Nest HomeCare Limited

Nest HomeCare - Windsor

Inspection report

Claremont House
70-72 Alma Road
Windsor
Berkshire
SL4 3EZ

Tel: 01753847677
Website: www.nesthomecare.co.uk

Date of inspection visit:
23 May 2018
29 May 2018

Date of publication:
22 June 2018

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

Our inspection took place on 23 May 2018 and was announced.

This is our first inspection of the service since the provider's registration.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to younger adults, older people, and people with physical disability, sensory impairment or dementia.

At the time of our inspection, 23 people used the service and there were 16 staff.

The provider is required to have a registered manager as part of their conditions of registration. 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. At the time of our inspection, there was no manager registered with us.

People were protected from abuse and neglect. Appropriate systems were in place to safeguard people from the risk of preventable harm. People's care risks were appropriately assessed, mitigated and recorded. Recruitment practices and supporting documentation met the requirements set by the applicable legislation. We found appropriate numbers of staff were deployed to meet people's needs. People's medicines were safely managed. We made a recommendation about staff training for medicines administration.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. We made a recommendation about the required evidence for people's enduring and lasting powers of attorney.

Staff induction, training, supervision and spot checks were satisfactory and ensured workers had the necessary knowledge and skills to effectively support people. People's care preferences, likes and dislikes were assessed, recorded and respected. We found there was collaborative working with other community healthcare professionals. People were supported to maintain a healthy lifestyle.

The service was caring. There was complimentary feedback from people who used the service and relatives. People told us they could participate in care planning and reviews and some decisions. People's privacy and dignity was respected when care was provided to them.

Care plans were appropriately personalised and contained information of how to support people in the right

way. We saw there was a complaints system in place which included the ability for people to contact any office-based staff member or the management team. We made a recommendation about compliance with the Accessible Information Standard.

People, staff and others had positive opinions about the management and leadership of the service. There was a good workplace culture and we saw the staff worked well together to ensure good care for people. Audits and checks were used to monitor the safety and quality of care. The provider met the conditions of registration and complied with other relevant legislation related to the adult social care sector. The service had built good relationships with community stakeholders to benefit people who used the service.

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.

Effective systems were in place to protect people from the risks of abuse or neglect.

Appropriate risk assessments about people's care were completed and regularly reviewed.

There were sufficient staff deployed to meet people's needs, and people expressed there was good continuity of care.

People's medicines were safely managed.

Incidents and accidents were reported and investigated.

Is the service effective?

Good

The service was effective.

There were satisfactory levels of staff induction, training, supervision and reviews.

People's consent was obtained and the service complied with the requirements of the Mental Capacity Act 2005.

People's likes, preferences and care routines were well-documented.

The service worked well with other community healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff were patient, dedicated and kind.

People had developed positive relationships with staff.

People were encouraged to participate in care decisions.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care was tailored to their needs.

People and relatives knew how to make a complaint.

The service meets people's communication needs, but can further improve by reviewing the requirements set by the Accessible Information Standard.

People's end of life care was provided in a dignified manner.

Is the service well-led?

Good

The service was well-led.

People and relatives told us the service was well-led.

There was a positive workplace culture with clear organisational goals and objectives.

Staff were involved in the operation of the service and had good access to the management team.

Relevant audits were completed to ensure safe, quality care.

Nest HomeCare - Windsor

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.

Our inspection site visit took place on 23 May 2018 and was announced. We gave the service 48 hours' notice of the inspection visit so that the management team would be available.

Inspection site visit activity started on 23 May 2018 and ended on 29 May 2018. It included visiting the office, observation of care in people's homes and telephone calls to people who used the service. We visited the office location on 23 May 2018 to see the manager and office staff and to review care records, policies and procedures.

Our inspection was completed by two adult social care inspectors. Both inspectors visited the office, and one inspector observed care of people and completed telephone calls with people.

Our inspection was informed by evidence we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office (ICO).

We used 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.

Leading up to our inspection, we sent 33 surveys to gather feedback. This included people who used the service, staff, relatives and community professionals. Only two responses were received and we have not used this information as the response rate was too low.

During the home visits we spoke with two people who used the service and with three care workers. We spoke with another three people and three relatives by telephone. We interviewed three other carers at the office. We also spoke with a company director, nominated individual and manager. We observed interaction between people and staff. We reviewed three people's care records, two personnel files and two medicines administration records.

After the inspection, we asked the manager to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Good

Is the service safe?

Our findings

People and relatives told us the service enhanced safety. One person replied, "Of course" when we asked if the service ensured their safety. Some people had pendant or wrist worn alarms for emergency use. We saw that a person was wearing a wrist alarm and knew how to use it. A relative told us that their family member's package of care was changing to having a twenty-four hour 'live-in' care worker due to safety concerns, such as the danger of falls. Some people chose to use the 'key safe' system that allowed care workers access to a house key via a secure, coded box. This meant a care worker could enter the house even if the person could not reach the front door.

Senior staff told us that risk assessments were reviewed at least every three months or as changes occurred. When we reviewed documentation, we saw that assessments included the person's mobility and equipment needed to facilitate this. For example, a person was "weight bearing" and walked using a stick or Zimmer frame. The person was "not supposed to go upstairs (in their house) as advised by the hospital team." This was to protect them from falling or injuring themselves. In care plans, we also saw a section that asked whether a person had been assessed by a speech and language therapist (SALT) and if they required thickened fluids. This was to ensure the person's risk of choking was reduced. A carer told us that risk assessments included the risk of falls. They also told us that information on "…allergies go in care plans".

Staff undertook safeguarding training and updates as part of mandatory training. All care workers' training was delivered face to face. A staff member told us they were up-to-date with safeguarding training. They gave examples of indicators of abuse and "physical" and "mental" and signs that might cause concern. Another care worker referred to "financial" abuse and what signs they might see to raise an alert. A further staff member told us it was important to be vigilant. They said, "You have to open your eyes." If a person had a previously unreported bruise or mark they would, "Check what's wrong, do the map (body map) and call to the office". Senior staff would advise on any further action.

A care worker told us that changes in behaviour might be a cause for concern, "If their (a person's) behaviour changed to how we normally see them", they would report it. Staff also told us they would report concerns both by telephone and via the care documentation system, which would highlight the issue and be visible to staff at the office. Care workers we spoke with were aware of whistleblowing. A care worker told us, "If I'm concerned (I) would report this."

In care plans we reviewed during home visits, we saw incident forms in the "client folder" for use in the event of an accident or incident. We reviewed the process with the manager and nominated individual. They were clear about the expectations for care workers to report incidents. The nominated individual told us they reviewed and signed off any incident reports. A computer spreadsheet was used to log and track incidents and accidents. There was evidence the management team checked for any trends or themes as to the cause of any injuries.

Sufficient staff were deployed to provide safe care. Care staff worked a range of hours; full time, part time or on a casual basis. Some people required the support of two carers to perform personal care. Some staff

completed home visits as part of a team of two care workers providing support to people with more complex care needs. For example, the team was used when a person required a hoist for mobility and supporting personal care. This ensured their safety. Most people's needs were met by a lone care worker working independently. A person told us that there was an initial assessment of their care needs. The person said, "They (the service) did (complete an assessment). They went through what was expected. It's fine." The nominated individual told us, "We always do a four- week review." A person told us that staff were reliable. They said, "They haven't let us down." A relative told us, "They (care workers) come when they say they'll come." A relative told us that there were, "No problems at all" with the service provided. They went on to state, it was "very good" and staff had "always been on time".

A care worker told us, "With this company it's really good." They added this was because calls were for at least an hour which allowed "plenty of time" with the person. Another staff member told us that the time allocated enabled them to "focus on the person". They told us, "I've got enough time" and could "have a chat" with the person as well as complete the necessary care activities. The staff member added people were, "not feeling that we are rushing".

People's calls were logged using an electronic call monitoring system. Care workers logged in and out of calls using their work mobile phone. This meant that calls could be monitored as they occurred by staff based at the office. Any disruption to the calls was highlighted by the computer system at the office, and the managerial staff would call the person, swap care workers or complete a visit if there was no available staff due to extraordinary circumstances.

Some people who used the service did not require any assistance with their medicines. Two people we visited at home received support with medicines. Some of these were prepared in weekly multiple dosage system packs according to time of day and referred to as the 'pharmacy tray'. Care workers assisted with the administration of medicines from individual prescription packs and monitored dosage systems. Staff told us they either administered the medicines to the person, or prompted them to take their medicines. When the person had taken their medicines, the care workers signed the medicines administration record (MAR).

We saw that MAR charts were completed with no gaps . In the people's care folders, we saw forms for care workers to use in the event of a medicines error. A person told us, "They've got a list (of medicines). They do remind me (and) they do check." When we asked about medicines, a relative told us, "They (staff) do it very carefully." We asked if the relative observed care workers sign the MAR. The relative replied "absolutely". A care worker told us, "I had training here". Training included using the "dosette box" and completing the MAR chart. Another staff member told us that, "It could happen there's a mistake." If the care worker noticed any irregularity with medicines or the MAR chart then, "Even if the client tells you, it doesn't matter, you call the office." Another care worker told us that medicines training included how to administer medicines safely. They said training included, "What you can and can't give" and knowing that medicines "must be prescribed."

We checked how much practical training staff received before being permitted to administer medicines unsupervised. The nominated individual told us the practical part of medicines administration was completed at people's houses with supervision from a senior staff member. Practical training in a simulated environment before assisting people with their medicines did not occur. We explained the prospective risks this posed with the nominated individual and they were receptive of our feedback. We signposted them to national best practise guidance and provided contact details for the local authority and clinical commission group training groups.

We recommend that the service explores methods for simulated training of staff in medicines

administration.

Care worker told us they had completed infection control training. During home visits, we saw that staff used personal protective equipment such as disposable aprons and gloves when preparing to give personal care. A stock was available at the office and staff could collect supplies when they needed to. The service's training matrix showed staff received infection control training. This included how to correctly perform hand hygiene to prevent the spread of infection.

Good

Is the service effective?

Our findings

People told us that staff were well prepared for their roles. A person we visited at home told us care workers were knowledgeable and well-trained. One care worker told us they had a week's initial training. It comprised three days at the provider's office and two days in a care home with nursing. They told us, "Going to the nursing home helped a lot". The care worker referred to the opportunity to become familiar with equipment such as hoists and slings. Initial training was followed by a period of shadowing (a staff member supervising new staff), based on the care worker's needs and prior experience. A relative, whose family member had particular needs related to a neurological condition, told us that the "Four or five 'girls' (staff) we have here are very well-trained and very caring".

All the care workers we spoke with told us they were up-to-date with their mandatory training. One staff member told us, "Everything is up to date." One care worker we spoke with was completing a diploma in health and social care at level three. When we asked about supervision meetings, a care worker told us "I've got a supervisor" and named the care manager. They told us "It's very useful if I have any issue." The service's training matrix showed staff received regular training in a variety of appropriate topics, such as moving and handling, health and safety, food hygiene, infection prevention and control and first aid. Spot checks (unannounced, random site visits) of staff were completed at people's homes to check they received effective care.

In the regulations, personal care only includes, "…physical assistance given to a person in connection with…eating or drinking", and does not include shopping or cooking. There were risk assessments and care plans which were appropriately tailored to the physical assistance of people with their nutrition and hydration. Some people had food and fluid charts where the service identified they may not eat or drink enough to ensure their safety. People's likes, dislikes and preferences about food and drink were recorded in their care documentation.

The staff worked well together as a team to ensure effective care was provided for people. The service also worked with a variety of health and social care professionals in the community. These included people's GPs, local pharmacies, district nurses (where nursing care was needed), an oncologist, social workers, and the safeguarding team. The nominated individual provided an example of one person who required additional support with regards to their physical condition and care needs. The service had effectively worked with the local health and social professionals to ensure the person's welfare.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff had a good understanding of consent. A care worker told us, "We treat our clients with full respect and dignity. Always we have to ask the client (for consent)." In care plans, we saw that people expressed their preference for which staff they wanted to receive support. We saw that a person had a list of 'preferred carers' in their electronic care plan. A person we visited at home referred to such preferences. Staff told us that they had completed training in MCA. Care workers we spoke with understood the MCA. A care worker referred to the "five rules" (or principles of the MCA) and could cite these, for example the presumption of capacity, best interests and supporting people's decision making. They told us, "It's about all the people having the capacity unless proved otherwise." One staff member we asked about this legislation could not recall any details immediately; however they showed us a booklet they carried with them that contained a summary of the key points of the MCA. Appropriate policies and procedures were in place and care documentation demonstrated compliance with the requirements of the MCA.

Good

Is the service caring?

Our findings

At the time of our inspection, there were nine reviews about this service on a popular domiciliary care agency website. Comments from reviews published included, "A very professional organisation with well-trained staff who have taken the time to build a great relationship with (the person)", "The carers show up on time, are warm and friendly and go the extra mile when necessary", "I have been impressed by the kindness and full care given to (the person). The 'girls' from Nest Homecare Ltd are all very friendly, thoughtful and have put (the person) at ease. She looks forward to their calls. They cope with difficulties and demands well" and "I have found the carers that looked after my mum to be very kind and helpful and will give more than 100%. I am so pleased and it gives me and my family peace of mind that (the person) is being well looked after." These comments indicated that the service's staff were caring.

People we spoke with were positive about the care provided. During home visits, we observed positive relationships between people and care workers. It was evident that staff knew people well and were fully aware of their interests. A person told us "I'm very fond of my 'girls'. We have a good old laugh. I've got some lovely carers. They really are." Another person told us, "They vary. There's good and bad in all of them. If they're good, they're in my books!" Another person told us "I've not really had care before. I was a bit apprehensive at first. They've (staff) always been very kind and good." Another person told us, "The people (staff) who come are very good." A relative stated, "The carers are really excellent. They really are. It's made a huge difference. They're very, very nice people. They're very helpful." A further relative told us, "The majority of the 'girls' are very good. Very prompt, very good, very caring."

A care worker told us "I enjoy the job. I look forward to coming to work." They told us that they logged in to a person's care plan (via the care system) even when they were off duty for a period, to learn of any changes. The staff member would then "have something to talk about" with the person. Another care worker told us, "The most difficult thing is that you're working on your own, the responsibility is yours. You have to be very careful." The care worker added that it was important "to make the person comfortable".

As part of our inspections, we check whether people's independence is maintained and promoted and their level of involvement in decision-making. We asked a person we visited if they were assisted to have a bath or shower. They told us, "I haven't been able to for simply ages." We discussed this aspect of care with the person and viewed the bathroom with their permission. It comprised a toilet, washbasin and shower. Due to the person's mobility needs and the layout of the bathroom (which had a raised shower tray and a partitioned area with glass panels) the shower was not currently accessible with the assistance of two care workers. We passed this feedback to the management team to further investigate the promotion of the person's independence. This could involve a professional assessment by the local authority for the feasibility of fitting a 'walk-in' shower or accessible bath. The management team acknowledged our feedback assured us they would explore avenues of increasing the person's independence by contacting social and health care professionals.

Another person told us, "They (staff) give me a bath" regularly, while another person told us that care workers asked if they would like a shower or bath. A relative told us that two staff visited one person and

supported their family member, including having a "shower and change." A relative told us that, "It (personal care) was working well" but that their family member's needs were reviewed by the service they would soon be supported by a 'live in' carer.

People mainly relied on their relatives for providing input into care planning and decision-making, although they were asked for any feedback or changes. We saw that relatives and others could log into the care documentation system at any time, to review risk assessments, care plans and daily notes. This provided a real-time record of what care and visits the person had received. One relative wrote, "There is an online portal which allows us to log in and see the notes from each visit. This was new to us but has proved to be invaluable, we can monitor from a distance (the medicines), eating patterns and general wellbeing." Another relative recorded, "Although the first interview was very long, (the service) had made a note of everything we had discussed and the carer was more than aware of the needs and so she was prepared and able to give excellent care with 'TLC' and common sense." The care documentation reflected both people's input, and that provided from relatives and others. There was good evidence of involvement in people being activity involved in making decisions about their care.

People's privacy and dignity was protected and promoted. Staff described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains when delivering personal care and ensuring that people were covered up as far as possible. All the people and relatives we spoke with told us they were satisfied with their privacy and dignity.

Confidential information about people who used the service, staff and others was protected. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO), as required. The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislative requirements for record-keeping. Records were secured when not in use. In the Provider Information Return, the nominated individual wrote, "(We are) using their (the ICO) online tool for small and medium healthcare business to help guide policies and processes. (We have) regular attendance at data protection conferences, including upcoming GDPR and changes. People's, relatives' and staff's confidential information was protected.

Good

Is the service responsive?

Our findings

All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. During our inspection, we gathered evidence about these five steps by examining documentation, talking to staff, relatives and people who used the service.

People's communication needs were assessed and where they required, alternative means of communication were considered and applied. Care plans provided guidance for staff on how best to communicate with people. To meet the AIS requirements for relevant people who used the service, additional work was required. The service lacked pictorial or symbol-based information which people with cognitive and sensory loss could comprehend. Large print and easy-read information was not in place at the time of the inspection. The service was part of the local authority's assistive technology group, which held quarterly meetings but a relatively new group. This would bring additional tools and techniques that the service could use in care and communication with people.

We recommend that the service reviews the five steps of the Accessible Information Standard.

The provider used an electronic care planning system. We reviewed two electronic care plans at the provider's office. We also saw hard copies of these plans at people's homes. A care worker showed us a third care plan via a program on their mobile phone. Care plans were arranged in sections such as "communication", "medical details" and "hearing". When caring for one person, care workers were advised to "Please speak a bit more loudly than usual." Some personalisation was evident in the "all about me" section. Key information was included in the "digital care plan" section. A relative told us, "They write a lot of notes." A care worker told us, "You have to write exactly what happened at the time you were there." They added that care plans contained "conditions of clients and what you should expect". Another care worker told us that they completed "notes before you clock out" and that "They (senior staff) review it." Care plans were clear and detailed. The "home care support plan" stated how many visits were to be made each day, at what time and for how long.

People had the provider's contact number in their care folder at home. A relative told us that, "They (the service) always address" any issues raised and the provider was "quite happy" to do so. They went on to say, "If we have an issue with care, we tend to pick up the phone." Another relative told us, "I would be 'phoning if there was a problem." In the office, we checked the log of concerns, complaints and compliments. The manager and nominated individual told us they logged any concern immediately, to prevent issues escalating to formal complaints. There was good evidence the management team dealt with issues promptly and recorded any actions they took. There was an appropriate policy and procedure for handling complaints. The policy was also available on the provider's website. We checked our own records and with the local authority for any complaints about the service and found there were none.

Senior staff told us that the service provided personal care for people receiving end of life care. A carer told

us they were "caring for a person with (a life-limiting illness)." Several carers we spoke with were completing a course on meeting the needs of people receiving end of life care. This would ensure the service could care for more people at the end of their life, and staff would have specialised knowledge and skills in palliative care. Staff liaised with health and social care professionals in relation to people's pain management. Care records showed evidence that some people's end of life preferences were documented.

Good

Is the service well-led?

Our findings

There was no registered manager at the time of our inspection. The previous registered manager left their position on 23 March 2018 and cancelled their registration with us. A new manager had commenced in post, but had not applied for registration with us. Shortly after the site visit, the manager applied to register with us. Our registration team will assess the application and make a decision about the registration.

There were times when the service was legally required to notify us of certain events which occurred. We checked our records prior to the inspection and saw that the service had notified us of relevant events. The nominated individual submitted notifications regarding change of directors, changes of management. The provider had complied with their conditions of registration at the time of our inspection.

The service was required to have a statement of purpose (SoP). A SoP documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. The SoP for the service was appropriate and up-to-date. The SoP and provider's website set out a clear and credible strategy to achieve good care for people. For example, service objectives included that people be treated as individuals, care to be offered in a professional way and to ensure continuity of care.

There were strong values about how the service operated, and management had a clear vision about the care offered and provided. The organisational objectives were embedded in a variety of ways, such as regularly speaking with staff about the values, contained in the staff handbook, listed in the electronic care plan system and mentioned throughout policies and procedures. The nominated individual and manager explained the service's and provider's care-related goals, the progress made towards them and plans. A relative told us, "They're very organised. We are very, very pleased." Another relative told us, "I'm here every day of the week. We're happy." A comment on social media stated, "Nest Homecare's main focus is their clients and they want to make sure they are being looked after to their best ability … would highly (recommend)."

There was also a positive workplace culture. A care worker told us the manager had "been excellent" and they felt very supported. Another staff member told us, "We have spot checks carried out by a senior staff member." The staff member felt this contributed to checking how well the personal care provided was in line with the service's goals. Other comments from staff included, "(There is) always someone on call" for guidance if needed, that the management team were "really understanding, really supportive" and another carer told us "I have full support (from the management." One staff member wrote, "(I) have recently join(ed) the team at Nest Homecare. (I) have been made to feel so welcome and very refreshing to know that they really care about (their) clients and staff."

The nominated individual told us that several meetings were used at the service to ensure vital information was shared with relevant staff. The meetings were also used as a conduit for sharing experiences and explaining new concepts or gathering staff feedback. Information was also shared with staff via the mobile handsets used for home visits, text messages and social media. Surveys were completed to check for

feedback from staff. The 2018 results showed staff were satisfied with how management worked and communicated with them and that there was a sense of trust amongst all the employees.

Feedback from people who used the service, relatives and other stakeholders was requested by the service to drive continued improvement of the service. The 2018 survey results showed quality of the personal care provided, with respondents marking answers to questions with "satisfied" or "very satisfied." Compliments were also regularly received by the service. These were saved and shared with staff to provide positive feedback about their work. For example, in January 2018 a relative wrote to the management, "(The person) seems really happy in herself, the care package is working wonderfully, you and the carers are doing a brilliant job. (The person) was really animated when relaying the things she has been up to since my last visit to her." Another relative's comment was, "I will continue to recommend you to anyone in need of caring services. Thanks again for all of your help and support."

A small number of quality audits and checks were used to gauge the safety and quality of care. These were completed regularly according to the area of the service being assessed. There was a medicines administration record (MAR) audit completed monthly by the manager. The purpose was to check for any errors, check that people's medicines were administered in line with the service's policy and to log items for improvement in an action plan. There were also 'client reviews', where the management team looked at specific events and occurrences people may have experienced. The nominated individual told us they examined, "What happened there, how we could do that better and what can we do instead next time." We viewed examples of care file reviews and found these were detailed, comprehensive and listed actions for improvement. This ensured that people's documentation accurately recorded their individual needs and was provided in the right way.

Services are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and providing an apology (including in writing). The service had an appropriate duty of candour policy in place which gave clear and specific instructions for management to follow when the duty of candour requirement was triggered by safety incidents. When we asked the management team, there were no notifiable safety incidents which triggered the duty of candour requirement.

There was evidence that the service linked up with local organisations to benefit people who used the service, but also the wider community. As part of the dementia action alliance, an experienced dementia specialist was based in the local library at the time of our inspection. They were using their knowledge and skills from working at the service to assist the public with questions about dementia. Another example included working with 20 other companies and stakeholders to set up a local group Alzheimer's group in the area.