SAP Care Services Limited

Pantiles Chambers

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 6 November 2017. The inspection was announced. The provider was given two working days' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available at the locations office to see us. 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 older adults. This was the first comprehensive inspection since the agency was registered. There were eight people using the service who were receiving personal care at the time of the inspection.

Pantiles Chambers, is known as SAP Care Services Ltd, and will be referred to in this report by the name people use: SAP Care. SAP Care was registered with CQC in November 2016 and had not been inspected prior to this inspection. SAP Care are a domiciliary care agency based in Tunbridge Wells who are registered to provide personal care to people living with dementia, older people and people with a physical disability.

At the time of our inspection there was a registered manager at the service. 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 were kept safe from abuse and harm and staff knew how to report suspicions around abuse. Risks were minimised through the use of effective control measures. There were sufficient numbers of staff deployed to meet people's needs and ensure their safety. People received their medicines when they needed them from staff who had been trained and competency checked. Staff understood the best practice procedures for reducing the risk of infection and carried a bag of protective equipment such as hand gel and shoe protectors on every care call. The service uses incidents, accidents and near misses to learn from mistakes and drive improvements.

People had extensive and effective assessments prior to a service being offered. This meant that care outcomes were planned robustly and staff understood what support each person required. Staff were trained in key areas and had the skills and knowledge to carry out their roles. Competency checks of training ensured that staff members understood the training they received. People were supported to receive enough to eat and drink; staff used food and fluid charts to record intake for people at risk or malnourishment or dehydration.

The service worked in collaboration with other professionals such as district nursing and people's GP's to ensure care was effectively delivered. People maintained good health and had access to health and social care professionals. Environments were risk assessed to ensure people were safe in their homes and staff could work without the risk of danger. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful and the least restrictive option.

Staff treated people with kindness and compassion in their day to day care. Staff knew people's needs well

and people told us they valued and liked their care staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to be as independent as safely possible.

People received a person centred service that was supportive of their needs. People's needs were fully assessed and care plans ensured that personal details were carried through to care delivery. There was a complaints policy and form, though no complaints had yet been received. Staff were open to any complaints and understood that responding to people's concerns was a part of good care. End of life care had been planned for people who wished to do so. The service worked with local hospices to implement their own end of life care policy and ensure people had a dignified death in the manner of their choosing.

There was an open and inclusive culture that was implemented by effective leadership from the registered manager. People and staff spoke of a 'family' care company that was small but caring. The registered manager had ensured that audits of quality were effective in highlighting and remedying shortfalls and the registered manager understood their regulatory responsibilities. People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice and of working collaboratively with other professionals and health providers to ensure partnership working resulted in good outcomes for people.

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 agency was safe.

People felt safe and were protected from the risk of potential harm or abuse.

Risks to people, staff and others had been assessed and recorded. Procedures were in place for the event of an emergency.

There was a sufficient number of staff to ensure that people's needs were consistently met. Safe recruitment procedures were followed in practice.

People who received support with their medicines did so safely.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Is the service effective?

Good

The agency was effective.

People received extensive assessments that ensured effective support outcomes were set and worked towards.

Staff received training to meet people's needs. An induction and training programme was in place for all staff.

People were supported to eat and drink enough to maintain good health and this was monitored where needed by staff.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

People were supported to remain as healthy as possible and had access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice. Staff understood the importance of gaining consent from people before they delivered any care.

Is the service caring?

Good

The agency was caring.

People were supported by staff who were caring and respected their privacy and dignity.

People were involved in the development of their care plans. People's personal preferences were recorded.

Staff had access to people's likes and personal histories and used the information to support people in a way that upheld their dignity and protected their privacy.

Is the service responsive?

Good

The agency was responsive.

People's needs were assessed, recorded and reviewed.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to people.

Where people received end of life care this was planned and provided sensitively.

Is the service well-led?

Good

The agency was well-led.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people.

Staff understood their responsibilities and knew who the management team were, and felt able to approach them.

The views of people and others were actively sought and acted on.

The service continuously learned and improved and staff were given opportunity to progress.

The service worked in partnership with other agencies.

Pantiles Chambers

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 the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection activity started on 6 November 2017 and ended on 9 November 2017. It included visiting the site office, visiting people in their homes with the registered manager present and speaking to people and their relatives on the phone. We visited the office location on 6 November 2017 to see the registered manager and office staff; and to review care records and policies and procedures. Not everyone using SAP Care received personal care. 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.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are 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.

As part of the inspection we spoke with the registered manager, the administration assistant, a senior carer, one carer, 4 people using the service and three people's relatives. As some people who received a care package from SAP Care were not able to tell us about their experiences, we observed the support being provided. We looked at a range of records about people's care and how the service was managed. We looked at four people's care plans, medication administration records, risk assessments, moving and handling assessments, four staff files, accident and incident records, complaints records and quality audits that had been completed.

SAP Care have not been inspected by CQC before.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe being cared for by SAP Care. One person told us, "They [staff] make every effort to keep me safe and we have two permanent carers: recently we had a meeting with my family to renew the contract as we couldn't get this standard of care from anywhere else." Another person commented, "We certainly do feel safe: we can't fault them they're lovely, friendly, caring people and we're very happy." A relative told us, "Yes mother is very safe. I watched SAP in action as we had a previous provider mum was not happy with, but she's happy to be left with SAP. I also take in to account if they care for mum as a person and they do."

People were kept safe from abuse and harm and staff knew how to report suspicions around abuse. The provider had an up to date safeguarding policy that listed all current legislation and contained the most recent definitions of abuse including modern slavery and organisational abuse. The policy set out the six principles of safeguarding adults as set out in The Care Act (2014). There were correct reporting procedures which were clearly defined and consideration had been given on how to safely involve people in safeguarding investigations. We noted that a copy of the local authority multi-agency safeguarding adults policy and protocol was not available to staff and discussed this with the registered manager. By the end of our site visit this had been printed off and left in the office for staff to access and certain sections, such as flowcharts for reporting concerns had been discussed with staff members. Staff members spoke confidently about reporting suspected abuse. One staff member told us, "Safeguarding is making sure everybody is safe and each person in their own home is entitled to safety. I know about the whistle blowing policy and depending on whom the perpetrator is I can call the local safeguarding team or my manager."

Risk assessments were effective in keeping people safe and used control measures to mitigate hazards whilst ensuring not to curtail people's choices unnecessarily. Care plans contained individual risk assessments for people around potential hazards such as moving and handling. People's homes had been assessed through an environmental assessment and changes were made where needed. Risk assessments had been used to assess peoples' environments and took account of trip hazards, lone working risks and potential hazards in relation to accessing the property. Each area of risk was described and given a rating of danger. The assessment then described control measures in a clear and detailed way that staff members could follow to reduce potential harm. For example, one person's moving and handling assessment identified that staff would need to use grab rails to support the person to walk up and down the stairs; that the person would be able to hold on to grab rails and support themselves and that one member of staff would be required to support the person by holding their waist and guiding them. This level of detail ensured the person could maintain a level of independence whilst remaining safe and was repeated through the assessment. It was typical of the robust approach to managing potential hazards we saw during our inspection. When risks had been assessed they were given a new rating to reflect the reduced level of danger.

There were enough staff deployed to keep people safe and staffing levels were agreed at contract commencements. One person told us, "There are two people who go out of their way to make life easy for us, and we appreciate that." One relative commented, "We have three regular carers one main and two who

interchange and it's good and we get to know them very well: so far so good." SAP Care receives potential care packages via hospital discharge teams and private referrals. The registered manager told us, "We look at the packages of care we have and we look at the staff we have and the amount of hours required. When we see we haven' got enough staff we decline packages." SAP Care had asked people during their initial assessments what times they would like their care and were careful to consider the distance between calls. The registered manager explained that this approach to planning and setting staffing levels was the reason they had never missed a care call. The registered manager said, "We have an on call service and if someone calls in sick we can cover the call." We checked the service rota and saw that staff were given sufficient time to travel between clients and were providing the correct amount of care that people had been assessed for. One relative told us, "I pay for a 45 minute care call and invariably they stay longer to make sure it's all done properly."

Recruitment systems were robust and made sure that the right staff were recruited to support people to stay safe. We checked the recruitment files for four members of staff. In all cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible.

Medicines were managed safely and people were trained and competency checked by the registered manager who was a registered nurse. People's medicines and their medical histories were tracked from the initial assessment through their care plans. Where staff supported people to take their medicines they recorded this on medicine administration record (MAR) charts. MAR charts were audited every month by the registered manager and during spot checks to people's homes. We checked four peoples MAR charts and saw that medicines had been recorded safely and staff had signed to indicate each medicine had been given. Where people had as when required (PRN) medicines these were also recorded correctly and there were PRN guidelines to explain when the medicines can be given and how much of each drug to give. There was a set of medicines policies which contained up to date and relevant information and set out the correct procedures for, amongst other things, how to manage controlled drugs, how to manage covert medicine administration and medicines errors and near misses.

The risk from infection had been assessed for each person and the risk of infection was reduced by staff who were knowledgeable and used their training to keep people safe. People had infection control risk assessments to reduce the spread of infection and all staff were issued with and instructed to carry a bag when on care calls containing: gloves, aprons, hand wash and other personal protective equipment (PPE). We observed staff using PPE correctly when supporting people. One member of staff told us, "I have been an infection control champion before and am very proactive. We only use gloves once for each task and don't move from one room with our gloves on to get something else." People we spoke with confirmed that the staff were very careful and extremely clean when providing care in their homes.

SAP Care learned from incidents and accidents and used the learning to make improvements. We reviewed the accident and incident file and saw that two incidents had been recorded in the past 10 months. On each occasion we saw that the incident had been recorded clearly and factually and had been reported appropriately. The registered manager had conducted an investigation in to the cause of each incident and where there were changes that could be made to increase people's safety these had been implemented.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they had the training and skills to meet their needs effectively. One person told us, "[Manager] is a nurse and all the staff have training and know how to care for me." Another person commented, "Yes they know how to care for us. They do the things we want and their training is good and we have no cause to complain." A relative said, "We use a [standing hoist] for mum and they are very competent and therefore must be well trained."

There were extensive assessments of people's needs prior to a service being provided. The assessments identified a range of people's needs from which support plans were drawn up and worked to accordingly. Each person's care plan had a 'pre-service checklist' to ensure that essential steps had been taken, such as sending a service brochure and completing a service user risk assessment. People had their environment assessed so that staff could provide effective care. For example, one person's assessment had identified a risk around the cooker and had mitigated this hazard. There were also physical health assessments which described the person's history, level of GP involvement and diagnoses; a skin marks and bruises assessment; an assessment support tool that looked at different areas of support, such as drinking, memory and sleep and assessed whether the person had a low, medium or high level of dependency and the help they would need from staff; a series of risk assessments; a thorough medicines assessment that gave staff a detailed picture of the exact support each person needed around their medicines; and finally a support plan assessment which examined a wide range of needs such as social networks, life history, religion and significant relationships. This body of detailed assessment work enabled the registered manager to produce highly personalised and detailed care plans that contained relevant information and enabled staff to meet peoples' outcomes, such as always having their medicines at a certain time, or receiving personal care in the way, and at the time, of their choosing.

Staff were trained and competency checked by the registered manager. Staff told us they had the training to carry out their roles and people felt their staff knew how to look after them. One member of staff told us, "I went to London to do a course to cover all mandatory areas. We can always choose extra training and I have asked for extra training and we're discussing how I can be trained in diabetes." The agency used a training matrix to document and track staff member' training needs. All members of staff had recently been trained in courses such as safeguarding adults, health and safety, moving and handling, infection control and food hygiene. The registered manager had carried out competency checks on staff who had completed training to ensure they had the necessary understanding to carry out their roles. We reviewed competency checks for five different training courses such as mental capacity and dying, death and bereavement training. The competency checks consisted of multiple choice questions which were marked by the registered manager. Staff were receiving regular and effective supervisions from their line manager and annual appraisals were used to review staff members' performance and set goals. New staff were inducted in to SAP Care with a comprehensive induction pack that covered areas such as, record keeping, good communication and palliative care amongst other topics.

Where people had a need around nutrition or hydration this was assessed and support planned with the person. Fluid, food and urine output charts were used where appropriate. One staff member told us, "If we

think there is a big concern especially if they live alone we do fluid and bowel charts, urine output charts and it gives a good idea." Care plans contained nutrition and hydration plans for people with a need in this area. One person who was frail and unable to get meals and drinks for themselves had a plan to ensure that they received sufficient food and drink. The plan ensured the person had the best chance of eating and drinking by using information about the person's preferences. For example, plates being heated prior to serving food, meals being set with the person's spouse so they can eat together and choice of drinks and snacks at different times of the day. Through use of this information staff were able to support the person to eat and drink sufficient quantities to maintain good health.

SAP Care works closely with the local hospital, social services and health agencies to ensure effective care is delivered to people in the community when they transfer from services. The registered manager explained that referrals were regularly received from the local hospital discharge team for patients who wish to private fund their care. SAP Care worked collaboratively with the hospital to fully assess the person, liaise with occupational therapy about any equipment needed to enable the person to live in their own home and district nursing if the person had an ongoing but non-urgent nursing need.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People were monitored effectively and where necessary healthcare services were contacted and people were seen by professionals. Healthcare needs had been tracked through peoples support plans. For example, it had been identified that one person had previously developed pressure wounds. This had been tracked through to a skin integrity care plan and was being managed effectively. The plan identified that the person had lost weight and was frail and had reduced movement, so staff were directed to perform regular checks, given specific areas on the body to pay extra attention to, provided with clear guidance on what to do if there were any signs of redness or soreness and directed how to re-position the person.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In domiciliary care, these safeguards are only available through the Court of Protection. No one was subject to an order of the Court of Protection. However, people's consent was not consistently being documented as clearly as it needed to be. Although people's consent had been checked and best interest meetings had occurred with relatives where necessary, the process had not been recorded clearly on MCA or best interest meeting forms. We raised this with the registered manager and by the end of our site visit the registered manager had implemented a MCA/BI form in line with national guidance and had appropriately carried out assessments.

There was a consent record completed prior to the start of a service that established if a person, or a relative on their behalf if they lacked capacity, consented to their information being shared with other professionals and whether staff could read their assessments and care plans. The consent form was reviewed every three months to check that capacity or consent required a formal review. Staff were trained in the principles of the MCA and were able to describe how they implemented these in practice, such as, offering people choices about what they want to wear or eat. One person told us, "Yes they ask our consent: indeed there's full co-operation and we discuss what we like or want and we get on well with them."

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care and spoke highly of the staff supporting them. One person said, "We couldn't ask for a better service and have the highest regard for the service. The carers are very friendly and caring." Another person told us, "The carers are all very good and really lovely." One relative commented, "The staff are very caring because when they come in they come and they speak to mum: they are her friends and she sees them as a visitor coming to see her, as opposed to an employee." A second relative told us, "Yes the ladies we have are caring and try very hard to make everything work."

People told us that they valued their care service and liked their carers and we observed some good interactions. We observed two care calls and saw that people and their care staff knew each other well and interacted warmly. Care workers spent time chatting with people's spouses and family, asking how their afternoon had been and how they were. This created a friendly and congenial atmosphere that people clearly enjoyed. After the atmosphere had been set care workers were able to assist people with support tasks, such as using standing hoists, in a relaxed and caring manner. One person's relative spoke to us about how much the person enjoyed his carers visiting him each day. The relative told us, "He looks forward to them coming to see him actually. When they've finished with [husband] they will iron, wash up, put our clothes in the washing machine and get the clothes out of the dryer: I didn't realise they would do all that and its' a real help to me as well."

Care workers had built up positive and caring relationships with people they were supporting. One member of staff told us, "One lady was refusing to take medication with another staff member. I came in and explained the importance of the medicines and how it helps them, and maybe we can try it this way, e.g. take it with squash not water and try different things. They took it after having a conversation with me as we had that relationship". Staff knew how to communicate with different people and where people had a communication need this was explained in their care plan. One person was living with dementia and required staff to introduce themselves whenever they came. There were additional instructions for staff to explain clearly to the person prior to doing any procedure and help them to understand so verbal consent could be attained. Staff knew people's routines and preferences well and were able to provide support in the way they wanted. For example, one person with mobility issues was worried about an appliance being left on. Staff had anticipated this and were able to relay to the person exactly where the off switch was and when it had been turned off: this reassured the person that they were safe.

People are able to input in to their care plan, and where they were not able to do so their family and relatives are invited to participate in care planning. During the initial assessment stage people and their relatives were involved in the extensive and detailed assessment process. One person and their relative told us, "We had an assessment at first and I chose this agency and I'm glad I did." We asked three people if they had signed their care plan or updated it. One person commented, "Oh that, I never look at it." This response was representative of all the responses we received about signing care plans: that people were not interested. One person told us, "They're all doing a good job and doing what I want them to so I haven't bothered with [the care plan]." The registered manager explained that they sought the views of people and

always tried as much as possible to involve people in their care plans. Staff sought people's views and tried to involve them in their care on a day to day basis. One staff member commented, "You always have to involve people during care and communication is vital. I would not go to someone and start doing something without asking them. We don't tell someone this is what we're going to do, but instead you ask them and give them a choice and treat them in the way you would want to be treated."

Staff were aware of people's privacy and dignity and worked in a way that maintained their rights. One relative told us, "They wash his hair with shampoo, make sure he is clean and it is a blessing for me." We noted that staff took care to provide personal care to people in a dignified manner that maintained their privacy. Staff spoke to people in a dignified manner when supporting them, for example to use a standing aid. Lots of explanation and gentle encouragement was used and when the task was complete the person shared a joke with their staff. Staff were careful to treat people with dignity. One staff member commented, "With male clients, for those that are able to, I ask them to pull down their underwear to their knees and I hold a towel up whilst they clean themselves so I can't see anything and if they're able to be left I leave the room so they can dry themselves in private." Another staff member told us, "When I'm giving personal care to the top half I cover the bottom half and then when cleaning bottom half cover the top half: I just treat people with respect. Treat people well, respect them, and let them know that is happening next: it's just being polite and professional."

Good

Is the service responsive?

Our findings

People's relatives and staff described a person centred approach to care delivery. One relative told us, "As soon as they come in they call mum by her name and have a very personalised approach: if she's worried about anything they will ask mum and she may feel she can talk to them rather than worrying her family as the staff are her friends." A second relative commented, "They come late at night to put X to bed because he wants to go to bed later on. I can make changes when he has hospital appointments and they cancel visits and don't charge us. I'd recommend the agency to anyone and he enjoys the staff coming." One staff member explained person centred care as, "Everybody is an individual and has their own specific needs which concern them. I wouldn't work with Mr A the way I work with Mrs B. I always make sure to do things the way that person likes things to be done."

People received an individualised care service that was tailored to their needs: this stemmed from a thorough assessment process that fed in to detailed support plans for people. We reviewed four assessments and they had identified individual needs in people, such as a person requiring specific assistance with mobility, or a person requiring personal care in a set way and at a specific time. These identified needs were tracked through to individual care plans, were risk assessed for the specific person and evidenced in daily notes. For example one person had been initially assessed as needing a wheelchair to move about their home upon discharge from hospital. The care plan had identified that this could be gradually removed with the correct support, i.e. if staff supported the person to walk. This support task had been risk assessed and the daily notes evidenced how the person had been supported to walk and how their mobility was improving. Some people received a live-in care service, where a care workers stay in the persons home to provide round the clock support. The daily log notes for people with live-in care were detailed and showed how peoples' assessed needs were being met. For example, for people with night time care who required monitoring through the night their sleeping patterns were well documented and their moods or presentation were tracked throughout the day.

Where people's needs changed the registered manager was quick to respond and ensure people received the care they needed. Some support outcomes had not been met and these were described and explained, such as a person too nervous to try walking alone with a stick. Action had been followed up by the registered manager to ensure people's needs were being met safely. We saw correspondence from the registered manager to people's GP surgeries when staff noted changes or concerns. The registered manager arranged to attend the calls on these occasions to assist the person with their appointment and ensure any changes were incorporated in to care plans. We saw examples where queries around people's medicines had been noted, followed up with GP appointments and reflected in care documents.

Although the service had not received any formal complaints there was a policy and system in place to monitor any complaints that may arrive. There was a complaints file containing a complaints policy which had been reviewed in April 2017. The complaints policy set out responsibilities and stated clearly who the lead manager was for complaints. The complaints procedure was sent to people at the start of service when the care contract was issued. A range of ways to complain was available for people either through, e-mail, phone, in person or written. There was a clear process for resolving complaints and if the complainant was

not satisfied with the outcome they were correctly signposted to the local government ombudsman. There were no official complaints recorded in the file and people and relatives we spoke with told us that they had never had reason to complain. There were blank complaints forms in the office for staff to use when the need arose. Verbal complaints or 'niggles' and comments were being recorded but all of these had been positive in nature. Staff members understood the complaints policy and the importance of recognising when people were not happy about an issue. One staff member told us, "I would listen to someone and take it positively. I am very quick to apologise and saying sorry is very important if someone feels that you've done something wrong. There's always something to learn from people."

People had DNACPR forms in their files and there were end of life care plans in place for people who wanted them. There was nobody receiving end of life care during our inspection. We saw plans for people who wished to make future arrangements for their death. People had set out whether they would like to die at home, in a hospice, and what their funeral arrangements would be. The registered manager explained that they would work closely with local community hospices to ensure that people could spend their final days in the manner of their choosing. Where people choose to remain at home the registered manager would ensure that their support would continue where appropriate. There was an end of life policy to guide staff on how to provide good care in people's last days. This covered topics such as discussions as the end of life approaches, best practice in the dying phase, and care after death.

Good

Is the service well-led?

Our findings

The registered manager provided effective leadership to the service and people, their relatives, and staff members spoke in positive terms about the management of the service. One person told us, "The management is very good." A relative commented, "I respect the manager as a person and as a carer. I think the service is well run." One staff members told us, "They are excellent to me because they understand people and treat you with respect and treat you well: they make sure that you feel valued and they appreciate things that you do." A second member of staff said, "100% they are absolutely superb. Easy going but always appreciative of what you do for them and they show their appreciation and that makes us work harder. As it's a small company we all get on really well."

There was an open and inclusive culture in the service. The service was person centred and each person was supported according to their own needs. Staff and people confirmed that there was an individualised approach to peoples' care. The registered manager told us, "We don't have a blanket approach, so would never say 'wash people with soap and water' as one person may like shower gel and another person bubble bath." This approach of individualised care was carried through by staff. People's relatives and staff told us the culture in the service was caring and supportive. One relative told us, "They are caring and reliable and that sums up the company. I would recommend them to someone else and I wouldn't put myself on the line that way if I wasn't confident." A member of staff commented, "I have found the company to be good, caring and they support their staff very well. They listen and when you have an issue, like personal issues, they support you very well. They do regular supervisions and give you the chance to speak or contribute in meetings about ideas to help people we support: they value you as a member of staff." The registered manager explained that the service was a family service and they aim to be part of people's families as their carers are working regularly in people's homes. The registered manager told us, "We are still small so the cases we have help us to remain like a family service. The feedback we receive from people and relatives is that we feel like a part of the family as we only send the same workers to provide care." The registered manager discussed how they plan to grow the business in a slow and steady manner to enable them to retain the highly personalised culture.

The registered manager was monitoring the quality of service delivered with regular audits and spot checks. The registered manager had implemented checks on new clients within two to three weeks of the service commencing. Notes from these meetings showed that people and their families were asked how they rated the care staff and how the care service is generally. The registered manager had also completed spot checks at services as carers were leaving to ask people immediately after they had received care if anything was wrong, or could be done differently or better. We saw that some people had requested just one main carer and changes to visit times and these requests were actioned by the registered manager. Spot checks had documented if people were being addressed by their preferred name, whether staff had used protective equipment, such as gloves and aprons, correctly and whether staff were working to the care plan. Other audits included a medicines audit every month, checking people's medicines charts and their care notes. There were audits completed where the registered manager had identified signatures missing from medicines records. The registered manager had counted the tablets to check that the medicines had actually been given to people, had called staff and reminded them of the correct procedure and action had

been taken to ensure the charts were correct. Other audits had identified daily logs not being completed, and medicines records missing. Each shortfall was investigated and remedied by the registered manager where there was found to be a shortfall.

People their families and staff were involved in the service and regular feedback was sought through questionnaires. We saw questionnaires completed by people and family members that contained very positive feedback. The registered manager had worked to include people, their spouses and wider families in the care that was offered to people. For example, care staff had reported that a person's wife was feeling unwell. The registered manager spoke to the spouse and after gaining consent called the GP explained the situation and arranged a home call for the spouse. The registered manager also attended the appointment in case any further actions was needed such as collecting a prescription from the chemist. The registered manager explained that staff were involved in the service via a confidential encrypted group chat application on mobile phones. Staff were actively involved in meetings and were able to make suggestions to improve services for people. For example, one staff member suggested using separate water to wash a person's leg when it was sore. This idea was implemented and shortly after the person's leg improved. The registered manager explained that staff were consulted on new clients. The registered manager told us, "We ask our staff: 'do you think we can manage this package?' We listen to staff and if they tell us we have X at this time so we can't cover Y we refuse the package." One staff member confirmed, "We always look at the situation and turn down packages if we couldn't do a double hander call and we consider distances as well."

The service was continuously learning and improving and learning is shared with staff. Staff were encouraged to take on new responsibilities. The registered manager had arranged for an external training company to engage all staff with the Care Certificate. The care certificate was based on an identified set of standards that health and social care workers adhere to in their daily working life that has been designed to give everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care. One staff member had expressed an interest in doing more office based work and is now accompanying the registered manager on assessments. Another care worker had asked to study for a higher care qualification and the registered manager was looking at how to provide this. The management are part of a network of managers in the care sector that shares good practice. For example we saw that the registered manager had requested that another manager from the network visited SAP Care Ltd and conduct a spot check on their files and share good practice. We also saw other examples of good practice being shared such as guidance on when to notify CQC of the death of people who use the service to ensure compliance with regulations.

There was good partnership working with a local church, the hospital discharge teams and OT, local district nursing and GP's to ensure people's services are effective. The registered manager explained that they had set up the agency through looking after people at their local church on a voluntary basis. The registered manager told us, "I liaise with the district nurses and GP's all the time. If I have any queries they give me advice and they are very co-operative. I ring the occupational therapist in hospital if I have any concerns or need equipment." The registered manager had contacted the occupational therapist on several occasions to ensure that equipment was in place for people and worked closely with other professionals to ensure people had adaptations they needed to stay safe in their own homes.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events

occurred. The registered managers confirmed that no incidents had met the threshold for Duty of Candour.