Care Quality Commission

Care 24 (UK) Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on the 21 September 2016 and followed this up with phone calls to people using the service, relatives, staff and healthcare professionals on the 29 September 2016. This was our first inspection of the service since it was registered with the Commission in May 2014.

Care 24 (UK) Limited is a domiciliary care service based in Manchester. It provides personal care and support to approximately 50 people in their own homes whose needs range from elderly care, to people living with dementia and physical disabilities. Care and support services included a sitting service, respite for families, outings in the community, help with domestic tasks and emotional support.

A registered manager was in post at the time of our inspection who had been registered with the Commission to manage the carrying on of the regulated activity since May 2015. They were not present on the day that we visited the office of the service and so we did not meet them on this occasion. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe when receiving care from the service and their relatives said they had no cause for concern based on the observations of care that they had made. Risks that people were exposed to in their daily lives and those within their own home environments, had been appropriately assessed and measures had been put in place to mitigate these risks as much as possible. The provider had considered emergency planning and a business continuity plan was in place to be followed in the event of any unforeseen circumstances occurring such as a loss of staff or IT failures. Accidents and incidents were appropriately recorded and policies and procedures were in place to protect vulnerable people in receipt of care from being exposed to abuse.

Medicines were managed appropriately within the service and care plans about medicines were in place. Some records would benefit from more detail around the levels of support that people needed with medicines and their abilities to administer their own medicines safely.

People and staff told us that staffing levels were appropriate and continuity of care was evident, in that staff were organised into small teams delivering care to the same individual. Staff had received training in key areas relevant to their roles and this was regularly updated. A supervision and appraisal system was in place which meant staff were supported to maintain their skills and deliver effective care. People were supported to eat and drink in sufficient amounts if this was needed as part of the care package delivered. People were also supported to maintain their health and wellbeing, if they needed support to arrange or attend appointments with external healthcare professionals such as GP's and dentists.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act

2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The care co-ordinator was clear about their responsibilities in line with the Mental Capacity Act 2005 and decision making for those people who may lack the capacity to make decisions for themselves. We discussed the needs of people currently supported by the service and the care co-ordinator informed us that no person lacked the capacity to make their own decisions at the present time. They also confirmed that to their knowledge, no person currently using the service was subject to a court of protection order to deprive them of their liberty in a domiciliary care setting. They were clear about the application of the MCA within the service and said they would arrange any best interest decision making as and when necessary, through people's care managers in the local authority.

People and their relatives reported that staff were kind, caring and considerate. They gave us examples of how staff supported them to maintain their dignity and privacy and staff also provided us with relevant examples, such as people being given privacy when bathing. People said they were kept informed by the service and communication was good.

Care records demonstrated that the provider appropriately assessed people's needs and planned and reviewed their care. Detailed information was available to staff to guide them about how to deliver care in a person-centred manner. Where necessary, systems were in place to monitor people's conditions, for example if they had poor food or fluid intake.

A complaints policy was in place and historic records showed that complaints were well managed and resolved. Questionnaires were issued to people in receipt of care from the service to gather their views about the care they received. Staff meeting also took place regularly and provided a forum through which staff could feedback their views and raise topics for general discussion.

Staff and people reported that the service was well led and the manager, nominated individual and other office staff were very approachable and helpful. Auditing was carried out regularly and matrices were used to monitor issues such as staff training and when it needed to be refreshed. Where shortfalls were identified actions were taken to address and rectify these promptly. Spot checks were also carried out on staff practice to ensure that they remained competent in their roles and to ascertain that they were effective and safe, when delivering care.

External healthcare professionals spoke highly of the service and described it as responsive, reactive and accountable which they appreciated and considered to be a good quality in a service.

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.

Risks that people were exposed to in their daily lives and their own environments had been appropriately assessed and plans were in place to mitigate such risks.

Safeguarding of vulnerable adults was promoted throughout the service and systems were in place to protect people.

Staffing levels were appropriate to meet people's needs and recruitment checks were thorough.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by competent staff who were trained to deliver care safely. People's needs were met.

Staff were supported with supervision, appraisal, training and induction to ensure they had the competence and skill mix to fulfil their role.

The Mental Capacity Act 2005 was appropriately applied and

Is the service caring?

Good

The service was caring.

People told us they were treated with dignity and respect and their independence was promoted.

There was no evidence to suggest that any one was discriminated against in respect of their human rights.

People said they were kept fully informed by the service and relatives echoed this.

Access to advocacy services could be arranged by the service,

should people need such support.

Is the service responsive?

Good

The service was responsive.

People received care that was person-centred and individual to their needs.

Appropriate and up to date care plans and risk assessments were in place that were regularly reviewed.

Complaints were well managed.

Feedback was obtained from people in receipt of care on a regular basis, to gauge people's levels of satisfaction with the service they received.

Is the service well-led?

Good

The service was well led.

A registered manager was in post and the provider was meeting the requirements of their registration.

People gave positive feedback about the leadership of the service.

Auditing and spot checks on staff practice were carried out which monitored the quality of service provision.

The provider had a questioning practice and sought to drive improvements throughout the service.

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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 21 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in at the provider's office to assist us. The inspection was carried out by one adult social care inspector.

Prior to this inspection we asked the provider to complete a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed all of the information that we held internally about the service, including statutory notifications that the provider is legally obliged to inform us of. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern. We also sought feedback from Manchester local authority safeguarding adults and commissioning teams. We used the information that these parties provided us with to inform the planning of this inspection.

During our inspection we spoke with six people who used the service and four relatives of people in receipt of care. We also spoke with two healthcare professionals who worked closely with the service. The feedback that each of these parties gave us has been incorporated into this report. We also spoke with the provider, the nominated individual (who is the provider's representative), a care co-ordinator and four members of the care staff team. We looked at four people's care records and a range of other records related to the operation of the service. These included three staff files containing training, supervision and recruitment information, and other care monitoring tools and quality assurance documentation associated with the operation of the service and delivery of the regulated activity.

Good

Is the service safe?

Our findings

People told us they felt safe when in receipt of care from staff and comfortable in their presence when they assisted them with personal care in their own homes. Comments people made included, "I am very happy with the care staff, they make me feel comfortable and at ease" and "I feel totally safe".

Relatives told us they had not seen anything that worried them from a safety or safeguarding perspective, when staff supported their family members. One relative said, "I have never seen anything unsafe.

Risks that people were exposed to in their daily lives had been appropriately assessed and documentation was in place to inform staff about how to deliver care in a way that mitigated these risks as much as possible. For example, detailed risk assessments were in place for bathing and showering where people needed support in this area, and also for medication needs and moving and handling. The care co-ordinator told us that people's needs were determined by an assessment carried out during the development of their 'Personal service plans', which we viewed, and that risk assessments were drafted based on their needs as identified in this assessment.

A detailed environmental risk assessment had been carried out for each person related to their own home environments and any risks which may be present to both the person and staff. This considered, for instance, health and safety risks, security, utility supplies, flooring, pets and any external areas. People confirmed that staff supported them to manage risks in their daily lives and they appreciated this. The care co-ordinator told us that the majority of people in receipt of care from the service lived with their own families and if their families did not resolve any emergencies as they presented themselves, whether they be household issues like a water leak, or medical emergencies, care workers would call 999 for urgent responses as needed, or alternatively the office for advice and action where issues were minor.

The provider had considered emergency planning. They had drafted a business continuity plan to ensure the service could continue operating in the event of unforeseen events occurring such as a loss of staff, fire and IT failure. This provided information about what actions the provider would take in response to a list of business emergencies occurring.

Accidents and incidents that occurred within the service were appropriately recorded and managed. Forms were available in each person's home for staff to access and complete when necessary. Staff were responsible for returning completed forms to the office at which point they were reviewed for any actions that needed to be taken. Records showed that there had not been any accidents or incidents in the last two years, although the system in place to deal with such events should they occur was thorough.

Safeguarding and whistleblowing policies and procedures were in place and staff were aware of their own personal responsibility to report matters of a safeguarding nature. They had undertaken recent training in this area. Information was available to aid and inform staff about the reporting channels they should follow should they suspect that abuse or harm had occurred. Records showed, and the care co-ordinator confirmed that there had been no matters of a safeguarding nature within the 12 month period prior to our

inspection. In addition to staff training and promoting safeguarding protocols, the provider had introduced a 'Safeguarding Adults Body Map' designed to focus staff thoughts on safeguarding and assist in promptly identifying potential abuse. This document contained body maps and head and neck pictures, where staff were instructed to mark down any unusual bruising or injuries, for further investigation if necessary, or, for monitoring if these were of a minor nature. The document also focused staff on what to record about any incidents of bruising, injury or suspected abuse, including the details of who they had reported the matter to and any actions taken. This showed the provider was aware of their responsibilities to safeguard vulnerable people and they had promoted safeguarding within their organisation so that all staff shared this responsibility to protect people.

Staffing levels were determined by the needs of people using the service. Staff were generally structured into small groups supporting the same group of individuals to ensure people received continuity of care and people were confident and comfortable with the staff who supported them. Staff did not raise any concerns about staffing levels or their abilities to complete their care work within allotted call times. People said they were not rushed when staff supported them and they felt staffing levels were appropriate to meet their needs. One person said they would appreciate more time at their care call. The care co-ordinator told us that there had not yet been a need to use agency staff within the service and any shortfalls in staffing due to, for example, unforeseen sickness or annual leave, had always been covered by other members of the staff team. An electronic system was used to allocate staff, with all staff having sight of on an electronic application on their mobile phones. The provider told us they planned to introduce the Care 2000 call monitoring system imminently, so that a more accurate picture of staffing needs within the service could be obtained, as staff would electronically sign in and out of each care call visit they undertook.

Evidence in staff files demonstrated that the provider's recruitment and vetting procedures of new staff was appropriate and protected the safety of people who received care from the service. Application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children. This demonstrated the provider had systems in place designed to ensure that people's health and welfare needs were met by staff who were of good character and who had the appropriate competence and skills to carry out their jobs.

Where people were supported to take their medicines this was managed well. Clear detail about the current medicines that people were prescribed was listed within paper based care files retained within people's homes and a Medicines Administration Record (MARs) was used to demonstrate what medicines people had taken, at specific times, on specific dates. Individual medication care plans detailing people's abilities to take their own medicines and the levels of support they needed in this area, were available to staff, as were risk assessments associated with medicines administration.

Good

Is the service effective?

Our findings

People told us they considered the staff who supported them to be well trained and competent in their roles. One person told us, "Staff are definitely well-trained" and another person said, "Staff know what they are doing".

Staff told us and records confirmed that a thorough induction was in place which new staff commenced on appointment into their role and then completed in the first few months in post. The induction incorporated the Care Certificate and most staff employed by the service had completed NVQ Level 2's in Health and Social Care. The Care Certificate was brought into force in April 2015 and was developed jointly by Skills for Care, Health Education England and Skills for Health. It is a set of minimum standards that social care and health workers stick to in their daily working life and sets the new minimum standards that should be covered as part of induction training of new care workers. The care co-ordinator told us that they personally took new staff out to meet people before they started working with them, to ensure that the person was suited to that particular care worker providing support. Care workers were required to undertake a period of shadowing before being deemed competent to work alone and then a spot check of their work after six weeks was carried out, to ensure they were working appropriately and to identify if any further support was needed.

Staff received regular supervision, appraisal and training. Supervisions and appraisals are important as they are a two-way feedback tool through which the manager and individual staff can discuss work related issues, training needs and personal matters if necessary. Training records showed that staff had been trained in a number of key areas such as medication, safeguarding and moving and handling. The care co-ordinator told us that training was accessed through the local authority and also an external company where training packages were bought in and delivered internally by office based staff with 'Train the Trainer' qualifications. We saw there was a hoist and training bed in the office for use during practical training about moving and handling. One to one training was available to staff if they were struggling to understand subject matter delivered in a communal training sessions. We saw the provider had obtained subject specific training DVD's and CD's and also drafted mock exams for staff to complete at the end of individual training sessions, to test their knowledge and understanding. A training matrix was also in place to assist the provider in monitoring staff training needs and the times by which some training needed to be refreshed. This showed the provider supported the staff team with appropriate training, professional development, supervision and appraisal, to ensure that they were equipped with the necessary skills to deliver care to people safely and appropriately.

Both people and staff told us that there were no concerns about communication within the service. People said they felt changes were communicated to them in a timely manner and they felt fully informed. Staff said that communication tools were used to good effect and they felt relevant messages from the provider and other members of the management team, were shared as and when needed.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We discussed the Mental Capacity Act (2005) and Court of Protection orders to deprive people of their liberty in a domiciliary setting, with the care co-ordinator and the nominated individual. They told us that people's cognitive abilities were assessed at the point the service commenced and then afterwards, if necessary. The care co-ordinator was clear about their responsibilities in line with the Mental Capacity Act 2005 and decision making for those people who may lack the capacity to make decisions for themselves. We discussed the needs of people currently supported by the service and the care co-ordinator informed us that no person lacked the capacity to make their own decisions at the present time. They also confirmed that to their knowledge, no person currently using the service was subject to a court of protection order to deprive them of their liberty in a domiciliary care setting. The care co-ordinator informed us that should any concerns or issues arise in the future in respect of a person's capacity levels, they would liaise with their care managers to ensure that capacity assessments were carried out and decisions were made in people's best interests.

Consent had been considered and people had signed their care plans to indicate they agreed with the contents and plans in place about how their care was to be delivered.

People were supported to eat and drink in sufficient amounts to remain healthy. Meal preparation was a service offered by the provider. The care co-ordinator confirmed that no people currently using the service had any nutritional needs that required any food and fluid intake monitoring to be undertaken, but that recording tools were available to monitor people's intakes, should concerns about their health and wellbeing arise.

There was evidence in people's care records that the service engaged with relevant healthcare professionals and made appropriate referrals to people's care managers when needed. The care co-ordinator told us that staff were available to make and attend healthcare appointments with people, should they need assistance, but people's families ordinarily supported them in this way.

Good

Is the service caring?

Our findings

People told us they enjoyed good relationships with staff who they found caring, patient and kind. Comments people made included, "Staff are very respectful and courteous" and "Staff treat me with dignity and are caring". The results from a recent batch of questionnaires issued by the provider indicated that people were very satisfied with the care workers who supported them. They described them as "jolly", "thoughtful", "considerate" and "understanding".

Relatives said they had not had any cause for concern in the way that staff engaged with and supported their family member. One relative said, "The staff are lovely; we are very happy".

We did not visit people in their own homes as part of this inspection and so we did not directly observe staff interacting with people. However, people described how they were supported with dignity and respect and how staff promoted their independence and their privacy at all times. One person said, "Staff always treat me with dignity". Staff also gave us examples of how they respected people and maintained their dignity, for example, by assisting people to the toilet but them waiting outside the door (where people were able and safe to be unobserved) until they were finished and needed assistance to move. Other examples included closing curtains in people's rooms so they could not been seen when personal care was delivered and encouraging people to assist with washing and bathing themselves to maintain their independence as much as possible.

Our discussions with staff revealed there were no people in receipt of care from the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied namely; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

The care co-ordinator told us that no people currently using the service accessed the services of a formal advocate but that this could be arranged through their care managers if needed. They informed us that people's relatives usually advocated on their behalf where necessary and that staff and management also did this whenever necessary across all aspects of people's care packages.

People also told us they felt informed by staff and the provider, and they had no doubt they would be contacted should any changes to the service or their care package be necessary. They said they had regular contact with the service and they were given a service user guide when they first started using the service which had given them all of the information they needed. We viewed this document and saw it contained information about the services provided, how to go about making a complaint, safeguarding, quality assurance and confidentiality, amongst other things. The provider had a confidentiality policy in place, which highlighted to people the conduct expected of staff in respect of confidentiality, and also the overall company approach to this. We saw that people's paper-based care records, and also staff records, were stored securely in the provider's office facility, so that they could only be accessed by those persons with the relevant authority to do so.

Good

Is the service responsive?

Our findings

The service that people received was person-centred. People told us they felt they were treated as an individual and staff ensured their individual needs were met, including any preferences they had. One person told us, "The service we get is very good. We are well satisfied". Another person said, "I have no complaints whatsoever; the service is great".

Relatives said they were happy with the care their family member received and it had made a positive difference to all of their lives. One relative commented, "The service is really, really good. They couldn't do anything better for my dad". Another relative said, "They help (person's name) with everything that (person's name) needs".

The care co-ordinator told us a structured process was in place prior to people starting to use the service whereby 'Care co-ordinators' carried out initial assessments of people's needs, with the person themselves and their family members (if required or desired), to establish how care was to be delivered. One of the care co-ordinators roles was to introduce and match staff with the correct skills to the person being supported. At set intervals care co-ordinators visited people to review their care packages and gather feedback about the service delivered. Initially people received a review of the care they received after six weeks and then six monthly after that. There was evidence in people's archived care records that changes had been made to their plans of care as their needs had changed. The care co-ordinator told us that if people's care call time was increased or decreased, new contracts of care were drawn up which people signed and dated. This showed care was appropriately planned, reviewed and adjusted accordingly.

An overall care plan and individual risk assessments were drafted based on people's needs, as identified in pre admission documentation received from care managers, (if applicable) and the initial assessment of people's needs as identified in the 'Personal support plan', which was completed when people started using the service. There was information about people's needs and preferences, and what level of support they needed to complete activities of daily living such as eating and bathing. There were agreed routines and tasks for care workers to complete during each specified care visit to people's homes. People who needed more specialised support, for example, in relation to transferring position, had detailed moving and handling plans in place. This showed care delivery was person-centred and specific to individual people's needs.

The provider had recently introduced documentation entitled 'All about me' and 'Likes and dislikes' which allowed the service to explore people's backgrounds with them and their preferences about how they wished to be cared for. This meant staff had information available to them to enable them to deliver a more personalised care service. The care co-ordinator told us that this documentation was currently being completed for all people in receipt of care.

Care monitoring tools such as food and fluid charts and bowel monitoring charts, were used to track people's health and wellbeing where necessary. Communication logs were completed by staff daily to reflect people's mood, health and wellbeing and any issues or monitoring needed. These logs were detailed

and clearly signed and dated by staff. Electronically, the provider held a 'Notes' file for each person where records about any contact with external parties, healthcare professionals and families was retained. This meant any range of matters could be monitored and followed up accordingly.

The provider had an 'Emergency grab sheet' in place in people's homes for staff to pass to ambulance services should this be needed in an emergency. This contained important and key information about people's healthcare needs and appropriate ways to support and care for them in line with their needs and risks they faced in their daily lives. This showed the provider had considered the transition of information between their service and other services, particularly those that would need to be accessed in an emergency.

People accessed the community at their own leisure, and if this was part of the care package delivered by the provider, staff supported people to pursue activities of their own choosing. People said staff supported them to make their own choices whilst they were with them delivering personal care. The provider promoted social inclusion within the service in the respect that people could choose to receive enabling services, where staff would, for example, assist them to access the community, and to visit their friends.

The provider had a complaints policy in place which gave people clear guidance about the steps to follow to register a complaint with the service. Records showed that there had been no complaints received in the service within the 12 months prior to our inspection. Historic paperwork related to complaints showed that details of the concern or complaint were recorded, alongside the actions taken to address the matters raised. Letters of apology were evident from the provider to the complainant (where this was relevant) and we saw in one case the provider had reimbursed house maintenance costs that a person had incurred, due to an error made by a member of staff. This showed the provider dealt with complaints appropriately and they recognised their duty to apologise and rectify situations where they, or their staff, were at fault.

People's feedback about the service they received was sought via questionnaires issued to people at review meetings. We looked at the latest completed questionnaires and found people had written positive comments about their experiences of receiving care from the service. In response to most questions people had answered either 'good' or 'excellent' in terms of their satisfaction levels. People commented that they were 'very satisfied' with what they considered to be an 'excellent' service. This showed the provider had systems in place to gather people's views and use that information to measure the quality of the service they delivered.

Good

Is the service well-led?

Our findings

People told us they believed the service to be well-led and staff shared this view. One person told us, "The leadership is good. (Nominated individual's name) is very amiable and helpful. I can approach them at any time with anything". Another person said, "I think the leadership is very good; they are all very helpful".

Staff said they found the registered manager and provider very approachable, as well as the care co-ordinators and office staff. They told us they felt supported in their roles and had access to a range of information materials and records to assist them in their roles. One member of staff said, "If I am unsure about anything I always ring up the office and they help me". Another member of staff said, "If I have ever had any issues, whether it be with a client, staffing or families, the managers 'nip it in the bud' straight away. They always listen. We have a good relationship".

Healthcare professionals linked with the service told us they enjoyed a good relationship with the management team of the service. One healthcare professional told us, "I have found the service to be really positive. They have been responsive if we have increased care packages and they have done everything they can to help us in a crisis situation. They are accountable, responsive and reactive; everything we would want really".

The service had a registered manager in post who had been registered with the Commission to manage the carrying on of the regulated activity since May 2015. They were not present on the day of our inspection and we therefore did not meet with them on this occasion. The care co-ordinator assisted us with our inspection in their absence. Records showed that the provider worked in partnership with other organisations and individuals involved in people's care, such as healthcare professionals and family members.

The ethos of the service was reflected within their company aims. These read as, "The company aims to: provide the highest quality comprehensive domiciliary care service to all service users. Support service users to remain in their own home for as long as it is safe and practical to do so. The company manages and provides at all times, in a way which meets the individual needs of the person receiving care as specified in their care plan, whilst respecting their rights, privacy, dignity, individuality, values and beliefs". It continued by addressing service users directly and stated, "The company aims to: Encourage your independence; Treat you as an individual; Offer choice in all things whenever practical and possible; Treat you with respect; Endeavour to fully understand your needs and enable you to make decisions; Ensure that your privacy is maintained at all times; and Ensure that security is never breached". People's feedback was positive and showed that the provider achieved their aims.

We looked at whether the provider was meeting the requirements of their registration and found that they were. There had been no incidents that had needed to be reported to the Commission in line with the Care Quality Commission (Registration) Regulations 2009.

Auditing was carried out in the service to ensure that where shortfalls arose they were identified and addressed promptly. The care co-ordinator told us that communication logs completed by staff were

audited when they were returned to the office on a regular basis. This was also the case with people's MARs and any gaps in recording or missing records were followed up with staff on duty at that time. The service used a range of matrices to monitor the operation of the service and we saw that these were used to good effect. For example, there were matrices used to monitor staff training, charts to track when staff needed to be supervised or appraised and tables listing when reviews of people's care were needed.

On a practical level spot checks were carried out to ensure that staff practice was in line with best practice and they were competent in their roles. This included checking staff competency with the safe handling of medicines. Staff meetings were held regularly to pass important messages to the staff team and also to provide staff with a forum to discuss best practice and feedback their views. Questionnaires were also issued to people using the service so that the provider could assess how satisfied their customers were.

Actions was taken promptly where issues were identified that needed to be addressed. This auditing and analysis of the results showed the provider had effective systems in place to monitor the quality of the service provided and an attitude of questioning practice and driving improvements.