Beam Bug Limited

Caremark (Chichester)

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?	Requires Improvement

Summary of findings

Overall summary

Caremark (Chichester) is a domiciliary care agency, which provides personal care to people living in their own houses or flats in the community. The registered office is on the Chilgrove Road near Lavant outside of Chichester in West Sussex and provides a care service to the surrounding areas. At the time of our inspection the service was supporting 50 people in their own home who had a mixture of needs. This included people living with dementia, older people and people with a learning disability.

The service had a new manager in post who had commenced their employment in May 2017. They had yet to register with the Commission. 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.

People and their relatives told us they felt safe receiving care from staff in their own homes. Some people received support with their medicines. We observed and records confirmed medicines were mostly managed safely. However, one incident involving a person who had missed their medicines had not been referred to the local authority safeguarding team for their review. The manager completed the incident report retrospectively and we made a recommendation and have discussed this further in the Well-led section of our report.

Staff supporting people in their own homes, had been trained in safeguarding adults at risk and could describe different types of abuse and what action they would take if they were concerned.

Risks to people were identified, assessed and managed appropriately. Care plans provided staff with guidance on how to support people and mitigate risks. Staffing levels were assessed based on people's needs. People and staff felt there were sufficient staff and were supported at the agreed times. Safe recruitment practices were in place.

Staff had completed training in a range of areas considered essential in order to look after people effectively. New staff completed the Care Certificate, a universally recognised qualification. Staff were encouraged to study for additional qualifications such as diplomas in health and social care. Staff had regular supervision meetings with their line managers and attended team meetings. Staff had been trained in mental capacity and worked within the principles of the Mental Capacity Act 2005.

Some people required support at meal-times and the staff team met those needs with flexibility. Staff were able to support people to access a range of healthcare professionals when needed.

People were supported by kind and caring staff and spoke positively of the relationships that had developed. People were encouraged to be involved in all aspects of their care and to express their views. They were treated with dignity and respect by staff.

Care plans contained personalised information about people that was responsive to their needs. Information included people's personal histories, likes, dislikes and preferences. Complaints were managed in line with the provider's policy.

People were involved in all aspects of the service and their feedback was sought through the completion of an annual survey. Responses were positive. Staff felt supported by management team and were asked for their views on their employment through an annual survey. People spoke of the good quality care they received and of the caring staff team. A range of systems was in place to measure and monitor the care delivered and the service overall.

Since our inspection the manager has left the service and the deputy manager has achieved the post of manager. The provider has informed us the new manager will be applying to register with the Commission by the end of August 2017.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were trained to recognise the signs of potential abuse and people felt safe receiving care in their own homes from the service.

Risks to people were identified, assessed and managed appropriately. Guidance in care plans was available to staff on how to mitigate risks.

Staffing levels were sufficient to meet people's needs and safe recruitment practices were in place.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had completed training in a range of areas which supported them to care for people effectively. They had regular supervision meetings and attended staff meetings.

The registered provider was working within the principles of the Mental Capacity Act 2005.

Some people were provided support to maintain a nutritional balanced diet and people had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

Positive, caring relationships had been developed between people and staff.

People were encouraged to express their views and to be involved in decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans provided care staff with personalised information about people and their support needs to enable them to carry out their role and responsibilities.

The service routinely listened to people and their relatives.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Requires Improvement

One aspect of the service was not consistently Well-Led.

On one occasion an incident was not reported at the time to the West Sussex safeguarding team.

People, relatives and staff were asked for their views about the service and responses were positive.

A range of systems was in place to measure and monitor the care delivered and the service overall.

Caremark (Chichester)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 June and 3 July 2017 and was announced.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by one inspector 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. This expert-by-experience had experience of dementia care, domiciliary services and other care environments.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR, the previous inspection report and other information we held about the service. This included statutory notifications sent to us by the previous registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. In addition the Care Quality Commission had sent questionnaires to people using the service to gain their views on the care they received from the service. We reviewed 14 responses from people, five responses from staff and two responses from community health and social care professionals. We used all this information to help us decide which areas to focus on during our inspection.

On the first day of our inspection, we shadowed a staff member whilst they made care visits to four people in their own homes. We were able to chat with people and observed how they were supported by staff and we looked at their daily files. We visited the registered office where we met separately with a care co-ordinator, who amongst other tasks organised rotas and care visits to people. The care-coordinator also provided direct care and support to a group of five different people living in their own homes throughout the week.

We also met with the deputy manager and the provider. On day two of our inspection we met with the then manager of the service who has subsequently left. The expert-by-experience spoke with nine people over the telephone who used the service and three relatives to gain their views on the care and support they received. Shortly after our inspection we wrote to a social worker who had been working with the service, they provided their professional view on services received.

At the registered office we spent time looking at four care records, medication administration records (MAR), complaints, accidents and incidents records, surveys and other records relating to the management of the service. We read three staff records, this included staff recruitment documents, training, staff memo and staff meeting minutes. We also checked to ensure supervisions and appraisals with staff were being carried out by the provider.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe receiving personal care from the service. One person said, "I am safe with my carers, I have confidence in them". Another person told us, "I am absolutely safe being cared for by regular carers who I call the A team, I do not know what I would do without them". A third person said, "I have a different carer every day, they are all brilliant. I am thrilled with them". A fourth person said, "They do what I want them to do. I couldn't ask better than that".

Staff had been trained to recognise the signs of potential abuse. They could name different types of abuse and knew what action to take if they had any concerns about people's welfare and understood the provider's whistleblowing policy. We asked the care-coordinator, who also had an additional role as a care worker, what would make them have concerns about a person they supported they told us, "If a person didn't seem the same or if they seemed frightened".

Risks to people were managed so they were protected and their freedom was supported and respected. People's risks had been identified and assessed appropriately. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments provided guidance to staff on how to support people safely. We looked at risk assessments within people's care records. Risk assessments were in place for areas such as skin integrity, falls and moving and handling, medication, showering/washing, nutrition, hydration, Each risk assessment highlighted the task, the assistance needed, any personal risk factors, equipment required and hoist information. For example, one person required the support of staff members to move them safely and the risk assessment clearly defined how this should be achieved. Risk assessments were reviewed annually or sooner if the need arose. This included changes to the care the person needed or the introduction of a new piece of equipment to support the person to move safely.

The service offered different time periods to people using the service when staff would be expected to attend a care visit. For example, breakfast morning calls would be between 7am and 10am and evening calls were offered between 7pm and 10pm. People and their relatives told us there were sufficient staff working to meet their needs, they had their preferred times with staff they liked and felt confident with and calls were on time. One person said, "They are usually on time and if they are going to be late will ring and let you know". Another person told us, "I never feel rushed by carers; they take time and trouble to make sure I am comfortable when receiving care and are so gentle". A third person said, "Usually the girls ring to say if they are running late and the office also call". Whilst all people told us a care call had never been missed one person told us they had on one occasion received their breakfast call later then 10am and their evening call earlier than 7pm. We shared this with the manager who agreed this was unacceptable and wanted to look into it further to ensure all people received care calls at times they were happy with. The care-coordinator told us they worked hard to ensure people received their care when they needed and wanted it, they said, "To make sure everybody feels safe in their own home".

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm

their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting.

People had various needs regarding the level of support required with their medicines. For example, some people required a minimal prompt to check they had taken them from the staff visiting them. Others needed support from staff with every stage; this included the ordering of prescriptions and administering of medicines. Care records provided guidance on how people wished to receive their medicines. This included any associated risks and how they could be minimised to guide staff on how to administer medicines safely to them. Staff records contained details of medicine administration training provided to staff and routine checks carried out to ensure staff were competent with this task. People's medicines were stored in their own homes and staff would make a care call to support them with taking them at various times throughout the day and evening. We observed the staff member we shadowed administer medicines to people in their own homes. The staff member was sensitive in their approach and explained to people what they were doing including what the medicine was called and what it was for. Some people required support with topical creams for various skin conditions. Not always was this included on the Medication Administration Record (MAR). This was discussed with the manager who responded promptly to check this oversight. Shortly after our inspection they wrote to us to confirm they had checked all MARs and assured us topical creams were already added or have since been added. They also told us a reminder of the need to do this had been given to all staff supporting people with their medicines including topical creams.

We read a selection of MARs during our inspection within people's homes and on the service's electronic system. In the main MARs showed people received their medicines as prescribed and the MARs were audited at the office to identify any errors on a routine basis. Any errors identified were highlighted and the manager or allocated person in the office addressed any actions or learning taken from the error. For example, if a staff member had failed to sign the MAR or the wrong coloured pen had been used such as blue rather than black. However, whilst visiting one person in their own home we noted they received medicines from a blister pack and boxes and they had a care plan which included the need for staff to administer medicines to them. We found they had not received one of their boxed medicines which was an anti-anxiety medicine for four days in June 2017. Staff had overlooked the boxed medicine had ran out and it took longer than it should have for the prescribed medicines to be administered again. We discussed the incident with the staff member, who we were shadowing, who told us the management team were aware of the incident as staff had reported their concerns to the office. The deputy manager was able to confirm they were aware of the incident and told us medical advice had been sought at the time to consider any side effects from the medicine not received and the person had not suffered any side effects. We spoke further with the manager who confirmed on this occasion there had been a breakdown of communication in the office. They also told us the incident had not been raised with the local authority safeguarding team for their review at the time. By the end of our inspection, with the person's consent, the manager organised the boxed medicine to come in a blister pack. They felt this would minimise the risk of a repeat of the incident as the medicines would now all be in one place.

Good

Is the service effective?

Our findings

People received support from staff who had been taken through a thorough induction process and attended training with regular updates. One person told us, "They are well trained, they know just what to do for me". Another person said, "They are efficient and dependable". A third person commented, "Carers seem to know what they are doing, I have seen nothing to suggest they are not well trained". A fourth person said, "I can't fault my team". A relative told us, "I am positive they are all well trained, they are exceptional and do everything well".

All new staff attended an induction, which included moving and handling, safeguarding adults and medication training. This was followed by shadowing more experienced carers. The induction incorporated the Care Certificate (Skills for Care). The Care Certificate is a work based is a work based achievement aimed at staff that are new to working in the health and social care field. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment. The induction period also included competency assessments to ensure staff were ready to undertake their care duties in the community. In addition to the training provided, the deputy manager carried out unannounced 'spot check' visits on all staff approximately every six weeks. The deputy manager was responsible for supporting staff in the community and providing a link between care staff and the office. They also stepped in and covered care calls if a need arose. During spot checks the deputy observed how the staff member carried out their role and responsibilities on that particular care visit. Two staff meeting opportunities had also been provided to all staff since the new manager had been in post. This was an opportunity for staff to come together and discuss work related issues. The two staff meetings had taken place on 24 May 2017 to ensure the same opportunity could be provided twice on one day to allow staff to attend who worked various hours. Discussion points included a pending CQC inspection and a booked dementia friends session. Staff meeting minutes were made accessible for staff who were unable to attend. In addition a 'staff newsletter' was collated by the office team to ensure all staff were presented with important updates at the same time.

There were 24 staff employed by the service supporting people in their own homes. Fifteen staff had completed a National Vocational Qualification or were working towards various levels of health and social care diplomas. These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard. Staff complimented the training and support provided from the management team. The care coordinator told us, "I have enough training and support which includes supervision every three-six months".

Overall people and their relatives were very satisfied with staff, their training and their ability to implement what they had learnt whilst supporting them. A relative was happy with the care their family member received however felt the staff, "Could do with more dementia training". A social worker who had worked alongside the service for a year wrote to us and said, "I think overall they have provided a good/satisfactory service over the past year but would benefit from developing their skills further working with people with learning disabilities". They added, "I would consider using their services in the future". Training records

checked provided details of staff undertaking training on the topics mentioned such as dementia and learning disabilities however, we fed back the comments made to the manager to ensure they reviewed staff's understanding of dementia and learning disabilities".

People were involved in making decisions which related to their care and treatment. When we visited people's homes, we saw people were offered choices by staff. Consent to care and treatment was sought in line with legislation and guidance and this was reflected in care records. 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 MCA 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. Best interest decisions made on behalf of people who lacked capacity were made by health and social care professionals, the manager and team and the relevant family members. Staff received training on the topic and understood how consent should be considered. They told us most people they supported had capacity to make decisions about their daily care needs. However, if they identified any changes to people's ability to make decisions about their own care they would highlight the concern to the manager.

People were assessed to identify the support they required with food and drink and care records reflected this. Nutritional assessments were carried out and staff completed various documents relevant to the individual support, which had been provided on each care visit. Support provided with meals were flexible depending on the needs of the person. This included supporting the person with their breakfast, cereal or toast or cooking main meals or heating up, "Ready meals". People spoke positively about the support they received from staff with their meals. One person told us they only ate one meal a day which was breakfast which the staff prepared, they told us, "Carers are aware of this and nag me about it". The person appreciated the support staff tried to give however, this was their routine and were pleased staff respected their decisions. We observed a staff member supporting three people with their meals in their own homes. We observed choices were offered and people were involved about what they ate. One person was receiving support with their breakfast the staff member asked, "Have you had any breakfast yet", the person responded, "No" so the staff member went about asking them what they would prefer and made it for them. Mostly, nutritional assessments were detailed and provided staff with the guidance needed however whilst reading records at the office we noted one assessment lacked the detail required. The manager agreed with this and organised for a review of the person's specific needs to ensure they were accurate and up to date.

People felt confident that staff could manage their healthcare needs if needed. The support provided would vary depending on a person's needs; some people or their relatives were able to book and attend their own health appointments. People told us the staff team accommodated changes in care visits when there was a need to ensure they accessed health appointments on time. One person told us they had an earlier than usual hospital appointment and the office organised for a staff member to support them to be ready and "Prepared before the ambulance", picked them up. Where healthcare professionals were involved in people's lives, this care was documented in their care plan. For example, we noted that GP's and district nurses were involved with some people's care.

Staff informed the office of any concerns and documented any changes in people's daily files which highlighted the issue to the next staff member on the next care visit. People gave us examples of how staff contact either a person's GP or dialled 111, which ever was the most appropriate at the time when they became unwell. For example, recently one person had a raised temperature, their GP was contacted and the necessary advice given. One person, who was prone to pressure sores, told us how vigilant staff were in checking their body on the morning and evening call to assess if there were any areas on their skin of concern. They told us the staff would contact the district nurse as and when required. Another person, who

we visited in their own home, had in June 2017 experienced a fall. They had returned to their own home and had been seen by a physiotherapist the same day of our visit. We observed the staff member contact the office to inform them a list of exercises had been left by the physiotherapist for staff to support the person with. This meant the office could ensure the change to the person's care could be communicated to all staff who needed it. The same person told us they enjoyed the company of the staff and said, "I look forward to them coming".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed staff knew people well and people appreciated the time and care they gave. Staff were sensitive in their approach and informed the person what they were doing throughout the care visit. One person said, "My carers listen to me and are always so kind. When they have finished my care, they bring me downstairs and we sit and have a coffee together and chat before they leave". Another person said, "My carer is able to tell how I am as they me so well and know when to encourage me to have a rest". A third person told us, "I have different carers and am thrilled with them all, having them to help me and have a cup of tea with me is the loveliest thing and I appreciate it very much". Relatives also made positive references to how happy they were with the caring approaches used by the staff team. One relative said, "The carers are a lovely bunch. My [named person] looks forward to them coming". Another relative told us, "I am very pleased with everything the carers do". People and relatives extended their appreciation to the office staff and told us they were both polite and helpful.

One person told us, "They (staff) have been wonderful". They could name all the staff that visited them and told us they were happy with any of them providing care to them. Care plans recorded people's personal histories, their likes, dislikes and preferences. It was clear from our observations that staff knew people well. One person's care plan made reference to the, enjoying hymns and singing. They told us, "We have a good laugh and a good sing". The staff member supporting them told us, [Named person] likes to sing hymns".

People were encouraged to be as independent as they possibly could be. Staff offered people choices regarding the care they received. This included what they wore and what they ate and drank. People were able to decide the gender of the staff member providing their care and people said the service supported this. Two people told us they had told the office when they had not wanted a particular staff member to return and the office had respected this. One person told us, "They encourage me to do what I can for myself and respect my wish to be independent".

People told us they were supported to express their views and were involved in decisions relating to their care, treatment and support. People were aware of daily files which were in their homes and what they were for. They included contact information, their care plan and other daily monitoring health forms pertinent to the individual they were being written about. Care plans showed that people were involved in reviewing their care plans and people had signed them to confirm this. One person who we visited in their own home was so pleased with the support they received from one staff member they told us they wanted them to come all the time. The staff member told us they were part of a core team who supported the person which meant the person had been listened to and their request had been honoured.

People were treated with dignity and respect and had the privacy they needed. We observed staff knocked on people's front doors and waited to be invited in before entering. If they had to enter as the person may not have heard we observed they entered cautiously whilst introducing themselves which was respectful and avoided surprising people who lived by themselves. The care coordinator told us it was important to be, "Be respectful, friendly and kind".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person told us, "Carers know me and what I like, they are kind but not patronising, they allow me to do what I want". They added, "During my review we discuss what additional help I might need". Another person told us, "Managers listen to me and review meetings are usually positive". A third person said, "They (staff) are very supportive, they recognise my situation".

Each person using the service had a care plan. This was kept in the person's home and a copy at the office. Care plans provided information about people in a person-centred way. The essence of being person-centred is that it is individual to, and owned by, the person being supported. A person-centred approach to care focuses on the person's personal needs, wants, desires and goals so they become central to the care process. People's needs take priority. We found people's physical, emotional and well-being needs had been considered when care had been assessed and reviewed. Items highlighted within care plans covered many areas depending on the person's needs. For example, one person's care plan included a summary of the support they needed from staff. Information was provided on their personal history, interests, goals and objectives. We read that the person used to enjoy painting and was a keen artist. Another person's care plan read, 'I would like carers to ensure I eat and drink' and it focused on the support they needed in this area and why. A third person's care plan described how they were prone to skin integrity issues and how staff could support the person within this area to help prevent a pressure sore. Care plans were reviewed annually by senior staff and core care staff or sooner if a need presented itself. For example, the deputy manager explained how one person they supported had been admitted to hospital. They told us, "All risk assessments and their care plan will be reviewed as their needs have been increased and we may have to increase the visits".

Whilst care plans mostly provided detailed guidance for staff we found one example which lacked the detail required. This related to a person who received support from staff with their meals. Their nutritional support assessment needed further details on the level of support required and had not been recently updated. We discussed the gap with the deputy manager who could tell us the exact support staff should be providing at each care visit and promptly added the further written guidance required. In addition, the manager told us they would use this as an opportunity to check all nutritional assessments to ensure they were fit for purpose and an effective working tool for the staff supporting them.

Daily records were completed about people by staff at the end of their visit. They included information on how a person presented during the visit, what kind of mood they were in and any other health monitoring information. Changes to people's needs were highlighted through various methods including reviews, spot check visits and speaking to people and families direct over the telephone or face to face. Information written in daily records meant staff were prepared and able to respond to people's current needs and amend their practice accordingly. In addition, the office emailed staff details of any changes to a person's care to ensure any changes were current and meaningful.

There was an accessible complaints policy kept in people's daily files, however there were no open formal

complaints at the time of our inspection. People and their relatives told us they knew they could approach staff members and the management team if they needed to. The care coordinator told us, "Most (people) feel more comfortable talking to a carer. So we very often get calls from the carer on the person's behalf." They told us if people tell them they do not want a particular staff member to attend their care calls this was respected. One person told us, I more than satisfied with the service, I know who to get in touch with if I need to speak with someone". We read the complaints file at the office. It provided details of the nature of complaints the office had received, the actions they had taken and any learning the service had used to improve how they provided care. For example, a complaint in June 2017 discussed how a person wanted care calls to be earlier than what they were. The manager had met with the person and stated they had apologised and changed the timings of the breakfast call.

Requires Improvement

Is the service well-led?

Our findings

Prior to our inspection, we received various statutory notifications from the service regarding incidents which had occurred impacting people they were supporting. Statutory notification is information about important events which the provider is required to send to us, the Commission by law. They included information about what had happened and how the service had managed the situation and what other agencies had been informed including the local authority safeguarding team. For example, one notification informed us of an incident involving a person who managed their own medicines. The service had informed the local safeguarding team and had taken appropriate steps and measures to ensure the risks to the person were minimised. However, during our inspection we found one incident whereby the service had failed to inform the local authority safeguarding team about an incident whereby staff had failed to administer boxed medicines to a person. Please refer to the Safe section of this report. The management team had also failed to consider whether a notification to the Commission was required of any potential abuse. The manager assured us the person had not been subject to any harm and promptly reported the incident to the local authority safeguarding team during our inspection. We were told the issue had been logged as an incident and it was not going to be taken further. We recommend the provider reviews their monitoring systems to ensure all incidents and allegations of abuse are reported to the local authority safeguarding team for their review and/or the Commission if required, to ensure all people are protected from abuse.

Despite this example we found, during our inspection, the manager, deputy manager and the provider were open and passionate about providing a good standard of care to the people they supported. We found the office team offered a committed and friendly atmosphere which focused on providing personalised care to people. People and their relatives shared numerous examples of positive care experiences; we observed this in the community when visiting people in their own homes and when speaking to people and their relatives over the telephone. One person told us, "I am perfectly satisfied with my care, nothing to worry about with the service". Another person told us, "It is a good service, everybody is happy and polite".

A range of informal and formal audit processes were in place to measure the quality of the care delivered. The quality assurance documents showed audits had been completed in areas such as care plans and staff performance. This information had been stored electronically. Staff records were audited and this indicated when supervision and training updates were required. When the supervision meetings or training had taken place the electronic system was updated. This showed the manager monitored the support provided to the staff team.

There was a range of methods used to gather the views of people and their relatives on how they found the care and support the service gave. This included telephone monitoring calls and an annual 'Satisfaction Survey Report'. There were 14 survey's returned in June 2017 completed by people and/or their relatives. The responses were positive, one commented, 'It's nice to have someone to talk to and I don't know what I would do without the girls'. Staff were also asked their views on how they felt about their role and responsibilities and the ones we read contained positive comments.

The manager and deputy manager were open to discussions during our inspection on how to improve the service and quality of care provided to people using the service and responded promptly to any shortfalls we found.

Since our inspection the manager has left the service and the deputy manager is now managing the service. The provider told us they held a discussion with the deputy manager regarding their responsibilities including the importance of working in accordance with the West Sussex safeguarding policies. The deputy manager had been working at the service since it was registered and knew people well. They were also working towards achieving a level five health and social care diploma to support them in their role. They told us, "I love what I do". They also told us they found the provider very supportive and said, "There is always somebody for you to call". The deputy manager said, "Our clients are very lovely" and added, "As an office we try and meet their (people's) needs, if somebody calls we try our best".