Mr James Malcolm Westcott

Care At Home

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

Care at Home is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older and younger adults and people with a physical disability. The domiciliary care agency office is situated Newport and provides a service across the Isle of Wight.

This inspection was undertaken on the 21 and 28 June 2018. Not everyone using Care at Home received a regulated activity; 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. At the time of the inspection nine people were receiving a personal care service from Care at Home.

Following the inspection in May 2017 three breaches of regulations were identified. At this inspection we found action had been taken to make the required improvements and the service was no longer in breach of regulation.

The provider was registered as an individual provider and therefore did not need a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. The provider understood their legal responsibilities as a registered provider.

Improvements had been made to ensure that recruitment was safe and that staff had a suitable induction and all of the training relevant to their role. The provider's new structures and quality monitoring systems were helping to ensure people received a safe service.

People who used the service expressed satisfaction and spoke highly of the staff. Everyone told us they would recommend the service to others.

Care staff had received safeguarding training and were clear about their safeguarding responsibilities. The provider was aware of their responsibilities and had reported safeguarding concerns when required.

There were sufficient numbers of care staff to maintain the schedule of visits and ensure a high level of continuity for people.

There was an infection control policy in place and protective equipment such as gloves and aprons were provided to staff to minimise the spread of infection.

People who used the service felt they were treated with kindness and said their privacy and dignity was respected. Staff knew the people they provided care for well and understood their physical and social needs.

Individual and environmental risks to people and staff were managed safely and plans were in place to mitigate these risks.

People and, when appropriate, their families were involved in discussions about their care planning and given the opportunity to provide feedback on the service. There were safe medicines administration systems in place and people received their medicines including topical creams when required.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses. The learning from these drive improvements within the service.

Staff asked for consent from people before providing care and understood the implications of the Mental Capacity Act 2005 for their role.

People were able to raise complaints should they wish to and the provider actively sought their views about the service they were receiving.

At the time of the inspection no one using the service was receiving end of life care. However the provider assured us that people would be supported to receive a comfortable, dignified and pain-free death.

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.

Improvements had been made to ensure that safe recruitment procedures were followed. Staffing levels were sufficient to take account of people's needs.

Individual and environmental risks to people and staff were managed safely and plans were usually in place to mitigate these risks.

Care staff had received safeguarding training and were clear about their safeguarding responsibilities. The provider was aware of their responsibilities and had reported safeguarding concerns when required.

There were safe medicines administration systems in place and people received their medicines including topical creams when required.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses.

Is the service effective?

Good

The service was effective.

Improvements had been made which ensured staff received an appropriate induction and on-going training.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

People were supported with eating and drinking where required. Information about healthcare needs was included within assessments and care plans.

Is the service caring?

Good

The service was caring.

People said that staff treated them with kindness and care staff

would undertake additional tasks where appropriate.

People's dignity and privacy was respected at all times.

People were encouraged to remain as independent as possible.

Is the service responsive?

Good

The service was responsive.

People were assessed before their care started to ensure that their needs could be met in line with their individual preferences.

The manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well led

There were improved systems in place to monitor the quality and safety of the service provided.

People and their families were positive about the service and told us they were very satisfied with the organisation and the running of the service.

The provider was aware of their legal responsibilities and acted to meet these.

Care At Home

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 was announced; we contacted the provider two days prior to our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available.

This inspection was conducted on the 21 and 28 June 2018 and 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, we reviewed previous inspection reports, notifications and other information we had been sent by the provider. A notification is information about important events which the service is required to send us by law. We also considered information the provider sent us in the provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people who used the service, three relatives of people who used the service by telephone and visited two people in their own homes. We spoke with the provider, three office staff and four care staff members. We looked at care records for four people. We also reviewed records about how the service was managed, including staff training, staff support, three recruitment records, complaints records and audits completed by the management team.

We last inspected the service in May 2017 when we rated the service 'Requires Improvement' overall and identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service safe?

Our findings

At our previous inspections in November 2015 and May 2017 we found that safe recruitment procedures had not always been followed which had placed people at risk. This was a breach of Regulation 19 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014. We told the provider they needed to make improvements. At this inspection we found action had been taken and the service was no longer in breach of Regulation 19.

Appropriate arrangements were in place to ensure that the right staff were employed at the service. An audit tool was in use to help ensure no staff commenced employment before all essential checks had been completed. Staff recruitment records for three newer members of staff showed the service had operated a thorough recruitment process in line with their policies and procedures to keep people safe. For example, Disclosure and Barring Service (DBS) checks, which would identify if prospective staff had a criminal record or were barred from working with vulnerable people had been completed. Staff files included application forms, previous employment history, health declarations and references. New staff confirmed they had undergone a comprehensive recruitment process and had not commenced employment until all checks had been completed.

Prior to the provision of a care service the provider and senior staff undertook an assessment of the person's needs to determine if the service could meet these safely and to identify risks to people or staff. Copies of completed assessments were seen within care files. Most risks to people had been individually assessed and risk management plans were in place to minimise these risks. Within care records viewed we identified a small number of areas where risks had not been formally assessed however staff were able to describe how these risks were being managed and people and staff were safe. For example, one person had a pet dog. This was noted on their care file and staff described how the risk to staff and the person whilst care was being provided was managed as the dog was not in the immediate area at this time. However, this was not recorded within the care file. The risk of one person receiving their medicines too close together was being managed however the procedures for this were not documented in the care file. The provider arranged for these risks and management plans to be updated as required during the inspection. Other risks posed by the person's home or environment had been assessed. These covered areas such as fire, gas and electric supplies and any risk the environment may pose to staff whilst providing care.

Systems were also in place to manage the risks to staff when working on their own. In April 2018 the provider introduced a new electronic care management system which staff accessed via mobile phones. Part of this included a section whereby care staff could log into the system once at the person's home and this noted arrival and departure times. Should staff not arrive when scheduled an alert was received by office or on call staff who could then contact the staff member to ensure they were safe. This system also protected service users as it helped to prevent missed calls as these would be detected immediately and action taken to ensure people received care as required.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and the level of care they required. The provider told us new care

packages were only accepted if sufficient staff were available to support the person. The provider said "We have turned down over forty packages [referrals for care] in the last year as we didn't have the right staff available." The duty roster showed, and staff and people confirmed, that two staff were allocated when this had been assessed as necessary to meet the person's needs safely. Care at Home had an 'on call system' in place to cover short notice staff absences and respond to any concerns that occurred out of office hours. Improvements to this had been made when the provider had been unable to answer the on call phone on one occasion. Arrangements were now in place, when required, for the provider or a senior office staff member to respond to cover care calls when necessary.

The provider told us staff were now allocated traveling time between care visits and we saw from staff duty rosters this was in place. Staff were very clear that they were not rushed to get to visits and that they had sufficient travel time allowed. One staff member said, "There is enough travel time, I never feel rushed." Another said, "It's usually ok except for unexpected traffic problems." People confirmed that staff usually arrived at approximately the correct time and always stayed for the full length of time allocated.

People told us they received consistent care from staff they knew and care staff were assigned regular visits each day. Office staff produced a rota to record details of the times people required their visits. These were then sent to the person so they knew when staff were scheduled to visit them.

People told us they felt safe. People's comments included, "I feel safe with the staff", "They are very good and we feel safe with them. They wear their badges." and "They [staff] know what they are doing." Family members also told us they did not have any concerns regarding their relatives' safety.

The provider was able to explain the action they took when a safeguarding concern was raised. In March 2018, the local authority safeguarding team requested the provider investigate a safeguarding concern. The investigation was comprehensive and concluded that staff had acted appropriately. Staff protected people from the risk of abuse and were clear about their safeguarding responsibilities. Staff knew how to keep people safe in their own homes, and described the importance of home security. One family member said, "If I'm not here they always make sure the [name of emergency call system] is within reach at the end of their [care staff] visits." Training records showed that all staff had completed safeguarding training which was covered during induction.

Care plans included information as to the support people required with their medicines and who was responsible for collecting prescriptions and disposing of unused medicines. The electronic care planning system included prompts for staff when medicines support or administration was required. Records viewed showed that when staff failed to confirm medicines administration, action was taken to explain why this had occurred such as the person not wanting 'as needed' pain relief. Records showed that topical creams were being applied when required. All care staff undertook medicines management eLearning and the provider undertook an assessment of their competency following completion of the learning module. Annual competency reassessments were also undertaken as per best practise recommendations.

The provider had an infection control policy in place and records showed all staff had completed infection control eLearning in the previous year. Protective equipment, such as gloves and aprons, were provided to staff to minimise the spread of infection. People and relatives told us that staff always wore gloves and aprons when completing care tasks and washed their hands. One staff member told us, "We always have access to gloves and aprons which we always wear when providing personal care." Another said, "If we need more (disposable gloves) we just get them from the office they have loads in there."

The provider encouraged staff to report concerns and safety incidents. There were processes in place to

enable the provider to monitor accidents, adverse incidents or near misses. They informed us there had not been any such incidents since the previous inspection; however, should these occur they said they would undertake a comprehensive, timely investigation, notify relevant professionals such as the local authority and the Care Quality Commission and identify any potential learning or improvements required to promote safety.

Good

Is the service effective?

Our findings

At our last inspection in May 2017 we found the provider had failed to have an induction programme in place which prepared new staff for their role. We also found that staff had not been provided with ongoing training to ensure they had the necessary skills and knowledge to meet people's needs safely. This was a breach of Regulation 18 of the health and Social Act 2008 (Regulated Activities) Regulations 2014. We told the provider they must make improvements. At this inspection we found action had been taken and staff were now receiving an appropriate induction and ongoing training.

People felt staff knew how to care for them. One person said, "The staff are nice and know what they are doing." A family member said, "They [care staff] are good in what they do and are very caring and chatter away to us. We have got into a routine."

Each member of care staff had undertaken an induction programme, including a period of shadowing (working alongside) a more experienced member of care staff. Following completion of the shadow shifts, the provider told us they asked the senior care staff member if the new care staff member was competent before they were allowed to work on their own. If necessary, additional shadow shifts could be arranged. Newer care staff confirmed that they received an induction, which where appropriate such as for staff who had not previously worked in a care role included completing the care certificate before working independently.

The provider had a system in place to record the training that care staff had completed and to identify when training needed to be repeated. Records showed that care staff had completed appropriate training to meet people's needs safely. All the care staff we spoke with told us that they felt they had received appropriate training to help them provide effective care for the people they supported. Care staff said the online training was generally good and confirmed that they also received practical training in subjects such as first aid and moving and handling. Should people have specific health care needs the provider stated additional training to meet those needs would be organised by health staff. For example they told us, which records confirmed, that care staff had received training to support a person who might need emergency medicine due to epilepsy.

Care staff felt they were appropriately supported in their role. The provider had a planned schedule of staff supervision which included staff meetings, one-to-one meetings with individual staff and observation of care staff in people's homes. Care staff confirmed that they received one-to-one supervision with a senior staff member. Staff employed for longer than 12 months had also received an annual appraisal of their overall performance. Care staff said they felt able to contact the provider or office staff for ad hoc advice and support should this be required.

People and their families told us they felt the service was effective and that care staff understood people's needs and had the skills to meet them. People and their families described the care staff as being well trained and said they were confident in the care staff's abilities. A family member told us, "Yes, they seem to know what to do and how to do it". One person said, "Anything that I want done, they'll do it." Another

person told us care staff were willing to provide extra help if they could.

There was no process in place to seek people's permission to gain information about prescribed medicines or past medical history from the person's GP. A senior staff member explained that as all people receiving a personal care service from Care at Home at the time of the inspection had either the ability themselves to provide this information or a relative able to do so they had not needed to confirm information via health professionals. Care files contained details of long term health conditions people had been diagnosed with.

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. We checked whether the service was working within the principles of the MCA.

The provider and care staff demonstrated an awareness of the MCA and had an understanding of how this affected the care they provided. A senior staff member explained that all people receiving a service were able to make decisions about the care that was being provided by the agency. They understood when they may need to use mental capacity assessments and make best interest decisions. Staff had undertaken training in the MCA and described how they offered choices to people, were guided by their responses and were clear about the need to seek verbal consent from people before providing care or support. People and their families told us that staff asked for their consent when they were supporting them. One person said, "They [care staff] ask me if I want a shower or wash and do what I say." Another person said, "They [care staff] do what we ask them to do", whilst another said, "If they are going to do anything different, they will ask for our consent." People had signed consent forms showing they were in agreement with their care plan.

Most of the people we spoke with said they or a relative prepared their meals. Those for whom staff prepared meals were happy with the way this was done and told us they were always given a choice about what they wished to eat and drink. One person told us, "They ask what I want and then get that ready for me." Care plans contained information about any special diets people required and staff were aware of people's dietary needs.

Staff worked well with other organisations to ensure they delivered good care and support. Training had been organised with a specialist nurse to meet a specific need for a person. People were supported to use technology and specialist equipment to meet their care needs and to support their independence where appropriate. Where equipment was required, a senior staff member was aware of how to access this. The electronic care planning system included a process whereby selected health care professionals such as paramedics and GP's could link into the system and access information about the care the person required including their prescribed medicines. This helped to ensure the person would receive prompt and appropriate care based on up to date information.

Good

Is the service caring?

Our findings

People and their families consistently told us they were happy with the care provided by the staff and management team at the service. People's comments included, "We have had four [care staff] with this agency and they have all been very nice. We currently have one [care staff member] who comes most of the time and they are very good and know what they are doing." Another person said, "They [care staff] are very good and helpful." One family member said, "The staff are really good, always happy. They are now like family". Another family member said, "We now just have the one very good carer. Their attitude is brilliant. You would not find a better carer. There is nothing too much for her to do if you ask her." When people and their family members were asked if they would recommend the service to others, each confirmed they would.

The provider told us about occasions when staff had identified additional needs for people and ensured these were met for the benefit of the person even where they were not part of the scheduled plan. For example, one care staff member realised that a person was paying far more than they needed for all the communication services they were receiving. The person did not feel confident about such matters and did not understand what they needed to do. The care staff member offered support and helped the person to locate the cheapest providers for the services needed. This resulted in a significant monthly saving and the person was really pleased that the care worker had helped them. On another occasion, when adverse weather brought the island to a standstill a care staff member walked a considerable distance to a vulnerable person and cleared the path/driveways and made sure they had food and water and other supplies to reduce the impact the snow would have had on the person's day to day living. Whilst one person's informal carer was in hospital, a care staff member voluntarily visited the person, outside of the normal care calls, and made sure they were all right until their relative returned from hospital.

People were cared for with dignity and respect. People told us that all personal care was provided with consideration to their dignity. One person explained how staff always used a towel to keep them covered whilst personal care was being provided. Another person said, "They [staff] treat me with dignity and respect; I have never had to complain." Staff understood the importance of maintaining people's privacy and dignity when providing them with personal care. They described how they would close curtains or doors and ensure people were covered when having a wash.

People told us they received good person-centred care and support. People, and their family members, spoke highly of individual staff members and confirmed they had a good rapport and relationship with the staff who supported them. People told us they looked forward to the visits from the care staff. One person said, "I would not be without them. I cannot speak highly enough about them". A family member said, "The care staff do not rush [the care calls] and always do a good job." Care plans contained information about people's social histories and any cultural needs they may have. For example, one staff member described how they had ensured they did not discuss Christmas or wear festive clothing when visiting a person whose religion did not celebrate this festival.

Often family members were also supporting the person but may not be present when care staff undertook

visits. Systems were in place to ensure they were aware of any changes or care that had been provided. One relative told us, "Although all [name of person] visits are documented on the care staff work phone, they also write in [name of person] care book, which we keep at home, so that we have a hard copy record. This is important to us, as we do not have access to a computer or smartphone ourselves." This showed that the service understood the importance of ensuring others involved in the person's care were kept informed about care that had been provided.

The provider recognised that it was important to people to have continuity of care staff and had worked hard to ensure rosters met people's needs. People told us, and allocation rosters confirmed, there was a high level of consistency in the allocation of care staff. This meant people received care from staff who knew them and how they liked to be cared for. Where requested, arrangements would be made to suit people's preferences.

People were encouraged to be as independent as possible. A person told us how staff supported them to continue to attend to their own personal care needs where they were able to do so and did not 'take over'. A staff member said, "I always encourage my clients; I would make sure that I don't take over." People's care plans contained information about what people could and couldn't do for themselves. Additionally, due to the consistency of the staff, they knew the people they were supporting well and the level of support each person needed.

People were supported to express their views and to be involved in making decisions about the care and support to be provided. People were a central part of the assessment and planning process and we saw they had signed care plans and reviews.

Information regarding confidentiality, dignity and respect formed a key part of the induction training for all care staff. Confidential information, such as care records, was kept securely within the registered provider's office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected and restricted to staff who would require this information. We were told about one person who was concerned about the storage of their confidential personal information on computers so arrangements had been made to keep this to a minimum.

Good

Is the service responsive?

Our findings

People were assessed before their care started to ensure that their needs could be met in line with their individual preferences such as times of calls, gender preferences of staff and religious or cultural needs they had. The information gathered from the initial assessment was used to inform the person's care plan. Care plans included information in relation to people's communication needs, personal care needs, health needs and dietary requirements.

Following assessment by the provider, or a senior staff member, care plans were produced for each person. These had all been reviewed in April 2018 when the new electronic system had been introduced. Care staff told us they were always informed about the needs of the people they cared for and could easily access this via a smart phone app. Care staff recorded the care and support they provided at each visit and a sample of the care records demonstrated that care was delivered in line with people's care plans and their wishes.

People told us that care staff were responsive to their needs and were adaptable if their needs changed. For example, we saw changes had been made to the planned times for a person's morning care visit as they had a hospital appointment and needed to be ready earlier than was usual. The provider described an occasion where a person had fallen and appeared unwell. The care staff member had contacted emergency medical advice and the agencies office to rearrange their next scheduled visit so that subsequent people were kept informed.

Staff knew the procedure to follow in the event of an emergency. The provider had completed a train the trainer course in first aid in 2016 and provided practical first aid training for care staff. The provider had also completed a train the trainer course in fire awareness in 2015 and staff were next scheduled to attend fire awareness training in August 2018.

People were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service. The new electronic care planning system enabled people to indicate their level of satisfaction following each visit which was immediately accessible to office staff. This meant feedback could be related to specific staff and action could be promptly taken should people be unhappy with the service they had received. Feedback was also gathered on an informal basis when the provider or senior staff covered care calls and formally during review meetings. The provider also sought feedback from people and their families on a formal basis through the completion of quality assurance questionnaires which were sent to people and their families where appropriate. We saw quality assurance questionnaires were sent in March 2018 however the number of responses was low. Those that had responded showed that people, and their family members, were happy and satisfied with the overall quality of the service provided. People and relatives described care staff and the provider as approachable and all said they were confident that any feedback they gave about the service would be acted upon.

The service had a policy in place to deal with complaints. This provided information on the action people could take if they were not satisfied with the service being provided. People and family members knew how to complain if they needed to and were provided with written information in relation to this. We reviewed

records of complaints received since the previous inspection in May 2017. Full records had been kept and these showed that complaints were investigated and responded to appropriately.

Although no one using the service was receiving end of life care, the provider gave an assurance that people would be supported to receive good end of life care and support to help ensure a comfortable, dignified and pain-free death. Furthermore, they told us that they would work closely with relevant healthcare professionals and ensure staff were appropriately trained and supported.

Good

Is the service well-led?

Our findings

At the last inspection in May 2017 we found that the provider had failed to operate effective systems and processes to monitor the overall quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found the provider had introduced new systems to monitor the service and this Regulation was now being met.

The provider had a structure in place to monitor the quality of the service. This included a variety of audits such as those for medicines records, care files, staff files and training. The audits were repeated at various intervals throughout the year. At this inspection we found that where we had previously identified concerns with aspects of the service such as recruitment and training action had been taken showing the provider's new quality monitoring systems were helping to ensure a safe service for people.

Since the previous inspection in May 2017 the provider had introduced structural changes within the organisation and staffing of the office. They had recruited new office staff who had been given specific responsibilities related to the running and organisation of the service. For example, one staff member who had previously worked in a training environment was responsible for ensuring all staff completed training whilst another was now responsible for matters relating to recruitment. One office staff member said, "We have a structure now, we each know what we should be doing and the system works better now". Senior care staff were based some of the time within the office but also undertook care visits when required. They were also involved in reviewing care plans and ensuring these were kept up to date.

As well as implementing changes to the organisation of the service the provider had improved the office environment. Although still located within the same office complex they have moved to a larger unit which provided both space for office staff and a private meeting room. The office was fully accessible for visitors who might have a disability.

The provider was present for the majority of the inspection and it was evident from their responses that they were in day to day contact with the operation of the service and clearly knew the people the service supported well. It was also clear they were keen to make improvements for the benefit of the service and people receiving a service from the agency. The provider's vision and values were focused on the importance of putting the person at the centre of what they did and promoting independence. To this end they were working in cooperation with health and social care services to support people to have a prompt hospital discharge whilst having all necessary support in place alongside a focus on the person's rehabilitation to maximise their recovery and independence. New staff were being recruited and trained to enable this service development to move forward.

Policies and procedures were purchased from a national organisation and individualised where needed to reflect the service. The provider told us they received updated procedures on a regular basis. Staff were able to view these at any time via their phone app and were informed when updates to policies were received and were required to review these. The provider was receptive to suggestions as to how the service could be improved. For example, we asked whether care plans might be developed to include additional guidance for

staff on how they might observe early indicators that people with long term health conditions might be experiencing a relapse and require medical intervention. The provider undertook to look at how this could be incorporated into care plans for the benefit of people.

People and their families told us they were very satisfied with the organisation and the running of the service. A comment included, "We have had this agency since last year when the last agency just phoned and said that they were not doing it anymore. This agency is much better." People were aware of who the provider was and most were able to name him. They told us they felt able to raise issues with him if necessary.

Staff also told us they felt that the service was well run and they enjoyed working for Care at Home. One staff member said, "The training is now much better, I know I could work for other places but I enjoy working for Care at Home." Another said, "I like this job, the staff are nice, all of the clients are lovely." Staff reported feeling supported by management and felt that the provider and office staff were supportive and open. For example, comments included, "If I have a problem, it gets sorted straight away if that's possible" and "I've never had a problem. They [management] are all very supportive."

There was a duty of candour policy in place which was followed and understood by the provider who was also aware of their responsibilities and notified CQC of significant events and safeguarding concerns. The provider said, "I promote an open-door policy with all staff, clients and their family members. I understanding what is expected by CQC under this regulation [Duty of candour]. Fortunately, there has not been a need to report any incident that has taken place under this regulation yet, I am confident on doing so should I need to." The ratings from our previous inspection in May 2017 was displayed as required both in the agency office and on the services website.

The provider welcomed feedback about the service. They told us, "I have recently signed up to use a reviewing service that allows our clients and family members to review the care being provided confidentially". The provider identified that this promoted "Openness and transparency to all clients and the public as all feedback will be published on the website and I [the provider] have no control over what is published."