Sherwood Prime Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

We inspected the service on 11 October 2018. The provider was given 48 hours' notice of the inspection. We gave notice because this is a small service where staff are often out of the office during the day and we needed to make sure that the registered manager would be available to meet us.

This service is a domiciliary care agency. It provides personal care to adults living in their own houses and flats in the community. The service is registered to support; older people, people with physical disability, people with sensory impairment and younger adults.

Not everyone using Sherwood Prime Care ltd receives a regulated activity. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. We would also consider any wider social care provided. At the time of our inspection it was confirmed that 52 people using the service received 'personal care'.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was safe. Staff had good knowledge of safeguarding procedures and how to keep people safe. Risks were thoroughly assessed and incidents responded to effectively. We found that recruitment was safely managed and there were sufficient staff to meet people's needs. Staff followed infection control procedures. We found medicines required some improved written recording, the registered manager had begun to action this by the end of the inspection day.

The service was effective at meeting people's needs. Care plans allowed people's needs to be effectively met. Staff had received training specific to the people they supported. The service effectively supported people with multiple complex health conditions by close involvement with health and social care professionals. People's dietary needs were assessed and supported effectively. We found that staff had a good knowledge of consent. However, some written capacity assessments (mental capacity act) required further improvement. The registered manager had begun improving this by the end of the inspection day.

The service was exceptionally caring. During the inspection day we saw evidence of multiple caring interactions. We felt that the service had gone "above and beyond" with its support of people using the service. Of the 19 people we spoke to, they all reported very caring staff.

The service was responsive at meeting people's changing needs. People reported that they had a choice in how care was delivered and this could be adapted easily for them. We found that people were encouraged to report concerns and complaints and these had been responded to fully and openly. At the time of our inspection, no one was receiving end of life care. However, we saw evidence that end of life care had been

supported effectively in the past.

The service was well led. The high quality of management support had impacted on the quality of the care provided. The Sherwood mission statement was "High quality care and happy staff". Our inspection found this was highly accurate. People's care needs were well met, and staff were well supported in their roles. People were encouraged to feedback to the service and the registered manager and provider worked together closely to sustain improvements.

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

People were kept safe. Risks were identified and incidents responded to effectively. Recruitment was safely managed and there were sufficient staff to meet people's needs. Infection control procedures were followed. The written recording of medicines required improvement, but this was seen by the end of the inspection day

Is the service effective?

Good

Care plans allowed people's needs to be effectively met. Staff had received training specific to the people they supported. There was evidence of multi-professional working. People's dietary needs were assessed and supported effectively. Improvement was required in recording mental capacity decisions.

Is the service caring?

Outstanding

The service was exceptionally caring. We felt that the service had gone "above and beyond" with its support of people using the service. Of the 19 people we spoke to, they all reported very caring staff.

Is the service responsive?

Good

The service was responsive at meeting people's changing needs. People were encouraged to report concerns and complaints. End of life care was well managed.

Is the service well-led?

Outstanding

The service was well led. People's care needs were well met, and staff were well supported in their roles. People were encouraged to feedback to the service and the registered manager and provider worked together closely to sustain improvements

Sherwood Prime Care Ltd

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 11 October 2018. We gave the provider 48 hours' notice of our inspection. We completed a comprehensive inspection. The inspection team consisted of two inspectors and an 'expert by experience'. An 'expert-by-experience' is a person who has personal experience of using or caring for someone who uses this type of care service. For this inspection, our 'expert by experience' was an expert for people who had a physical or sensory disability. The expert by experience was responsible for making phone calls to people and relatives who used the service, to gather feedback about the service offered.

Before the inspection visit, we gathered information known about the service. We considered notifications the provider had sent to us. A notification is information about important events which the provider is required to send us by law. We also considered any information received from the public and professionals.

Before the inspection we requested the provider submits a Provider Information Return (PIR). The PIR asks the provider to give key information about their service, how they are meeting the five questions and what improvements they plan to make. We received this PIR as requested.

We also contacted the local authority commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home. Neither had been involved with the service, so declined to comment.

On the 11 October 2018 we visited the providers office base. We spoke with the Responsible Individual, who was also the owner of the business. We also spoke with the registered manager, five care staff, a care co-ordinator, and the Recruitment and Training Co-ordinator. We looked at the relevant parts of the care records of five people who used the service. We looked at staff recruitment files and other records relating to the management of the home. These included audits, policies and incident records.

On the 23 and 24 October the 'expert by experience' made phone calls to people and relatives who are using the service or had used it since out last inspection. The expert by experience spoke to five people using the service and 14 relatives

Good

Is the service safe?

Our findings

The provider ensured staff were aware of their responsibilities to safeguard people from harm or abuse. Staff were provided with guidance on how to do this and we saw safeguarding issues were reported appropriately.

The provider had a process in place to assess people's needs prior to starting to use the service. This included assessing all aspects of care to identify the risk associated with administering care. For example, a risk assessment had been completed on people's homes. This was to identify and where possible reduce the risk to people and staff such as trip or fire risks. We saw the service had liaised the local fire service to ensure they understood fire risk and how to mitigate that risk. Staff were also made aware of risks such as how to leave people safe in their own homes and how to cater for people living with conditions such as a food allergy. Where staff had concerns, records showed that they acted on them. The registered manager had processes in place to record and review accidents and incidents. This was to ensure the safety of people and to prevent, where possible a re-occurrence of the accident or incident.

We saw that recruitment procedures were managed safely. We looked at the records of three of the most recently recruited staff. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal records checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

There was enough staff to meet people's needs and ensure their safety. Records and conversations with people and their representatives showed visits were delivered in a timely manner for the contracted time. The provider was aware of the needs of the service and had provided a company car for use of staff should they need it. This helped prevent late or missed calls. A staff member told us, "We don't change call times, (person) is dependent on regular times for their (health condition). So it is extra important. But we wouldn't change anyway". We saw unavoidable late or missed calls were identified quickly and actions taken to rectify this. This could be caused by staff staying with a sick or poorly person whose needs meant they couldn't be left. The registered manager told us, "We would never leave anyone, we would always get a member of staff to them". Records supported this.

The provider ensured staff were trained to work independently and to care for people safely and effectively. This included all new staff completing a two-week induction process. This included safe practices. For example, if a person required two staff to meet their needs, then staff must wait outside the property for the other to arrive. The registered manager said "It is to make sure that they aren't tempted to try to do things alone. It can feel pressured to start to help people if you go in alone. That wouldn't be safe"

There were systems in place to ensure staff were trained and had the information necessary to administer people's medicines effectively and safely. This included complex regimes such as monitoring people's blood thinning medicines and specialist feeding devices.

Some medicine records required further information about how medicines should be administered. However, staff did have access to this guidance in another format and this had no negative impact on people. The management team had begun to take action on this by the end of the day to ensure best practice.

We found people were protected from the prevention and control of infection. People told us that staff were always had access to disposable gloves and aprons. The office had supplies of personal protective equipment (PPE) available for staff. A staff member told us, "I go in to the house with four or five gloves, depending on how many creams they have. I don't want to use the same gloves for different creams because they are for different things and would be less effective. I also don't want people to have to wait round while I change them. That's not dignified". The staff induction paperwork showed staff had agreed to good infection control dress code.

Incidents had been recognised and action was taken to make improvements. The registered manager was open and transparent in communication. Areas of concern were responded to promptly during our inspection visit. The registered manager showed us an "improvements log" which they had been recording since their last inspection. This had details on improvements that the service had made, which was not necessarily identified by structured audits and incidents responses.

Good

Is the service effective?

Our findings

The provider ensured people had a care plan in place. This is documentation of people's care needs and wishes. It is stored in both the persons home and in the office. The care plan gave clear directions to staff on how to meet people's recognised needs and wishes. They were created with people and other related health and social care professionals to respect people needs and rights. One person told us, "From day one, the care has always been delivered at the times and the way in which it was important to both my wife and I that it was organized. Very impressed."

Staff had skills, knowledge and experience to deliver effective care. Staffs training included, how to move people safely, food hygiene and the administration of medicines. Specialist training included training specific to the people they cared for. Where people had complex needs, specialist health professionals such as the Alzheimer's Society had attended to deliver personalised training. This allowed staff to support people's complex health conditions effectively. Staff told us "training is really good, each month we have a training meeting. They get guest speakers in from different areas. It's so helpful, I can take some of the learning back to my own life."

Staff found the training very good and one said, "It was really good to learn the stages of Dementia and how the brain changes. They gave us an example of a book case. I see one relative and their family member has dementia. I used the bookcase to explain how dementia effects (person)."

Staff supported people to eat and drink enough to maintain good nutrition and ensure people had assistance to store their food in a hygienic and safe manner. Food care plans were personalised to individual's likes and dislikes. Where appropriate, a record of food and fluid amounts was maintained. We found staff had a good knowledge of individual dietary needs. A staff member told us "[Person] is a stickler for eating Smash every day. But that's their choice. We know that we give (person) what they like. It makes (person) happy."

The service supported multiple people with complex dietary needs. Care plans identified individual dietary risks and instructions for how staff could effectively support these risks. Speech and language therapy (SALT) had been contacted to assess people who may be at risk of choking.

Staff worked with other organisations to deliver effective care. Risks around skin integrity were assessed with community nurses and care plans were created to effectively manage these risks. A staff member said, "We meet nurses when they come out. The nurse advice is put in the care plan to enable the next staff and family know what we are doing." We saw professional advice had been clearly documented and acted upon for people.

People had their physical and mental health promoted. The service had supported people to access multiple professionals. These included G.P's, Occupational Therapists, physiotherapists, the memory clinic, the visual impairment service, and the specialist falls service. Staff understood what these professionals did, and how to access them. One staff member told us "If an Occupational Therapist (OT) is needed, we'd report

back to the manager. (Person) was in a care home for two weeks and had become less mobile. So, I let them know and the OT came in". We saw staff had responded quickly to professional advice. A G.P had recommended someone remained downstairs. The registered manager arranged for this to happen. This included collecting equipment that would not arrive quickly enough by delivery.

The service effectively managed the transition of care between themselves and other providers. We were told of examples where Sherwood Prime Care staff had shadowed the previous provider's care visits to ensure a full understanding of need before agreeing to support the person. The care folder had also been given to paramedics to allow consistency of care in a hospital setting.

The Mental Capacity Act (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.

The staff and registered manager had good knowledge about the MCA. Staff could give clear examples of how they gained consent from people they worked with. Best interest's decisions had been made to support people if needed. The registered manager advised that the social services team usually completed capacity assessments however they had completed some assessments themselves. We identified that these assessments needed some quality improvement. However, this had not had any negative impact on people using the service and no one was unnecessarily restricted. The manager had begun amending this by the time we left the inspection.

Outstanding ☆

Is the service caring?

Our findings

People were involved with creating their care plans. Care plans effectively identified what people liked and care was centred around this. One person said, "I really feel I've been involved with everything about planning my care and I've been very happy with how easy it is to talk to everybody here at the agency whether they're a carer, office worker or the manager."

The registered manager said, "You could point out any of our people, and I could tell you all about them." This was reflected in our inspection as the registered manager had exceptional knowledge of everyone using the service. There was evidence of repeated situations where the registered manager had gone above and beyond to support people, for example remaining in hospital with someone who required surgery as their family were on holiday. One relative explained that they needed surgery and were worried about leaving their loved one alone so told staff that they may cancel the surgery. They said "(registered manager) phoned me the same day, to say that she'd arrange for someone to sit with (person) and not to worry about the cost. I think I nearly cried when I got off the phone. I don't know how to thank her enough."

Staff knew what people liked and worked to support these interests. A person said "She's almost like a sister to me and will often bring me little treats, like some cakes or biscuits or even a magazine to read. She doesn't have to do any of this, but she does and it makes a huge difference to me." A staff member found that one person enjoyed textured objects. They had then made an activity board for them. This included locks, chains, ribbons and switches which gave them enjoyment. Another person enjoyed writing poems, so a staff member swapped poems with them. These were displayed in the office. The staff member said "(Person) knows I'm not very good and I could cheat and get them off the internet. So, I try hard to do them myself because it makes them happy. We've shown them a picture of them hung up. (Person's) chuffed that they are in the office."

People told us that staff adapted their approach to provide reassurance. One relative said, "I know (care) embarrasses him because he's a very proud man, but they will chat away to him about mundane, funny things and I can see the guilt lifting from him." Another person told us that they were worried about the use of a key safe. A key safe is attached to the property to store the house keys. Staff will use this to allow entry into a person's house. They told us staff now ring the doorbell when they have put the key away safely. This gives them reassurance that they are safe.

People were assisted to celebrate special occasions. When we asked staff about working on public holidays a staff member told us "I like knowing that I have my kids and but have my service users too. I don't mind working at Christmas as I care so much about people. It's not like work, it's nice." The registered manager had also shown a caring attitude by buying advent calendars and Christmas gifts for staff and people using the service.

The care team was structured around a core group of six to eight staff who knew the individual's needs well. People using the service were sent a weekly rota of which staff are coming to see them. A person told us "I like the fact that I get a list every week which tells me who is going to be coming to me and when. I know it's

a silly little thing, but it at least makes me feel that I haven't been forgotten." The registered manager showed us that photo rotas were provided for people who found written rota's difficult to understand.

One person wanted carers to support them at a traditionally male dominated hobby. Female staff made effort to learn the hobby and therefore meet the social needs of a male person. However, fed-back to the registered manager that they felt a male carer would allow better integration into this hobby with their peers. The registered manager said "They would have been fine with the girls, but we knew we could make them happier if they had a male carer. So, we found them a care agency with a male carer interested in (hobby) instead of us."

Staff used the knowledge about people to ensure they received good quality care from other services. A person using the service had moved into a care home, the staff continued to support this person by visiting and reading to them. A staff member told us "(Person) can't speak now, they communicate with their eyes. I know from the way (person) looks at you what they want. I've filled in the staff in about (person's) communication needs and quirks. So, they can communicate with (person) too."

The service supported people to express their views. Staff and managers at all levels understood their views, preferences, wishes and choices. People were consistently involved with planning their care. We saw that in the initial pre-assessment documentation, people were encouraged to identify goals of what they wanted to achieve. People decided when reviews would occur, and whether it would be in person or over the phone. One person said "(Registered manager) and (registered provider) came out to visit us and talk to myself and my (relative) about what help I needed, how I would like it organised during the week and what had gone wrong with my previous care. They spent some time talking to me about how I like things to be done and this was all put into the care plan. Everything has been delivered exactly as we chatted about. It's been such a relief". We saw that if staff identified additional support was needed, they approached this sensitively with the person. For example, staff were not supporting meal times but noticed that the person was choking when fed by family. This was fed-back and the registered manager supported them to approach health services for swallowing assessments.

The service was particularly skilled when exploring and trying to resolve any conflicts and tensions involved. For example, we saw that one person would only accept care from their relative. This relative was finding the role increasingly difficult but due to the expectation of their loved one found it difficult to engage with services and reduce their support. The registered manager supported them to approach the Local Authority to arrange a sitting service. This would allow the relative time to relax while carers sat in the house with the person. This supported the family relationship by providing the relative with some respite.

We saw that records carefully considered people's preferred name. Staff knew people's preferred name and how they liked to be addressed. We saw that a review had been sent to people using the service, this questioned whether they liked the term 'service user' and whether they would prefer to be addressed as this or something else. People fed-back that they were either indifferent to the term or preferred 'people'. We found the staff referred to people as 'people' rather than 'service users' in order to engage with this ethos.

Staff were aware of individual goals and worked with people to meet them. For example, one person wanted to go into the community as independently as possible. While they could drive, they found it difficult to fill the car with fuel. Staff supported them by re-fuelling the car and then helping them choose personal activities to remain as independent as possible. This allowed the person to maintain their independence.

Throughout the inspection there was an obvious culture of privacy and dignity. Staff and managers had excellent knowledge of General Data Protection Regulation (GDPR). This is a legal requirement to manage

people's personal information appropriately. We saw that some personal information was only accessed by senior staff. The registered manager told us that they decide what the care staff need to know, and do not pass on information unless it is required to support the person effectively.

Staff delivered care with privacy and dignity at the forefront. One person experienced confusion and would then pack their bags to return home (despite being at home). Staff and family were concerned that they may attempt to leave the house and put themselves at risk. The family worked with the service to identify the early signs of anxiety. They then identified the favourite song that would settle the person, which hair routine to complete and how to encourage them to remain settled. The registered manager reflected that the person's independence had been maintained for longer than expected due to this night time routine and ability of staff to provide this.

The induction process involved staff shadowing care calls, so they could learn the support that individuals needed. The people receiving support would sign paperwork giving consent for new staff to enter their home and watch the care being completed. Once the induction was completed, people were asked if they were happy for the person to continue to support them. This followed the provider's motto of "your care, your choice." We saw staff had not been employed if people using the service had feedback negatively about their caring attitude. The registered manager told us "We know from feedback if they aren't a caring 'Sherwood girl' and they won't stay."

Staff gave examples of how they maintain dignity during care tasks, "When we give personal care, I always the lock the door behind me. I always ask permission and check what they want before. Like do they want a bath or shower? We look after their modesty. Like covering the bottom half with a towel while helping them with their top half. They do as much as they can themselves". We saw that team meetings had included a section on dignity and respect. The registered manager explained that at one team meeting, the staff sat in a chair and experienced others caring for them. This allowed them to experience how it felt to be supported, and encouraged staff discussion on how to provide care in the most respectful and dignified way.

Good

Is the service responsive?

Our findings

All people using the service had their care needs assessed in a care plan. This gave staff good information on how to care for people. For example, a communication section in the care plan allowed family, visitors and staff to feedback to each other. We saw this resulted in prompt and effective continuity of care for the person receiving the service. When we spoke to staff, they repeated the importance of the communication section of the care plan. One staff member said, "Trained that way, first thing we do is go in to the care plan and read what has been happening." The registered manager said this fed into the care plan and effected change when needed. The registered managed said, "Care plans always change. But if we haven't heard from people, I'd check every three months. They tend to say, if I had a problem I know where you are and I'd ring you."

People received personalized care that was responsive to changing needs. One person said "Just because it says in my care plan that I have a bath each teatime, doesn't necessarily mean that I will do. Some days I just don't feel like it, so when my carers come in to me, I'll tell them I'm not really wanting one. They will usually help give me a bit of a strip wash." Staff had good knowledge of how they adapted daily care to people's needs. For example, a staff member spoke of supporting someone with a visual impairment "We are softly spoken, we stand on right side because that is where their vision is strongest. Also closed questions and give (person) time to answer."

Care plans included person-centred instructions on how to support someone's physical and mental health conditions. A staff member told us "I work with (person) regularly. They've had (health condition). I've taken them to doctors' appointments. So, I've learnt all about their health and how to support them better".

Care plans also explained how to meet people's social and cultural needs. Staff were aware of people's religious needs. The registered manager told us that someone wanted staff to engage in a religious routine with them. The person showed staff how they would like them to be involved then the registered manager created a print out of instructions. This was left in the property, to ensure staff supported the person appropriately.

Small groups of staff worked with people. This allowed staff to recognise people's changing needs. A relative told us, "This has enabled (relative) to get to know them, and importantly they have got to know (person) and each and every one of them can now pick up even just the tiny signs that (person) is beginning to struggle". The registered manager said "We don't run out of staff that know people. But if we did, we'd introduce a new carer to the person.". People told us that they were always introduced to new staff, and gave permission before they supported them

The registered manager ensured there was enough staff to meet people identified needs. This included having spare capacity to meet emergencies. For example, one staff member's work is flexible and therefore they are ready to respond to situations as needed. The registered manager is also able to respond to emergency care needs. Conversations with people and their representatives supported this. A relative told us their relative was admitted to hospital while they were away. They said, "(Registered manager) text me

that evening to say that everything had been taken care of and that we weren't to worry and that [registered manager] would put extra care in to be on the safe side until we were back. We are all very grateful to them." A person said, "Because the carers are always on time, I get my tablets at the same regular time each morning, as I need them." They confirmed they were always told if there was a delay in staff arriving.

The registered manager was open and transparent when handling complaints. Everyone we spoke to knew the complaints process. One person told us "We'd talk to (registered manager) first if we had any concerns, but there's truly been nothing even to worry about. We can't praise them highly enough." Two complaints had been received, these had been fully documented and investigated. The people were happy with the investigation outcome. Staff also recognised the importance of openness, one said "If they're unhappy, I'd encourage them to call office. They have all the numbers in their house to contact. Or we can give them the on-call number over the weekend."

At the time of our inspection, no one was receiving End of Life care. The registered manager informed us that they do not usually accept people who require end of life care. This is because the type of care needs can change quickly, and as a small care company they struggle to meet this change in need. However, we were shown an end of life care plan for someone who had been a long-term client, and then become palliative. This showed thorough and responsive care planning. We discussed end of life care with the staff. They said, "Losing people is the hardest. They become part of your family, they have a big impact on you." The registered manager explained that when a person's health fails, they can need two carers instead of one. She said "it can be difficult for carers to see the deterioration. I will ask carers if they're managing okay as they have built relationship with the person". All staff displayed great empathy towards people's deteriorating health. While no one was receiving end of life care at the time of the inspection, we were re-assured that those who required it would be supported fully.

Outstanding ☆

Is the service well-led?

Our findings

The vision and values of Sherwood Prime Care put people are at the heart of the service and were imaginatively presented. The registered manager worked closely with the provider to create a clear vision statement, the 'Sherwood Mission Statement.' The registered manager summarised this as "High quality care with happy staff." This was reflected in the service we observed, the records we reviewed and the feedback we received from people, their relatives and staff. One relative said, "Everything they promise to deliver, they do, if they say they will speak to someone, they will and they are honest and focused on [relative] and their wellbeing." Staff were strongly collaborative in achieving this goal, by making suggestions to improve the service and making effort to promote the best quality care they could. For example, staff identified one person enjoyed doing jigsaws but struggled due to dementia and sensory impairment. They had suggested dementia friendly large scale jigsaws. This had been purchased by the provider and offered to other people that it may benefit.

The vision was clearly person centered. The provider told us they aimed to continually improve the service offered to people. They wanted to keep the service small, local and community based, to ensure quality was not compromised. This was embedded in the service. For example, the management team ensured they had met everybody who used the service and understood their needs and wishes. Small groups of staff supported people and understood their needs well. People and their relatives all feedback positively about the registered manager and provider. A relative said, "We have [registered manager] on speed dial! But seriously, she never minds you contacting her and she's been a godsend as far as [relative's] care is concerned. Above all that though, she also supports the entire family – priceless."

The provider and registered manager put people and their families at the heart of the service. This included inviting people to training events. Relatives had been invited to the arranged Alzheimer's society training. People spoke positively about this opportunity and the knowledge this training gave them. One said, "It was invaluable at the time and enabled me to support [relation] much better and share some of the knowledge I received, with friends and family who were close to [relation] and who visited her."

The provider and registered manger worked together to develop and implement innovative ways of delivering high-quality care and this good practice was sustained. The provider had created guidance to enable staff to effectively support people. For example, they had the "Dementia Tree". This explained the different types of dementia and how symptoms could affect someone. This had been presented in an innovative and engaging way and had been given to staff. Staff referred to this document and had excellent knowledge on the types of dementia each person had and how this affected them.

There was a strong organisational commitment to equality and inclusion across the workforce. The management team had identified staff's diverse needs and catered for these with shift patterns and supervision arrangements. For example, accommodations had been made to cater for staff's caring responsibilities and their health needs. The registered provider encouraged employment of a diverse workforce and considered race and culture when matching people with their carers. Furthermore, the management team had recognised people's learning needs and had adapted systems to cater for this. For

example, medicine records were printed on a lilac coloured paper. The registered manager said "some of our staff struggle to read white paper. There have been definite recording improvements since this. Less mistakes."

Good governance was embedded into the running of the service. There were effective systems in place to ensure the safe and effective running of the service. Regular audits of care were completed, these included document reviews and spot checks to ensure staff were working effectively and safely. Where issues were identified, effective action plans were put into place to make improvements.

Staff were highly motivated and proud of the service and there were high levels of satisfaction across all staff. Without exception, staff told us morale was high and they were respected and valued as a workforce. A staff member told us, "They are really good at listening to us. We never feel like burden. It then shows with the work we then provide." The provider sent out a questionnaire asking staff what was most important to them in work, their answer had been, 'receiving positive feedback.' The registered manager ensured positive feedback from people was shared with staff. They showed us evidence of this. Staff reported positively about the feedback they received and the impact it had on their work. They told us, "Because you have such good support from employer you give more, you go the extra mile, you feel appreciated." During our inspection staff told us many stories of things where they had gone over and above what was expected of them. For example, a group of staff had arranged a Christmas meal for a person who would have otherwise spent Christmas alone.

There were high levels of constructive engagement with staff. Staff were provided with the opportunity to make suggestions for improvement in regular team meetings and told us they felt comfortable sharing ideas. Suggestions from staff were acted upon to improve the quality of the service offered. For example, staff identified that one person did not drink enough. They suggested that medicines were given one at a time to encourage fluid intake. This had been implemented and had a positive impact upon the person's health. We saw that staff who made suggestions recognised the scope of their role and would approach management for permission before acting.

The registered manager had systems in place to keep up to date with current good practice information. This included accessing local authority training and completing further education courses such as palliative care. The registered manager said they supported a lot of family carers. In an effort to support these carers they attended the 'carers hub' to enhance their knowledge of what's available to support family carers. She explained "I learnt about reducing council tax, and different support available for families. It's about being able to signpost families to other places that can help them. Not just us."

There were consistently high levels of constructive engagement with people who used services. People using the service were actively engaged with through regular reviews with the management team. Satisfaction surveys were sent out to people using the service every year. Feedback from the latest survey was unanimously positive. One person we spoke to said, "We've completed a couple of surveys over the years, but there's never been a need to make any suggestions about improvements. They're perfect as they are." The registered manager was aware people can be reluctant to feedback negatively, to address this they were given a card with details of an internet review site to allow them to post their comments. The registered manager then reviewed this regularly. We viewed this site, and noted feedback was overwhelmingly positive. Despite the positive feedback, the manager discussed where she felt improvements could be made and gave in depth consideration to how changes could impact the service.

Staff and management worked effectively with different health and social care professionals. Professionals who visited people were always met by either the registered manager or provider. The information received

from these professionals was then effectively communicated to families and staff. Throughout our inspection we saw evidence of multi-agency working and this having a positive impact on people's support. This included staff collecting equipment if it was deemed that delivery would cause an unnecessary delay.

There was a culture of continuous improvement. Advice from specialists had been used to further develop and improve their policies and documentation. While information was shared effectively, we also found that staff had a good knowledge of data protection and had made system changes to ensure peoples data was protected. They had also worked with professionals to create bespoke medicine recording forms. This allowed complex health conditions and medicine regimes to be effectively managed.

The provider's excellent relationship with health professionals had enabled them to support people with very complex health needs to remain in their home. The provider had worked in conjunction with health professionals to provide staff with training and support to enable people to receive high quality care in their homes and prevent the need for residential care. The registered manager explained that staff are approached to see if they feel comfortable managing these complex needs before agreeing to provide support. One person required specialist equipment, staff watched an online video to understand what was being asked of them before agreeing to support. Training was then arranged with a specialist health professional. Staff had excellent knowledge on how to support these complex health conditions and the impact that mismanagement would have on people. Excellent relationships with health professionals had led to positive outcomes for people using the service.

The service had a good track record of working in partnership with other services to provide high quality care and was an important part of the local community. The provider worked with another care agency, to shadow their care calls to allow a seamless transition in care provider for a person. We also saw that Sherwood Prime Care had created a relationship with another provider. If care could be managed better by the other agency, then people were signposted (for example preferences in staff gender). On one occasion the staff from the other service became unwell and a person was without support. Sherwood Prime Care assessed the risk and briefed a staff member on this person's need. They then covered this care call to prevent this person being at risk from the other provider's inability to arrange a staff replacement.

The service had a registered manager in place. 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.