Bespoke Health & Social Care Ltd

Bespoke Health & Social Care

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This announced inspection of Bespoke Health and Social Care was carried out on 15 December 2016.

Bespoke Health and Social Care provides support packages to children and adults in their own homes across the country. The head office which is the location we inspected is based in Nottingham City centre At the time of our inspection 69 people were using the service.

The service had a registered manager in place. 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 could not always be assured that their medicines were managed or administered safely as Medicines Administration Records (MAR) charts were not completed correctly or reviewed regularly.

People could not always be assured that where they did not have capacity to give informed consent their best interests and rights would be protected under the Mental Capacity Act (2005) (MCA). MCA assessments were not in place for all people who required them. People's wishes regarding their care and treatment were respected by staff. People provided consent to any care and treatment provided.

People told us they felt safe receiving care in their homes from staff of Bespoke Health and Social Care and did not have any concerns about the care they received. Staff knew how to protect people from harm and referrals were made to the appropriate authority when concerns were raised.

Risks to people's safety were identified and managed, and assessments were carried out to identify how to minimise the risk of harm. For example in relation to falls or environmental risks.

People received care and support in a timely way and there were sufficient numbers of suitably qualified and experienced staff employed. Appropriate pre-employment checks were carried out before staff began work at Bespoke Health and Social Care.

People were supported by staff who received training and support to ensure they could meet people's needs. Ongoing training and assessment for care staff was scheduled to help maintain their knowledge.

People were supported by staff to maintain healthy nutrition and hydration. People had access to healthcare professionals when required and staff followed their guidance to ensure people maintained good health.

People were treated with dignity and respect and their privacy was protected. People told us they had

positive, caring relationships with staff. Where possible people were involved in making decisions about their care and support.

Staff understood people's support needs and ensured they received personalised responsive care. People knew how to raise a complaint and were confident these would be listened to and acted on.

There was an open and transparent management culture at the service. People, their relatives and staff were encouraged to have their say on their experience of care. Some people experienced difficulty in contacting senior staff to raise issues about their care.

Quality monitoring systems were in place to identify areas for improvement and ensure these were actioned..

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe

People were protected from the risk of bullying and abuse.

People were supported to maintain their safety and risks were assessed and managed to reduce risk of harm

Sufficient numbers of skilled and experienced staff were employed to meet people's needs.

Medicines were not always managed safely as MAR charts were not completed accurately or reviewed regularly

Is the service effective?

Good

The service was effective.

People were cared for by staff who received support and training to help them meet their needs.

Where people lacked capacity to make a decision about their care, their rights and best interests were protected. Although not everyone who needed one had an MCA assessment in place

People were supported to maintain healthy nutrition and hydration.

People had access to other healthcare services when they needed it.

Is the service caring?

Good

The service was caring.

People and their relatives had positive relationships with staff.

People were treated with dignity and respect and their privacy was protected.

Where possible people were involved in the design and review of their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support that was responsive to their needs.

People and their relatives felt able to raise a concern or complaint and were confident it would be acted on.

Is the service well-led?

Good

The service was well led.

There were quality-monitoring systems in place to drive improvement at the service.

There was an open and transparent culture at the service.

People who use the service, their relatives and staff were encouraged to give feedback about the service and their feedback was acted on. Some people experienced difficulty in raising a concern.

There was a clear management structure in place.

Bespoke Health & Social Care

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 15 December 2016 and was announced. We gave the service 48 hours' notice because the location was a domiciliary care agency and we wanted to ensure there was someone available in the office.

The inspection was carried out by one Inspector. Prior to the inspection, we reviewed information we held about the provider including reports from commissioners (who fund the care for some people) and notifications we had received. A notification is information about important events which the provider is required to send us by law.

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

Due to the nature of peoples support needs we were not able to speak with any people using the service. However we spoke with eleven people's relatives. We spoke with three support workers, a training coordinator, the clinical manager and the registered manager. We reviewed four care records, six MAR charts, quality audits, records of meetings and looked at the recruitment files of five members of staff.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us their loved ones received their medicines when required and had not experienced any difficulty with this. One person told us, "All of my [relative]'s medication and that includes some injections, have to be administered by their carers and they have training to do this. They fill in a MAR (medicine administration record) chart on each occasion that they administer some drugs to them." A relative told us there were not proper records kept of the medicines given to their relation because new charts were not put into place in time so care workers were having to 'make do.' This was confirmed by our findings during the inspection. We looked at some complete MAR chars and found that these had not been completed correctly so it was not possible to determine if people had been given their medicines as intended. Additionally we found that that MAR charts were not being reviewed or audited by the provider. We raised our concern with the registered manager and clinical lead who told us they were introducing new auditing systems in the month following our inspection which they felt would identify and address these concerns. Following our inspection, the clinical lead provided us with evidence of the steps taken to address these concerns.

Members of staff and the registered manager told us they received regular training on the management and administration of medicines. We saw that staff competency was checked by care coordinators and any issues requiring attention were identified and additional training needed to address these was provided. A member of staff told us, "The training is good. I work with a clinical lead who trains and observes us. We had our appraisal and they went through all that." A second staff member told us, "Any client that needs medicine administration, we put a training package together for staff to meet the practical needs of the client at their house. We go through the MAR chart and the correct procedure."

All of the people's relatives we spoke with told us their relations felt safe receiving care and support in their home from staff and did not have any concerns about the care they received. One person's relative told us, "If I didn't feel safe leaving my child to be looked after by any of their carers then I would do something about it straight away." A second person said, "I feel safe." Staff we spoke with told us that maintaining people's safety was a priority for them and that they felt the provider and managers worked to ensure they (staff) and people they supported were safe at all times.

The staff we spoke with demonstrated a good understanding of safeguarding procedures including signs and types of abuse and their role in raising a concern. Staff that had raised concerns in the past told us that the registered manager had acted appropriately in response to these. We saw numerous examples of joint working between staff and the local safeguarding authorities to protect people from risk of harm and abuse. For example, care records showed that staff raised a concern about a person living in unhygienic conditions, who would not always allow care staff to enter their home. A referral was made to the local safeguarding authority and care staff worked with the clinical commissioning group (CCG) to provide more appropriate accommodation for the person. This resulted in them living in more hygienic and safer conditions which improved their quality of life and allowing staff into their home

The registered manager kept a record of all safeguarding referrals they made and the outcome of any

investigations. The learning from these was shared with staff across the organisation. Training records showed that all staff had completed safeguarding training and staff told us they found this useful. One staff member said, "Yes, it was good. It enhanced my understanding of how to deal with incidents, especially in the community. It gives you guidance on who to escalate things to. Our manager is a good liaison between the staff and people (who use the service)." All of the staff we spoke with were aware of the provider's whistleblowing policy and told us they felt they would be able to raise an issue without fear of reprimand.

Records of any accidents and incidents people had were kept in their care records. A copy was also kept in a central file at the head office which was intended to enabled the provider to identify any trends or concerns to help manage any future risks. However, we found this system was confused and at times contradictory. Similar incidents that occurred at one location were classified as a different type of incidents at a second, and the lack of consistency had made it difficult to identify trends and themes. We discussed this with the registered manager and clinical lead who told us they had identified this issue during a recent review and were in the process of implementing a standardised system across the organisation.

Information about how to reduce risk of injury and harm was available in people's care plans. The provider employed clinical lead staff who had completed individual assessments of people's care needs and their homes to identify and manage risk for a number of areas including trips, falls, and the environment. The assessments included information for staff on how to manage risk and were reviewed monthly or when a person's needs changed. For example, we saw a risk assessment for a person whose health condition could be exacerbated by discomfort or staff assisting them to move incorrectly. Staff were guided to ensure the person was comfortable at all times and carry out a number of specific checks prior to assisting them to move. Care staff we spoke with were aware of people's needs and the support they required to reduce any risks. They told us that, where people required it, they had the equipment and resources needed to meet their needs.

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Sufficient staff were employed to meet people's support needs and provide care in a timely manner. Care staff we spoke with told us, "Yes, we've got quite a lot of staff on each team." A second staff member said, "Yes, we normally as a company train extra staff, more than we need." The registered manager told us that more than the minimum number of staff were trained to meet each person's needs to ensure they had sufficient staff to cover anyone who were absent from work. The staff member said, "we don't want the client to be left without care." The provider used a system to assess the number of staff required to meet people's needs safely based on the number of hours of care the person was allocated and Their assessed needs. People's relatives told us their relation's received their care from a regular staff team that understood their needs. One person's relative told us, "It is absolutely imperative that because of my [relation]'s condition, they have only a small number of regular carers who know them inside out and are able to cope with any emergencies that could befall them." A second relative said, "I wouldn't have stayed with this agency were it not for the fact that they've been able to put together a small number of carers who have stayed with us for a long time and who know my [relation]'s needs as well as I do."

People told us staff were never late and stayed for the allotted time of each call. People's comments

included, It's never a problem because if a carer had to leave before the next carer could get here, then one of us is always here to step in just to hold the fort in an emergency," and "There is never a problem about anyone running late. If a carer is detained, then the carer who is here is always happy to stay until they get here because they know they would be treated the same way if it was them in difficulties." Staff confirmed that they had sufficient time allocated for their calls and to travel in between these. They told us, "What the manager does is train staff who are closer to the package geographically so there is less travel time. Most of the time we are early. That helps us to have time to talk and build a relationship with the parents."

The provider had processes in place to ensure staff employed were of good character and had the necessary skills and experience to meet people's needs. We looked at staff recruitment files and saw they all contained evidence that the provider had carried out appropriate pre-employment checks including references from previous employers, proof of identity and a current DBS check. A Disclosure and Barring Service (DBS) check allows employers to make safer recruitment choices.

Good

Is the service effective?

Our findings

All of the relatives we spoke with told us they felt care staff had the skills and competencies to meet their needs and that the staff appeared to be well supported. One person told us, "All the carers have had to have specialist training before being allowed to look after my son. They have spent time in hospital with us, learning from the staff there before they came home with us and started to provide the care here. We found this really helpful, because then when difficulties arose, we had the hospital staff there to help us all work through what it was we needed to do to put the situation right. This certainly gave all of us much more confidence in the first few weeks of coming home from hospital with him."

We found people were cared for effectively as staff were supported to undertake training that helped them meet people's needs. Records showed that before beginning work with a person staff had to successfully complete training specific to that person needs. Staff could not begin working with the person until they had their competency assessed by the clinical lead. Staff we spoke with told us they welcomed the training they received and felt it helped them to support people and understand their requirements. The registered manager told us, "Carers are trained in competency for each particular client. Once they have achieved competency for them they can work unsupervised. Carers can't move between clients until they have completed competency."

Records showed that staff had access to a range of training sessions beyond that identified as mandatory by the provider to help them meet people's needs. Staff told us, "We have continuous training for each package and each new care need people have like, tracheostomy and (Basic Life Support) BLS and we have had train the trainer so we can train others." Staff training files we reviewed showed that if staff did not successfully complete their induction training satisfactorily during their probationary period of employment, this was extended until staff had demonstrated they had the necessary skills and competence to meet people's needs safely.

Staff told us they felt supported by the registered manager and management team and were able to talk with them and discuss any issues. A staff member said, "I've got a really good manager who is always ready to support you." We saw that all staff received a regular face-to-face supervision meeting with their manager. Staff told us they valued these meetings and felt able to be open and honest. A staff member said, "The clinician gives me the one to one support. It identifies what additional training I need. I realise that everyone's practice needs to be assessed all the time."

Records in care plans we saw confirmed that people or their relatives had signed to indicate their consent to any changes and reviews and that their wishes were respected. A relative told us, "We have an extremely detailed care plan which is looked at not only by us, the agency and the CCG, but also his hospital consultant and therapists who all contribute to the care that he needs. Reviews take place at least once a month because of the nature of his condition." Each care plan included a decision making guidance document which recorded the persons capacity to make a decision for the activity and who ultimately had the right to make that decision. We saw evidence in care records that this was put in to practice. For example one person's care plan indicated that they could sometimes be reluctant to accept medical intervention.

Guidance for staff stated they should accept the decision but record and report any concerns to the office immediately so a plan could be discussed.

In the majority of care records we looked at, where people lacked the capacity to make a decision the provider followed the principles of the Mental Capacity Act (2005) (MCA). 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.

Staff we spoke with did not display a solid understanding of the MCA and none had received training in its application whilst working for Bespoke Health and Social Care. A staff member told us, "I've done quite a lot of training but not at Bespoke actually." A second staff member said, "Not really (had MCA training) but I have read about it. We have some people in particular we need to be aware of for this and they don't have capacity to make decisions."
This was reflected in people's care records. One care plan we reviewed contained a detailed MCA assessment, including details of areas where the person could make a decision if they lacked capacity in other areas. However the other care plans we reviewed did not contain MCA assessments, including one for a person who was identified as having 'reduced cognition' and two people's relatives confirmed to us that their loved one lacked capacity to make any decisions for themselves. We informed the registered manager of this omission and they and the clinical lead informed us this was an issue that they were addressing with a new care plan recording system.

People were supported by staff to maintain healthy nutrition and hydration. This included making people regular drinks and supporting them to make meals. One person's relative told us, "My daughter can eat normally and the carers will help me prepare what she would like. They then have to feed this to her and I must say, having observed them over many months, they never rush her and always talk to her while she is having her food. They will do their best to encourage her to eat as much as she can in order that she gets the daily calorie intake that she needs." Where people required specialist support to manage their nutrition and hydration, staff had received training to provide this. A relative told us their relative's nutritional needs were met using specialist feeding equipment. They told us staff had the appropriate skills to manage this for their relative.

People had access to health professionals when required and the service was proactive in making referrals and requesting input when required. One person's told us, "The carers very much have to work on their own initiative and that's why it's important that carers know my (Relative)really well and know the signs of when they need medical intervention. They have never let me down when such an emergency has occurred and have always placed my Relative 's well-being before anything else".
A second relative said, "If carers are here on their own and there is a medical emergency, it is up to them to call the ambulance. They have had to do this on a number of occasions in the past and I have always found that immediately after calling for the ambulance, they have contacted me and also let the agency know what was happening."

Staff told us, "Most of the time, if there is something going on we liaise with the other professionals. Normally before people are discharged we get all the contact numbers for everyone who is involved with the persons care. We also contact each other via email. If anything is going on we can communicate with each other as a multi-disciplinary team and we can raise any concerns we have." We saw notes in daily records that showed when care staff had called the emergency services. People's care records showed they had regular appointments with the optician, dentist, chiropodist and district nurse. Care records showed that

staff followed the guidance of health professionals where possible if the person or their relatives gave consent.

Good

Is the service caring?

Our findings

People's relatives told us they had a good relationship with care staff and felt they treated them with care, respect and compassion. They told us they felt staff treated them as individuals and were focussed on their wellbeing rather than tasks. One person's relative told us, "I really cannot fault the carers at all, they would do anything that was needed to keep my (relative) safe and well looked after and that's all that I can ask for. This is not just a job as far as they are concerned." A second relative said, "Our small group of carers have been loyal to us as a family for over two years now and they are really like members of an extended family these days. I would have no hesitation at all in leaving my relative with any one of them because I know they have (name's) best interest at heart." Care staff we spoke with told us how much they enjoyed working at the service and how it gave them job satisfaction.

People received a comprehensive assessment when they first started using the service including recording of their preferences for a male or female care worker, support needs, treatment plans, capacity and dietary requirements. Staff we spoke with demonstrated a very good understanding of people's characters and treated everyone as individuals. They were aware of people's likes and dislikes and how this would affect the care they provided. People's religious and cultural needs were identified and staff endeavoured to respect and meet these where possible. For example by supporting people to attend religious services. One person's care record include guidance for staff about the importance of daily prayer in the person's life.

Care records we reviewed showed that where possible, people and their relatives were involved in the design of their care plans and had signed these to indicate they agreed with them. The service had robust systems to ensure people were involved in the design planning and review of their care and recording people's consent to treatment. One person's relative told us, "We are fully involved in the planning of his care, the fortnightly review meetings and the multidisciplinary meetings that take place every few months. We make sure that our views are listened to at all times." A second relative said, "I have to say that there has never been a problem with our thoughts, views, opinions and ideas being taken into account whenever we have been at any review meetings about (name's) care."

The registered manager informed us that at the time of our inspection, no one using the service required the services of an advocate. People were offered the use of an advocacy service when they first started at the service but no one had chosen to do so. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

People told us they were treated with dignity and respect and their privacy was protected. One person's relative told us, "All I can say, is that (name's) nurses and carers look after them as if they were theirs and I have never had any problems whatsoever about anyone violating their privacy in any way at all." People told us that staff were polite and respectful when speaking with them and always called them by their preferred name. Staff told us they always ensured people's privacy and dignity were protected when delivering personal care. One staff member said, "In the care plan it is always written to make sure people are covered and their privacy protected. We make sure we knock on the door before we go in and always ask

for permission before we do anything. "A relative told us, "(Name's) carers are always very good and make sure that curtains are shut and the bedroom door is closed before they start to do anything like undressing (name) to get them ready for bed. When having a shower they always make sure that the temperature is nice - so that (name) won't be undressed for longer than is necessary."

Good

Is the service responsive?

Our findings

People's relatives told us they received personalised care that was responsive to their needs. One relative told us, "The l (administrative)Support could be greatly improved, but the carers themselves bend over backwards to look after our relative ." Also "Nothing is ever too much trouble for the carers, even providing me with emotional support from time to time."

People were cared for by staff who had a good understanding of their care needs and ensured that the care was provided at the right time. We saw that staff were allocated sufficient time for their call and did not have to travel between calls. A relative told us, "We have 24 hour care so this allows all the flexibility we need thankfully." People told us staff generally arrived on time and stayed for the allotted duration. They told us they knew which member of staff would be calling and were informed if the staff member was going to be late or a different care worker was calling. A relative told us, "The carers are always punctual."

Staff we spoke with had a good understanding of people's needs. There was an effective system in place to ensure that staff were informed of changes to people's planned care; this included updates from the care coordinators and regular team meetings. Staff told us they aimed to provide person centred care and they respected the choices people made. We saw that care records included guidance for staff on the importance of choice and involvement of people in decision making. A relative told us, "(Name) is not able to make any choices for themselves and doesn't even understand their condition. Therefore we are the ones who have to ensure that (name) has the best care possible to keep them in the best of health for as long as possible." We saw examples in care records were people's choices were respected. For example, in ensuring people were given choices for their meals and what clothes to wear.

Care plans we viewed were very detailed, accessible, relevant and very person centred. They focused on giving staff an understanding of the person as well as their care and support needs. Staff told us they found these useful and we found that they gave a very good understanding of the person, their needs and personality. A staff member told us, "Yes, it's got quite a lot of information about the client and what we need to do for them. It tells you how they prefer to have things done so we can personalise the care to them." A second staff member said, "I like them because this is where you get to know the patient and know their needs. It helps the carers to give as good quality of care to the patients as they would get from their parents."

Staff offered people support where required but encouraged them to be independent when they could. For example, we saw that staff supported people to attend college or take part in social activities outside their homes. Relatives we spoke with told us they valued the support they received and it had a positive impact on their loved ones lives. "(Name's) carer supports them to go to college and have some social time with their friends and it is gratifying to see how happy (name) looks when they comes back in. It's a small slice of normal life." A second relative said, "(Name) is totally dependent on us for everything. But the carers take Them out during the day and (name) loves swimming in the hydrotherapy pool and bouncing on the large trampoline."

The provider had established links with other health providers in the areas were people they supported lived to ensure they received responsive care that met their needs at all times. We saw examples were this had a positive impact on people's lives and the care they received. For example, each care record we reviewed included the contact details of all other health professionals involved in their care. We saw that agreements were in place for staff from Bespoke Health and Social Care to go into Hospital or other services to provide care for the people they supported to ensure continuity of care.

We saw that where complaints were received they were dealt with in line with the provider's policy and to the satisfaction of the complainant. We looked at the providers complaints records for the year preceding our inspection. Staff told us of complaints they had dealt with and how they were resolved. "If we need to apologise we always do. I would rather people told us if they were not happy, we truly empower them to complain and give us feedback about how we are doing and how we can make the company better." People's relatives told us they would be happy to raise an issue or complaint at the service and were confident they would be listened to. One relative said, "I certainly know how to make a complaint and there is a leaflet in the folder with all the information about who to contact and the timescales for answering a complaint. I haven't actually had to make a formal complaint because I tend to sort things out before they get to that stage with one of the managers." A second person said, I tend not to let issues get to the stage where I need to make a formal complaint. I would much rather tackle a problem at an early stage by contacting (clinical lead) and talking it through with them."

People received a copy of the complaints procedure when they began using the service and a copy was available in each person support plan. Staff were aware of the complaints procedure and knew how to advise complainants. A staff member told us, "We listen to them, ask them for more information. We would pass the complaint to the manager. If the complaint is about a carer we investigate to make sure everything is safe. We talk to the client and tell them how we are investigating it."

Good

Is the service well-led?

Our findings

There was an open and transparent culture within Bespoke Health and Social Care and people felt able to have their say on the running and development of the service. People we spoke with told us they felt they were encouraged to give their feedback about the service. People's relatives told us they were comfortable speaking with support staff and the registered manager. However people felt there was a disconnect between care staff in people's homes and the head office. One relative said, "I can ask (care manager) anything, but whether they can deliver the change or address the issue I have, is debatable." This was echoed by a second relative who said, "I have a very honest, open relationship with (care manager) and often they'll say they agree with me, but has no power to change things." We informed the registered manager of these concerns who told us the service was aware of the issue and were taking steps to address it. Following our inspection we were provided with evidence of visits by managers and administration staff to people's homes and to meet with care workers to help improve communication and identify an y concerns.

Staff agreed there was an open culture at the service and would feel comfortable in raising an issue with or asking for support from, their line manager or the registered manager. One staff member said, "In all my working time (registered manager) is the best manager I have ever had. I have never felt unsupported I have enjoyed working with him so much. I am able to say anything knowing that I will be supported professionally or when I vent my frustration. He listens and he always gives me solutions. He is always honest, they don't hide, even if they can't do something for me."

People's relatives told us they felt the service was generally well led but they had experienced difficulties with administration and communication with the service beyond the staff associated with their care. "The named Manager who I always call is extremely good. They are always available whenever I need them and within the scope of what they can do and decide, they will do their best." A second relative said, "I have worked with my manager for some time now. If I need them, I have their direct dial number, and if it goes to answer machine they will always call me back as soon as they are free." They went on to say. "The Clinical Leadership and the admin side of the business are not brilliant though and I find the easiest way is for me to sort out rotas directly with our carers, because if I leave it to the office, my carers wouldn't be offered any work with me and I would be left with carers who didn't know me."

Staff had a number of ways available to offer feedback on the service including supervision meetings, informal conversation and team meetings. The provider had established a range of meetings to allow all staff the opportunity to have their say and to help monitor the quality of the service. We saw records of meetings for office staff, managers, clinical staff and care workers for the months preceding our visit. These showed that issues including development of the company, further training and staff retention were discussed. Records showed that staff had the opportunity to contribute to the meeting and raise issues, and that these were followed up by the registered manager. Staff told us they found these meetings useful and they were able to have their say. One member of staff told us, "It's a free for all, we all take turns and anyone can say anything." A second staff member said, "It's a nice time to say things because issues get sorted. People don't feel like they can't say something."

People, their relatives and health care professionals had the opportunity to give feedback about the quality of the service they encountered. The provider had a number of ways of gathering feedback including an annual satisfaction survey as well as regular questionnaires and quality monitoring visits to people's homes. People told us they valued these visits and felt able to give honest feedback about their experiences. One person's relative told us, "(The manager) drop's in for a visit every week. At least with them being about regularly, it allows us to have a discussion about anything that needs changing so that it doesn't fester." A second relative said, "They (manager) will visit every fortnight and call every other day to make sure I am happy."

Feedback from the surveys showed that people were happy with the service they received. Comments included, 'I am satisfied and grateful for the support we have received', 'I feel very involved in setting up and delivering my care' and 'My carers are punctual and make me feel safe.'

We saw that where people made comments or suggestions these were acted on. For example, where people felt they did not work well with their support staff, the staff were moved straight away regardless without question. One person's needs changed which meant they were able to leave their house to socialise more often. As a result they had requested that only staff who were able to drive them to events were allocated. We saw that this was implemented.

The service had a registered manager who understood his responsibilities. Everyone we spoke with knew who the manager was and felt he was always visible and available. Clear decision-making processes were in place and all staff were aware of their roles and responsibilities. Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

The quality of service people received was assessed by the management team through regular auditing of areas such as complaint and compliments, missed calls, lateness, environment, staffing, medication and care planning. Where issues were identified, staff took action to address these. For example a review of safeguarding referrals had identified am issue with notifying CQC. We saw that the procedure was changed and all notifications were submitted as required.

The registered manager, clinical lead and senior staff carried out regular audits and unannounced observation of staff practice. These checks identified any areas where improvements needed to be made. All audits were reviewed by the clinical leads and the registered manager to ensure consistency and quality.