Transition and Laterlife Matter Ltd

Transition and Laterlife Matter Head Office

Inspection report

393 Hertford Road
London
N9 7BN

Tel: 07717016192

Date of inspection visit:
03 May 2018

Date of publication:
04 July 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults of all ages, including people with dementia or physical disabilities.

This was the first inspection of this service. Not everyone using the service receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care, which is help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the start of our inspection there were 12 people using the service in this respect.

The service had a registered manager which 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.

There was overall positive feedback about the service, from people using it and their relatives and representatives. Everyone said they would recommend the service to friends and family.

We found people were treated with kindness, respect and compassion. Their privacy, dignity and independence was respected and promoted. Staff were consistently described as 'caring'.

People's needs were comprehensively assessed to help ensure their specific needs were identified and addressed. The registered manager demonstrated good knowledge of the community resources available in support of meeting people's needs. The service, therefore, worked well in co-operation with other organisations to deliver effective care and support.

People received personalised care that was responsive to their needs. The service people received was kept under review and adjusted accordingly. People were regularly supported to express their views and be actively involved in making decisions about their care and support.

The service supported people to receive ongoing healthcare support. People were supported to eat and drink enough. Referrals were made if concerns arose.

Consent was obtained before personal care was provided. Where anyone could not make that decision, the service was working towards ensuring an assessment, in line with the principles of the Mental Capacity Act 2005 (MCA), occurred.

There were sufficient numbers of suitable staff to support people. Overall, staff had the skills, knowledge and experience to deliver effective care and support. Staff were supported in their roles, for example, through

developmental supervision. The registered manager worked closely with new staff to make sure they were equipped to meet people's needs before letting them work alone.

We identified areas where the service could not consistently demonstrate safe practices. Whilst there were systems of checking whether people were supported to take medicines as prescribed and that involved staff had sufficient competency, these were not clearly documented. Documents such as risk assessments, care plans, and medicines records were not consistently dated. This had potential to undermine the accuracy of these records when needed, such as for reviews or investigations.

Where the service supported people with medicines management or to move around, risks were not comprehensively assessed to minimise the chances of unsafe support. However, the registered manager provided prompt updates to these assessment process records soon after the inspection visit.

Any safety risks identified for individuals were well managed in practice, such as through making community support referrals or advising the person using the service or their representative. The service also upheld good standards of cleanliness when working with people, which helped prevent infection.

The registered manager demonstrated appropriate leadership values such as through wanting to ensure staff could provide good care when first working with someone new to the service, and pursuing matters in practice to ensure people received safe and responsive care. Systems at the service enabled sustainability and supported continuous learning and improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Where it supported people with medicines management or to move around, risks were not comprehensively assessed to minimise the chances of unsafe support.

Checks of safe medicines support and staff competency were not comprehensively documented.

However, safety risks identified for individuals were well managed in practice. Systems, processes and practices safeguarded people from abuse, and were generally in place to ensure that on-going learning took place when things went wrong.

The service ensured sufficient numbers of suitable staff to support people to stay safe and meet their needs.

The service protected people by the prevention and control of infection.

Is the service effective?

Good

The service was effective. People's needs were comprehensively assessed to help ensure the service was able to meet their specific needs. The whole service worked in co-operation with other organisations to deliver effective care and support.

People were supported to maintain good health and access appropriate healthcare services. The service supported people to eat and drink enough and maintain a balanced diet.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support.

Consent was obtained before personal care was provided. Where anyone could not make that decision, the service was working towards ensuring an assessment in line with the principles of the MCA occurred.

Is the service caring?

Good

The service was caring. It ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed.

People received the same staff for their visits, which helped trusting relationships to develop.

The service ensured people's privacy and dignity was respected and their independence promoted.

Is the service responsive?

Good

The service was responsive. It enabled people to receive personalised care that was responsive to their needs and preferences.

The service people received was kept under review and adjusted accordingly.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

Is the service well-led?

Good

The service was well-led. The provider had a clear vision and credible strategy to deliver the good quality care and support that people and their representatives told us of.

Systems at the service enabled sustainability and supported continuous learning and improvement.

The service promoted a positive and inclusive culture that achieved good outcomes for people. Staff told us of good management support.

The service worked in partnership with other agencies to support care provision and development.

Transition and Laterlife Matter Head Office

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 was an announced inspection that took place on 3 May 2018. We gave the provider 48 hours' notice of the inspection. This was because of the service's smaller size and we needed to be sure the registered manager would be available.

The provider completed a Provider Information Return (PIR) in advance of the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked notifications made to us by the provider, safeguarding alerts raised about people using the service, and information we held on our database about the service and provider. This included the feedback one person using the service provided to us through surveys we sent out at the end of last year.

The inspection was carried out by one adult social care inspector. There were 12 people receiving a regulated activity from the service, and eight care staff, at the time of our inspection. During the inspection, we received feedback about the service from two people using it, the relatives of two other people, and two community health and social care professionals. We also spoke with three staff members and the registered manager.

During our visit to the office we looked at the care files of four people receiving a personal care service, the personnel files of the four staff members, and other records relating to the care delivery and management of

the service such as visit planning records. We were also provided with, on request, a copy of the employee handbook along with some forms the registered manager had updated following our visit.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they believed the service to be safe. One person told us, "Staff called 999 immediately" in response to a sudden health concern they developed. Another person said, in respect of being helped to move around, "They're careful; they know what they're doing." They added that staff always left their house secure after the visit. A relative told us the registered manager was "very careful" in terms of safety hazards around the home which had resulted for example in frayed carpets being taped down.

A number of areas of risk were assessed as part of the initial meeting with anyone starting to use the service. Good attention was paid to identifying and taking action on environmental hazards such as fire safety matters or things that could cause the person or staff to trip. Actions documented included referrals to community professionals, or advising the person using the service or their representative, where safety concerns arose. The registered manager told us the referrals resulted in safer care, as for example, an occupational therapist would visit and provide equipment specific to the person's needs.

However, individual moving and handling assessments provided little information on the load, the equipment and the environment for each specific manoeuvre. There was seldom information on whether equipment such as hoists and slings had been professionally checked and so were safe for use. This did not help ensure that all reasonable moving and handling risks had been considered in support of providing safe care.

Staff informed us of appropriate ways of supporting people to move or be hoisted. Staff files showed staff were either sent on face-to-face training on this topic or had to provide a certificate from recent previous employment. The registered manager said they oversaw that new staff could move and handle people safely by working together with them when first introducing them to new people. They added that they checked equipment during the assessment. In one case, the hoist handle was damaged, which they referred to the community occupational therapist. This enabled the hoist to be fixed the next day and the new care package to start. The registered manager sent us a revised and more detailed moving and handling assessment form soon after the inspection that helped address our concerns.

The service had systems for ensuring the proper and safe use of medicines, but these were not consistently documented. Whilst there was a broad risk assessment at each person's home that included a few questions on medicines, there was no specific risk assessment on how medicines were to be safely managed by the service if that was to be part of the support package. There was, therefore, no record of considering all reasonable risks relating to how the service supported each person with their medicines, nor of any actions being taken if needed. Following our visit, the registered manager sent us a copy of a specific medicines risk assessment that would now be implemented.

We found medicine administration charts were not consistently accurate. There was no documented system for reviewing them regularly to identify the occasional administration gaps in charts or where staff signed incorrectly. This put people at unnecessary risk of not receiving medicines as prescribed as potentially incorrect practices were not being identified. However, the registered manager was able to show us records

which informally demonstrated recognition of some inaccuracies on the charts and efforts to rectify this. They also explained how the risk of one person over-medicating had been addressed.

There was no specific audit of each applicable staff member's capability around medicines support in people's homes, to demonstrate their competency and reduce risks of medicines errors. However, the registered manager told us this was informally completed by senior staff who held nursing qualifications overseeing new staff members' capability. This was in addition to the medicines training provided at the office when staff were first employed.

We met one staff member who was supporting people with medicines. They could explain how to safely support people with taking their medicines and recording the support accurately. They knew to inform the registered manager if any previous medicines remained in dosette boxes without explanation.

The service protected people by the prevention and control of infection. People had no concerns about the service's standards of cleanliness. One person said, "They clean up afterwards." People confirmed staff used disposable gloves and aprons when needed. Staff told us of ensuring they washed their hands and using gloves. We saw a staff member come into the office to get further supplies of gloves. People's care files included enough information about their infection control needs.

The service ensured sufficient numbers of suitable staff to support people to stay safe and meet their needs. The registered manager told us they did not provide services to new people until they were sure they had the right staff available to work with them. People said staff were capable, generally punctual, and had not missed planned visits. One person told us the registered manager "stepped in at short notice when someone couldn't attend." Another said staff were "very punctual." There was feedback that when two staff were needed for care visits, both staff arrived together or soon after each other. Staff confirmed this was also their experience, and that their visit schedules allowed them enough time to get to people on time and stay the right length of time. We saw that visit scheduling software included automatic travel time estimates, which helped enable timely visits.

Staff files demonstrated the service undertook recruitment checks before new staff were employed and enabled to work alone in people's homes. The checks included proof of identity, right to work, references from previous care employers, and criminal record (DBS) disclosures. Staff told us of having to wait for employment references to be cleared before they were assigned to work in people's homes. We overheard the registered manager clarifying with a prospective staff member about a reference coming through and so they could start work. This helped show the service took reasonable steps to ensure staff were appropriately vetted before working with vulnerable people.

The service's systems, processes and practices safeguarded people from abuse. Staff told us of being trained on abuse awareness. They knew to report any concerns such as unexplained bruising or unusual behaviour to the registered manager in case it was a sign of abuse. They told us they were confident the registered manager would respond if concerns were raised. The registered manager told us there had been no safeguarding cases, but demonstrated enough knowledge to assure us any allegations of abuse would be reported to the local authority and investigated.

Lessons were learnt and improvements made when things went wrong such as accidents occurring. For example, the registered manager told us of looking into why one person was having falls. They helped provide care for that person, to see what the risk factors were in practice. Once a specific hazard had been identified, it was possible to work with the person and their family members to reduce the risks. Another person told us of a revised approach from staff following a health incident, which they explained reduced

the chance of the incident reoccurring. These scenarios demonstrated ways in which the service took action to make improvements to people's care and support.

However, we identified areas where further learning could take place. Documents such as risk assessments, care plans, viewpoint surveys and medicines records were not consistently dated. This could undermine processes whenever the document was looked at again, such as for reviews or investigations.

Good

Is the service effective?

Our findings

The registered manager told us new staff completed a four-day induction course in line with national standards. Staff confirmed this occurred, telling us of four full days in the office covering training on, for example, personal care, dementia, and safety. One staff member told us, "It was very interactive, lots of talk and explanations." Records showed staff had completed training via an online resource on a variety of relevant areas including privacy and dignity, person-centred care, and mental health conditions. Many also held a national qualification in care, which the registered manager said others would be supported to acquire.

The registered manager told us of working closely with new staff to make sure they were equipped to meet people's needs before letting them work alone. This meant initially working with them to provide care, and regularly checking up on them. A relative confirmed this, telling us the registered manager "always came with new staff, to train them up." Staff also told us of shadowing the registered manager "to explain clients' needs" and "show me the ropes." This provided them with the skills they needed, to work alone.

Staff were supported for their roles, for example, through developmental supervision. One staff member told us this enabled them to explore any difficulties they had in their work, and to receive feedback from the registered manager on their performance. There were records of two supervision meetings for one new staff member within their first month of work, which helped demonstrate appropriate support for their care role.

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. The registered manager showed good understanding of how a local authority offered care packages out for tendering. If successful, the person usually needed care within 24 hours, so they went to assess the person's needs immediately along with the care worker chosen to work primarily with the person. The assessment included, for example, the person's health and personal care needs, their capacity to consent to care, what equipment was in place to support the care package, and whether the person's home environment presented any particular care delivery risks. People's needs assessments we checked indicated this all occurred promptly. The service also reassessed people's needs after periods in hospital, to make sure any changes in the person's condition were recognised and acted on.

The registered manager told us of assessing people discharged from hospital and informing the local authority of more substantial care needing to be put in place. They spoke of attending meetings to explain this where needed, to help make sure the person received the support they needed. Records also showed the service had successfully increased funding for some people to receive longer care visits that better met their needs, for example, due to needing more support with medicines or mobility than was previously recognised.

The whole service worked in co-operation with other organisations to deliver effective care and support. A community professional told us the service worked well in difficult circumstances in support of someone using it. The registered manager demonstrated good knowledge of the community resources available in support of meeting people's needs. They told us the service's first assignment for a local authority was

someone who presented a lot of challenges and for whom other care agencies had withdrawn. They worked to develop trust with the person by taking the time to talk with them, clean their house and shop for them. This enabled the person in time to accept the personal care support they needed. The registered manager showed us a comprehensive initial assessment of the person's needs. They explained the person had an underlying mental health condition that had not been recognised. Meetings were subsequently arranged with community health and social care professionals to clarify the person's needs and ensure they received appropriate support. The whole process helped the person's holistic needs to be met. The local authority subsequently started asking the service to provide care to other people.

People were supported to receive ongoing healthcare support. One person told us the registered manager had supported them to attend a hospital appointment. Staff told us of reporting concerns such as someone using the service having swollen feet so that action could be taken. The registered manager told us of staff phoning with concerns about the healthcare equipment a new person was using, so they visited the person and made a prompt referral for community healthcare professional support. The service's initial assessments paid good attention to people's health history and current needs, and sometimes recommended further input from community professionals such as occupational therapists or GPs. Further records indicated the service made these referrals in support of better outcomes for people.

People were supported to eat and drink enough where this was an assessed need as part of the care package. Needs assessments considered whether there were risks of malnutrition or dehydration, or health conditions such as diabetes that impacted on the foods the person could eat. Referrals were made if concerns arose. These were considered further at the six-weekly review meeting and actions noted where needed.

A relative told us of a care staff member "shopping and preparing additional food to Meals on Wheels, as there were obviously very small portions." A staff member told us of helping the person they visited to "eat healthily, not just tinned food." They knew signs of dehydration and how to help people overcome this, citing the service's initial training as providing this knowledge. The registered manager told us of making a referral to the local authority for support as one person was found to eat the same meal every day based on what was available for them in their home.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS.

We found the service was working towards the principles of the MCA. Induction records showed staff received training on the MCA. Staff told us of making sure people understood and agreed to the care they were offering, of reporting care refusals to the registered manager, and of receiving advice on how to handle this. The registered manager told us of ongoing training of staff on supporting people who refused care despite appearing to need it. For example, where one person refused to go for a shower, staff would bring a

bowl and washing equipment to them and offer care where they sat. Another person would always say they had just eaten, but if accepted at face value, they would not get the support they needed to have a meal. Staff were coached on ways to engage with them in a way that encouraged them to accept a meal.

We found that the service's written capacity assessments of people did not always fully follow MCA principles. Three people's capacity to consent was assessed without clearly stating what it was they may be consenting to. The registered manager explained these were for consenting to the service providing care. The best interest form was then filled out despite two people being found to have capacity to consent to the care delivery, meaning there was no need to fill out the best interest form. The registered manager agreed to review documentation on people's capacity assessment, to ensure they fully followed MCA principles.

Good

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion. People and their relatives told us this was the case. Their comments included, "The staff are very kind and very good", "Caring and interesting staff" and "Lovely staff, very warm and caring." The registered manager told us of vetting new staff to make sure they held a caring attitude. This occurred during recruitment, their initial training in the office, and when first working in people's homes, all of which the registered manager directly oversaw.

One person said, "The staff talk a lot with me." They explained that shared interests had been found, which helped them feel valued. Another person told us, "They're very nice, we all have a chat, it's like friends coming in." Staff told us of treating people like cherished family members, for example, "I treat them like my 99-year-old grandmother."

The service ensured people were given emotional support when needed. The registered manager told us this was key for some people who would refuse care. They said, "It's the talking" with new people which helped build trust or regain confidence. This helped to gain insight into what troubled them, for example, how one person refused to shower because of the dangers they perceived. Consistent and reassuring staff were put in place who were guided on what the person's concerns were, which helped the person regain confidence.

One person told us of a particular staff member who was "very reassuring." They also spoke of being consistently visited by same staff members. Visit records and staff feedback confirmed this was the practice for everyone as far as possible. The registered manager showed us care visit planning software that enabled the same staff to always be allocated to people automatically. Another person told us of transferring from another care agency. They explained some of the care staff also transferred and continued to be supplied regularly by this service, adding, "I'm lucky two staff transferred across." The consistency of staffing helped people to form and maintain trusting relationships with staff.

The service ensured people's privacy and dignity was respected and promoted. People and their relatives informed us of this, for example, by closing doors during care or being kept informed if staff were running late. A community health and social care professional told us the service worked well to uphold the dignity of someone using the service in what they described as a challenging situation. Staff told us their initial training included specific training on privacy and personal care, citing for example to keep people covered as much as possible during personal care.

The service ensured people's independence was respected and promoted. People's care plans guided staff on how to support individuals with regaining or promoting independence. One person said the service was "very much helping me regain independence", but added that staff provided support where needed. Staff told us of promoting people's independence, for example, of avoiding assumptions of dependency due to the person having a condition such as dementia. They explained this might mean supporting someone to cook rather than doing it for them. One staff member told us of how someone they visited now needed less visits. They said they were "proud of helping her get better and boosting her confidence." The registered

manager also told us of many different people who the service had enabled to regain skills despite being very dependent initially. Review meeting records confirmed ways in which the service had supported people to regain independence.

Good

Is the service responsive?

Our findings

The service enabled people to receive personalised care that was responsive to their needs. People and their relatives told us of individualised care. For example, a relative said staff "will come earlier if asked to." One person told us of having to rearrange a visit due to a prior engagement they had. They had already been advised to contact the registered manager in such circumstances, and their care visited was duly rearranged.

Needs assessments at the start of the service showed people and their representatives were involved in designing their care packages and signing agreement to care plans where possible. The registered manager told us the assessments helped ensure the service was responsive to people's preferences. For example, one person liked to dress in a suit and tie, so it was important staff understood and enabled this. The assessments also established how people wished staff to address them. This showed the service supported people to express their views and be actively involved in making decisions about their care and support.

One person told us the service checked on their holistic needs such as for culture and religion during the initial assessment. Needs assessments we checked confirmed this was the case. The assessments also sought to identify, for example, people's interests, past vocations, what they liked to eat and preferences around personal care. Care staff and the registered manager knew people's individual needs, preferences and routines well, and in line with people's care plans. A community health and social care professional told us of good care planning at the service.

Records showed there were review meetings with people using the service and their representatives, after around six weeks of using the service. These summarised how the person's needs and abilities had changed in that period, and what consequent action was proposed. For different people this included recognition of either increased independence or risks arising from greater dependency. The process helped ensure the service continued to meet people's changing needs and preferences.

The service supported the communication needs of people with a disability or sensory impairment. The service's initial assessments considered what communication needs people had. Where one person was hard of hearing, we were told the same staff consistently visited the person who understood them better. One such staff member spoke of recognising and responding to the person's body language, and of giving the person enough time to respond.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care. People told us they were reminded to let the management team know if they had any concerns or complaints. One person said the registered manager "told me to get in touch if I wasn't happy." Another person told us the morning staff started visiting them later than planned. On discussion with the service, this was fixed by switching their shower to the evening visit, which suited the person. A relative told us there had been no concerns but if there had been, they felt the registered manager "would address them."

Records in the service showed people were asked if they had any concerns or complaints when the management team visited them. The registered manager told us there had been no formal complaints. They believed this was because they encouraged people to raise any concerns, which enabled the service to address them immediately and before they escalated.

Good

Is the service well-led?

Our findings

The service had a registered manager who was also the sole director of the company. They held appropriate management and care qualifications, including for training other staff. They described many years' experience of working in the care sector, both providing care and in a financial role. They said this was now their "best ever job" because they could make a direct difference to people's lives.

The registered manager demonstrated appropriate leadership values such as through wanting to ensure staff could provide good care and displayed appropriate values when first working with someone new to the service. They also showed how they liaised with other professionals to ensure people received safe and responsive care.

We found the service worked well in partnership with other agencies to support care provision and development. Community health and social care professionals told us this was the case. For example, one described always being able to get through to the office, getting good responses from the service, and of colleagues holding similar views. The registered manager told us of attending the local authority's meetings for providers. This helped them become aware of some wider resources such as how to contact the local fire brigade for support if someone using the service did not have a smoke alarm in place. Similarly, the local health and safety team could be accessed if there were significant safety risks in someone's home such as taps dripping onto electrical appliances. Records showed timely and appropriate community resource referrals on behalf of individuals using the service.

The provider had a clear vision and credible strategy to deliver high-quality care and support. There was good feedback about the registered manager's approach from all sources. One person said, "The registered manager is very helpful." Another person said the service was "well-organised." Staff described office staff and the registered manager as approachable and always available. One staff member said the registered manager "is everywhere". They told us the registered manager or senior staff undertook occasional checks of their work in people's home. This was usually unannounced, to include checks on their punctuality and initial approach. Records of these checks also showed consideration of the staff member's appearance, communication with the person, and capability to meet the person's needs.

The registered manager told us about liaising with local colleges to support staff to develop their national qualifications in care and potentially management. The aim was to enable staff to attend the course at the agency's office, to involve less travel.

The service promoted a positive and inclusive culture that achieved good outcomes for people. People told us the registered manager checked up on the service they were receiving. One person said the registered manager visited "to check what I needed." They said the registered manager "would tell me" if there was anything about the service that needed passing on. A community health and social care professional told us the registered manager's knowledge base and values had been very helpful in achieving positive outcomes for the person they represented.

The provider engaged with and involved stakeholders in the development of the service. The registered manager told us that, along with phone calls and visits to new people to check on service quality, they sent viewpoint surveys a few weeks after the service started. Those we saw in people's files indicated satisfaction with the service.

Systems at the service enabled sustainability and supported continuous learning and improvement. The registered manager could demonstrate changes made to how the service worked in light of feedback. For example, the structure of people's care plans had changed over time as confidence grew on recognising what worked best for everyone. The prompt updating of risk assessments for medicines and moving and handling of people following our feedback also demonstrated this.

The registered manager showed us software which enabled real-time monitoring of staff visits to people's homes and alerts if staff were running late. Devices were about to be placed in people's homes which staff would scan. The registered manager said this followed the realisation that many people did not consent to staff using their home phonelines.

There were no documented service-wide audits. The registered manager understood that these would need developing if the service grew in size, but at the moment, the registered manager was involved in all aspects of service and so made sure risks and quality of service was kept under review for each person using it. This was formalised through regular review meetings and spot-checks of staff, plus new staff being intensely coached until the registered manager believed they were safe to work alone. However, the registered manager also pointed out that a local authority had visited the service to check on systems. This had resulted in the service being included in their tendering processes, and retaining that role now based on how they had met people's needs.