Westminster Homecare Limited

Westminster Homecare Limited (Buckinghamshire)

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

Our inspection took place on 28 and 29 August 2018 and was announced.

This was our first inspection of the location since a change in the service's office address. We last inspected the service in 2014 under our prior inspection methodology .

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

Westminster Homecare Limited (Buckinghamshire) is part of a corporate provider of care at home services, with 21 registered locations. At the time of our inspection, more than 140 people used the service and there were more than 50 staff.

The provider is required to have a registered manager as part of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was a manager registered with us.

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

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

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

The service was extremely caring. There was consistently complimentary feedback from people who used the service and relatives. Staff often went beyond their usual role to ensure people were safe, well-cared for and treated holistically. The service prevented social isolation of people who lacked contact with their local community. People told us they could participate in care planning and reviews. People also told us they

were consistently encouraged by staff to make decisions for themselves, and only assisted when needed. People's privacy and dignity was respected when care was provided to them.

Care plans were appropriate and contained information on how to support people in the best possible way. We saw there was a complaints system in place which included the ability for people to contact any office-based staff member or the management team. Concerns and complaints were recorded and reviewed to ensure positive outcomes. Questionnaires were used to determine people's satisfaction with the care.

People, relatives and stakeholders had overwhelmingly positive opinions about the care, staff, management and leadership of the service. There was an excellent workplace culture and we saw the staff worked cohesively to ensure good care for people. Robust, frequent and extensive audits and checks were used to gauge the safety and quality of care. Where necessary, improvements were made to continuously make the service better. The service offered their support to the group of locations operated by the provider. The provider had a detailed knowledge of the service's core operations and performance.

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.

People were protected from the risks of abuse or neglect.

People had comprehensive risk assessments in place to prevent harm and ensure their safety.

There were enough staff deployed to meet people's needs and ensure calls were on time.

Incidents and accidents were reported and investigated.

Is the service effective?

Good

The service was effective.

People's likes, dislikes and preferences were assessed and informed their care.

Staff received very good support which provided them with the knowledge, skills and experience to provide effective care for people.

People were supported to lead healthy lifestyles, and were assisted by the service organising health and social care professional input.

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

Is the service caring?

Outstanding

The service was extremely caring.

People were protected from social isolation within the community, and staff encouraged and promoted holistic wellbeing.

There was extremely positive feedback about the care provided by staff.

People's emotional, spiritual and physical health was included as part of the complete care package.

People had developed meaningful and trusting relationships with staff.

People and relatives were always involved in care decisions and regularly asked for feedback.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care was very person-centred, and care documentation included the right information to provide responsive care.

People's communication needs were assessed in line with the Accessible Information Standard.

People and relatives knew how to make a complaint. When feedback was provided, the service acted upon it to ensure people's satisfaction.

Is the service well-led?

Outstanding

The service was extremely well-led.

People and relatives told us the service was consistently well-led and to a very high standard.

There was always a very positive workplace culture with clearly defined service aims and objectives for care.

Robust and frequent audits were completed to ensure safe, quality care for people. The audit results ensured continuous improvement.

The provider had excellent oversight of the service's performance and ensured continuous monitoring of the quality and safety of people's care.

The service worked very well with other health and social care agencies.

There was a learning culture; the service and staff were keen to implement any changes to improve the care provided for people.

Westminster Homecare Limited (Buckinghamshire)

Detailed findings

Background to this inspection

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

Our inspection site visit took place on 28 August and 29 August 2018 and was announced. We gave the service 48 hours' notice of the inspection visit so that the management team would be available.

Our inspection was completed by three adult social care inspectors and two experts-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. Our inspectors completed the office visit, interviewed management and staff and observed personal care provided in people's homes. Our experts-by-experience completed telephone calls to people and relatives.

Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office (ICO).

We did not ask the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The service had a prior PIR prepared, and we used information from this to inform of our inspection process.

We spoke with twenty people who used the service and five relatives. We also spoke with the registered manager, operations manager, operations support manager, deputy manager and recruiter. We spoke with five care workers and two field care supervisors. We visited six people in their homes and observed care

practises. We reviewed parts of 20 people's care records, five personnel files, medicines administration records and other records about the management of the service.

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

Good

Is the service safe?

Our findings

People told us they felt safe when staff delivered their care. One person said, "They [staff] know what they are doing, they talk to me and ask my opinion, and it matters to them that I feel comfortable and settled before they leave"

Staff we spoke with demonstrated knowledge of abuse, including self-neglect. For example, staff said they advocated people's wishes about personal care in discussions with relatives and knew their responsibility to monitor and report concerns of self-neglect. Staff understood signs of abuse and their responsibility to raise safeguarding concerns internally and externally with the appropriate agencies. One care worker provided information about a specific safeguarding concern she reported where management fed back to her and other care workers what they had done. The care worker said the management reported it to the safeguarding authority, and instructed staff to continue to monitor, record and report which was also being shared with the local authority.

Staff stated that managers regularly shared whistle-blowing procedures and encouraged staff to raise concerns. One said, "All managers are approachable; I would raise my concern or incidents with head office if I needed to." Another care worker said that she, "feels safe" when supporting someone who had behaviours that challenged as, "the office communicates any safety issues or changes and always follow-up with care workers after new calls…managers are 'hot' on changes in need and take things very seriously, looking into any incident quickly. They safeguard clients and staff, they look after us too and are especially vigilant for staff safety at night."

Staff said the recruitment and interview process they experienced was efficient and the induction process gave them the knowledge and confidence to support people safely. Staff did not feel rushed in delivering support. Two staff regularly worked together to support people who had mobility difficulties and had sound knowledge of the people's needs and use of equipment. Staff reported that safeguarding training was "very good" and felt they were given quality information to help prevent and protect people from harm.

Sufficient staff were deployed to ensure safe care. Care delivery was correctly scheduled as people's care calls were delivered at the agreed times. People told us, "They [staff] are always on time and do what they say they will do. They are very reliable", "They are not late, and are always obliging. They go the extra mile and are friendly and professional," "I get the same carers on my calls and they are a great team and "If they have to be a few minutes late because of local traffic problems, they 'phone ahead and tell us."

The service used an electronic visit recording system for care management. We noted from the information provided at the time of our inspection that people almost always received their care call at the agreed time. We observed staff phone in and out of each call, as they arrived and left. There was an inbuilt 15-minute leeway arrangement with a local authority who contracted with the service. Staff stayed for the correct length of the visit, to ensure that all allocated tasks were carried out and records were completed before leaving. Scheduling of the calls had been planned to consider people's individual needs and preferences, with a five-minute travel time allowance.

Personnel files contained all the necessary pre-employment checks which showed only fit and proper applicants were offered roles. Checks included asking for a full employment history, checking the reasons why staff had left their previous roles, obtaining a criminal history check from the Disclosure and Barring Service and obtaining references from prior employers. Interviews of staff were robust and often carried out by two senior staff. The information required by the relevant regulation and schedule was stored in the staff personnel files.

Medicines were safely managed. Staff spoken with demonstrated sound knowledge of the service's medicines procedures and their responsibility to administer medicines and record on medicines administration records (MAR) in line with people's care plan agreements. Staff said they knew to report any concerns or changes about people's medication and received training every twelve months, including a competency assessment. MAR charts were submitted to management monthly to be checked and staff received direct feedback about their performance for administered and recorded medicines.

People were protected against infections. Staff were trained in infection prevention and control and had access to personal protective equipment like disposable gloves and aprons. Staff received information and competency checks for effective hand hygiene.

Incidents and accidents were always reported and acted upon. Incident forms were within folders at people's houses and could be completed by care workers at the point of occurrence. Staff also called the office to report any issues and the care coordinators or other senior staff logged the matters electronically. Issues for investigation were promptly escalated to senior staff to ensure people's safety. The service, and provider, monitored for trends and themes in accidents and incidents. Any identified patterns were highlighted for further examination, to prevent recurrence. Where necessary, investigations of staff performance were completed and appropriate improvement management plans were put in place.

Good

Is the service effective?

Our findings

People and their families told us that comprehensive assessments were undertaken and a plan of care agreed before they received support from the service. They assured us they had had input and were actively involved in the planning and development of the plan. In all of the people's houses we visited, we saw an up-to-date copy of the care plan. Records we viewed showed robust and detailed assessments of personal care, medical history, social and dietary needs had all been considered. The plans were highly detailed, and mirrored those kept in the office.

Staff we spoke with had a good understanding of peoples' healthcare needs, for example catheter support procedures. Staff felt they were equipped with the right knowledge to monitor effectively and refer appropriately to the community team in response to any problems and risks. Care plans included a summary of medical histories and health conditions, and documented staff support strategies and responsibilities in relation to these. For example, a care plan stated, "look out for pressure sores and broken skin" and included details of who to report this to.

There were robust and effective systems in place to provide updated and on-going staff support. This included staff meetings, newsletters, supervisions, "spot checks" of their practice, and an annual appraisal. Staff told us they had a very comprehensive five-day induction process before they were allocated to undertake care tasks. This incorporated dementia awareness, fire safety training, first aid, food hygiene and health and safety. Other core subjects included infection prevention and control, medication support and competency, moving and handling, pressure ulcer prevention and tissue viability, and safeguarding adults level one. Safeguarding level two and three was undertaken by more senior staff.

Staff also received three 'shadow' sessions before moving onto being the second person on people's double-up calls. If staff were not confident they were offered additional shadowing sessions. Staff also observed that newer staff allocated to work with them were well prepared to meet peoples' needs.

Staff assured us their training helped them to effectively support the people they cared for. The in-house training was described as face-to-face and very good. There was no e-learning, and staff told us they liked this because face-to-face training gave them the opportunity to ask questions if they were unsure. They had also received further regular training to make sure they stayed up to date, and these were reviewed online to check annual or three-yearly compliance. This meant that people benefitted from staff who were aware of changing policies and up to date practices. The training programme provided staff with the knowledge and skills to support people.

Staff told us they had received regular supervision, which was described as "two-way conversations" and was said to be a helpful process to support and encourage development. Supervision was carried out quarterly, and conversations and observations were logged. Spot-checks of practice were also undertaken quarterly, and appraisals were annual. We reviewed these records and the training matrix, and this showed that these were up-to-date except for one member of staff on long-term leave.

People had access to specialist healthcare services if they needed support with their nutrition. They were supported with their nutritional needs by knowledgeable care workers and their preferences were respected. We observed people being offered choices for their lunch. People were complimentary about the staff preparing meals for them , saying they were offered choice, sufficient to eat and drink, supported if necessary to eat, and the kitchen was left clean and tidy before the care workers left.

Staff within the service and across the provider worked well together to ensure effective outcomes of care for people. Staff told us they felt valued by the managers and office staff. Some of the office staff had previous caring experience and could support care schedules if necessary. This had the added benefit that they knew the people they supplied contracts of care for, and were involved in writing the care plans for them. The deputy manager told us they had supported a staff member to improve their written English. This had been identified as a need and an agreed goal through quality audits of daily logs, and as a result the member of staff was rewarded "carer of the month" award for the improvement they demonstrated.

Staff liaised with healthcare professionals to monitor and maintain people's health and wellbeing. This was evidenced by some early interventions by the local tissue viability nurses, and the GPs. One family told us of an incident with a high importance and impact for them, where a care worker had identified the beginning of a pressure area and immediately contacted the district nurse. Because of this very early intervention, a pressure sore was completely avoided, resulting in better quality of life for the person who remained bedbound over long period of time. Records we reviewed demonstrated that information was recorded clearly by staff when they liaised with other health care professionals, and accurately recorded visits undertaken to the person's home by, for example, a GP. Follow-up information was also recorded, showing the outcome of conversations and contact with other healthcare professionals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Care workers could tell us who was able to provide consent to care, and who lacked capacity and that support provided was in their best interest. The service had a proforma in place to record assessment of people's capacity as well as the best interest process and decision. However, we found that part two of the form had not been completed and the information recorded in part one conflicted. For example, one person's granddaughter was recorded as making advanced decisions for the person, but also that the person had capacity to consent. We discussed this with the field care supervisors who were not able to explain the correct purpose and application of advanced decisions. They told us they would act to correct the documentation to reflect the person's needs.

Outstanding ☆

Is the service caring?

Our findings

People and their families provided consistently high positive feedback about the skill, knowledge, attitude and kindness of the staff. They clearly described how meaningful, supportive and positive relationships had been developed with the care workers who supported them. People told us staff were always respectful, professional, kind, compassionate and unfailingly treated people with dignity and respect. For example, comments about staff included, "They're kindly, respectable and respectful…I have complete faith in them" and "Yes they're kind and they try to spoil me. I do what I can for myself." This actively supported people by promoting their physical and psychological wellbeing. Relatives told us they felt this helped people live in their own homes for longer and avoid unnecessary trips to medical professionals and hospitals.

Care workers clearly demonstrated high ethical, moral and non-judgemental values as part of their duties. Without exception the care workers we spoke to highly valued building positive rapports and trust to improve people's experiences of the care and support they delivered. One care worker said, "I love to sit with people and have a chat to find out about them. Our office staff value that too and we understand that 90% of the care we provide is companionship". Care workers told us they were not rushed, had more time to engage with people and to find out about their life stories. This ensured care was holistic; people's support included social accompaniment, emotional wellbeing as well as everyday activities of daily living.

During our visits to people in their homes, we found evidence that care was consistently delivered to a very high degree. Families described some exceptional episodes of care which had impacted upon the wider family as well as the person being supported. Where staff supported the holistic wellness of people they were caring for, this had a further and repeated benefit of enabling family members to feel emotionally supported during some difficult times and circumstances. One person said, "They support my family too, and that makes such a difference to me, as I know this is a difficult time for them." A relative told us, "The relatives stated, "It's not one thing we can put our finger on, it's everything. The way they [the staff] speak to us, laugh, and bring fun and some sense of normality, make us feel valued and understood. Not in a sentimental manner but in a really active and positive way." People described to us how this care had made them feel, and gave numerous examples of how it improved their own psychological health. One person said they felt much happier when the care workers arrived and thoroughly enjoyed the time with them. This person did not have a large network of friends or relatives, and was reliant on the positive interaction with the care workers. Another person told us they felt they suffered from depression during the period they received personal care from another provider. They said that when the care workers from the service commenced, they immediately developed a bond and the person's feelings had positively changed. They told us they no longer felt depressed, and that they often awaited the visits from the care workers because of the positive influence they felt from the staff.

People told us how much they trusted and valued their care workers, how they had sometimes "…felt like [my] own family" and how staff had "…gone out of their way to go far beyond what was required of them". For example, a care worker arrived at a person's house to provide the personal care. The person stated their pet had passed away overnight. The care worker asked the person how they would like the matter managed, and the person said they wanted the animal buried in their garden. The care worker took it upon themselves

to carry out the person's wish and the person said this made them feel happy. Likewise, staff told us they were proud to work for the company, and they demonstrated a genuine interest in the people they supported and their families. This was reflected in their everyday practice and was evident in their social interactions with people they obviously knew well.

The service actively prevented social isolation of older adults in their homes who were often without frequent contact in the local community. The registered manager told us this was at the core of the service . Examples of this included additional welfare visits to have a social conversation and not provide the personal care, encouraging the person into the local community for shopping and other tasks and supporting visits from people's friends or contacts into their homes for socialisation. People and families also described how the care workers often, "…felt like real friends, who understand us as people, as a family, not just as a client" and how this relationship built trust and humour and developed daily care into, "… sometimes quite a social event". One person told us how much they enjoyed being visited by the care workers, how it gave structure and laughter to their life, and how much they looked forward to them arriving. They said, "Sometimes I watch the clock to see how long it is until they [the staff] come again with their good humour and jokes. They make my life so much better, not just because of the care, but because they take time to ask how I am, how I feel and we discuss things that matter to me. It is also a sociable time which is important to me."

Some people told us of the calm nature and atmosphere that came as part of the care provided. One person commented, "Even when I know they [the staff] have other people to see, they see me as a real person and take time to see me as someone with hopes and fears. Everyone feels better when they have been…it is so much more than we hoped for, so positive. I (jokingly) try to bribe the agency to let them live here, we like them so much!" The family of this person told us how much of a difference the visits made. They said, "We so much look forward to them [the staff] coming, even in a difficult period of our lives, and it makes such a huge difference to us. We know we will never forget them, and it feels as if we have known them for ever. For them to gain that amount of understanding and relationship in such a short term is amazing, and great for us. Their whole care and attitude is more than outstanding."

Comments from other families and people reflected that the team of carers "simply cannot do enough for us. Whatever we discuss, they are onside, want to help, to support. It might be a little thing for them but huge for us". "They just want to get it right, every time. We know they are on their way to another visit, but they never make us feel rushed, always make time to talk, and go "above and beyond what we expected."

People and relatives consistently described the inclusivity they experienced in the care planning and review processes. They said staff always gave people the time to express their wishes and respected the decisions they made. They worked together, with the people they supported and their families, to ensure that personal voice and consideration was given to truly develop a partnership which encouraged and sustained co-production. In people's homes, we found information was very person- centred and highlighted what was important to people, including detailed information about their interests and hobbies, social, occupational, and familial history, religious and cultural needs, and emotional wellbeing. Staff we spoke to said that care plans were very effective in preparing them to know how to support people the way they wanted and contained background information about people which helped them to build a rapport with new clients.

People's independence was consistently promoted to ensure, restore and retain their ability to continue living in the community. People said, "They're [the staff] kind and make me feel comfortable. They appreciate my situation and I don't feel like I'm an inconvenience to them. I feel like a person and not a customer", "[The care worker] asks things like 'are you all right making your bed'?" and "They [the staff]

don't rush me and ask if there's anything else I want them to do." One person received 10.5 hours of support per week from two care workers. We saw detailed information about support strategies and the person's preferred routines. Language used in the care plan was respectful and empowering with phrases such as, "…when the person is] ready", and instructions to care workers to check the person was comfortable and had everything they needed. People's abilities were clearly documented, which demonstrated the service used principles of empowerment to maintain people's independence. Another care plan identified that it was important to the person to spend time chatting with the care worker. We spoke to five care workers who all stated they had ample time to chat and spend quality time with people rather than being task-orientated.

Staff clearly understood the concepts of privacy and dignity and told us how they made sure this was respected in practice. For example, one person sometimes had a friend visit during their call and so staff adapt ed their approach and gave discreet support to give the person and their visitor privacy.

Confidential information about people who used the service, staff and others was protected. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO), as required. The General Data Protection Regulation requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislative requirements for record-keeping. Records were secured when not in use. Personal information held on computers had restricted access and staff used electronic passwords to access records. Information was only shared with third parties where consent was provided by people or their representatives. Data, including paper-based records, were stored and archived in the correct way.

Good

Is the service responsive?

Our findings

We saw some highly-personalised care planning which promoted individual decisions and maximum choice. For example, there was detailed information around household objects and people's pets. These care plans clearly defined not only the name of the pets, and their temperament, but where animals should be kept when care was being delivered, what should happen in the event of a medical emergency requiring the person to leave their home, and how best to approach the pets. This provided a high level of assurance to people that their personal preferences were understood and implemented. People were supported to have maximum choice in the delivery of their care, and we heard conversations with people that confirmed and promoted this. They told us they liked having regular staff to attend them, and that, as far as possible this was maintained. They said this provided consistency of support by well trained staff who knew the people well.

We spoke with five care workers who all demonstrated thorough knowledge and understanding of people's individual needs and preferences. Staff detailed people's support strategies, backgrounds and personalities with warmth and respect. One care worker said that she always took time with new clients to check through their plans with them, to make sure it was accurate and included everything she needed to know to support the person well.

The service completed assessments in collaboration with people, their relatives and other professionals. Information was gathered about people's medical and social history, levels of independence, their environment, associated risks, and their aspirations. Initial assessments for care packages were completed and we saw that information and agreed support was dated and recorded into standardised care and support plan templates. We viewed care plans for five people and found information to be relevant to people's needs and highly personalised. Care and support plans were clearly documented and easy to follow. They referenced further specific information in relation to people's needs, for example guidance such as, "What to do in the event of a service user falling", and "Urinary Tract Infection Fact Sheet".

Staff supported people to overcome disabling barriers and went beyond delivering support in line with people's care plan. In addition to providing support staff demonstrated insight into people's potential and acted upon this to improve their quality of life. For example, we were told staff had given advice to one person about mobility aids as they believed this would help the person to access the community and broaden their social opportunities. Staff described that as a result the person was now able to meet up with friends several times a week and had increased his confidence and zest for life in general; the person had begun baking independently at home, whereas before he was dependent upon a 'meals on wheels' service.

Care workers also spent time encouraging and supporting a person with involvement from a family member to set-up a social media account to stay in touch with relatives abroad, which they also described as having a positive impact upon the person's interactions. Staff described that another person they supported appeared socially isolated , which was demonstrated through their behaviour in seeking more support from care workers. Care workers reported this to management who worked with the person's social worker to access more social activities, and the care workers found they were needed less.

The service had an appropriate system to deal with feedback and address concerns. People told us the service acted promptly on any feedback they provided. One person said, "I've got all their numbers [the managers] in the book. I wouldn't say I've made complaints but I've talked to them twice about things, and they do seem to take our comments on." Another person stated, "We have a dog, a friendly Labrador. [Some of the staff] seem to be petrified of dogs. I have told them [the service] to only send people who are OK with dogs." The service responded by checking which staff were comfortable with dogs or owned dogs themselves, and therefore could provide the person's care responsively. The person then said, "I've been showing them [the staff] how to tell (name of the dog) to sit, and he does sit, and they seem to like that…" When relatives provided feedback about people's care, this was also handled sensitively. Another person said, "I have a daughter who does the 'complaining'; it's her house we live in. We complained once about needing to have someone [care worker] at the same time every day. They [the service] handled it very well, and on the whole, it's improved. They come between 9 to 9.30am." This showed the service was responsive to people's needs and personal requests.

Staff showed they understood the organisation's complaints procedure and said management kept them informed of any concerns or changes to people's care because of complaints. Staff also said that the office listened to staff concerns, for example staff had the "right to refuse" if they did not feel comfortable supporting a person with behaviours of concern or people at the end of their life, needing palliative care. Staff said that management valued staff's specific skills and matched people accordingly.

All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements. Staff had received specific training in the principles of communicating with people effectively, and this was an ongoing process. The management team explained effective communication was raised with staff to ensure that people received positive, responsive and efficient care. The care documentation clearly showed that the service identified and record ed communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand it. Care documentation explained what communication aids, such as glasses and hearing aids, people required as part of their daily lives. The service had contributed to the better introduction of technology by introducing mobile communication to people with sensory impairments. We encouraged the management team to continue the implementation of technology within people's care, and they were receptive to our feedback.

At the time of the inspection no one was being supported at the end of their life, however, staff we spoke to said they had supported people and felt they had the right skills and support from management to provide the right care. We also saw there was an organisational policy in place to support people at the end of their life.

Outstanding ☆

Is the service well-led?

Our findings

Adult social care services are required to have a statement of purpose (SoP). A SoP documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. We found the SoP for the service contained all the necessary information and was up-to-date. The service had a clear strategy to provide safe care and treatment. Staff we spoke with were aware of the provider's ethos, and could tell us some of the values such as "to ensure that each service user's needs and values are respected", "recognise the individual uniqueness of service users, staff and visitors, and treat them with dignity and respect at all times" and "acting in an honest and open manner." The provider's strategy, mission statement and values were clearly displayed throughout the office, on their website, and within various documentation including the 'service user guide'.

When we spoke with people who used the service, their feedback resonated with the phrases used in the service's ethos and statement of purpose. People comments included terms such as "...they know how unique I am...", "they always respect me, no matter what..." and "They [the staff] tell me the truth...even when it's bad news..." People's and relatives' feedback demonstrated the service and provider had embedded in the system of care what was written down in the words of their mission statement.

The service had a variety of methods to monitor, measure, evaluate and act on the quality of care people received. Many people told us they were often asked for their feedback and suggestions for further improvement. In addition, people and relatives said they often saw or spoke with the senior staff or management. One person said, "Yes, I did a [satisfaction] survey but I can't remember when." Another person said, "[Although] we don't see her [the registered manager] very often, we do speak on the phone sometimes". Other comments included, "She [the care coordinator] introduced herself and I felt comfortable with her caring questions", "Yes, absolutely a well-managed service", "I'd give them an 8 out of 10. Nothing's perfect. I don't know what they could do to improve!", "Yes, they [the service] do surveys. It comes twice a year with the carers" and "I'd give them an 8 out 10…they're pretty good."

The service's satisfaction survey results matched the comments we received in our telephone interviews and home visits with people. We looked at the 44 results from the 2017 data. The service asked several relevant questions to ascertain people's opinion about various aspects of care. For example, questions included, "Do your regular care workers make you feel safe and comfortable?" and "Please rate your care workers, are they honest and trustworthy?" Other areas the service asked for feedback on were timing and punctuality, quality of life, control over the care received and supporting independence. Results of the survey showed almost all respondents rated each question positively, with "excellent" and "very good" as the answers. The service had analysed the results, and identified strengths and areas for improvement. We saw the service sent a letter to people and relatives in September 2017 with the results of the survey. This showed the score for each question in the survey, what the service aimed for and planned changes. For example, part of the letter stated, "88.64% [of respondents) felt that our care practitioners made you feel safe and comfortable…we are working hard to keep continuity of care by keeping our practitioners on regular runs to build relationships with individual clients. We are still striving to reach 100% by advice, guidance and coaching in supervisions and spot checks. We as a company want clients [to] feel confident and comfortable to

approach us with any issues or concerns." The letter also encouraged people and relatives to contact the management team if they wanted to provide further feedback or arrange an individual meeting to discuss matters.

The management team explained what they felt contributed to a well-led service. The registered manager said, "It is necessary for staff to have approachable managers, inclusiveness, express views and wishes… because they know the clients better than we do in the office. This is so we can make the service users' lives better. The connection between the staff and the service user is because the staff feel valued and they are open for new challenges, they are not frightened to suggest anything, they are always suggesting new ideas and they research for the service user new ventures. Everything they learn in the community is passed on. Communication is important because the office staff get to know the service user and then can communicate special or different needs to the care staff."

Robust systems were in place to monitor the quality of the service and there was good support from the provider. This included a series of local, regional and national audits. We reviewed the 'internal audit' dated 8, 9, 10 May 2018 which was written in the style of a CQC inspection report, using the key questions we always ask. We noted this was very detailed and comprehensive, using data from people, staff, records and systems. For example, a gap in a staff member's employment history was detected and comments were made in the content of the audit. At the end of the audit, was the overview; a report detailing the actions or further improvements to practise required by the inspection. This included findings, (compliance) and actions required or recommendations. Reminders were also used, also in the form of recommendations of how the service could improve even further. An example from May 2018 was that a person had a certain medicine, although mentioned on the MAR, was not mentioned in the care plan. This was corrected to ensure the person's records did not contain any inaccuracy.

There was good oversight of the service from a larger perspective. We viewed the 'weekly report' for the week ending 12 August 2018. This showed hourly activity, unallocated schedules, missed visits, staffing information, business development activity, recruitment, and other important information. This was reviewed by the registered manager and the senior team to identify any actions to be taken. Monthly reports were constructed for care plan reviews, complaints, safeguarding, outstanding actions and spot checks, staff appraisals and supervisions. A combined report was then presented to the provider's executive team. Each month there was an executive meeting, at which the service's key performance indicators were discussed, and reviewed.

The operations managers met quarterly and were asked by the executive team to look at one key line of enquiry each and present this information to the other team members. The service was asked to compare themselves with other providers who have achieved outstanding ratings from CQC inspections. The registered manager explained they offered to help with any challenges within the provider group, upskilling and helping other services and managers to improve. The registered manager said, "Working as a team is the key ingredient for success [and will] prevent uncertainty." There were 'branch buddies' so that registered managers could connect with other locations, sharing resources such as staff trainers. The operations manager explained the service's positive contact with other managers helped support the service when additional resources were required. Feedback about improvement was taken back to the operations managers and executive team, with the aim to make the service even better.

The service had a very positive workplace culture and staff explained why they liked to work there. Staff described the management as very helpful and happy to cover their shifts where necessary. Staff did not feel pressured, and said they were also happy to help and cover shifts where needed. One care worker said, "The behaviour of top management is respectful…that's why we stay." Another said, "I love working for them.

They are a great team and all approachable." Staff we spoke with felt they were given equal opportunities. One care worker said, "I have been offered to complete qualifications and to try out office-based work. Management like to offer that so we can experience and understand different aspects of the organisation, so every part is valued."

The staff turnover was low, which indicated a high degree of staff satisfaction. With staff staying in their posts for longer periods of time, people could receive better continuity from care workers who knew them the best. The service encouraged and rewarded staff to develop and expand their own skills and knowledge. This meant the service retained and deployed staff whose abilities enabled the provision of the most complex types of care. The registered manager explained how they, and others in the management team, identified staff in everyday interactions that could be encouraged to progress their careers. Staff also corroborated the registered manager's assertion about this. Staff explained they were offered learning opportunities that they had not previously had, that they were approached by managers to seek their input about becoming better practitioners. One employee was nominated for the regional Great British care awards home care worker of the year 2018. They had used their initiative and lateral thinking to ensure people received the best possible care. For example, the they had climbed a fence and opened a window of a house to ensure someone's welfare when they were not answering the door. The registered manager explained why the staff member was nominated and how valued the staff member was to ensure people were placed at the heart of the service.

Staff said they received feedback about their performance and understood expectations of them. For example, one care worker said management were very good at ensuring staff used technology correctly to log calls and would "call staff in" to follow-up if they had not. One care worker said they understood this practice helped to safeguard clients and staff and was proud of their 99% call log record and had received a lot of praise from management about it. Another care worker said they received supervisions every three months and regularly received feedback about medicines administration and records, call logs, health and safety, work capacity, updates about people and their relatives. One care worker who had worked for the organisation for a number of years said that the current management team were "…very supportive and approachable. Communication is good both ways. I love my job and have a real sense of achievement that I am helping people."

People benefitted from the service's connections with other health and social care avenues. The service and registered manager had a strong community presence and network within the wider adult social care sector. The service used a variety of methods to check for best practice care and implement it. For example, a person with Alzheimer's disease mentioned to a care worker that they were lacking social contact. The care worker identified that the Alzheimer's' Society could connect the person with other people in the community with similar needs. The benefit was the person no longer felt isolated. They were visited by volunteers and who took them to social meetings and out for coffee. Staff told us, "He was bored. He is able to go out with his chair, but he did not have the connections and the care worker organised a meeting with him and he could start to go to the day centre. The care worker supported the person on the first day of attending the day centre. He loved it, and we asked him if he wanted to go for further days and he increased his number of days to twice per week." There were also good connections with the local authority, the clinical commissioning group and local NHS England. The service and management had accessed best practise, implemented it into the care people received, and evaluated the impact to ensure it was beneficial.

Care workers told us that they were trained in equality, diversity and human rights as part of their induction and were aware of people's cultural and religious beliefs and their preferred gender of support was respected. Staff said they would always respect people's gender identity, sexual preferences and any other characteristic and would seek advice from management in how to meet people's needs. The service was

fully committed to provide support to people that might be discriminated against in attempts to find a suitable service to provide personal care. We were told of how the service had examined the impact that people from LGBT groups and others might have in attempting to find a suitable care provider. The registered manager explained the endeavours the service had commenced to promote inclusivity of these members of the public. This included preparing staff to examine their own values and bias about caring for people who were traditionally discriminated against. The benefit for the general public was that the service would have an 'open door' policy to caring for people who identified as hard to reach in the provision of care.