

The Good Care Group London Limited

The Good Care Group

Inspection report

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

This inspection took place on 15 and 16 June 2016 and was announced.

The Good Care Group is registered as a domiciliary care agency providing live-in homecare to people. At the time of this inspection the service was providing care and support to 215 people nationally. The service had a registered manager. 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 receiving a service were safe because staff were trained to identify signs of abuse and knew what actions to take if they suspected it. People were protected from the risks of preventable harm as a result of the provider's robust risk assessment and risk management procedures. Staff were recruited safely with extensive checks undertaken to ensure their suitability to work with people. Staff supported people to take medicines safely and record medicines administration appropriately.

People received support from staff who were trained by experts. Staff undertook specialised training to meet the needs of people living with dementia and Parkinson's and who had experienced strokes. People's consent was obtained before care was given and people received care in accordance with mental capacity legislation. The provider was highly effective in liaising with healthcare professionals and following best practice in meeting people's needs. People were supported to maintain nutritious diets and received the support they required to eat and drink safely.

Staff supporting people were described as caring and compassionate. People who were at the end of their lives received high quality care that enabled them to live at home with dignity, without pain and in accordance with their wishes. People were treated with respect and their privacy and choices were respected.

The provider was exceptional in its responsiveness to people's changing needs and prevented unnecessary hospital admissions through its flexible service delivery. The provider actively sought feedback from people and responded to it enthusiastically and creatively. People's needs were regularly assessed and people were at the centre of their care plans. People engaged in a wide range of activities of their choosing.

The provider demonstrated excellence in leadership. Staff felt committed to the provider's vision and values and involved in how the service developed and improved. Evidenced based practices were promoted and examples of the best staff practices were celebrated. The leadership team was proactive in its response to trends revealed by its detailed analysis of incidents. The provider worked closely in partnership with a range of providers and agencies and engaged extensively in raising dementia awareness beyond the health and social care sector.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. Staff reduced and managed people's risks of avoidable harm.

Staff were trained and confident about identifying signs of abuse and knew what action to take to keep people safe.

People were supported by staff who were recruited using safe vetting and assessing procedures.

People were supported to take their medicines safely. □

Good ●

Is the service effective?

The service was effective.

Expertise and evidence based best practices informed the provider's delivery of dementia care.

Staff received regular in-depth training and were supported by their managers.

Staff were supervised and appraised to ensure high performance.

People's consent was sought and their rights under legislation were upheld.

Staff routinely engaged and liaised with a range of professionals to meet people's health needs.

People were supported to eat healthy balanced diets and risks associated with eating were assessed in detail and managed.

Good ●

Is the service caring?

The service was caring. People were supported to maintain their independence and chose the staff that supported them.

People's privacy was respected

Good ●

Staff treated people and their homes with respect.

People received compassionate care at the end of their lives.

Is the service responsive?

The responsiveness of the service was outstanding.

People's needs were comprehensively assessed and regularly reviewed.

The service was exceptional in its preparedness to respond to people's rapidly changing needs.

People were involved in the development of their highly personalised care plans.

People were supported to participate in their preferred activities.

The provider sought feedback from people and was exceptional in how they responded to it.

People's complaints were addressed appropriately.

Outstanding 

Is the service well-led?

The leadership and management of the service was outstanding.

People, relatives, staff and healthcare professionals gave high praise about the service people received.

The provider used a range of methods to capture the views of staff and acted creatively on their feedback to improve the service.

The registered manager ensured regular and effective communication was used throughout the organisation to improve knowledge and promote continued excellence in service delivery.

Accidents, incidents and trends were thoroughly analysed so lessons could be learnt, patterns understood and recurrences avoided.

The quality of the care people received was subject to continual auditing.

The provider worked in close partnership with others and worked to promote best practice in and awareness of dementia.

Outstanding 

The Good Care Group

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 was undertaken by one inspector on 15 and 16 June 2016 and was announced. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager and staff were available. This meant the provider and staff knew we would be visiting the agency's office before we arrived.

Prior to the inspection we reviewed the information we held about The Good Care Group, including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with 14 staff, the registered manager and the director of operations. We reviewed documents relating to the delivery of care and support. We read 16 people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We read 11 staff files which included pre-employment checks, training records and supervision notes.

We reviewed the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives. Following the inspection we spoke with six people and four relatives. We also contacted 19 health and social care professionals for their feedback.

Is the service safe?

Our findings

People receiving care felt safe and well supported by the live-in staff providing it. People told us they were reassured by the presence of staff who they considered to be trustworthy. One person told us, "I can rest at ease because the [staff] are a stone's throw away". Another person said, "They [staff] are vigilant to my needs. They are careful and gentle and make sure I don't come to harm, particularly on days when I am not as coordinated as I would like."

People were protected from abuse and neglect. Staff were trained to recognise different types of abuse and were confident about taking action to protect people if they suspected abuse. A member of staff told us, "It is my moral and professional duty to act immediately if someone tells me or I see evidence to suggest abuse. I would inform my care manager straight away, support and protect [the person] and cooperate with any enquiry." Another member of staff said, "Time is of the essence in these situations and I would report it straight away." When safeguarding concerns had been raised we found the registered manager had informed safeguarding teams and the regulator in a timely manner.

People's safety was protected because staff understood the provider's whistle-blowing procedures. Whistle-blowing is the name given to the practice of employees reporting concerns to external agencies. A member of staff told us, "I would report directly to CQC or a local authority safeguarding department if my managers were ignoring my concerns about people's safety."

People were protected from the risks of avoidable harm. The service assessed people's risks and ensured care plans were used to ensure staff knew the actions to take to reduce risks. For example, people who had experienced falls or were at risk of them were referred to healthcare professionals to determine if an underlying health issue may be responsible and to assess their mobility. The assessment informed individual falls management plans which provided staff with guidance about keeping people safe. They included the safe use of mobility aids, removing trip hazards and in some cases employing additional staff. This meant people's risks were identified and action taken to reduce the likelihood of their occurrence.

People at risk of developing pressure ulcers were assessed and supported with plans to prevent them. Staff had guidance on the actions to take if they were concerned about a person's skin integrity. For example, one person's care records stated, "If [staff] notice any changes or redness they should liaise with the district nurse and inform the care manager." Another person's care records directed staff to, "observe for signs of skin breakdown, such as redness, during personal care." We found people were supported with pressure relieving cushions, barrier creams, hydration monitoring and repositioning charts. Body maps were completed during the handover between live in staff to ensure their management of pressure ulcer risks was informed by the most recent information available about people's skin integrity.

There were enough staff to safely meet people's needs. The service provided live-in care with the specific hours of support determined during people's needs assessments and specified within people's care plans. People agreed the rota arrangements of staff. For example, some staff lived-in with people for two, three or four weeks at a time before handing over to a colleague who would live-in for an agreed period. We found

arrangements were in place to ensure people were safe when live-in staff took breaks during the day. For example, some people were supported by family members for short periods whilst other people had care delivered by staff from local domiciliary care agencies. When live-in staff took annual leave the provider deployed staff from a relief team who were familiar with the person, their needs and their care plan. This meant there were arrangements in place to ensure sufficient resources were available to provide a safe continuity of care.

People were protected from the risk of receiving care in their homes from unsuitable staff. The provider undertook stringent checks to ensure the suitability of staff. Prospective staff were required to successfully complete a telephone screening interview before an application form was sent to them. Application forms obliged candidates to submit full details of their employment histories and explain any gaps within it. Two written references and two telephone references were taken up for candidates who passed selection interviews and psychometric testing. The provider used these psychometric tests to check if candidate's values were aligned with their own and assess their resilience to cope as a lone worker. Successful applicants were subject to checks of their details against criminal records and individuals barred from working with vulnerable adults. Where candidates stated they were registered professional bodies, for example the nursing and midwifery council, this was verified. The provider confirmed the identities, addresses and eligibility of successful applicants to work in the UK. This meant people were supported by staff who were safely recruited.

People were supported to receive their medicines safely. One person told us, "The [staff] receive training in this area and are evidently capable of following the GP's directions. I am fully satisfied in their performance in this regard." A member of staff told us, "I always ensure people understand what medicine they are taking, what it's for and they consent to take it. I give the medicine when I am supposed to and record it." Another member of staff said, "If there were any type of medicine error, like a missed dose, I would report it immediately to my manager, record it on the person's medicines records and get advice from the GP." We found medicines records were regularly audited by managers. This meant the service ensured that people were supported to take the right medicine at the right time.

Risks associated with administering people's medicines were recorded in care records and staff had guidance. For example, when people were at risk of not swallowing their medicines staff were advised to supervise carefully. Where the interaction of medicines with certain foods was known to have a possible adverse effect on people this was clearly stated. For example, the care records for a number of people who were prescribed cholesterol lowering medicine stated they should not drink grapefruit juice.

People were protected from the transmission of avoidable infections by the infection control practices of staff. Staff wore personal protective equipment when supporting people with personal care. For example, staff wore single use gloves when assisting people to shower and bathe.

Is the service effective?

Our findings

People and their relatives told us the staff were skilled and competent. One person told us, "[Staff name] has a wealth of knowledge, having dedicated a lifetime to care. This is most apparent when I see her in conversation with my nurse as well as how she helps me." A relative said, "Through watching them support my [relative] and frequent conversations with them, I am convinced the staff are skilled and well trained."

People were supported by staff who received on-going training. Staff told us the training they received enabled them to support people effectively. One member of staff said, "We swim in a sea of knowledge. Training is everywhere and all the time. We have training here [the provider's offices], we have workbooks, we have the newsletters, email updates, online information and webinars." Webinars are interactive on-line presentations and workshops. For example, the provider's stroke awareness training comprised a webinar followed by the completion of a workbook. This meant staff could complete course material and attend the online training without having to leave people's homes or disrupt the delivery of care.

Staff received training to maintain and develop their knowledge and skills. Staff undertook training in a range of areas including, dementia, mental capacity, safeguarding, moving and handling, first aid and palliative care. The provider created a number of innovative training programmes. For example, in association with Parkinson's UK the provider developed a three day classroom based certificated training programme entitled 'Understanding Parkinson's'. In collaboration with the Stroke Association the provider developed online training which included a webinar and accompanying coursework material for trainees. This meant people affected by strokes and living with Parkinson's were supported by staff who received specialised and up-to-date training. Training was coordinated by a training department. Staff were notified when refresher training was required and training records, including a matrix of all completed and forthcoming training, were accurately maintained.

New staff underwent induction training. This comprised an initial week of training at the provider's offices and the completion of the Care Certificate workbook within their first three months of employment. The provider produced a document entitled 'frequently asked questions' to support staff during induction. New staff shadowed experienced colleagues as they delivered care and read people's care records before providing support. One member of staff said, "The induction was invaluable. Whilst it's good having induction training and a supportive care manager you can't beat practical experience and the opportunity to copy the way a colleague works well." Another member of staff told us, "I was ready and confident for the first day I worked alone." This meant people were supported by trained staff who were familiar with their needs and planned care.

People received care from staff who were supervised. Staff had regular one to one supervision from their line managers. Meetings were conducted face to face as well as via telephone due to the distances involved. When supervision meetings were carried out by telephone, the minutes were emailed to staff for agreement. We found supervision sessions were used to discuss people's changing needs and share good practice. For example, in one staff member's supervision we read a discussion about the symptoms and steps to take if a person experienced a stroke. This meant staff were supported in their roles as live in carers.

The performance of staff in delivering care and support was monitored, evaluated and appraised. Staff received annual appraisals from their line managers when their performance was reviewed, accomplishments acknowledged and feedback from people passed on. Appraisals were used to identify staff training needs and plan staff progress using individual personal development plans entitled 'carer's pathways'. These documents identified the objectives, outcomes and support for each member of staff to achieve their potential.

People were supported with referrals to specialists for an assessment of their communication needs. Care records reflected the recommendations of speech and language therapists. For example, one person's care records stated staff should explain tasks in short sentences and not to use connecting phrases such as 'but' and 'therefore'. This meant communication was person centred and staff had practical guidance to meet people's needs.

People consented to the care and support they received. One member of staff told us, "I never take someone's consent one day to be consent for tomorrow and the next day. I have to ask each and every time." Care records stated how people without speech gave their consent. For example, they confirmed the meaning of people's specific facial expressions.

People's mental capacity was assessed. The registered manager and staff we spoke with understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberties Safeguards (DoLS). The MCA exists to protect people who may lack capacity and to ensure that their best interests are considered when decisions that affect them are made. DoLS ensure that people receive the care and treatment they need in the least restrictive manner. Records showed that people who lacked capacity were supported with assessments and best interests meetings. We found people were supported by relatives and lawyers who had been granted powers of attorney by the court of protection. Powers of attorney enable health, care and financial decisions to be made on a person's behalf and in their best interests when they lack capacity to make the decisions themselves.

People received healthy, balanced diets. People's nutritional needs were assessed and their preferences were stated in care records. For example, one person stated they wanted to eat traditional English food. Another person's care records noted they preferred sandwiches without crusts whilst a third person's specified, "Nothing microwaved." Where people's appetites were identified as a concern staff had guidance to follow. For example, staff had instructions in one person's care records stating, "Do not overload the plate as this is immediately off putting to [person's name]." People's preferences for where they ate were stated in care records.

People were protected from risks associated with unsafe swallowing. Where people were at risk of choking referrals were made to healthcare professionals for assessments. The findings and recommendations from these assessments were detailed in care records along with the actions to be taken by staff to minimise choking risks. For example, one person's care records cautioned, "No skin, no bone, no gristle, no rice, no pasta". Another person's records stated, "No mixed textures, no nuts or crisps". This meant staff had clear guidance on foods to avoid whilst supporting people to maintain nutritious diets. Care records noted when people required food to be cut into small pieces and moistened with gravy and when thickening agents were required for liquids to ensure safe swallowing.

People had timely access to health and social care professionals. Staff made referrals to health teams when people's needs changed. For example, when one person's mobility needs increased the service made a referral to an occupation therapist (OT) for an assessment. The OT identified the bathroom as being the location of highest risk and made a number of recommendations. The service took action to implement the

recommendations and supported the person to install a bath lift, toilet riser and non-slip flooring. This meant the service worked with healthcare professionals to effectively meet people's health needs.

People were supported to manage their pain. The service completed the 'Pain assessment in advanced dementia scale' to ascertain the level of discomfort people felt and to identify how people expressed pain when their communication abilities had been impaired by their health needs. People who experienced chronic pain were supported with referrals to healthcare professionals for assessment.

The provider promoted good health and awareness about health issues. For example the provider, in partnership with others, had analysed data from incident forms and hospital admissions and identified a correlation between hot weather and urinary tract infections (UTI's). The provider used these findings proactively by informing staff about the importance of hydration in advance of anticipated warm weather periods. Additionally, as a result of information sharing through its newsletters, webinars, training sessions and supervision meetings staff told us they felt confident in recognising common UTI symptoms in older people.

People living with dementia received effective support based on best practices. The provider's support for people with dementia was championed by a Consultant Admiral nurse. Admiral nurses are specialist dementia nurses who give expert clinical and emotional support to people living with dementia, their families and support staff. The Good Care Group's Admiral Nurse provided training to staff and direct guidance to them when providing support. For example, we found the Admiral nurse had given advice to staff supporting a person, liaised with their healthcare professionals and informed the writing of their care plan. This meant the provider used an expert in planning and delivering care and support to people.

The provider's office was located on the 15th floor of a tower building beside a mainline London train station. Both the station and building were wheelchair accessible and four lifts were available to access the office. This meant people with mobility needs were able to visit their service provider.

Is the service caring?

Our findings

People received care and support from staff who were described as caring and kind. One person told us, "The kindness of the [staff] shines through." A relative told us, "You can't measure empathy or a caring nature, but I see it in the way staff look after [relative] every day. It's touching to see. Our whole family is grateful"

People were supported to maintain relationships which were important to them. Care records contained the names and ages of siblings, children and grandchildren. The inclusion of dates of birth meant staff could remind people about important events including birthdays and offer assistance in writing and sending birthday cards.

People chose the staff who supported them. The provider had a matching process which identified people's assessed needs and matched them to a pool of staff with the corresponding experience and training. For example, we read one person who self-referred to the provider wanted staff with the experience of palliative care. The service met the person's preference. The provider forwarded staff profiles to people. These contained detailed information about the care experiences, training, personal backgrounds, interests and photographs of staff. For example, one staff member's 'carer's profile' stated how many years of experience they had supporting people with early on-set dementia. This information enabled people to make informed choices as to who would be providing them with care and support.

People's independence was respected and promoted. Staff supported people to maintain their everyday living skills and care records detailed the tasks and activities people were able to do without assistance. We found people had been supported with referrals to healthcare professionals to assess the support they required to remain independent or regain independence. For example, a person was referred to occupational therapy for assessment to support their independent use of their bathroom. Staff followed an incremental programme to increase the person's confidence and decrease the support they required from staff.

People told us staff respected their privacy. One person told us, "[Staff] are courteous and respectful to a fault. That extends to the respect they show my property and indeed my visitors." A member of staff told us, "Most rules of privacy are just common sense and decency; close doors, keep your voice down if talking about something personal and give someone personal space to use the commode." Where people didn't want live-in staff entering particular rooms of their homes this was stated in care records and was respected by staff. Another member of staff told us, "[People's] homes are their castles, you must show as much respect for people's homes as you do for them."

People were supported through their end of life journey with compassion and sensitivity. People who were dying were supported with an assessment of their needs and an end of life care plan. End of life care plans detailed people's wishes and preferences. For example, one person's records stated "Do not wish to be taken to hospital under any circumstances." The service worked in partnership with local hospices and community matrons to meet people's needs and wishes. Care records stated the location of 'Just in case'

boxes. These sealed boxes contained anticipatory medicines to be administered by district nurses to ensure people entering the final phase of palliative care were free of pain. We read moving correspondence from a number of relatives to the provider expressing gratitude for the caring way staff had supported people at the end of their lives.

Is the service responsive?

Our findings

People received personalised care designed to meet their individual needs and preferences. One relative told us, "[Person's name] has specific care requirements and, to be frank, quite exacting standards. I would say each of the carers has risen admirably to the challenge, which is no mean feat." A healthcare professional told us, "It is because of the carers from the Good Care Group that [person's name] has been able to remain in [their] home."

People's needs were assessed prior to a service being offered. This meant the provider knew if it was able to meet people's needs and people could make an informed choice about how their needs should be met. People were supported by relatives and health care professionals to complete assessments which included their health, mobility, mental capacity, emotional wellbeing and communication. People were supported with reassessments 30 days after their service started. Reassessments reflected changes in people's needs and any new information arising from a month of observations and care records written by staff.

People's care records reflected their preferences and provided clear guidance to staff as to how they should meet people's needs. Care plans contained detailed information about people's health needs which staff kept up to date by recording the involvement of healthcare professionals and the advice they gave. When appropriate staff maintained records required for monitoring by health professionals. For example, when required staff recorded people's weight, diet, elimination, mood and mobility. When people used mobility aids such as hoists and walking frames, care records stated how staff should safely support people to use them. Care records were reviewed regularly and updated as people's needs changed. This information ensured staff had guidance in care records based upon the most up-to-date information about people's needs.

People were supported by a service that was highly responsive to a change in their needs. The provider was timely and effective in its response to emergencies. A rapid response team was available for short notice deployment to support people. The team comprised some of the provider's most experienced staff and could support or replace a live-in member of staff for up to six days. This allowed for a person's needs to be reassessed, a new care plan implemented and the situation to be stabilised. We reviewed records that showed the team was deployed to support people discharged from hospital with increased needs, when staff required short notice leave and when people's health deteriorated rapidly. The provider's prepared responsiveness to crisis had prevented unnecessary hospital admissions, shortened people's stays in hospital and ensured the stability and continuity of people's care and support in their own homes. For example, one person's early discharge from hospital was made possible by the use of the rapid response team which enabled the person to be supported by two staff at a time to ensure their changed and increased mobility needs were safely met.

People were supported to engage in their choice of favoured activities. During the process of choosing the staff who supported them, people were given information about potential staff. A member of operations staff explained, "We try to match people's needs with staff skills but recognise the importance of compatibility and choice." People viewed staff profiles which included information about staff member's

hobbies. For example, we read that staff described having interests which included music, antiques, the theatre, swimming, cooking, rugby, beauty treatments, knitting and card games. This meant people could identify staff with whom they had a shared interest and engaged in activities they both enjoyed. We found an instance where the shared interest of a person and their live-in carer with pets was creatively used to implement an occupational therapists recommendation for daily walking by joining a 'borrow my dog' scheme. In another example, a person's life was enhanced by staff supporting them to pursue their love of the theatre by frequently attending performances.

People and their relatives were asked for their views of about the service they received. Half of the people receiving a service from The Good Care Group responded to the last survey for which analysis was available. People's views were positive. For example, survey results included 94% of people agreeing that their live-in staff were "kind and thoughtful, treat[ed] them with dignity, understood and support[ed] their lifestyle, has high standards, can be trusted and is skilled and confident." The provider took action in response to people's views about their experiences of the service. For example, the provider reduced the frequency of quality monitoring phone calls to people and increased the seniority of managers making them because people felt they were phoned too often and found it difficult to air concerns to managers they were familiar with. In another example, people asked for greater continuity in staffing when staff took annual leave. The provider responded by creating a relief team. This pool of staff shadowed existing staff and became familiar with people and their needs. This meant people were supported by temporary staff who people knew and were conversant with their care plans. This meant people continued to receive support from staff they knew when their principal live-in staff were unavailable.

People and relatives told us they understood the provider's complaints procedures. We found the provider responded to written complaints within their policy timeframe. Complaints were investigated and complainants were informed of the outcome.

Is the service well-led?

Our findings

People, relatives and healthcare professionals told us the service was well led. A person told us, "One would certainly have to commend the group's management. They tick all the right leadership boxes from their business model to their communication methods." One relative said, "I would recommend this company to anyone who needs reassurance that their elderly relative would be looked after professionally and with respect." Another relative told us, "Were I to describe the management in one word, I would choose 'exceptional'. They are almost obsessed with improving what they do". One healthcare professional told us, "Everyone has been impressed by their professionalism and ability to manage such a unique situation."

The directors and registered manager encouraged a positive and open culture and embraced the input of staff. The provider employed a range of means to obtain the views of staff. For example, a suggestion box email scheme was developed for staff to share ideas with senior managers. These were read by the registered manager and responded to. One suggestion we read was for staff to be issued with business cards to hand to health and social care professionals visiting people. The provider implemented the suggestion. We read messages from staff welcoming the distribution of business cards and expressing the view that they made staff appear more professional and aided communication with external agencies. The provider's openness extended to staff having the opportunity to share their views directly with the chief executive at regular lunches during refresher training courses. We found suggestions made by staff at these meetings were recorded and responded to.

People were supported by staff whose views were sought by managers and used to shape service delivery. Seventy percent of care staff responded to the last analysed staff survey. Staff feedback was positive. Where negative feedback was given or staff made suggestions, the provider produced detailed action plans. For example, 14% of staff surveyed felt their training needs were not being met. The provider responded by creating a training department to ensure staff had the knowledge and ability to meet people's needs. The training team included the posts of learning and development manager, training administrator and a full-time trainer. The team coordinated and delivered training across a range of media including classroom sessions, workbooks and online through e-learning and webinars. Staff we spoke with were enthusiastic about the training they received and how it improved and expanded the skills they used to support people.

The provider undertook a separate survey of operations staff, which included care managers. This questionnaire achieved an 86% response rate. Results included "93% of respondents agree[ing] that the directors had a clear vision about the [provider's] future and their actions [were] consistent with attaining that vision." Another survey result showed, "96% of respondents agree[ing] that they understood the [provider's] strategy and goals." Among the suggestions from surveyed staff was the creation of a management development scheme. The provider responded to this proposal by introducing a leadership training programme. Course content for the programme addressed additional issues raised by the provider's mid-level managers in their feedback. For example, training included managing complaints, conflict resolution, developing a rapport and quality assurance. This meant the provider recognised the areas where some managers did not feel confident and provided them with the skills and knowledge to improve their competence and effectiveness in managing staff to deliver high quality care and support to

people.

People were supported by staff who were enthusiastic about the vision and values of the service. People and staff from all levels of the organisation participated in a working group to review and rewrite the organisations values. When the group asked for staff to feedback on the new values they were proposing 336 staff responded with their views. This meant staff were motivated to participate, shape and share the ethos of the organisation. Each new member of staff received a 'professional carer guidelines' booklet during their induction which contained the vision and values of the organisation. Each member of staff we spoke with understood the provider's values and spoke with passion about them.

The provider celebrated achievements to reinforce good practice. We found that when people, relatives and healthcare professionals forwarded compliments about staff, significant efforts were made by senior managers to ensure this was acknowledged. For example, records showed that following positive feedback the chief executive, director of operations and registered manager had phoned staff to deliver the compliments personally and thank them. We saw a large number of compliments reproduced and published for other staff to read online and in the provider's newsletters. This meant the provider promoted excellence and role model behaviour by staff in the delivery of care and support.

The registered manager ensured effective communication throughout the organisation. The service produced a monthly newsletter and distributed a weekly online operations update. As well as promoting the provider's values and keeping staff up to date with organisational developments, these weekly updates were used to increase staff knowledge and skills. Hyperlinks within the updates directed staff to articles online about legislation and good practice in health and social care as well as links to the 15 standards of the care certificate. Hyperlinks are highlighted text in an online document which when clicked opens another document. Additionally the registered manager used the forum to promote a 'theme of the month'. For example, the theme of the month for January 2016 was safeguarding and hyperlinks connected staff to articles, webinars, a power point presentation, programmes and a test on the subject. This meant that people received care from staff who were continuously and innovatively supported by managers to develop their knowledge of best practice.

Staff felt emotionally supported by the management. A member of staff told us, "As live-in [staff] we form strong emotional bonds with the people we support and a death can be very hard." Following a person's death staff were supported with debriefing by a regional manager and support from the Admiral nurse. The registered manager told us that compassionate leave and counselling were available when staff felt they needed it.

The provider ensured that staff had support available to sustain lone working. An out of hours on call service was accessible to all staff. A member of staff told us, "When I feel myself getting anxious I just give them a call and they're great." Another staff member told us, "I feel the managers are there for me." The on call service was staffed by two tiers of management to ensure cover was maintained and decisions could be made by managers with the appropriate level of authority.

The provider ensured that managers were up-to-date with best practice. The provider's consultant Admiral nurse provided clinical group supervision to regional managers each month. This meant managers coordinating care regularly discussed best practice and research findings with an expert in dementia care. Managers passed on their learning to staff in team meetings and supervision sessions to improve the delivery of care and support to people.

The quality of the care people received was audited, assessed and analysed. The provider operated a range

of quality assurance processes. These included spot checks, quality phone calls to people and feedback requests. Managers completed regular audits of care plans. These ensured that people's consent had been obtained and that care plans were person centred. Paperwork from each person's home was forwarded to care managers, reviewed, audited and filed for future reference.

The registered manager reviewed incidents, accidents, adverse events and complaints and produced action plans to meet any shortfalls detected. By gathering and collating data on an ongoing basis the registered manager and senior team had been able to detect trends and assess the impact of the provider's actions on them. For example, the provider's analysis of accidents identified an increase in falls during hot weather. The provider used these findings to inform people's risk assessments relating to hot weather, hydration and falls. The provider used accidents and incidents as learning experiences by identifying causes and proposing means of prevention.

The provider engaged in extensive partnership working with organisations which promoted knowledge and understanding of particular conditions. Innovative classroom based and online training courses were developed in collaboration with Parkinson's UK and the Stroke Association. The provider's participation in the production of a booklet produced by the United Kingdom Homecare Association in response to the Prime Minister's dementia challenge was acknowledged in the publication. The provider's Admiral nurse provided clinical supervision and training to other providers, published articles in care industry publications and undertook public speaking duties. This meant the provider developed and shared its knowledge and expertise to improve the quality of care people received.

The provider had demonstrated commitment to raising public awareness about dementia. We saw that the provider had delivered eight seminars to district councils in Kent at which information was shared about dementia. Information sessions were also delivered to the independent police advisory group, constituents gathered by a member of parliament and to staff and patients at GP surgeries. The provider also delivered information sessions about mental capacity and dementia to solicitors. This meant the provider shared its expertise with other agencies to improve the quality of the services they offered to people living with dementia.