Exclusive Therapies Limited

Mayflower - Gateway Business Centre

Inspection report

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Date of inspection visit:
16 July 2018
19 July 2018

Date of publication:
11 September 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?	Requires Improvement

Summary of findings

Overall summary

Mayflower Gateway Business Centre is a domiciliary care agency and supported living service covering coastal areas in North Yorkshire and Redcar and Cleveland including Brotton, Goathland and Robin Hoods Bay. Domiciliary care agencies provide personal care to people living in their own houses and flats in the community and specialist housing. The service was not providing any supported living at the time of inspection.

Mayflower Gateway Business Centre provides support for people with a range of needs including those living with dementia, people with learning disabilities or autistic spectrum disorder, mental health and older people. Where the care service supports those with learning disabilities or autism it has been developed and designed in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary life as any other citizen.

The amount of time for care visits ranged from 15 minutes to 12 hours. When we inspected, 44 people were receiving care. Not everyone who used the service received a regulated activity. The Care Quality Commission (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.

The inspection took place on 16 and 19 July 2018 and was announced on both days. The provider was given notice because the location provides domiciliary care services and we needed to be sure someone would be available to assist with providing information for the inspection. We contacted people who used the service and their relatives on 17 July 2018 to ascertain their views.

The service registered with CQC on 1 August 2017. This was its first inspection.

The service had a registered manager in place, who was also the nominated individual and registered provider. They were present throughout the inspection. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had not submitted a Provider Information Return (PIR) to detail what the service was doing well and any improvements they planned to make. This was completed following the inspection site visits. Not sending the PIR when this was requested limits the rating for well-led.

A log of significant events that happened in the service to ensure these were addressed consistently and to review any changes needed as a result had not been kept. The registered manager agreed to keep a record with these details. Audits were not being completed to identify and analyse trends across the service and

show how improvements were made. We have made a recommendation about quality assurance.

Staff worked with families, involving them in people's medication arrangements. Information was shared amongst staff, the person's GP and family to ensure all parties had up to date details and were supporting people safely and effectively. The registered manager undertook to introduce protocols for 'when required medicines'.

An electronic alert system informed the registered manager and deputy manager when key information had not been recorded following care visits for hydration, medicines or security. Alerts were checked to enable any action to be taken. This helped keep people safe.

The registered manager provided us with a health questionnaire on the second day of inspection and had made arrangements for staff to complete these.

Consent was understood by staff. We saw consent forms completed for people that had capacity to agree to their care arrangements. Where documentation had not been completed for one person who lacked capacity the registered manager agreed to action this.

There were sufficient staff to meet people's needs and people received care at their preferred times. Changes were made to people's care visit times to fit with their appointments and family arrangements. People's care took into account their communication needs and how they wanted to be treated with dignity and respect. Care plans contained detailed information about people's care needs and how to support them. Step-by-step instructions helped ensure a consistent approach to more complex care interventions. Staff were sensitive and respectful towards people and their properties. End of life care was recognised as requiring a unique, respectful approach.

Staff received training to equip them for their role. Some staff had 'champion roles' where they had completed additional training or experience in specific aspects of care.

The service was trusted and valued by people and their relatives. We received consistently positive feedback. There was mutual respect between staff and the registered manager. This helped ensure a motivated, high performing workforce.

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.

Medicines were administered to people as prescribed.

Staff were recruited safely and employment checks were carried out before they started work. There were sufficient staff deployed to meet people's needs.

Staff knew how to safeguard people from the risk of abuse or harm.

Risk assessments were completed and an electronic alert system identified when information relating to people's hydration, medicines or safety was missing. Alerts were promptly investigated and resolved.

Is the service effective?

Good

The service was effective.

Signed consent forms were used for people who had capacity to agree to their care arrangements.

People received care at their preferred times and staff supported them to meet their nutritional and health care needs

Staff received training, supervision and support to equip them for providing care to people.

Is the service caring?

Good

The service was caring.

Staff had a respectful and sensitive approach when delivering care to people.

Individual communication needs were understood by staff.

People, their properties and possessions were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans contained detailed information about people's needs and step-by-step instructions for more specialised interventions.

The service was flexible and people's care visits were changed to fit around their lives and their families.

End of life care was recognised as requiring a unique approach.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The Provider Information Return had not been completed prior to inspection.

Robust systems were not in place to record significant events to ensure lessons were learnt and inform continual improvement.

The registered manager and staff respected one another and responsibilities were understood.

Staff were motivated and committed to providing high quality support.

The culture of the service was open, transparent and friendly.

Mayflower - Gateway Business Centre

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.

We gave the service four days' notice of the inspection visit because the location provides a domiciliary care service, supporting people in their own homes. We needed to be sure that the registered manager would be available. Inspection site visit activity took place on 16 and 19 July 2018. We visited the office location to see the manager and office staff. We also reviewed care records and policies and procedures. We made telephone calls to people and their relatives on 17 July to seek their views on the service. The inspection team consisted of one inspector.

Prior to the inspection, we reviewed information we had about the service. We sought feedback from the local authority and three professionals. Initially, only the local authority responded. On inspection we met a nurse, who provided feedback.

The provider did not meet the minimum requirement of completing the PIR at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report. Arrangements were made with the provider to submit their PIR following the inspection site visit. This information has been considered in the report.

During the inspection, we spoke with four members of staff and the registered manager. We contacted seven people and/or their relatives by telephone and visited three people in their homes. One professional involved with a person receiving support from the service spoke with us. A range of records were reviewed during the inspection including the care files for four people, which contained their care plans, daily records

and medication records. We looked at three staff files which included their recruitment, induction, supervision and training records. We viewed a variety of information about the service such as policies and procedures.

Good

Is the service safe?

Our findings

Medication care plans were in place for some people to identify the level of support people required to take their medication. The registered manager agreed they would put information in place to ensure staff were using 'when required' medicines safely and consistently.

Staff worked with families where they were involved with medicines. A relative confirmed that when their family member needed more topical (skin application) medicine they were given plenty of notice in advance to order stock. This showed staff were working with families to share responsibility for medication according to their preferences. People and their relatives told us when there were frequent changes to their medicine doses, updates were communicated amongst the GP, family and staff to ensure all parties were informed and managed medicine safely. People and their families had confidence in staff providing support with medication. One relative said, "They know exactly what medication they are giving. They all know the routine".

The registered manager identified that hospital discharges may present risks as people's medication may have changed but they may continue to use old medication stock at home. To prevent such issues, a 48hour review system was used to check on people's prescriptions and to ensure hospital discharge letters were available. They described examples where this approach had prevented medication issues and supported people to good effect.

An electronic care tasks and care plan system was in place. The system displayed alerts when information for people's hydration, medicines or security was missing in real time. The registered manager or deputy manager checked and investigated any alerts three times a day. This meant where incidents occurred they were addressed promptly. We looked at where medication had been missed and found on each occasion this was due to the electronic care system 'timing out', preventing staff recording the medicine given. This had been checked by the registered manager or deputy manager, who confirmed the medication had been given with the care staff as prescribed.

We looked at accident and incident records. When one person had fallen, staff contacted the emergency services. The person was subsequently referred to health professionals to manage their risk of falls and to provide ongoing support with their mobility. When one person did not receive a care visit as planned, alternative cover was arranged. The incident was looked into by the registered manager, who identified there had been an error with the staff rota. This demonstrated accidents and incidents were managed appropriately and lessons learned to improve practice.

We looked at the recruitment files for three recently recruited members of staff. Appropriate checks, including DBS checks were completed to minimise the risk of unsuitable staff working with vulnerable adults. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands and help reduce the risk of unsuitable people working with vulnerable groups. References were obtained before staff started work and interviews were completed. We saw no health questionnaires had been completed to consider any health issues, which may impact on the staff's ability to

work. The registered manager explained they had stopped doing these when short listing staff in line with equality and diversity legislation. On the second day of inspection the registered manager had developed new health questionnaires, which they planned to ask all staff to complete at the next team meeting. This meant staff's health was being considered to keep them and people they were supporting safe.

Staff rotas showed there were sufficient numbers of staff to support people, with the same members of staff supporting the same people for consistency. People and their relatives felt staff had sufficient time to support them. A relative said, "They are not in a rush and are prepared to give time to things." Staff confirmed they had time to support people safely. They told us if they needed to stay at a care visit for longer than expected, they would make arrangements to allow for this. The registered manager, deputy manager and team leader were supernumerary which meant the service had additional staff cover to respond to emergencies or unplanned events and staff were able to support people safely.

We saw evidence travel time was regularly reviewed and accommodated into the rotas, enabling staff to have time to travel between care visits.

A contingency policy was in place to manage specific emergencies. The service had an on-call system in place from 07:30 - 22:00 daily, which provided a point of contact for people and staff. The registered manager provided emergency cover outside of these hours. The service used a traffic light system to identify which people required care most urgently in the event of an emergency or disruption to the service, including adverse weather. This showed the service could react to unplanned events and operate safely.

Staff understood their safeguarding responsibilities and were aware of different types of abuse such as physical or domestic abuse. They knew to contact the deputy manager or registered manager to raise any concerns or raise any issues directly with the relevant local authority.

People and their relatives consistently told us they felt safe with the staff supporting them. One relative said, "They are very safe when they help with transfers." Risk assessments were used to maintain the safety of people and staff. Environmental risk assessments were in place for people's properties, which identified potential hazards. Staff had a pro-active approach to managing risk and recognised risks may change. For example, we saw one person's care plan stated they felt unsafe when showering. A referral had been made to an occupational therapist to assess their needs in order to identify equipment which would help to keep the person safe.

People's care plans referred to when staff should use personal protective equipment (PPE) for care interventions. We saw evidence of PPE during visits to people's homes. This showed staff were observing infection control guidelines.

Good

Is the service effective?

Our findings

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. Staff were aware of the MCA and the need to consider what information people could remember in order to make a decision. There was one person the registered manager felt may be deprived of their liberty, which would require an application to the Court of Protection to authorise. The service was working with other professionals involved with the person's care and had sought advice on this.

The importance of consent was understood by staff and considered in providing care. A care worker said, "I can't do something someone doesn't want." Signed consent forms were in place where people could consent to their care arrangements. The registered manager agreed to ensure a capacity assessment was in place and obtain copies of the certificates for someone who lacked capacity to evidence their relative had the legal authority to make decisions on the person's behalf in line with MCA.

People's care needs were assessed prior to them receiving a service. During the initial assessment, care call times were discussed. One relative told us, "Care was fixed when we wanted it to be." Where the service could not accommodate people's preferred care times initially, this was changed at the earliest opportunity. This showed people and their families chose their care times. People and their relatives told us their care visits were usually on time and they were offered an explanation when they were late.

All new staff received an induction followed by the opportunity to shadow a senior member of staff. A care worker said they had requested an additional day of shadowing, which had been accommodated. New members of staff then received a spot check, where their practice was observed to check their competency. This showed new staff were receiving support and having their skills reviewed.

We saw evidence of staff having received face to face and e-learning training. The provider had identified all staff should complete training in key areas such as safeguarding, moving and handling and medication within six weeks of staff starting in post. The registered manager explained staff had the option to complete training in specialist areas such as tissue viability (skin care), end of life care or catheter care. This showed staff received training to equip them for care work. Staff told us they were supported to develop their knowledge, skills and experience. One care worker said, "I learned about brain injuries. It's really developed my role and helped me understand what I'm doing." Where staff had been working toward qualifications, they confirmed they were given the time and support to complete this work. This showed the service recognised the importance of staff having knowledge of care needs and skills. One relative said, "They are well-trained and know just how to help." This demonstrated people and their relatives felt staff were equipped to provide care.

Some staff had 'champion' roles, which covered areas such as medication, MCA and equality and diversity. Champion roles reflected where staff had experience or qualifications in specific areas. The registered manager was the medication 'champion' as they had previous experience working as a nurse practitioner. They explained they reviewed people's medicines, checking for any interactions between medications and referring them to their GP if required. This meant staff could share their knowledge and experience with colleagues to support people effectively.

Information about people's food and drink preferences was recorded in their care plans. One person's care plan referred to them liking bran flakes, fruit and yoghurt for breakfast and a fried egg and bacon sandwich at weekends. This showed the person's preferences were understood. The food people consumed during their care visits was recorded by type on their records, for example, carbohydrates. This helped staff to monitor what people were eating and promote a balanced diet. Relatives confirmed their family members had benefited from the support and monitoring with eating and drinking. One relative said, "[Person's] eating and drinking is better; drinking has always been a problem but we can see it's being done."

People and their relatives told us information was shared amongst the staff team. A relative said, "If you say anything to one carer, they're all kept in the loop." Electronic care records meant changes could be made to people's support plans when staff became aware of new information. This helped ensure information was updated in a timely way and all the staff team could access up-to-date details.

People and their families felt staff communicated effectively with them and accommodated their preferred method of communication, for example leaving written notes. A relative told us, "If anything is wrong or out of the ordinary, they always tell me. We keep a good relationship." This showed people and their families were informed of any changes with care and support needs.

When medical attention was required staff arranged this. One person had needed an ambulance and said, "They stayed behind while someone [ambulance] was on their way." When incidents occurred, staff recognised relatives may also be affected. One relative told us, "They came back in their own time to check on me and to get me breakfast." Staff were aware of where incidents may leave others in need of support and were willing to provide this.

When people became unwell staff contacted their GP or informed their relatives. A nurse confirmed, "The carers are really hot at letting me know things. Our relationship with Exclusive Therapies is excellent." This highlighted health professionals valued the communication and links they had with the service, enabling them to support people to live healthier lives.

Good

Is the service caring?

Our findings

People told us spending time with staff helped build relationships with them. One person said, "At the end of their visit we have a drink of coffee and they ask about your life and the weather; I find it quite nice." The person valued having time to get to know the staff supporting them and in return, staff showing an interest in their life.

For another person, how they were supported was important to maintaining their dignity and them accepting care. They told us, "The carers cut up my food away from me. I would be embarrassed if they did this in front of me." This demonstrated that staff understood how to provide support in a way that was sensitive and respectful to the person. The approach by staff had helped the person feel confident and accept their care; "I'm comfortable around them. I don't find any part embarrassing." This showed staff recognised spending time with the person and conversing with them helped build rapport. One care worker said, "It's about them learning to trust carers and that they will respect their dignity."

People told us they valued how staff would offer additional support. One relative said, "The carers often check if there is anything else they can do." Another person confirmed, "I find them friendly and happy, nothing is too much trouble when they are here." This showed staff were committed to assisting people.

Staff described how they would adapt their skills to support people in different ways. One care worker said, "I constantly explain and talk to people." This helped people understand how staff would support them with each care task. When people had difficulty accepting support, staff explained they worked with their family members, who they did accept care from, to observe and learn from them. One relative felt this approach was effective and said, "Mum wasn't enamoured with the care to start with but she welcomes them now." This demonstrated staff adapted and built on their skills to support people.

People's individual communication needs were understood. One relative described how their family member had complex communication needs. They said, "Staff are really getting there with understanding their communication. It's because it's the same ones." This demonstrated staff supported people to express themselves and listened to them. A relative said, "The carers speak to [person] and involve them. They don't talk over them." This demonstrated staff were patient and gave people time to communicate.

When needed, the service advocated on behalf of people. A person had experienced a lot of pain and discomfort when attending a health appointment some distance from their home. The registered manager had worked with the person, their family and relevant hospital staff to consider other options for the person attending the appointment closer to home. This showed staff tried to help people be involved in decisions relating to their medical treatment.

Care plans contained information as to how people wanted their dignity maintained. One care plan documented that the person liked to wear their dressing gown to the bathroom to protect their modesty. Staff understood what dignity and respect meant to different people. One person remarked, "They wash me and treat me with dignity. I've always got clean clothes on." For some people, treating their property and

belongings with dignity and care mattered to them. A person said, "My house is my palace, they respect what I have." Staff recognised what was important to individuals and treated them, their property and possessions respectfully.

Care plans detailed how to promote people's independence. For example, applying toothpaste to a person's toothbrush to enable them to brush their own teeth. Staff understood how to promote independence. One worker said, "If I know they can get up off a chair, I'll encourage them to do it." This demonstrated people were encouraged to maintain their abilities. One person's relative described how their independence had improved with support, which had enabled them to go from four visits daily to one a day within ten weeks of discharge from hospital. The relative confirmed they were involved in deciding how and when to reduce the number of care calls.

Good

Is the service responsive?

Our findings

Staff knew people's preferences. One care worker said, "I know people's routines. I feel confident with this and I know if something isn't right with them." People confirmed their support suited their needs. They had seen their care plans and signed them to show they agreed with the information they contained. Care plans contained detailed information about people's needs and how support should be delivered. Where people required support with specific care interventions, step-by-step instructions were in place to ensure staff provided appropriate and consistent support.

Care plans identified links between people's care needs. For example. One person had experienced a significant change in their health, which had resulted in them losing independence. Their mood and isolation care plan detailed how the person 'continued to struggle coming to terms with their life change.' The impact on the person's spouse, who had taken on a caring role was also acknowledged. People and their families confirmed they were happy with the care provided and that it benefited the wellbeing of people and their relatives. One relative said, "[Person] is a lot happier. It's relieved pressure on the family; it's a lot off our minds." This showed the ongoing impact of changes in people's situations and effects on their wellbeing and relationships were understood.

People felt their care was personalised for their needs. Comments from them included, "The service that I have is what I want." This demonstrated people were involved in their care planning and that their support was person-centred. One relative described how their family member needed assistance with eating in a particular way. The relative said, "It is done the exact way we showed them." The service was responsive to the family's request.

Some people chose to receive support to enable them to access the community and pursue their interests. One person described how the staff shared their interests about motor vehicles and would talk about this with them. They were supported to access local cafes and amenities on a daily basis, reducing their social isolation. The person told us, "I feel great in myself". This showed the support was benefiting the person's wellbeing.

People often needed the times of their care visits to be altered to fit around their appointments and other care arrangements. One relative said, "Things are changed straightaway." For some people, care visits were needed at short notice, for example due to their continence needs. One person told us they were very tired after a hospital appointment and wanted to go to bed immediately on returning home. They explained this was arranged and they praised the staff for their flexibility. The service had been responsive and adapted to changes in the person's circumstances.

A complaints, questions and comments log was in place. It detailed where issues had been raised and the action taken. Complaints were responded to promptly. People and their relatives knew how to complain and felt able to raise any issues at different management levels. One relative recalled that staff had not been providing care in a way the person was used to, impacting on how the person responded to the care. This was fed back to staff, who adapted their approach. This highlighted that any complaints and suggestions

were seen as constructive and actioned.

The service often supported people who required end of life care; no-one was receiving this care at the time of inspection. Staff responded to the unique needs of those people who were at this life stage and recognised that they were in position to discuss their end of life wishes, which other family members may have found difficult or distressing. A care worker recalled a recent conversation they had had with someone who was terminally ill and had started to have these discussions. One member of staff described how when a person was receiving end of life care, their needs and ability to communicate changed. They learned to understand the person's non-verbal communication and said, "We learnt their facial expressions as to what they did or didn't want." This showed staff responded to the change in needs and adapted their approach accordingly. Staff acknowledged that the families of those approaching the end of their lives may need support. They told us, "It's not just the patient we're looking after, it's their other half." This demonstrated staff were sensitive to the situation as a whole and recognised the impact on all those involved with the person. A nurse said, "They go above and beyond, especially when people need end of life care."

Requires Improvement

Is the service well-led?

Our findings

The provider did not meet the minimum requirement of completing the Provider Information Return (PIR) at least once annually. This contains details about how the service is operating, its achievements and any improvements it plans to make. The registered manager explained they did not feel the emails from the Care Quality Commission (CQC) requesting the PIR provided sufficient explanation as to what information needed to be completed electronically. The registered manager completed the PIR following the inspection and we checked this information against our findings on inspection.

We asked the registered manager how they would know when accidents and incidents occurred and any medication omissions/errors. They advised they knew this information from memory. Whilst any incidents were addressed at the time and action taken, we could not be sure the registered manager could refer back to these incidents to ensure a consistent approach and consider any wider learning that may be needed to help the service improve. The registered manager agreed to consider keeping a record to provide an overview of any significant events that occurred in the service.

Audits were not completed to identify any patterns or trends across the service and to develop plans to address them. Late calls were not routinely audited to identify and analyse this information. The registered manager advised a sample of late calls was looked at when this was requested by local authority commissioners. The quality assurance policy and procedure referred to assessing people's needs and their care plans. It did not detail how quality would be reviewed across all aspects of the service, including late calls. This meant we could not tell what information the registered manager was using to consider what improvements they wanted to make. In light of this we recommend the provider reviews their quality assurance policy and practices.

The service used spot checks to observe and monitor staff. These were completed at regular intervals. At the time of inspection, there was no system in place to track when spot checks were completed and which members of staff had been observed. The registered manager advised they would develop this.

There was mutual respect amongst staff at the service. The registered manager spoke highly of their staff. They told us, "I have fantastic carers, I would be happy for them to look after my Mum." Staff confirmed they felt their work was valued. One member of staff said, "It was nice to get some positive feedback from the registered manager. It's nice to feel you're making a difference." Another care worker said, "We go above and beyond because we want to." This demonstrated that staff felt valued and this helped motivate them.

Staff told us they felt supported by their colleagues. A care worker commented, "I was put in a team that was really friendly and helpful. They would give me advice if I needed it." At the time of the inspection, the service was experiencing difficulties with staff sickness. The additional demands this had placed on staff was recognised by management. Despite the pressure, staff felt a positive culture was maintained at the service. A member of staff said, "We've all pulled together and you go home feeling I've done the best I can for people." This showed the service could cope with additional stresses and staff continued to feel motivated.

The service was valued by people and their relatives. We received consistently positive feedback about the staff and support provided. Comments included, "They've all been very nice people, extremely pleasant." People and relatives praised the registered manager. One relative told us, "I had complete trust in them right from the start. They're wonderful." This highlighted that people and relatives felt the service had a positive, open and transparent culture and that it achieved good outcomes for them.

The service had a management structure in place. There was a registered manager, deputy manager and two team leaders. The registered manager and deputy regularly visited people in the community. They both recognised the importance of having a visible presence and leading staff by example. Staff knew to ring their team leader as a first point of contact should they need advice or assistance; they described receiving helpful guidance. Staff knew other senior members of staff were available and felt able to escalate matters to them if needed. This showed the service had a governance framework in place where responsibilities were understood.

When concerns about staff conduct and performance were identified, we saw disciplinary action was used fairly and proportionately. We saw a record where the registered manager had met with a member of staff to discuss issues and put in place support and monitoring to help the care worker improve their practice. When a more serious incident had occurred with a member of staff, they were dismissed. The registered manager ensured staff took responsibility for their actions and used any information of concern to drive improvements in staff performance.

A satisfaction survey for people and relatives was completed on a three-monthly basis to obtain their views on the service. The survey used a scale to score staff on four areas including their attitude, professionalism, appearance and approach. This showed the service was continually reviewing staff performance.

The service used benefits to help staff retention. For example, the provider had their own cars for staff use. The registered manager explained this was due to the rural area the service covered and the demands placed on staff's own cars. This helped prevent vehicle or transport issues impacting on staff's ability to get to care visits.