provided the registered manager with a plan for service improvement.

The provider did not complete additional audits of the service. The two electronic systems used by the provider audited in real time. Staff had to scan in and out of people's homes and the scan to exit people's homes flagged up incomplete tasks such as medicines providing a prompt to staff to complete them. Additionally, a people planner system required supervisions, appraisals and spot checks to be completed. The registered manager had entered all areas that required completion into the system and actions were

added to a list for each user. There were no outstanding tasks on the registered managers list when we inspected.

The provider had a clear set of values that staff worked to. These were 'P.R.I.D.E.'. Professionalism, respect, integrity, dedication and empathy. The values were prominently displayed in the offices and staff we spoke with showed they worked to the values by the way they spoke about people and how they felt about working for Good Oaks Home Care. The companies mission statement 'To be the go-to provider of quality care at home by valuing, developing and rewarding the caring people who work with us', was evident in the support staff had through supervisions, informal support and the encouragement to train and progress their careers in care.

The provider had good local links with healthcare providers. They were mainly known to care navigators in GP surgeries and district nurses. The registered manager was also looking to develop community links by running a Dementia Friends information session in a local venue for community members to attend.