The Shires Home Care Services Limited

The Home Care Connection

Inspection report

5 Breasy Place
Burroughs Gardens, Hendon
London
NW4 4AT

Tel: 02082022622
Website: www.hcchomecare.co.uk

Date of inspection visit:
12 October 2016
20 October 2016

Date of publication:
30 November 2016

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

The inspection took place on 12 and 20 October 2016. This was an announced visit because we needed to make sure the registered manager was available and that people's care records were available in the office for us to look at.

Prior to this inspection this service was inspected on 6 August 2014 where all standards inspected were met.

The Home Care Connection is a domiciliary care agency that specialises in providing live- in care staff. There is a registered manager in post. A registered manager a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The agency was well organised and managed. The registered manager and office staff were well informed about people who used the service and had a close working relationship with the care staff. There were robust systems of monitoring to ensure the service given was of a high standard. People and their relatives were encouraged to contact the office and asked to provide feedback about the service they received.

All users of the service including people, relatives and professionals spoken with spoke very highly of the agency and the service they provided. People and relatives told us the continuity of care provided by the agency was a strength of the service. The agency had systems in place to ensure there were appropriately skilled care staff to live in people's home and provide a good level of care and support. The service had a robust recruitment process to ensure the care staff were safe to work with people. Care staff received a thorough induction and ongoing training and supervision to support them to undertake their role. Care staff were employed at different levels to reflect their knowledge, experience and skills. The care agency aimed to match people with suitable carers and completed introductions prior to commencing and agreeing a package of care. Care staff demonstrated they understood their responsibilities to report abuse under safeguarding adult's legislation and obtained people's consent before providing care and support acting in line with the Mental Capacity Act 2005.

The agency had an ethos of keeping people as independent as possible in their own homes. Care plans focussed on what the person could do for themselves and identified where they required assistance from the care staff. Care staff were knowledgeable about the people they cared for and ensured they received appropriate support from health care professionals. Care staff had received training to support them to administer medicines in a safe manner and were knowledgeable about the medicines and their use. All people and relatives spoken with found the care staff very caring and respectful and spoke highly of their competency in managing the care provided.

People were supported with their diverse needs and care plans were person centred with care given tailored

to meet the needs of each person. Care plans and risk assessments were reviewed and updated on a regular basis and if people's circumstances changed. People or their relatives were involved in care planning and signed care plans to show they agreed with the care and treatment provided.

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 and their relatives felt safe with their care staff. People were well supported with their medicines. Care staff were provided with appropriate information on medicines administration. Medicines administration records were checked to ensure they were completed accurately.

The service had individualised risk assessments that were regularly reviewed and provided sufficient information to care staff for safe management of the identified risks.

Care staff had received training and were able to identify abuse and knew the correct procedures to follow if they suspected any abuse or neglect.

The service carried out recruitment checks to ensure people using services were supplied with safe and suitable staff.

Is the service effective?

Good

The service was effective. Care staff received a thorough induction and ongoing training to equip them in their role. Regular supervision was provided that checked staff performance and gave an opportunity for care staff to raise concerns.

Care staff had received training about the Mental Capacity Act 2005 and asked people's consent giving choice before providing care and support.

Care staff supported people to access the appropriate health care services to ensure their ongoing health needs were met.

People were supported to eat healthily and remain hydrated. Care staff recorded food consumed and fluids taken. When people required support to eat this was undertaken in an appropriate manner by the care staff.

Is the service caring?

Good

The service was caring. All people and relatives spoken with said care staff were caring and respectful.

The agency had an ethos of supporting people to remain independent in their own homes and care was provided to support people to be as independent as possible.
People were supported to meet their diverse needs and care staff were knowledgeable about people's religious and cultural observances and knew what specific support they required.

People or their relatives were involved in their initial care planning and review of care plans.

Is the service responsive?

Good

The service was responsive. People had person centred care plans that detailed how care and support was to be provided. Care plans were updated on a regular basis to reflect the changing needs of the person.

People received service user guides to tell them how to complain. People and relatives told us they felt able to complain and concerns were addressed by the registered manager.

Is the service well-led?

Good

The service was well-led. There was an experienced registered manager who was approachable and well known by people, relatives and care staff.

The office staff were well organised and there were robust systems in place to ensure regular monitoring and auditing took place. There was effective documentation that provided guidance and prompts for care staff.

The service worked in partnership with other agencies and commissioning bodies.

The Home Care Connection

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.

The inspection took place on 12 and 20 October 2016. The provider was given 48 hours' notice because we needed to make sure the registered manager was available and that people's care records were available in the office for us to look at

The membership of the inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with six people who used the service and case tracked four people's care records. This included reviewing their risk assessments, medicine administration records and care staff recordings such as turning charts and daily notes. We were invited to visit two people in their homes, we talked with their family members, and their live in the care staff, reviewed their care plans, and associated documents. We talked with four relatives during our inspection process. We looked at five staff personal files this included recruitment, supervision and training records. We interviewed four staff members. We spoke with the administration officer, three health care supervisors and the registered manager.

Following the inspection we spoke with the local authority and two health and social care professionals.

Good

Is the service safe?

Our findings

People told us they felt safe with their live- carers "having the same carer for 4-5years makes me feel safe." All care staff spoken with had received safeguarding adults training, gave examples of types of abuse, and described possible signs of abuse. Care staff understood their responsibility to report any concerns to the agency. Care staff told us they would go to the police or CQC if appropriate. The service had an up to date safeguarding adult procedure that was available for staff to refer to in their staff handbook. The service demonstrated to us they considered all incidents to ensure there was not an underlying safeguarding adult concern. The service had robust systems in place to recognise and report any safeguarding adult concerns.

The service undertook risk assessments to ensure people's safety. These included medicines, skin integrity, falls, manual handling, bed rails and risk of fire. There was a risk evaluation matrix that considered all factors and a risk reduction action plan that named the measures required to reduce the risks. These included for example "close supervision and to assist in his activities of daily living to ensure his safety." The risk assessments were thorough and clear for staff to access. High risks were often in red to highlight them to the care staff. All risk assessments seen had been reviewed every four months or if circumstances changed. In addition all care staff received risk assessment training during their induction to support them to assess the changing risk to people on a daily basis. One care staff explained they looked after someone who at one time displayed behaviours that put them at risk of harm. The care staff member would risk assess the situation to decide if it was safe to continue an activity dependent on the person's mood and behaviour.

The service followed correct procedures by carrying out appropriate character checks before staff started working with people to ensure people's safety. We viewed five staff personnel files and all contained an application form and the job interview assessment form. There were copies of identity documents to confirm the right to work and proof of identification. Disclosure and Barring Service (DBS) criminal record checks and reference checks were carried out.

The care staff were employed at a variety of levels according to experience, qualification and level of care required by the person they cared for. As such although all the care staff were live in carers some staff were termed 'live-in carers' others 'senior carers' or when taking a greater responsibility for people with complex care 'unit managers'. The care agency aimed to match people with suitable carers and completed introductions prior to commencing and agreeing a package of care. The registered manager explained that all of the office staff had previously been employed as a care staff with the agency. This meant they had the necessary experience to understand the demands of the role and could offer informed support to the care staff. The registered manager explained they did not accept new packages of care unless they had identified the suitable care staff and had sufficient staff to provide cover for care staff leave. The care staff signed a contract to work with the individual person and the registered manager explained they matched care staff with people in terms of experience and character. They always introduced the person and offered a choice when possible. One person told us "we met in the hospital and so I knew who I was coming home to – I really appreciated this." We saw several instances where care staff from the agency worked alongside care staff from another agency that provided a different part of the care package. The care staff from The Home Care Connection would co-ordinate these visits and work closely with the other agency staff to deliver a safe

and well organised package of care to the person they cared for.

The service had safe systems for the administration of medicines. "My carer helps me with my tablets – I wouldn't bother with them [medicines] without her. She gives them to me and stays with me while I take them. She puts my creams on very gently and always says what she's doing. I wouldn't be without her." There was a medicines policy for staff to follow and a copy in the service users' guide. We saw in people's homes medicines were stored safely and medicine administration records (MAR) were completed without errors. In one person's home we visited the live in carer had put a description of each medicine and their use in the tin where the medicines were kept for covering care staff reference. In people's MAR there was a list and description of current medicines. Staff we spoke with were very knowledgeable about people's medicines and some staff told us of occasions when they had noted negative changes when medicine was changed and they had requested further medicines reviews that had resulted in a positive adjustment of people's medicines. Live in carers could describe how they safely administered medicines and one person told us their care staff member "always wears gloves to apply the creams – so that her skin isn't affected by them as they are a medicine." We saw that each person had a medicine risk assessment and it was clearly stated who ordered and collected prescriptions.

The care staff had received safe food preparation and infection control training and confirmed that they were always provided with protective equipment such as disposable aprons and gloves to prevent cross infection. Each person's risk assessment named current infections, gave the history of previous infections such as cellulitis or chest infections, and stated how these infections had been treated. Precautions to be taken were stated in the risk assessment. For example if someone had a history of urine tract infection then they would be encouraged to drink ample fluids.

Good

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA and found they had systems in place to ensure they upheld people's legal rights.

Care staff told us how they asked people's permission before supporting them and gave choice. All people we spoke with gave examples of how staff asked them what they wanted and negotiated with them. For example one person told us "We talk all the time and [my live in carer] never does anything without asking me and explaining". Care plans contained reminders for staff to obtain consent before offering care and support stating for example "obtain consent from the client prior to giving his prescribed medicines." We saw that people's files contained documents to confirm who held Lasting Power of Attorney to make decisions on behalf of the person if they did not have the capacity to consent to their care and treatment. Mental capacity assessments had been completed for example when medicine was given covertly (in food) and signed by the GP or community psychiatric nurse.

We found that the care staff were well supported by an organised approach to providing training and supervision. Staff received induction training that included safeguarding adults, health and safety, manual handling, first aid, medicines administration, food preparation, COSHH (The Control of Substances Hazardous to Health), recording and personal safety. Training also covered subject's specific to live in carers such as the care staff role, care staff and employer's responsibilities, pet care, and service user's legal rights. All staff spoken with said they found the training helpful and they also shadowed experienced staff before commencing their role.

Staff also attended refresher training or if there was a specific area of training required. Staff described they attended five days spread through the year this included moving and handling (practice with a hoist, one staff at the controls and one acting as service user being hoisted), medicines, health and safety and COSHH. We saw there had been more specialised courses offered such as 'dementia feeding' that covered the risk of choking and aspiration.

One care staff of a number of years duration with the agency described the agency as "really supportive" and "can phone the agency at] anytime." Another care staff member told us "The office staff are very good I feel supported." There was a supervision policy and all staff records reviewed contained a contract for supervision signed by both the care staff and the health care supervisor and a statement describing the purpose of the supervision. All care staff received supervision four times a year and a yearly appraisal. Supervision consisted of an observation by the supervisor, questions asked regarding the care staff role, a review of the care records and care plans. The person supported was asked their views on the care provided.

The supervisor discussed and commented on work well done and areas for improvement. For example one care staff was said to have good communication skills and overall comments of "good" and "thorough." Appraisals looked at staff performance such as attitude, productivity and attendance. Appraisals gave a thorough report of the care staff member's progress and an overall outcome such as "good" or "excellent."

Care staff were very knowledgeable about the people they supported and were able to tell us in detail about people's medical support needs. All people we spoke with were positive about their care staff member's abilities and skills. "I have never had cause to doubt my carer's abilities" and "the carer gave me confidence when I came out of hospital – it was a difficult time and they knew just what they were doing." One person described "a recent skin problem has been cleared with the dedicated help of my carer.' She always wears gloves and takes such loving care." Relatives spoke highly of the care staff skills and knowledge.

Some people's care plans stated a responsibility was "to maintain a therapeutic environment." We saw this was put in place whilst maintaining the person at home in a safe and familiar environment. Care staff we spoke with had been trained to manage people's pressure care needs and precautions were taken to prevent and treat existing pressure ulcers. People had regular skin integrity assessments throughout the year and there was frequent monitoring throughout the day of the pressure areas. Pressure relieving equipment was in place and treatment given as advised by health care professionals. Turning charts specified how often people required turning and recorded the position turned to, all turning sheets reviewed were completed without gaps and demonstrated turning took place as specified.

Care staff were knowledgeable about people's dietary support needs and took great care in ensuring people ate and drank well. Relatives described that care staff took time and care to ensure that people were supported to eat well and remain hydrated. One relative told us how their family member had stopped eating for a period of days, describing the care staff had liaised with the GP, the nutritionist and the speech and language therapist and made up to five different dishes at one time to try and encourage the person to eat, in addition to fortifying the diet with cream and other calorie rich foods as advised. Another relative told us supporting their family member to eat can take time, up to an hour, but the person is never rushed by the care staff.

People told us "We plan the menu and then she [care staff] does the shopping and the cooking. I choose what I want to eat. She always wants me to drink and puts glasses of water or cranberry juice on my tray." People who had more complex health needs had fluid input and output charts maintained that included urine colour to check they remained hydrated. Guidance charts for each staff were in place with diagrams for monitoring urine colour and skin concerns. Other people described being supported with a healthy diet, for example prunes to help avoid constipation. Care staff completed food intake charts to record what people had actually eaten of their meals. People's nutritional needs were risk assessed to identify risks around malnutrition or obesity. Care plans clearly stated allergies and foods people did not like. Care plans stated when people required pureed foods and thickener in their drinks in line with the dietitian recommendations. We saw in daily notes and food charts care staff had adhered to the guidelines as appropriate.

Care staff ensured people attended their health care appointments. People told us staff supported them to go to their GP for example "I manage all my own health appointments but I am more comfortable if my carer comes along with me which is never a problem." Other people's relatives described how the care staff took an active role in contacting health care professionals and going with them to appointments. For example one person attended appointments at The National Institute for Health Research and they were always accompanied by the family member and the care staff to feedback to the consultant about the person's condition and changing factors.

Good

Is the service caring?

Our findings

All people and relatives spoke very highly of their care staff. "I am treated like the Queen," "the carer is so good" and "the best care worker he's has ever had" and "if there is a carer award then they should truly get it" and "my carer is one in a million, marvellous, I'm so lucky." Relatives spoken with felt a strength of the service was the continuity of care staff that knew their family member so well.

Care staff told us how they build a relationship with the person they cared for. "The secret is to treat as your friend" another care staff member told us the person they cared for was not responsive due to their medical condition "although my client does not talk to us and does not open their eyes often we respect [X] as a human being, so we let [X] know when we are going to move them and we say we are going to move you now [X] and tell them why."

The service demonstrated respect for people by having an ethos of supporting people to remain as independent as possible within their own homes. People told us "We go shopping together, I choose and buy and then we cook together – my carer helps me to keep my independence." The registered manager told us that "staff are enablers for the elderly person." People's care records reflected their wish to remain as independent as possible with statements "to remain in my own home and maintain my impendence." Staff told us how they enabled people to be independent by giving choice and encouraging when people could manage by themselves. In people's care records there were updated assessments that clearly detailed what activities of daily living people could do by themselves stating the tasks where people required assistance. We found care staff understood the need negotiate with people and had a good understanding of people having good days and not so good days. For example one care staff member described the person they had cared for many years used to like to go out and walk for long distances, choosing the direction and location of where they went. However sometimes they became unsure of where they were and would require encouragement and support to remember. At these times the person could demonstrate behaviours that were hard to manage but the care staff told us "make sure you get attached to the centre of their heart, and then they will listen to you" we saw there was a very caring relationship between the care staff member and the person they cared for.

People's care plans stated "maintain client's dignity, health and wellbeing at all times." All people we met looked well cared for and groomed by care staff. One health care professional's letter remarked on this when describing a recent consultation "[X] was appropriately dressed and groomed. Tremendous pride had been taken with [X] appearance." Care plans stated for example "Make sure blinds or curtains are closed and that no one else is likely to walk into the bathroom". Care staff told us how they maintained people's dignity and privacy. "If I am giving [x] a bath I close the door and if family are visiting I ask them to wait in another room until personal care is completed." Other care staff told us how they close the door and curtains to maintain people's privacy. Care records were kept both at the person's home and in the office in secure cabinets. Care records were not shared with other people unless there was a specific need to do so. Care staff also described how they were careful not to intrude on people's family life and respected the 'rules' of the household. One care staff showed us what information they gave to care staff covering when they were on holiday. This included a list of the house rules to observe to promote the person's and the family's

privacy.

People were supported with their diverse needs. Care staff received training in diversity and the specifics of different people's cultural and religious observances. Care records specified people's religion and culture and what observances they required. Care staff could tell us about the person they cared for with the specifics of their cultural requirements. "I respect [X] values, [X] has 'moderate' kosher requirements, some dietary restrictions, there are no kitchen rules, no separate kitchen sinks, but they like to celebrate Friday night Shabbat with their family members." Another care staff told us as per their person's care plan. "[X] loves to go to church" "they are Catholic and go to church each Sunday."

Care plans were written in consultation with people and /or their family members. Although not all people we spoke with were able to tell us about their care plan, all were very happy with the care provided. We saw that the office visited four times a year to review the care records and people's relatives we spoke with confirmed they had all been involved in the care planning and any changes made. All care plans we reviewed had signatures where relatives or representatives had signed care plans to show they agreed with the care and support identified.

One person's records we reviewed contained a 'do not attempt resuscitation' form that was completed appropriately by the person's GP and with the signature of a family member. This was in addition to a red file that contained all arrangements in the event of their death. Other people's records seen had contact details of people to contact in the event of a life threatening medical emergency.

Good

Is the service responsive?

Our findings

People had individualised care plans that were person centred, and tailored to their specific needs. Care plans were clear and detailed for staff guidance. Care plans contained aims such as "to assist to remain in their own home." There was an 'activities of daily life functional assessment' that identified when each person required support with a particular aspect of daily living. Care plans both detailed the support required and the preferred way support was given for example some people would prefer a shower another person a strip wash. One care plan stated for example "client has a complete strip wash every day with complete assistance from two carers." Other personal care support needs were detailed in the plans such as "give mouth care every morning" or "apply barrier cream." We saw several people's records contained a daily plan specifying what the person liked to happen each day. When we visited one person their daily routine was written by their permanent care staff member and put in their care records to tell covering care staff how the person liked their day to be managed.

Care plans contained a social activities programme for example "talking and reading- like's activities to enhance memory such as family photos, favourite music, television - likes to go out in the wheel chair." Other people who required full support had plans that stated "do transfer from bed to the recliner chair where [X] sits on and watches television." We spoke to relatives who told us their family members went out with the care staff member on the bus in their wheel chair which the person really enjoyed and had until recently gone to 'singing for the brain' with their care staff member. The care staff member explained singing was so important to the person that when another care staff member covered for them they always made sure the care staff member would sing with the person and asked them to sing during their handover.

We saw from care records that care staff took action to enable people to undertake activities important to them. For example an occupational therapist had recommended a change of wheelchair as the person was complaining of leg pains so they could go out into the local community. The care staff had ensured a new wheelchair was obtained and care records demonstrated it was being used to take the person to church each week

Daily records were kept. All records seen were up to date and contained pertinent information such as food eaten, activities undertaken, mood, incidents and any appointments attended were recorded. Records were written appropriately using respectful language. People spoken with were aware of their daily records and knew these were kept in their home.

People and relatives told us they felt able to complain if they needed to. Some people gave examples of when concerns had been addressed swiftly. One person told us "I complained about 6 months ago. I rang the agency office to complain and they came over". They felt the complaint was addressed. The service user guide told people how to complain both verbally and in writing giving the procedure for both methods of complaint. The registered manager told us that her aim was to stop a concern becoming a complaint. As such she looked into the concern and addressed any issues with a speedy response and solution.

Good

Is the service well-led?

Our findings

People told us "no changes needed, would recommend The Home Care Connection 100%"

There was a registered manager who was experienced and could tell us in detail about the people using the service and the care staff. The registered manager was supported by the health care supervisors and an administration officer. People told us they knew the registered manager by name and there was "no difficulty speaking to the office." One relative told us they were "grateful of the support from the team." The service user's guide given to all users of the service had the agencies statement of purpose, included the aims and objectives, the structure of the agency, and gave information about how to complain and what to expect from the agency.
Care staff spoken with were all positive about the agency. One care staff member told us "I love my work, I am enjoying working? with this company, I am very well supported." For care staff reference there was a staff handbook that contained useful information for example service user's legal rights, data protection and prevention of abuse. All care staff found the registered manager approachable one care staff member told us "The registered manager] is very approachable, when I had personal problems she helped me. She listens to you. You can text day or night," another care staff member told us the office was "really supportive" and "you can phone them anytime" and "The registered manager is genuinely a person who cares for people."

The registered manager told us that she encourages her staff to be like her using herself as a role model. She explained that she was teaching the office staff the business side of running a care agency so they could if they wished progress in the field of health and social care. All office staff had been live in carers with the agency and were being supported to develop in their career. There was three levels of care staff from 'live in carers' to 'unit managers' this allowed the care staff to progress and take a greater responsibility that reflected their skills and experience. The recognition of care staff ability was a contributing factor in maintaining motivated and committed staff team many of whom had remained with the agency for a number of years giving people a continuity of care.

The agency had developed documentation designed to ensure care staff had the information they required available in the person's home. For example all people's care records reviewed contained prompts and guidance for care staff "focussing on normal everyday life - such as helping to dust or tidy up the garden, is important in giving people a sense of feeling useful" or "assess your client from head to toe- is there any bruising or swelling or broken skin?" To ensure good handover of information care staff covering leave shadowed the person they were covering and there was a handover tool that included sections titled situation, background, assessment of the client, recommendations and body map to ensure all relevant information was shared each care staff member signed this completed form to ensure a thorough handover.

The agency was very well organised and managed there were robust systems for auditing the service provided. All information for both care staff and people was kept securely in an accessible format that meant information could be provided immediately it was requested. Office staff were well informed and clear about their specific roles. Supervisors visited all users of the service on a frequent basis sometimes up

to twice a week if the person was unwell or care staff required extra support. The agency employed a car and driver so supervisors could respond quickly if there was an emergency and get to a person's house and could also travel to a wide range of destinations in one day. Every four months supervisors checked the information completed by the care staff this was looked at in the person's home. We saw evidence of auditing quarterly of care plans, risk assessments, turning sheets, daily notes, medicines administration records etc. There were no gaps and documents such as care plans and risk assessments had been updated to reflect the current situation on each visit. In addition information was collected each quarter and audited for content at the office. Staff practice was observed during these visits and we saw instances when supervisors had corrected care staff practice. Care staff told us the office visited them at their place of work to check records and watch care including hoisting. "If not done right, they show you how to do it."

The registered manager showed us that satisfaction questionnaires were sent out to all users of the service and professionals. She explained if there were any issues highlighted they go out to talk to the person or invite them to the office and aimed to address any situation where a person might not be fully satisfied. There was a full report produced each year that scrutinised the responses and gave an account of undertakings for the following year such as updating the service user guide. An action plan with timescales was included to show when specific pieces of work would be completed. AS such the agency was working in a transparent manner with the users of the service.

The service worked in partnership with other agencies this included local health and social care agencies. Professionals we spoke with told us the agency was "very good" and "very knowledgeable." Telling us the agency often supported people who displayed behaviours that were difficult to manage. All professionals spoken with said would use the agency, one stating "I cannot speak highly enough of them" and another stating the agency are "always professional in their approach." In addition the agency worked alongside other domiciliary care agencies to provide part of a package of care to support the people to remain in their own homes.