Midshires Care Limited

Helping Hands Derby

Inspection report

Unit 35 , Park Farm Shopping Centre
Allestree
Derby
Derbyshire
DE22 2QQ

Tel: 01332417138
Website: www.helpinghands.co.uk

Date of inspection visit:
12 September 2018
13 September 2018
17 September 2018

Date of publication:
05 November 2018

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

This inspection took place on 12,13 and 17 September 2018. We gave short notice of the inspection because we needed to be sure the registered manager would be available to speak with us. This was the first inspection of the service since they registered with the Care Quality Commission.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to a range of people, including older people and people with physical disabilities. Not everyone using Helping Hands Derby receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection, the service was providing care and support to 60 people.

The service had a registered manager in post. 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 and relatives told us they had confidence and felt safe with staff from Helping Hands Derby. Staff demonstrated a good understanding of the various types of abuse and knew how to report any concerns. Managers provided regular training and guidance to support staff understanding of their role in protecting people from abuse.

Potential risks people were exposed to had been identified and reviewed. Risk assessments included detailed information and guidance to support staff to follow measures to reduce the risk of harm.

People received care from a consistent team of staff who arrived on time and stayed the full length of the call. There were robust recruitment processes in place. These helped to ensure staff were suitable to provide care and support. There were enough staff available to meet people's needs as assessed in their care plans.

Systems were in place to ensure staff followed safe infection control procedures to prevent the risk of infection when providing care. People received their medicines as prescribed.

There were arrangements in place for the service to make sure that action was taken and lessons learned when accidents or incidents occurred, to improve safety across the service.

People's needs and choices were assessed and their care provided in line with their wishes and preferences. Staff completed an induction process when they first started working in the service and on-going training and supervision. Training was reviewed and evaluated to ensure it was effective. This supported staff to gain the skills and knowledge they needed to provide care based on current practice.

People received support to have enough to eat and drink and were supported to maintain their health and well-being.

Staff demonstrated their understanding of the Mental Capacity Act 2005. They gained people's consent before providing care and support.

People had positive, caring relationships with staff who knew them well and supported people to maintain their independence as far as possible. Staff were committed to protecting people's right to dignity and privacy and treated people with respect.

Care plans provided staff with detailed information and guidance about people's likes, dislikes and preferences. People and their relatives were involved in planning all aspects of their care and support and were able to make changes to how their care was provided. Records were regularly reviewed to ensure care met people's current needs. This helped to provide staff with the information they needed to provide care that was personalised for each individual.

Staff understood the risk of people becoming socially isolated and measures to reduce this were clearly included in people's care plans and the values in the care provided.

People concerns and complaints were listened to and responded to in order to improve the quality of care.

People, relatives and staff were able to express their views and opinions and were encouraged and supported to be involved in the development of the service. The management and leadership within the service had a clear structure. Staff felt supported and valued.

The provider had systems in place to monitor the quality and ensure the values, aims and objectives of the service were met. This included audits of key aspects of the service. Outcomes of quality assurance were used to critically review the service and drive improvements to develop the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were systems in place to protect people from the risk of abuse and staff demonstrated they understood their role and responsibilities to protect people from the risk of harm.

Risks were effectively managed and reviewed regularly to keep people safe from harm or injury whilst supporting their right to independence.

People were supported to take their medicines safely.

The provider was committed to learning from accidents and incidents and providing training and guidance for staff to reduce the risk of incidents occurring.

Is the service effective?

Good

The service was effective.

People's needs were assessed and met by staff who were skilled and had completed the training they needed to provide effective care.

Staff received regular supervision to support them to review their development needs.

People were supported to access healthcare and to maintain their health and wellbeing.

People's rights were upheld in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People received care from staff who knew them well and had developed positive relationships with staff.

People were involved in developing their care and staff

understood the importance of supporting people to make decisions and choices and maintain their independence.

People's privacy and dignity was protected.

Is the service responsive?

Good

The service was responsive.

People received care that was based on their needs and preferences.

Staff provided care and support that helped to reduce the risk of social isolation for people.

A complaints policy was in place and information was readily available to support people to raise concerns.

Is the service well-led?

Good

The service was well-led.

There was clear leadership and management of the service which ensured staff received the support, knowledge and skills they needed to provide good care.

People, relatives and staff were supported to share their views and opinions and these were used to drive improvements and develop the service.

There was a comprehensive quality assurance system and processes in place which were completed regularly and used to review the quality of care provided.

Helping Hands Derby

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 checked 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.

We gave the service 48 hours' notice of the inspection visit because it is small and we needed to be sure that someone would be in the office to meet with us.

Inspection site visit activity started on 12 September 2018 and ended on 17 September 2018. We visited the office location on 13 September 2018 to see the registered manager and office staff; and to review care records and policies and procedures. We undertook telephone calls to people using the service, their relatives and staff on 12 and 17 September 2018.

The inspection was carried out by one 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.

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. We received the completed document prior to our visit and reviewed the content to help focus our planning and determine the areas we needed to look at during our inspection. We reviewed the information we held about the service, including any notifications. Providers are required to notify CQC of any significant events or incidents that occur within the service.

During the inspection we spoke with six people who used the service and nine relatives. We also visited two people in their own homes. We met with the registered manager, the branch manager, the head of homecare, a quality assurance partner and spoke with four care staff. We looked at records relating to the personal care and support of five people using the service and their medicines records. We also looked at three staff recruitment records and other information related to the management oversight and governance of the service. This included quality assurance audits, staff training and supervision information, staffing rotas and the arrangements for managing complaints.

Good

Is the service safe?

Our findings

Everyone who we spoke with told us they felt safe using the service. Comments from people included, "I feel safe with the staff. I am visually impaired so rely on them to check things like the water temperature before my shower and that the floor is clear of things I could trip on," "I have a key safe and they always shout to say who it is as they come through the door. They [staff] are very good, they make sure I don't slip in the shower," and "[Name of staff member] is very good and walks beside me as I have to use a zimmer. I feel confident with [name]." Comments from relatives included, "We have two carers and they normally come together. If one is delayed, the other will only do things that don't require two staff. I assume this is for the safety of both themselves and my relative," and "My relative uses a walking frame and they [staff] walk at the side and just help if needed. I am happy [name] is safe with the staff."

People were protected from the risk of abuse. When we spoke with staff about people's safety and how to recognise possible signs of abuse, these were clearly understood. Staff were confident about how they would report any allegations or actual abuse. Staff demonstrated a good understanding of the provider's safeguarding policy and how to raise concerns about potential malpractice within the service to external agencies; referred to as 'Whistleblowing'. Advice and contact details for external agencies who could support staff with safeguarding and whistleblowing concerns was available in the staff meeting room. The registered manager supported staff knowledge and understanding of their role in protecting people from abuse through regular discussions and quizzes in staff meetings. This gave staff confidence in understanding and using safeguarding procedures.

All staff had been provided with a 'safe word' which was to be used in the event of an emergency where staff could not communicate the problem but needed urgent assistance. This helped to ensure the safety of staff whilst lone-working and enabled staff to seek the support they needed to protect people in the event of an emergency.

People were protected from the risks associated with their care as far as possible. Each person's care plan included an assessment of the risks the person may be exposed to. Risk assessments included areas related to people's health conditions, access and potential hazards associated with people's homes and risks to the individual, such as use of equipment and finances. Risk assessments were used to identify what action staff needed to take to reduce risks whilst meeting people's needs and promoting their independence. For example, one person was at risk of admitting strangers to their home due to their lack of personal safety. Staff, with the person's relatives, had developed a white board where staff names and photographs were included. This supported the person to check the board and only admit people who were known to them. One person who we visited in their own home explained how staff helped them to manage the security of their home including their key safe, which gave them peace of mind. We saw staff supported and guided people to use equipment safely, such as walking frames. Risk assessments also identified any factors that staff needed to be aware of that may increase the risk for the person. For instance, one person experienced breathlessness, particular in cold or hot weather. Their risk assessment guided staff to be vigilant to these changes when supporting the person. People's care plans included risks associated with adverse weather conditions and contingency plans in the event staff were unable to reach the person's home.

People were supported by a consistent team of staff who had the skills and knowledge to meet their needs. People and relatives told us they normally had the same care staff or a regular 'team' of care staff. Comments included, "I think it is very important to have regular carers, otherwise you are having to direct them all the time. I do tend to get the same group who work around one another," and "I mostly get the same staff. I have one that comes four times a week then another couple that cover." We reviewed staffing rotas and saw sufficient numbers of staff were deployed to meet people's needs as assessed in their care plan.

People and relatives told us staff usually arrived on time for their visits. People told us staff telephoned if they were going to be delayed, although one person told us staff did not always do this. The registered manager told us they were in the process of introducing an electronic monitoring system for staff to log in and out of visits. They told us this would ensure that all calls were provided within an agreed timeframe and staff stayed for the full length of the visit. This improvement would help to keep people safe and reduce the risk of late or missed calls. The registered manager was in the process of reviewing schedules for visits to ensure staff were provided with rotas in good time for their visits.

People were safeguarded against the risk of being cared for by unsuitable staff through the provider's recruitment procedures. Recruitment files we looked at included evidence that the necessary employment checks had been carried out before staff started working at the service. These included application forms, proof of identify, references and a check with the Disclosure and Barring Service (DBS). The DBS carry out criminal records and barring checks on prospective staff who intend to work in care and support services to help employers to make safer recruitment decisions.

Where required, people were supported to manage their medicines safely. People's care plans included details of their prescribed medicines, the level of support they needed to take their medicines and any risks associated with their medicines. Topical medicines, such as creams, were supported by a body map which guided staff on the correct area of application. Where medicines indicated potentially high risks associated with their usage or administration, these were accompanied by a risk assessment and fact sheet which included best practice guidance. This provided the information and guidance staff needed to safely support people to take their medicines and seek guidance in the event of the person experiencing an adverse effect from the medicine.

We observed staff supported people to take their medicines in line with their care plan and completed accurate records to demonstrate they had supported people to take their medicines as prescribed. Where people were prescribed medicines as and when required, for example for pain relief, we saw staff consulted with people to determine if this was needed.

We observed staff followed safe infection control procedures. We saw staff wore personal protective clothing (PPE) such as gloves and aprons when supporting people with their personal care, and changed these between tasks to reduce the risk of cross infection. Staff were provided with their own supplies of PPE, and staff told us these were regularly replenished so they didn't run out. The registered manager refreshed staff knowledge and awareness of infection control procedures regularly. For example, a training session demonstrating the correct method of cleaning commodes and safe disposal of continence aids was included in a recent staff meeting.

The provider had systems and processes in place to review and analyse accidents and incidents. At the time of our inspection, there had been no accidents or incidents in the service. However, the provider supported staff learning by sharing examples of incidents and accidents that had occurred in the provider's other services or in the social care sector. For example, the provider had produced a factsheet to support staff to

understand their role in preventing or reducing the risk of falling for people. This included an awareness of the person's environment and signposted staff to where they could seek additional advice in the event they had concerns. Other guidance included the correct use of wheelchairs to ensure staff supported people who relied on wheelchairs, to move around safely.

Good

Is the service effective?

Our findings

People and relatives had confidence that staff had the skills and knowledge they needed to meet people's needs. People's comments included, "New staff usually shadow more experienced staff and then I see them on their own later. I believe they are well trained" and "I believe they have the skills to look after me. They are all very good." A relative told us, "They all seem well trained. They will look at the book (daily communication log) first to see what has happened (during the previous visit) before they start."

People's needs were assessed during an initial assessment prior to them using the service. The assessment covered people's physical and emotional needs, wishes and preferences. This supported staff to gather the information they needed to form the basis of the care plan and ensure they were able to meet people's expectations and diverse needs.

Staff felt they had undertaken sufficient training to enable them to provide effective care. One staff member told us, "My training was really good. I had previous care experience but still had mandatory training to refresh my knowledge. I worked alongside different carers to get to know people and one of the carers became my mentor which I found really supportive. The training covers specific areas which gives me confidence that I know what I am doing before I support people; for example, the right to administer eye drops which I hadn't done before." A second staff member told us, "My training was a long process. I had three days mandatory training and some time shadowing staff. I was given extra time (for visits) so I could get to know people the first time I supported them. I have a mentor who is on-call during my visits. I was new to care and found it quite daunting so it really helps to have this support." Staff told us they had access to a wide range of training and this was confirmed when we reviewed the training matrix. Training included areas which the provider felt were 'essential' and more specialist training, for example, to support people with specific health conditions. Staff were able to access on-line training at any time and specialist healthcare advisors from the healthcare team in the event they needed extra support or specialist advice, for example in supporting a person living with dementia.

New staff were required to complete an induction which included the Care Certificate. This is a set of nationally recognised standards which support staff working in care and support to develop the skills, knowledge and behaviours needed in their roles. Following induction, staff were regularly assessed which helped to ensure they had applied their training in practice and were competent in their role.

Staff told us they felt well supported in their roles. One staff member told us, "I am supported. I know if I have a problem the office is always there and will provide help in an emergency. I have regular supervision where I can voice my ideas or concerns and these are listened to and acted on. They [managers] also discussed my job and make sure I am doing things correctly." Another staff member described how their supervision helped them to identify how they were performing in their role and areas they needed to improve in. They also told us supervision was two-way and managers were good at accepting critical feedback and took things on board to make improvements.

People were supported to have enough to eat and drink, where they required assistance. One person told

us, "They [staff] will make whatever I want at breakfast. At lunch I have a ready meal which they will heat up for me and sometimes I ask for a dessert which they make for me. It is always nicely presented." People were assessed where they were at nutritional risk. Information was included in people's care plans for staff to provide assistance in line with professional guidance. We saw staff consulted with people to support them to choose what they wanted to eat. Meals were reheated, or cooked from fresh with the person if this was part of their care plan. Staff demonstrated good awareness of people who needed support to ensure they had sufficient amounts to eat and drink. For example, assisting to cut hard foods into bite sized pieces and supplying sufficient drinks during the meal and leaving fluids within the person's reach until the next visit.

People's care plans included guidance about people's health needs and this information helped staff to provide effective care. People's health conditions were detailed and included the impact of their health condition on their day-to-day wellbeing. For example, one person experienced breathlessness as a result of their health condition. Their care plan instructed staff to be extra vigilant during extreme fluctuations in temperatures as this could increase the person's breathlessness and their ability to move around safely. Where people experienced specific health conditions, for instance heart conditions or diabetes; their care plans included fact sheets to enable staff to understand the health condition. People who required support to manage their health condition, such as stoma or catheter care, only received support from staff who had completed training and were assessed as competent to provide this support. Staff worked in partnership with other health professionals, such as district nurses, GP's and occupational health therapists to support people to access healthcare.

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 any particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff demonstrated a good understanding of the requirements of the MCA and sought people's consent to care and support before providing it. For example, staff consulted with people about where they wanted to be in their home, where they wanted to eat and if they were happy to receive support before providing it. Where relatives had Lasting Power of Attorney (LPA) to legally make decisions about their family members' health and welfare in their best interests, care plans included a copy of the LPA authorisation. This helped to ensure people were supported to make choices and decisions about their care.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. Comments from people included, "They [staff] are all good, all very nice. They treat me with respect. They support my independence really. One of them once told me that it was all about my life," "They are very nice, we have a chat. They are easy to get on with," "We have got to know one another really well and I think they genuinely care for me. That's why it is so important to have carers who know you," and "They are very good, every staff member is really nice and very helpful. They seem interested in me." Comments from relatives included, "They are really good with [name of relative] and to be honest it has taken a pressure off me too. They get involved in day to day life which I think is really important," and "They get on well together and I can hear them chatting and laughing. My relative gets to have conversation with others and they are all very caring."

Staff demonstrated a person-centred approach when providing care and support. They were knowledgeable about people's needs and how they liked their care to be provided. As far as possible, the registered manager matched people with care staff who shared common interests and attributes. For example, one persons' care plan stated they needed to have staff who were softly spoken as loud personalities frightened them. The relative of the person had recently provided feedback to the registered manager that they were happy with their family member's care staff as they were a good match. People who we visited in their homes told us they had a consistent team of care staff who knew them well, respected their home and did what they wanted them to do.

People's care plans reflected people's needs and wishes and had been developed through consultation with the person and their relatives. One person told us they had spent time with staff putting their care plan together. They told us, "I told them what I wanted and they do things how I want them to be done." Staff had completed training in equality and diversity which included guidance around the Equality Act 2010. This supported staff to understand people's protected characteristics and helped to ensure people's diversity was respected and supported, such as religion or relationships.

Staff spent time at each person's visit ensuring they had supported the person with everything they needed before they left. Staff told us they had enough time to provide care and we saw visits were planned and included travel time between visits. This helped to ensure staff had the time they needed to provide personalised care.

Staff understood the importance of protecting people's right to confidentiality. Staff who we spoke with were able to explain the procedure for ensuring information was only shared with relevant parties and on a need to know basis. People had copies of their care plans and documentation, which were maintained in a folder and stored in an area of the person's choosing.

Staff supported people to do as much as possible for themselves. Care plans provided guidance for staff on how to support people for each task, such as bathing and dressing. Care plans also detailed people's abilities and how much they were able to do for themselves. People and relatives told us staff supported people's independence to enable them to remain in their own homes for as long as possible.

Staff knew how to provide care in a dignified way. One staff member told us, "I always make sure the curtains and doors are closed when I am supporting a person with care. Even if they share their home with someone else, I still maintain their right to privacy." We observed staff were polite and respectful whilst supporting people, addressing people by their preferred term of address. Staff entered people's homes in line with their wishes and preferences and ensured they returned any equipment where they found it. The provider promoted dignity in all aspects of care and support.

Good

Is the service responsive?

Our findings

People told us they had been involved in developing their care plan which staff followed and was regularly reviewed. One person told us, "I think they [staff] review my care plan every six months or so. It was done by the manager recently. I recall they went through everything asking me if I needed anything else and if I was happy with everything." A relative told us, "When the care plan was first set up, we discussed everything that was needed. They [staff] came up with ideas of how to make things easier. For example, the best use of space in the [person's] room. It was really useful to have their expertise."

Staff usually received care from consistent care staff who knew them well. People told us staff were reliable, never missed a call and arrangements were always in place to cover for staff absence to ensure visits were not missed. This was confirmed in visit schedules and communications that we reviewed. The provider made a pool car available to support staff to get to calls in the event of an emergency, such as breakdown of their own vehicle.

The assessment and care planning process considered people's values, beliefs, hobbies and interests along with their goals and wishes for the future. Care plans included a summary of the person's life history, significant events, what and who was important to the person. Each care plan contained step by step guidance for staff to follow. For example, where people needed support with their personal care, how they liked support to be provided, routines and what they liked around them was detailed. This supported staff to provide personalised care.

Staff maintained detailed daily communication notes which they completed after each visit. People and relatives told us each staff member consulted notes from the previous visit before providing care. This helped to ensure effective handover of information between staff and supported staff to recognise and respond to any significant events or changes in people's well being.

People and their relatives were involved in reviews of their care to ensure the care provided met their current needs. People told us staff were responsive when they required changes to their care, for instance timing of their visits. Records showed people's requests were listened to and implemented.

Staff were aware of people who were at risk of social isolation. One person told us that spending time talking with staff during a visit was as important as the care they provided, this value was embedded in staff working practices. Care plans instructed staff to spend time talking with people during a visit and provided information about people's hobbies and interests to support shared interests. Where required, staff supported people to go out into the wider community to undertake shopping or attend community groups or activities. Staff engaged with and supported relatives. They recognised their role in the person's life and, in some instances, as the person's main carer. This helped to reduce the risk of social isolation for both people and their relatives.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in

place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given. For example, one person used assistive electronic technology to support their day to day living and communication. Their care plan provided guidance for staff on how to use the technology and how the person preferred to receive information.

People and relatives we spoke with knew how to report any concerns and were confident these would be listened to and acted on. One person told us, "I have no criticism. If I had I would ring the office, they are always there. In the past there may have been little things and they have dealt with them well." The provider's complaints procedure provided people with information as to how to make a complaint and how their complaints would be managed. Records showed the provider used complaints to make improvements to the service. For example, communications with the office.

The provider had policies in place to support people who required end of life care. The service was not currently supporting any people who required end of life care. Care plans included details of people's wishes and preferences for their end of life care and arrangements in the event of their death.

Good

Is the service well-led?

Our findings

People and relatives were consistently positive about the service they received. Comments from people included, "I was visited by the new manager a few weeks ago. She went through everything and left me her contact details and the out of hours number. I thought she was very nice," "I would recommend them [the service]. I am very satisfied with the service they give," and "I would recommend them as a company, they are very good. I can't fault them. They are regular and such a good help. They are helping me to stay in my own home." Relatives told us they were impressed with the service. Managers visited to introduce themselves and staff were caring and reliable. Comments included, "I would certainly recommend them as a company; there isn't anything they wouldn't do," and "I would definitely recommend them. In fact, I am so confident in the service knowing [name of family member]is safe, I have been away for a few days for the first time in ages."

The provider had a clear vision and values that were person centred and focussed on people being supported by staff who listened and understood them. These values were owned by staff and underpinned their working practices. We saw staff provided person centred care and support. One staff member told us, "People and staff have opportunities to share ideas and make suggestions and these are respected and listened to. Things are taken on board."

The registered manager provided clear leadership, with a management structure in place that was both supportive and encouraged others to be included in decision making. They were supported by a team of administration staff and regional representatives from the provider. These senior managers provided guidance and support to the registered manager and staff and ensured care was provided in line with best practice. Staff spoke highly of their managers and said they were accessible and approachable.

Staff were supported to share their views individually, through surveys and through meetings. The provider encouraged staff to leave on-line feedback about their experience in the service, including a suggestion box directly to the Director, and share ideas which were used to drive improvement. For example, staff feedback in recent surveys had led to a review and changes in conditions of employment. Records of staff meetings showed these were used to share information with staff, discuss key issues and share best practice. The provider had introduced a 'carer of the month' scheme which recognised care staff who had gone the extra mile or attained personal achievements. The registered manager had developed a 'Wow' wall in the office which highlighted good practice in the branch. key successes and comments from staff about their job. Comments showed staff enjoyed their work and felt valued and respected by managers.

The provider promoted equality and diversity within the staff team. People and staff were matched on areas of shared interests and backgrounds. All staff had completed training on equality and diversity and records showed staff had equal opportunities in their roles.

The provider actively sought the views of people and those important to them. People were able to share their views informally and through surveys. Analysis from surveys showed people were happy with their care and felt staff respected them and kept them safe. Where people had identified areas for improvement, the

provider had responded by making the required improvements. For example, some people had commented that it could be difficult to get through to the office by telephone and emails were not always responded to in a timely manner. The provider had introduced a new telephone system to address people's concerns and a new process where email communications were responded to promptly. The provider shared the result of surveys and actions taken through 'you said, we did' in newsletters and communications to staff.

Regular newsletters were sent to people and relatives informing them of key events and developments in the service. For example, new staff, events in the local community and information such as how people could protect themselves in their own home.

The quality of care was regularly assessed and monitored. The registered manager undertook audits within the service to ensure people were receiving good care. Comprehensive quality assurance audits were carried out by senior managers and these were collated by the provider. These included all areas of care and support, such as staffing, records, medicines and health and safety. The outcome of audits and checks was used to identify where improvements were needed and action plans were developed with target dates. Records we saw showed the registered manager had identified where improvements were needed and had raised these with the provider. For example, the provider was in the process of introducing a new electronic monitoring system to support staff to access care records and ensure care visits were provided in line with people's care plans. The quality compliance manager also carried out periodic independent reviews to ensure the service was compliant with legal requirements and provided advice on areas which may be improved. The provider benchmarked its other services and shared good practice and ideas which helped to ensure care was provided in line with best practice.

The registered manager received consistent support from the provider and senior managers. The registered manager and senior managers were involved in working with other agencies and key stakeholders, such as local authorities, to identify and share best practice, both locally and nationally. The provider had identified strategies to improve in areas such as staff recruitment and retention, which in turn provided people with consistent care from staff who were able to get to know them well.

The registered manager understood their legal obligations including the conditions of their registration. They knew how to notify us of any significant events and incidents within the service.