Caretree Limited

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Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Outstanding** ☆
Is the service effective?	**Outstanding** ☆
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Outstanding** ☆
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

We undertook an announced inspection of Caretree Limited on 31 October and 5 November 2018. We told the provider two days before our visit that we were coming to make sure that someone would be available to support the inspection and give us access to records. At the time of our inspection 50 people were receiving a personal care service from Caretree. Not everyone using Caretree Limited receives 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 consider any wider social care provided. The service was supporting people with a range of needs, including older people with living with a dementia type illness, people with physical disabilities and people living with mental health needs.

At our last inspection we rated the service outstanding in to areas and overall. At this inspection we found the service was outstanding in all areas and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

Why the service is rated Outstanding.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The leadership and management of Caretree Limited continued to be outstanding and the provider aspired to be a role model in the domiciliary care industry. The provider was always thinking of ways to highlight better ways of working in co-ordination with relevant parties such as the local authority and health services. With this in mind, steps had been taken to develop ways to improve hospital discharge with clearer communication and co-ordination. This was to avoid people being affected by delays with returning to their homes. This vision and values of the organisation were mirrored by care staff who were motivated to make a difference where they could, often acting outside of their contracted hours. The impact of this meant people felt valued and cared for and their feedback reflected this.

People's safety was paramount and due to the low turnover of staff it meant people's safety was enhanced. This was because staff knew people well and could note any changes in their condition and alert as necessary. Staff also undertook tasks related to people's safety in respect of taking action to identify any infections so they could be treated as early as possible. Some of these tasks involved going to the pharmacy and dropping off samples to surgery's often in their own time. Caretree Limited had devised their own IT system which linked visits to specialist tasks required and staff training. We saw the management of medicines was excellent with staff having an awareness of what medicines were for, side effects and a facility to call a pharmacy for advice if necessary. All these measures helped to fully optimise people's safety.

Staff had been well trained and in ways that met their learning style to ensure they had a full understanding

of what was required in their roles. Staff were supported well and their health wellbeing had been considered with recognition of the challenges their jobs could bring. Staff received both formal support meetings but could always contact the provider or office staff at any time for assistance and advice. This ensured that staff were able to deliver the best possible care to people and were motivated to carry out extra small tasks in their own time where they felt that would help someone.

People and their relatives repeatedly praised the kindness of staff. Everyone we spoke with praised the exceptional care that they received from the service and used the word 'outstanding' on many occasions. We were given numerous examples of times when staff had gone above and beyond people's expectations to provide truly personalised care. People and their relatives recognised and appreciated these efforts which allowed them to receive their support in a way that made them feel individual and cared for.

People were protected by the robust recruitment systems in place which ensured only suitable people were employed to support them. The registered manager was committed to only accepting new care packages where she was confident that the service had sufficient care staff with the right skills to care for them appropriately. As such people told us that staff had never missed a call and that their care staff usually arrived on time and always stayed for the entire time allocated.

People's health needs were met consistently well. This was enhanced by the provider having a current nurse registration and access to all the up to date and best practice advice. When people were unwell, the service had systems in place such as ensuring any symptoms were addressed early with efficient communication with health staff. This helped to avoid people's conditions deteriorating and potentially being admitted to hospital.

Where people received assistance with their food and drink, care staff had been trained to consider small details such as presentation of food to tempt appetite and encouragement to help with the cooking. Where concerns were noted about finances potentially affecting individuals immediate action was taken and referrals to relevant agencies made to ease the situation.

The service had good systems in place to ensure that people's needs were properly assessed at the start and kept under ongoing review. People and their relatives described how responsive staff had been to their needs. All levels of the service demonstrated a strong commitment to providing a personalised and holistic service. The registered manager had excellent and sustained relationships with other professionals and worked alongside them to deliver the best possible care to people. People told us how they felt fully involved in their care and care staff talked to us about the things they did to support people to be as independent as possible.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Outstanding ☆

The service improved to Outstanding

The provider took innovative measures to ensure people were supported by staff with a sound understanding of what was needed to keep people safe.

Risks to the health, safety and well-being of people were addressed in an enabling and proportionate way which promoted independence.

Care workers had the knowledge, skills and time to care for people safely and consistently.

There were safe and robust recruitment procedures to help ensure that people received their support from staff of suitable character.

The service had good systems in place to safely support people with the management of their medicines.

Is the service effective?

Outstanding ☆

The service improved to Outstanding

The service had excellent systems in place to ensure that people received effective care that met their needs and expectations.

People's lives were improved because of the care they received. All staff recognised people as individuals and worked together to give people high quality support.

Staff were provided with ongoing and advanced training, support and supervision to ensure they always delivered the very best care.

People were supported by staff who confidently made use of their knowledge of the Mental Capacity Act 2005, to make sure people were involved in decisions about their care and their human and legal rights were respected.

The service worked collaboratively with other professionals to ensure that people maintained their health and wellbeing.

Is the service caring?

Outstanding ☆

The service remains Outstanding

Is the service responsive?

Outstanding ☆

The service improved to Outstanding.

People's care was kept under continual review and the service was flexible and responsive to people's individual needs and preferences.

Staff responded quickly when people's needs changed and could adjust visit times and support packages at very short notice.

People were actively encouraged to give their views and raise concerns because the service viewed all feedback received as a natural part of driving improvement.

Is the service well-led?

Outstanding ☆

The service remains Outstanding

Caretree Limited

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 was 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 30 October and 5 November 2018. The provider was given 48 hours' notice. We did this to ensure the provider was available to meet with us and provide access to records. The inspection team consisted of one inspector and one Expert by Experience who made telephone calls to seek the views of people who used the service or from their relatives. An Expert by Experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed records held by CQC which included notifications and other correspondence. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider also completed a Provider Information Return (PIR) before our inspection. 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. Along with the PIR, the provider sent us a contact list of professionals involved with the service. Using this information, we asked for comments from 14 professionals and received responses from four of those.

During our inspection we went to the service's office and met with the registered manager who is also the provider of the service, the financial director, three co-ordinators and three members of care staff. We reviewed a variety of documents which included four people's care plans, three staff files and other records relating to the management of the service.

During the inspection, we conducted telephone interviews with eight people who used the service and five relatives of people who received care. We also undertook telephone interviews with four care staff to seek their views on working with the service.

Outstanding ☆

Is the service safe?

Our findings

At the last inspection, we found that people who used the service received safe care. At this inspection, we found the provider had taken further exceptional measures to optimise people's safety. Everyone we spoke with repeatedly told us how their care staff made them feel safe, for example, one person said, "I feel very safe. They help me with everything. They use a hoist to lift me and they do that very competently". Relatives endorsed that their family members were safely cared for. One relative said, "The carers take their job very seriously. They complete all the paperwork to record what they have done so I can check records to see how [relative] has been each day. That makes me feel she is safe. I also know that they are very gentle with her as she is very frail".

People were protected by a very robust approach to safety as the provider had sought ways to continually improve and embed changes into practice to keep people safe. We saw that the provider had drawn up a white paper in respect of hospital discharge and preventing admission to hospital. A white paper is a report or guide that informs readers about a complex issue and presents the issuing body's thoughts on the matter. It is meant to help readers understand an issue and potentially solve a problem. The white paper detailed a management summary, discharge planning, prevention, seven-point plan and action plan. The registered provider had met with a clinical lead for Emergency Medical Unit (EMU) at a local hospital to discuss improvements to discharge planning. Meetings were also held with the main hospital for the county to facilitate collaboration and implement the white paper.

To improve people's safety when they were discharged from hospital the provider had also developed a hospital discharge handover form. This was produced in response to the fact the service were not always getting the relevant information necessary to provide safe care prior to people leaving hospital, such as any new medicines that had been prescribed. Staff told us having the discharge form had improved both the quality and amount of information they received, which helped to ensure people had everything in place when they arrived home so staff could continue to support them safely.

Staff had developed positive and trusting relationships with people which staff and people told us helped them to feel safe. This was a result of staff having the motivation to carry out tasks, often in their own time, to optimise people's safety and comfort. For example, the provider collected out of date or soon to be out of date medicines and returned them to the pharmacy for those people or their families who could not do this themselves. Other examples of staff working outside their contractual duties included sitting with a person for three hours whilst waiting for the ambulance to arrive, taking prescriptions to pharmacies, making an extra call, (in their own time), to make someone a drink as they had been unwell at an earlier visit and taking urine samples to the surgery so antibiotics could be started swiftly to avoid deterioration and potential hospital admission. This thoughtfulness from staff meant people's safety was always at the forefront of everything they did.

People's safety was also optimised through the development, by one of the service directors, of their Information Technology (IT) system. This then meant that people's risks were well managed. For example, we saw that each member of staff's training was integrated into the rota system. This meant that when visits

were scheduled it would flag up if the person needed specific care tasks and if so, ensured the care staff allocated had been trained in that task. When staff received their rota, they could see if any specialist care tasks were required which was a further failsafe way of ensuring people were only supported by staff with the appropriate level of training to meet their needs. This meant people were only cared for by staff with the training and skills to keep them safe during care tasks.

People's safety was carefully balanced with their right to remain independent because the service had a positive and enabling approach to managing risks. At the start of every new care package, one of the co-ordinators completed a detailed assessment with people, including assessing any risks associated with people's needs, living environment or equipment. Risks that may compromise people's safety had been assessed. For example, we saw risk assessments had been carried out on risk of falls, medicines, finances and home environments. Advice was provided in the risk assessments, for example, a person's falls risk assessment said the person needed time and reassurance when mobilising. Where people needed assistance to move, we saw that a moving and handling risk assessment had also been completed and the service had taken steps to check that any specialist equipment, such as hoists were maintained in good working order. Staff had received the relevant training. The service had a safe bathing policy and bathing temperatures were seen in people's records.

Staff were encouraged to participate and apply learning to improve safety to reduce risk of harm to people using the service. Staff received training in safeguarding and the provider had met with the local authority safeguarding team to discuss how they could work more effectively together to improve the safeguarding system. This resulted in senior staff spending time shadowing the safeguarding team to gain a clear understanding of how safeguarding issues were dealt with and to provide insight on both sides. Staff had also spent time with the clinical lead from the local hospital's Emergency Medical Unit (EMU), to better understand their respective roles. One of the staff co-ordinators told us they had made contact with the local police and neighbourhood watch to gain any local information that may compromise staff safety during visits and also that may affect people they supported. This willingness to gain insight into a person's journey through health and social care, share appropriate information and develop better working relationships with other agencies contributed to increasing people's safety.

People and their relatives told us there were enough staff. The provider had an ethos that they would not take on packages of care until there was a safe level of staff to support them. There were safe and robust recruitment procedures to help ensure that people received their support from staff of suitable character. We found that staff files had all the required information, such as a recent photograph, full employment history, references and a Disclosure and Barring Service (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

The provider ensured that issues of poor performance were effectively and immediately addressed so that staff could improve and the safety of people was at the forefront of everything they did. Since the last CQC inspection, the provider had created a new co-ordinator role to support and monitor the quality and governance of the service. One of their responsibilities was to support staff to ensure high standards were maintained. For example, the co-ordinator could swiftly and proactively mentor staff to problem solve any issues that may arise.

The service promoted the safety of its staff. We saw risk assessments for staff including pregnancy, lone working, using computer screens and COSHH (Control of Substances Hazardous to Health) to either prevent or reduce staff's exposure to substances that could be hazardous to their health. The provider told us that during a period of extreme weather staff phoned the provider at the end of each shift to ensure they were safely home. We were told that all people received their calls during this period of time which ensured

people received the support they needed despite the conditions.

People were supported by staff that had received up to date and detailed medicines management training which meant people received their medicines safely and their effectiveness was optimised. Management and staff from the service had developed a good relationship with a pharmacy who provided timely and up to date advice which further enhanced the safety of people's medicines. The service had liaised with the pharmacy about side effects of medicines which meant staff could recognise if this arose and signpost to GP's if they occurred. The service had compiled a list of all common medicines used by people and thorough training had been provided to on-call staff and the office team to support care staff with any concerns. Where people had PRN (as needed) medicines, staff had raised queries where their effectiveness was in doubt. For example, the registered manager asked whether a medicine that had been prescribed on a daily basis could be changed to PRN as the person was not experiencing any benefits from it. This meant people were not kept on unnecessary amounts of medicine which could result in unwanted side effects.

The service was very proactive when people were prescribed new medicines they may not be able to manage alone. For example, a care co-ordinator told us a person had been discharged from hospital with eye drops to be administered four times a day. However, this was not possible. The person had a medical condition which meant they were unable to do this for themselves and they only received three visits a day. Therefore, staff liaised with the doctor to prescribe an eye ointment that could be administered three times a day meaning the person could have assistance during their care visits. Staff had also questioned when they had concerns about changes to medicines that could be a potential risk. For example, during a morning visit, care staff phoned the on-call care staff as the person they were visiting told them she wasn't to have breakfast as she had to have a fasting blood test. As the person had diabetes and nurses administer insulin each morning, they were concerned about the person's safety if the information was not correct. The person's relative was contacted to verify this was correct as the client experienced confusion at times.

People received medicines safely because they were supported by staff who were in receipt of very comprehensive medicines training, including theory and practice by the provider who was a registered nurse. This included the Oxfordshire Shared Care Protocol training to ensure staff knew what levels of administration they were able to provide. Staff also received information on all monitoring dosing systems that pharmacies supplied. These could vary from pharmacy to pharmacy so the provider wanted assurance that staff knew of all the different systems to ensure their safe use.

The service managed the control and prevention of infection well. Staff were trained and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene in the premises. Personal protective equipment (PPE) was checked during spot checks. A person commented, "They always use aprons and gloves and never do anything without them". Another person said, "I can't believe how many times they will put fresh gloves on in one visit. They are very good at infection control". The provider was thorough and proactive in ensuring people were supported safely, including researching about illnesses such as shingles and norovirus so they could respond appropriately to reduce the risk of infection to people and staff. This meant people were well protected from the risk of infection.

The service had systems in place to manage and report any accidents and incidents. The provider told us that none had occurred in the last 12 months, but was clear of the process that would be followed if they did.

Outstanding ☆

Is the service effective?

Our findings

At the last inspection, we found that people who used the service received effective care that met their needs, choices and preferences. At this inspection, we found the provider had taken further measures to optimise the effectiveness of the service.

All the people and relatives we spoke with said they had been involved with assessing their needs before they received support from the service. The provider undertook a holistic approach to assessing, planning and delivering care and support. The provider had written care plans in line with best practice and guidance using a researched model which assessed people both on the activities of daily living and to ensure physical symptoms and emotional well-being were incorporated. Self-care goals were set to facilitate interventions and further assessment as required. One person said, "They asked me how I would like to be supported. I told them what kind of person I thought I needed to help me; someone who is jolly and chatty. So, they matched me up with the carers they thought would meet my needs". A relative commented, "There was a meeting which we attended. I wrote down everything that I had been doing for my [relative]. They took the list and they incorporated all those things into her support plan".

The provider had ensured that all new staff were supported by a detailed induction programme and on-going support from mentors. The provider had also taken measures to optimise the recruitment and retention of staff. For example, the provider had established 'school run' rotas to open up options for working parents to fit in with their existing obligations. The service had also been involved with the local authority carers' recruitment campaign. Staff retention has also been explored and measures put in place such as staff indicating their availability for work to compile rotas. Although this required more organisation by the provider, the benefit was a reduction in absenteeism and more autonomy for staff about the hours they worked. Staff were clear about what was expected from them. They were provided with a staff handbook providing information on equal opportunities, code of conduct, core values, whistleblowing and data protection. This helped to ensure that care staff lived the visions and values of the service and provided support in accordance with best practice guidelines. This meant that staff turnover was reduced and temporary agency staff were not required meaning people had staff supporting them who they knew well.

People felt supported by knowledgeable, skilled staff who had the right competencies to effectively met their needs. Everyone we spoke with praised the care workers who supported them and said that they were well trained and competent in their work. A person said, "My carers are very well trained. They handle the hoist with great confidence and expertise. There are always two carers when they hoist me". A relative told us, "I think they have very good attention to detail. They have surpassed all my expectations. They have got to know [relative] very well and often do little things which go above and beyond". Another relative said, "They are very well trained and very astute. Only yesterday [relative] wasn't very well. I visited whilst the carer was seeing to [relative] and she drew my attention to a rash that she spotted". A social care practitioner commented, "Caretree provided a very high standard of care and the management were always available to discuss issues of care and other client-related issues as they arose".

People had their needs met effectively because staff training was developed and delivered around people's

individual needs and the provider placed high value on learning and the professional development of staff. The provider was a Registered General Nurse (RGN) and received support in revalidation of her nursing registration from a local external company director who was also an RGN. Training was provided by an external training company and online learning. Refresher training was provided by the provider who had completed a Train the Trainer qualification. Additional training was provided for certain conditions such as Rett's Syndrome, dementia and multiple sclerosis. Information handouts were also made available for staff on a variety of medical conditions. The quality and relevance of the training was monitored by referring to training journals and having close links with nursing and medical practitioners. Staff training was discussed at weekly meetings where the status of staff training was updated alongside confirming where staff were in completing the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care.

Training was tailored to the individual needs and learning styles of staff. We heard that role play was used in training to prepare care staff for situations such as behaviour that may challenge. One member of staff, who was very competent but lacked confidence, had been bought a book by the registered manager around promoting confidence. A member of staff told us that they struggled with written training modules and said "Training was adapted to my style. I'm not very good with text books and benefit from hands on training which was accommodated". This meant that people were supported by staff who had received training which met their needs meaning care delivery was optimised.

People had the benefit of being cared for by well supported staff. There was a proactive support and appraisal system in place for staff, which recognised that continuing development of skills, competence and knowledge was integral to ensuring high-quality care and support. Staff had formal meetings with their supervisors every 6-12 weeks but could approach any member of senior staff for support at any time. Staff had annual appraisals and maintained a Continuing Professional Development (CPD) file. We saw that care staff had opportunities to develop their careers. For example, three of the co-ordinators had been care staff before stepping up to be office co-ordinators. We heard support had been given to access a nurse degree course and they were provided with additional support and tuition as well as providing references. Staff's well-being was a priority for the provider. We heard of measures such as offering reduced gym fees, beverages and snacks offered to care teams when visiting the office. Staff were given break time allowing them to meet their dietary requirements and could use the office facilities to eat meals and relax between care calls. In the summer months there was garden chairs and tables for staff to relax outside.

People with complex or continued health needs were exceptionally well supported by a service that worked effectively with health services and implemented best practice. Oxfordshire Shared Care Protocols (OSCP) identifies healthcare tasks that can be delegated to paid care workers in the community, and there was a framework for training and agreeing funding to support this element of care delivery. Certain care tasks require staff have training by a nurse before they can carry them out, such as cutting nails and applying eye drops. As the provider was a qualified nurse she had received validation from the Continuing Care Team to be able to sign off these tasks. This meant staff could be trained immediately which meant that new clients care could commence without delay and existing clients were always provided with safe effective care. This also reduced the burden on district nurses as the service was not reliant on them to deliver the training. For example, the provider was qualified to offer training to staff on the application of graduated compression bandaging to help those that may have leg ulceration. We saw the provider had equipment in place such as dummies to practice using feeding systems when the person could not receive their nutrition through eating. We also heard that with people's agreement, photographs could be sent to a person's GP or District Nurse for rapid diagnosis and treatment in respect of pressure areas, wounds and rashes. This meant that people had a faster diagnosis through effective triage and this helped prevent hospital admission for some people.

There was a strong emphasis on the importance of people eating and drinking well and because staff knew people well, they were aware of people's individual preferences and patterns of eating and drinking. This meant people could be encouraged if they were reluctant to eat or had difficulty in eating and drinking. People's dietary preferences were recorded and any changes communicated to the care team to be implemented. Staff were keen to meet these preferences. For example, one person expressed a dislike of a particular flavour of food supplement. Therefore, staff checked each order to ensure the flavour had not been dispensed and if it had been staff took it back to swap for another flavour.

Staff ensured food was presented as attractively as possible to promote appetites and ensure dignity. For example, care staff knew if people liked their sandwiches cut into triangles or squares and preferred crusts on or off. Garnishes were used for presentation and condiments were placed on the tray or table. Food microwaved in plastic was always plated before being presented. Kitchen roll was folded and doubled as napkins if a napkin was not available. Care staff completed food charts accurately to monitor amounts given and amount eaten.

Staff promoted people's independence and autonomy by involving them and encouraging them to cook with staff if able. People were given time to eat and if they wanted privacy, care staff could perform other tasks so people didn't feel self-conscious. When care staff were leaving, they always left accessible snacks and drinks within easy reach with the handle pointing the correct way for the person's dominant side. If people attended a day centre or a hospital appointment and didn't want to purchase a meal there, care staff made sandwiches for them to take. We were told of one occasion when the registered manager purchased food for a person who couldn't afford it then referred them to food bank.

All care staff received food hygiene and nutrition training. Food safety was considered with dates checked and, with permission, out of date food discarded. Food labels were printed at the office for care staff to use. Fridge temperatures were checked and food storage guidelines adhered to. Care staff emptied food bins daily to ensure cleanliness and waste was segregated appropriately into recycling, food waste and waste. Bins were taken out on appropriate days and taken back in after bin collection

Where people needed specialist support with their nutrition and hydration, the provider discussed dietetic advice with relevant professionals. For example, we saw a feeding regime for a person who could not eat orally had been suggested to the dietician which was adopted and implemented. Training had been delivered to the care staff and the person's relative and we saw relevant paperwork was in place to authorise staff safety in the feeding task. Staff understood the importance of food safety when preparing or handling food or drinks such as how to prepare mashable, pureed and thickened fluids. When staff were trained on thickening drinks, the provider got staff to sample the taste to familiarise themselves with the different consistencies.

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. We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Staff were clear about their responsibilities under the MCA and staff had been trained to ensure they provided care in accordance with the MCA Code of Practice.

Consent was always gained before giving care and a full explanation given. People told us that staff routinely asked for their consent before providing care, telling us, "I am as independent as I can be and I make all my

own decisions". A relative said, "They do communicate with her all the time asking for consent or explaining what they are doing". People were supported to make their own decisions. A relative said, "They always ask [relative] if she wants a shower or a wash and they are guided by her decision. When they leave they ask if she would like the TV on or not rather than just putting it on automatically". Discussions with staff highlighted that they recognised the importance of gaining consent from people and doing so was something which was automatic to the way they delivered care. Through the provision of regular care workers who knew people and were able to effectively communicate with them, the service was able to ensure that the consent people gave was valid.

Outstanding ☆

Is the service caring?

Our findings

At the last inspection, we found people received outstanding care. At this inspection, we found people continued to receive care that was of an outstanding level.

Everyone we spoke with praised the exceptional care that they received from the service and used the word 'outstanding' on many occasions. Comments included, "I would definitely recommend the service to anyone. They have been superb. I can't fault them and I would say they offer an outstanding service" and "I would recommend the service without hesitation. I would say that they are still offering an outstanding service due to the splendid carers and the management. It is an amazing care group". People spoke of the kindness of the staff, saying "The carers are very good I can't fault them. They are kind, caring and friendly. They chat with me the whole time they are here and we have a laugh together"; "I really feel that my carers are like friends coming to visit. We chat away together quite happily"; "The carers are lovely, they can't do enough for me. They are always offering to do things" and "The carers are very kind they are my friends. They sit and chat with me and do puzzles which I enjoy". A relative said, "I can tell that the carers are very kind and caring just by the way the carers speak to [relative]. They are very patient and call her by name".

People's families also received support from the staff. The provider stated on their PIR, 'Care is not only about caring for the individual but about caring for the whole family as they make the client who they are'. We heard of occasions when emotional support was offered out of hours to a person struggling with their relative's needs and deterioration. Family members expressed how staff also treated them with kindness. One said, "My [relative's] partner has now gone in a home. Often, she expresses that she misses him and can get quite upset. The carers are brilliant they sit with her and chat with her telling her that he is in the best place to be cared for". We saw letters of thanks about how staff worked really hard to provide support that was personalised and special to people. One stated, "You went above and beyond your job roles so much of the time and my [relative] only ever had wonderful things to say about you".

The provider was passionate about providing an outstanding service and it was clear that this enthusiasm and drive was effectively shared with all the staff employed by them. A member of staff said, "There isn't money to be made in healthcare but the emotional reward makes up for it. We are like second families to some people and to others we are their family. It is such an important role". Staff remained highly motivated to offer care and support that was exceptionally compassionate and kind. The service ensured that care staff had sufficient time to support people in a meaningful way to enhance people's wellbeing and people's preferences were matched to care staff with similar interests. For example, a person who loved music and whose spouse had died, had dementia and required encouragement. They were matched with a carer who also loved music and had a track record of bringing purpose and meaning to people's lives through their personality and positive demonstrable approach to people with dementia and had availability to match person's requested times. A person had written in a review that, 'Humanity is the key to successful caring and I feel Caretree have put thought into matching me with staff who I can work with which has been very helpful'.

There were many examples of staff providing 'acts of kindness' outside their formal roles to make a

difference. Examples of this included, helping a person to write a letter to their grandchild, visiting a person in hospital whose relatives were unable to visit, buying a person headphones with their (staff) own money, teaching a person how to use their iPad, helping people to use new mobile phones so they could listen to music and take pictures.

Staff were keen to assist people in ways that made an emotional difference such as spending time with people, recognising that providing high quality care was about more than just delivering the care plan well. For example, one person was helped by a member of staff to find their wedding song which they hadn't heard for 20 years. The member of staff then downloaded the song onto a CD so that the person could play it anytime. We heard from staff that the person was delighted with this.

People were encouraged to express their views, preferences, wishes and choices. Staff appropriately advocated for people where necessary. For example, a person was not happy with their day centre facilities but felt unable to sort this out alone. Staff approached the person's social worker to put forward a case for an alternative solution. We were told a person in hospital had a 'Do not attempt resuscitation (DNAR)' on their records without their knowledge which they found upsetting. The service phoned the GP and it was removed. The service liaised on people's behalf with housing providers such as getting a fire door fixed and looking at the maintenance contract when their lift broke down.

Everyone we spoke with said staff were excellent at respecting their privacy and dignity. One person said, "They are respectful at all times. They always ask if I want my curtains open or left shut". Another said, "Without fail they always shut the bathroom door if I am in there". A relative said, "When they enter her bedroom they always knock on the door and ask to go in. They keep the curtains shut and close the door whilst they support her. When she is being transferred from the hoist to a bath chair they will cover her up in towels to respect her dignity". Another relative said, "The carers demonstrate that they respect her privacy and dignity by giving her time to complete tasks and they politely enquire if she would like help". One person who could not get out to a hairdresser had their hair cut by a member of care staff to make them feel better.

Information on people was handled confidentially. Online data was secured on an encrypted file system and carers were trained to report data breaches and these are discussed during weekly office meetings. However, no breaches had occurred. Information was destroyed confidentially by an on-site shredding company.

Outstanding ☆

Is the service responsive?

Our findings

At the last inspection, we found that people who used the service received responsive care. At this inspection, we found the provider had taken further measures to ensure people received personalised care and had the support necessary to experience the end of life they had expressed.

People's care and support was planned in partnership with them. People felt in control of the care that was delivered and praised the care they received. Every person and relative we spoke with stated that they knew of the care plan, where it was kept in the house and that they had been involved in its development and their wishes had been incorporated. Comments included, "I have a care plan which meets my needs perfectly and I have signed it. I have a review meeting in two or three weeks. They do change things in the plan when necessary when they have discussed changes with me and I have agreed to them". A relative commented, "The care plan is in place. I was involved in its development and signed a copy when it was completed. At the first meeting I wrote down everything I had been doing for [relative] on a daily basis. They took my list and incorporated all the things I had been doing into the plan. It is now kept in the house for all carers to read and for me to access too. There are review meetings, but changes are made as things change. I only have to ask for a change to be made and I know they will act upon my wishes or my [relative's] wishes. Everything in the care plan is recorded very clearly and it is easy to read and the carers carry out all the issues and jobs to be done each day in the plan. My [relative] and I are very happy with the plan, it fully meets her needs".

Care records were thorough and provided detailed information to guide staff and ensured consistent delivery of care. People's likes and dislikes were clearly recorded throughout the care plan and information such as how people wanted to receive their support were included in every care plan we read. The service understood the individual needs of people and delivered care and support in a way that met those needs. One person said, "I have a support plan in my house which meets my needs very well. I am very happy with it. Everything I want gets done, I have no complaints". People told us that staff had outstanding skills and an excellent understanding of their individual needs and their values and beliefs, which may influence how they want to receive care, treatment and support.

Staff said they found the information on care plans enabled them to deliver up to date and responsive support as it was accurate and reflected any changes made. The service took active steps to ensure they had all the information they needed to deliver appropriate and personalised care. The service had a secure portal with care plans on them which all care staff could access via a mobile phone. This meant up to date and accurate information was always available. We had feedback from the staff that they had found this invaluable. The portal was confidential as care staff could only access information about the person linked to their schedule.

All care plans promoted choice and were person centred and included areas such as communication, mobilising, medicines, sleeping and breathing. Staff told us how they worked with people to overcome any barriers to receiving the care they required. One person was fearful of the shower floor and slipping. Care staff spent time developing techniques to overcome this fear and this information was cascaded to the team

and the person now regularly showered. Care plans had prompts to remind staff to give time for people to communicate. Care plans contained information on people's interests for example leisure activities such as reading books, watching television or gardening. Thought had been given to incorporating all aspects of people's lives. A member of staff explained how they had supported a person who had a very much-loved dog and care staff often helped to care for the dog during their visits to ensure it got its medicines. Therefore, they drew up a support plan for the dog and gave it to the person. The support plan included mobility, medicines and a one-page profile. We heard this 'Meant the world to her owner' and they were really touched by the gesture.

Care plans were reviewed and updated regularly and as people's needs changed. People had an allocated account manager who oversaw their care package which resulted in consistent care and a person to discuss matters with directly. The account managers had taken time to meet all of the people they had responsibility for and told us how important it was to ensure they knew people individually. We saw recording on people's reviews with feedback such as "Delighted with care". The account managers ensured that the first reviews were held face to face with people and encouraged the commissioning service to attend these meetings so a comprehensive review could take place to ensure the person's needs were being met as intended.

Flexibility was provided and this was important so that people could accommodate their social activities. For example, a person liked to attend choir practice and attend church on a Sunday so these were considered in timings of visits. We also saw visits had been rescheduled to ensure adequate time was given to ensure all tasks could be carried out. A visit time had been rearranged as the medicines given at the initial time resulted in the person becoming drowsy. Therefore, the visit was rescheduled to ensure the person could have the medicine later so this did not impact upon their alertness.

Where requested the service helped people to access education or social and emotional support so they could live as full a life as possible. The service had actively built links with the local community that enhanced people's wellbeing and quality of life. A person was being supported to continue their education and care staff worked in collaboration with a local school on a home tutoring programme. This meant the person could attend school trips and outings out. The provider had also sourced volunteer agencies to provide companionship.

The service had a positive approach to handling concerns and complaints which they viewed as a part of driving improvement. A complaints policy and procedure was in place and people had copies of this in their homes. However, there had only been three low level complaints and those we saw were unsubstantiated and the fourth one resolved satisfactorily. All complaints were tracked with outcomes and dealt with in a timely manner in line with policy. Nobody we spoke with had made any complaints and people and their relatives said their opinion was sought at support plan review meetings and when chatting with the manager informally on the phone. A person said, "Once I phoned the manager up because I was finding it difficult to get on with one of my carers. She was doing nothing wrong it was just a personality thing. The manager sorted it out straight away, she obviously listened to my opinion and acted upon it".

Team meetings and supervisions were also an opportunity to identify potential issues to avoid escalation into full complaints. The introduction of a co-ordinator who could 'troubleshoot' any issues immediately also meant that quality was maintained as any situations were quickly worked upon and resolved. An example of how this role benefited was when a concern was raised that cleaning that was meant to be done during visits was not being done satisfactorily. The co-ordinator went to shadow the visit and investigate the issue. During this it was apparent that there was insufficient time to complete the cleaning as the environment had deteriorated to low level making any cleaning unnoticeable. Therefore, it was decided that

the service would undertake a deep clean of the person's home and then it would be easier to maintain for the care staff when they did their visit. The ability to identify the real reason for the concern and how to solve the problem meant the issue could be resolved and the required cleaning could then happen as requested as it was easier to maintain.

The provider was following the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. On assessment, people would be asked how they preferred to communicate. This would be recorded in the communication profile and any recorded needs would be flagged as highly visible. One person's communication care plan described two pieces of equipment to promote their communication. An 'expressing choice' care plan explained how the equipment helped and that time was needed to ensure the person could express their needs.

People and if necessary, their families, were sent rotas a week in advance so people knew which carers would be visiting and when. If changes were made to a rota, office staff contacted people and/or next of kin to update them. The service used an electronic system to monitor timing of visits by staff which helped to monitor that visits did not take place more than 15 minutes earlier or later than planned. Flexibility was provided, for example, a person had requested an earlier time for their visit the following day. The co-ordinator agreed to do this visit as there were no care staff available. Emails were responded to out of hours. The service was able to take responsive action when necessary. For example, a person needed an emergency occupational therapist assessment and the local authority could not provide this so the registered manager carried this out as they had the skills to do this effectively so the person was kept safe.

The service was responsive at helping people and their families to explore and record their wishes about care at the end of their life. People's preferences about treatment through all stages of their lives were discussed at assessment and when appropriate thereafter. This included religious beliefs and 'do not attempt resuscitation' wishes. This was recorded and shared with the care team. Where needed liaison took place with multi-disciplinary teams, the hospice and the continuing care team. Staff were able to provide a rapid response to people's changing care needs as they knew people well and could therefore recognise any changes in people's condition quickly so action could be taken. For example, care staff noted a person's condition had deteriorated. On request, the registered manager visited and noted the person's breathing had changed and they required medicines to manage the symptoms. The GP was called and within an hour the medicine was in place and a syringe driver set up to ease their symptoms.

As the registered manager was a qualified nurse, care staff were taught care techniques to a high standard such as bed bathing, mouth care, eye care, supporting with meals and hydration to ensure people received a high level of care, pressure damage was minimised and they received the best experience possible.

The service was flexible and responsive to meet people's needs. Emergency care that required two care staff could be provided if required. If needed, equipment could be sourced. The service worked closely with the community matron.

End of life training was available for staff in line with best practice theory. When death occurred, families were contacted by the registered manager to inform them of the death in an empathic manner and support offered. Staff were also supported by the service with empathy and understanding when people died. All staff were telephoned to inform them when people died and offered support and encouraged to come to the office and talk about their feelings. If staff wished to attend funerals time was given. On one occasion, the registered manager dealt with the funeral directors as the family did not feel up to doing so.

The service supported staff to attend funerals or assist others to attend these or other family events. For example, a member of staff was paid to assist a person attend a close friend's funeral. The person was not charged for this assistance.

Outstanding ☆

Is the service well-led?

Our findings

At the last inspection, the service was rated as outstanding in being well led. At this inspection, we saw that the provider and staff had continued to demonstrate the characteristics of outstanding practice and had further developed the service. Caretree Limited's vision was to deliver care in a way they would want it delivered to themselves and to provide a meaningful experience. They used a quote from a person who used the service which was, "The opportunity for distinction lies in doing the ordinary things extraordinary well". Despite this, the provider and staff were humble about their achievements because providing a truly person-centred standard of care was something they did automatically.

All the people and relatives contacted spoke very highly of the service and would or already had recommended the service to others. Several comments were made that the service offered an outstanding service and they would never change their care provider. Comments included, "She came to see me before the care started. She spent a long time chatting with me and finding things out about me. She was very friendly and approachable"; "She was the first person to come and see me. She was lovely, very approachable and I couldn't believe how friendly she was. She was also very on the ball she knows her job well. I can speak to her about anything and I can phone her easily any day, which I have and I have always got through" and "The manager is excellent. She is very polite and friendly and easy to talk to". A relative said, "I spoke to the manager just last weekend. [Relative] had to go in to hospital so I informed her so she could sort out the carers. We had a very good chat and she explained very competently about [relative's] medication; better than anyone else had". Professionals praised the competency of the management and the openness and quality of communication. The service was a role model for other services. One social care practitioner said, "Caretree Limited, both managers and staff, were high on my list for the quality of care that they provided for their clients".

The service showed a keenness to work in partnership with other organisations to drive improvement in the domiciliary care industry. We had feedback from a professional who had prepared a training programme for ten senior leaders from the World Health Organisation (WHO) in Oxfordshire to learn about 'System Transformation'. Caretree was contacted to see if they could meet with the leaders to share information about their organisation's work. This was to assist the WHO leaders to learn from Caretree on how they strove to realise their mandate, how to deal with competing interests and needs, and the extent of interaction with people using the service, and any other information felt helpful about how their system worked. The professional received feedback from the WHO leaders that they were very impressed and highly inspired by how Caretree was delivering their service and following regulations. Another example of promoting the industry was an article the provider had been interviewed for having been published in the 'The Parliamentary Review' which discussed how the service had achieved an outstanding rating and how they operated and challenges they faced. The Parliamentary Review is a political publication with articles from organisations. These are then distributed to business executives and policymakers across the UK. Each edition focuses on an individual governmental policy area such as healthcare.

Partnership working had also been developed with meetings with GP practice managers to effect better working relationships. The service also linked up with other care agencies and liaised with services such as

the fire service, ambulance teams and liaised with the local college providing healthcare courses. The provider attended regular meetings the Oxfordshire Association for Care Providers (OACP) to keep up to date with the current trends in the county. They also worked effectively in partnership with other organisations such as community hospitals, district nurses and clinical leads. These relationships benefited individuals as communication was effective. For example, relevant agencies would be contacted if someone was admitted to hospital so discharge could be considered immediately.

The service had excellent systems in place to ensure the management team had robust oversight of their dispersed work force. There were four care coordinators who were office based managing the day to day operation of the business in respect of care work. Their responsibility was to liaise with staff and clients to ensure that care was planned, managed and supported to a high level of quality. In addition, they provide supplementary services such as recruitment, training and development of staff. Mentorship co-ordinators were in place who were experienced carers that support and advise more junior carers in the field to offer shadowing opportunities and assisting in the training and development of their colleagues.

Governance was well-embedded into the running of the service and there were effective systems to monitor performance and risk leading to the delivery of demonstrable quality improvements to the service. The financial director had developed a bespoke database which was used to improve the governance of the service. The system was used to check compliance in areas such as staff training, and scheduling. The scheduling was linked to accurately reflect the invoicing system meaning there were virtually no errors on people's invoices and staff were paid accurately and on time. Audits could take place on both internal and external training to evaluate its effectiveness and data on staff could be uploaded continuously to the National Minimum Data Set for Social Care (NMD-SC). NMDS-SC provides information on the size and structure of the adult social care sector including the types of care services provided, how much care provision there is, how many people work in the sector and doing which types of jobs. The information is used by decision makers in Government and local authorities across England. The system also flagged up actions required such as non-compliant staff; open absence records, out of date customer reviews, incomplete carer records; expired quotes, open periods. The benefits of the IT system were that as Caretree Limited had developed the system and personalised it they could adjust its requirements when required which meant it could be flexible to always meet the service's purpose.

Other quality assurance audits took place on the quality of care practice including care plans, documentation and recording. The provider and senior staff undertook a combination of announced and unannounced spot checks and telephone interviews with people in order to review the quality of care provided. This included arriving at times when the care workers were there to observe the standard of care provided and also outside of visit times to seek feedback from the person using the service. The spot checks also included a review of people's care and a quality check of the records kept at the person's home to ensure that they were maintained in accordance with the services high standards.

People were regularly asked for their opinions about whether the service was meeting their needs and expectations. The provider ensured she had regular contact with people and by doing care calls herself; she was able to build her own relationships with people and ensure the objectives of the service were being met. Six monthly reviews were held and annual satisfaction surveys were carried out to capture an overall picture of effectiveness of the service. The results of these were analysed and a report published and distributed to people. As the service had developed close relationships with people and their families this meant that any concerns, requests and updates were well communicated.

The registered manager and co-ordinators met each Friday to ensure that everything was in place for the weekend visits and to anticipate any issues that may arise for the on-call staff. This contributed to staff being

prepared and also benefited people to ensure they had adequate medicines and that staff knew of any issues such as ill health or other arrangements. On each Monday morning, the team met again to get an update from the on-call over the previous weekend and this helped to plan one of the co-ordinators role which was to be reactive to any issues that needed following up immediately. We observed a meeting where issues were discussed such as needing to visit someone's new house as they had moved to do a risk assessment. The registered manager gave a staff update on issues such as what supervisions were scheduled, training, spot checks arranged and recruitment status update.

The provider was aware of the importance of the attitudes, values and behaviours of staff. Staff understood what was expected of them because the values of the service were embedded at every level. The values of the service were shared by staff and underpinned every element of practice. Right from the point of initial assessment through to the delivery of end of life care, people were placed at the very heart of the process. The findings in this inspection and report evidence that the provider wanted excellence in all areas of the service.

Care staff told us that they felt fully engaged with the service and were clear about what was expected of them in their roles. The provider said they had decided not to hold staff meetings as attendance was not consistent and some staff found it difficult to attend. To counteract this, there was excellent communication in the form of formal, regular and structured supervision meetings with opportunities in between to talk to any member of office staff or the registered manager. There was a weekly newsletter with full updates which all staff had access to and could contribute any views and comments. Opinions were sought and acted upon. For example, staff asked for thinner tunics during the hot summer and these were supplied. Staff could also have thicker ones and fleeces for the winter months. Mentorship co-ordinators also could feed in suggestions from their meetings with new staff. We heard a member of staff suggested having urine bottles in their possession so they could request a sample and get it tested swiftly. We saw this suggestion had been successfully incorporated into practice. Social events were held for staff such as barbecues so they could get together socially.

Care staff spoke enthusiastically about the service being a good place to work. They told us they felt supported, received regular supervision and had access to plenty of training opportunities. Care staff expressed satisfaction with their work because the service enabled them to provide high quality care that they could see. Comments included, "I love my job. I'm very proud to work with Caretree. We deliver really good care. Overall clients are very happy with us. If there are any problems, we get the support we need"; "[Provider] is very passionate. Keen to know what is going on and to put things right if needed" and "I feel valued in my role and get nice feedback".

The provider subscribed to updates on Skills for Care and Social Care Institute for Excellence (SCIE). The provider had also set up a forum for nurses to network to share best practice. The financial director subscribed to journals in relation to technology systems security practices and data protection and GDPR.