Shreeji Inc Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 9 November 2017 and was announced.

Shreeji Inc Limited is based in Rainham, Essex. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults.

Not everyone using Shreeji Inc 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 take into account any wider social care provided.

At the time of our inspection, 33 people were using the service, who received personal care. The provider employed 15 care staff, who visited people living in the community.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered care homes, 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.

Staff and managers had an understanding of the Mental Capacity Act 2005. We have made a recommendation about the provider's procedures on the MCA because people's capacity to make decisions and consent to their care was not always recorded clearly.

People received care at home from staff who understood their needs. They had their individual risks assessed and staff were aware of how to manage these risks.

Systems were in place to ensure people were protected from the risk of abuse. Staff were able to identify different types of abuse and knew how to report any concerns.

The provider had sufficient numbers of staff available to provide care and support to people. Staff had been recruited following criminal background checks with the Disclosure and Barring Service, to ensure they were safe and of good character.

Staff provided safe care in people's homes. Staff had received training on handling medicines. When required, staff administered people's medicines and recorded medicines that they administered on people's Medicine Administration Records (MAR).

Staff received training that was required for them to be able to carry out their roles effectively. They told us that they received support and encouragement from the registered manager. Senior managers took action where necessary to improve staff performance.

People were supported to meet their nutritional needs. They were registered with health care professionals and staff contacted them in emergencies.

People were treated with respect and their privacy and dignity were maintained. They were listened to by staff and were involved in making decisions about their care and support.

Care plans were person centred and provided staff with sufficient information about each person's individual preferences and how staff should meet these to obtain positive outcomes for each person.

People were able to access information they were able to understand to help keep them informed and safe. A complaints procedure was in place. People and their relatives knew how to complain and give feedback about their care. Complaints that were received were investigated appropriately.

The provider was committed to developing the service and introducing technologies to support staff in their work.

Feedback was received from people, staff and relatives and their views were analysed to ensure the service made further quality improvements. Where improvements were required, the registered manager ensured lessons were learned to avoid repeated mistakes.

The registered manager had instilled a positive culture of working together with staff, to help develop the service and monitor the quality of care provided to people.

Staff were able to raise any concerns and were confident that they would be addressed by the management team. The management team carried out regular spot checks on staff providing care in people's homes to ensure they followed the correct procedures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood how to safeguard people from abuse. They were aware of their responsibilities to report any concerns.

Risks to people were identified and managed safely by staff.

Staffing levels were sufficient to ensure people received support to meet their needs. A recruitment procedure was in place to employ staff who were of good character and provided safe care to people.

People received their medicines safely when required and staff received training on how to do this.

The provider was able to learn lessons and improve the safety of the service when required.

Is the service effective?

Requires Improvement

The service was not always effective. Staff understood the requirements of the Mental Capacity Act (MCA) 2005. However, people's capacity to make decisions was not recorded clearly and we have made a recommendation about this.

Assessments of people's needs were carried out to ensure effective outcomes for their care. Changes in people's care needs were not always updated in their care plans.

Staff received appropriate inductions, training, and support.

People had access to health professionals to ensure their health needs were monitored. Staff ensured people had their nutritional requirements met.

Is the service caring?

Good

The service was caring. People received care from staff who were kind. They were treated with dignity and respect.

Staff were familiar with people's care and support needs.

Staff had developed caring relationships with the people they supported.

People and their relatives had involvement in the decisions made about their care.

Staff were respectful of people's privacy and personal information.

Is the service responsive?

Good

The service was responsive. Care plans were person centred and reflected each person's needs, and preferences.

The provider ensured important information was accessible to people in a way they could understand it.

People were able to make complaints about the service. The provider investigated all complaints appropriately.

Is the service well-led?

Good

The service was well led. Staff received support and guidance from the management team. People and their relatives were happy with the management of the service.

There was a system in place to check if people were satisfied with the service provided.

Quality assurance procedures were in place to monitor that the service running effectively.

Shreeji Inc Ltd

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.

The inspection took place on 9 November 2017. This was an announced inspection, which meant the registered provider knew we would be visiting. This was because it was a domiciliary care agency and we wanted to make sure that the registered manager, or someone who could act on their behalf, would be available to support us with our inspection. The inspection team consisted of one adult social care inspector and an expert by experience, who made telephone calls to people who used the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service and provider. We looked at any complaints we received and statutory notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. In July 2017, the provider sent us a Provider Information Return (PIR). The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We looked at the information the provider had submitted. We also contacted the local authority for their feedback on the service.

During the inspection, we spoke with the managing director, who was also the registered manager, three care staff and a care coordinator. We also spoke with 19 relatives of people who used the service for their feedback about the quality of care their family member received. We spoke with relatives because most people were unable to speak with us on the phone.

We looked at nine people's care records and other records relating to the management of the service. This included ten staff recruitment records, training documents, rotas, accident and incident records, complaints, health and safety information, quality monitoring and medicine records.

Good

Is the service safe?

Our findings

Relatives of people who used the service told us they felt their family member was safe. Comments included, "Yes it is safe" and "Have no concerns about the staff. The staff are safe."

People were protected from the risk of abuse and there was a safeguarding procedure in place for staff to follow. Staff were aware of their responsibilities for safeguarding people and understood how to report any abuse. One member of staff said, "If I notice something different about a person, like if there is a bruise on them, I would report it to my manager." The service had a whistleblowing policy, which enabled staff to report concerns about the organisation to regulatory authorities, such as the police or the local authority.

Where people received care and support, any risks to them were identified during assessments of their needs. Risk assessments were undertaken, which informed staff how to manage and reduce any risks, to keep people safe. Care plans contained this information and any actions that were required to be taken. The assessments identified what the risks might be to the person and what type of harm may occur. These included risks associated with the person's mobility, nutrition, hydration and their home environment. The likelihood and severity of the risk was noted in their care plan and there was information and guidance for staff on minimising the identified risk. For example, one person's risk assessment stated that they were using a profiling hospital bed with bedrails and bumpers. Staff were required to ensure rails were "In good working order, there were no gaps between the rail and the mattress and to check bumpers were in place to prevent the person feeling trapped." Where a person required assistance getting out of bed or a chair, two staff worked together in order to move the person safely, using equipment such as hoists. This reduced the risk of any harm coming to the person as they were being moved.

Relatives told us that staff usually arrived on time or were notified by the service if, for example, their care worker was unable to attend because of sickness or were running late due to traffic. Relatives we spoke with said that care staff arrived and stayed for their allocated time with their family members. They also told us staff stayed a few minutes longer if required. One relative said; "Sometimes they are late but they tell me if they are going to be late; we have the same carer all the time, there are no problems."

The management team monitored if staff were on time, running late and had arrived at a person's home. The registered manager told us they had implemented a new electronic system which enabled care staff to log in and out of their calls using their smartphones. They said, "We are working towards rolling it out in the New Year so all staff will have to use it. We will train them on how to use it. At the moment we are also using timesheets to monitor staff."

Out of office hours and weekend call records showed that the service was monitored at all times. We viewed rotas for the days and times care was to be provided to people. We looked at daily notes and timesheets and saw that staff completed their tasks and calls for the scheduled times. Staff were also able to contact the registered manager or the care coordinator, who were on call during out of office hours and weekends, in case of an emergency.

Staff told us they were happy with their workloads and schedules. They told us they had enough time to travel between their visits to people and deliver the support detailed in people's care plans. One staff member said, "Yes, I have enough time for me to get to my clients on time." Cover arrangements were made when staff were unavailable to provide care to people. For example, if there were staff absences, the care coordinator who was based in the office, ensured they themselves or another care staff member visited the person.

The provider carried out the necessary background checks, such as a Disclosure and Barring Service check, before the member of staff could be employed. The DBS is a check to find out if the person had any criminal convictions or were on any list that barred them from working with people who use care services. This helps employers make safer recruitment decisions. New staff completed application forms, which contained their employment history and any previous experience. Professional references were obtained along with evidence that the applicant was legally entitled to work in the United Kingdom.

Staff followed the provider's infection control procedures. They used Personal Protective Equipment (PPE) such as gloves and aprons, to prevent any risks of infection when providing personal care. One relative told us, "The staff make sure they have washed their hands and things are clean."

Staff were observed by the care coordinator during spot checks, which are observations of staff to ensure that they are following safe and correct procedures when delivering care. We saw spot check records, which showed that staff were observed wearing their identification badge and using PPE to carry out their tasks safely. During spot checks, staff were also observed prompting and administering medicines to people for their competency to safely administer medicines, when required.

A medicine policy and procedure was in place for staff to administer medicines safely. Staff recorded the medicines they administered on the appropriate Medicine Administration Record sheets (MARS), which were dated and completed without any gaps. Staff who were required to prompt or administer medicines to people told us they were confident with managing medicines and had received training on how to do this. Records showed that staff were assessed as competent to manage medicines. Relatives told us they were happy with the way staff administered medicines to their family members. One relative, "Yes they help [person] with their medication."

People had a "medication care plan" which set out how staff were to support the person with their medicines. It contained information on the fluid to be taken with the medicines, the person's preferences for how to take them, where to take them and whether they wished to have them before or after their meal. Where people took 'PRN' medicines, which are medicines such as painkillers that are taken when needed, this was stipulated in the plan. If family members were responsible for administering the person's medicines, this information was noted in the "medication care plan" so that care staff were aware of this.

The provider was committed to learning from incidents or mistakes to ensure that there was continuous improvement and people using the service remained safe. We noted that the management team emphasised the importance of keeping accurate care records, such as daily logs, to staff as evidence that people were provided with safe care. This protected both the person and the staff member. The registered manager told us they had learnt from previous issues, such as complacency from care staff when providing care and completing records. They said, "We are draining this attitude out. We listened to feedback and wanted to establish a common culture of understanding between us and the clients. Communication and continuity are very important and we are doing better."

Requires Improvement

Is the service effective?

Our findings

We looked at the provider's policy on the Mental Capacity Act 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked that the provider was working within the principles of the MCA.

Staff understood their responsibilities under the MCA and what this meant in ways they cared for people. The registered manager told us all people had capacity to make decisions. We did not see that this was recorded on people's assessment forms, which meant it was not always clear whether they had capacity or not. We saw that people were asked for their consent for the provider to provide care and signed a declaration document to confirm it. If they were unable to sign it, family members did so on their behalf because it was in their best interest. The declaration had an option to state the reason why the person was not able to sign the document, for example if they had poor eyesight or dexterity. However, we noted that this option was not always completed when the person was unable to sign the document, to determine if they had capacity. We found that the provider's policy on consent did not make reference to the MCA. We saw some separate guidance on following the principles of the MCA but the two documents were not combined together as one policy, making it unclear what the provider's actual policy was.

We recommend the provider reviews its policy on the MCA to ensure that it is clear and up to date and follows best practice guidance on recording people's capacity status and consent to care.

Most relatives told us staff met their individual needs and that they were happy with the care provided to their loved ones. However, one relative said, "I had an issue about one of the new staff but it was resolved immediately. On the whole I am satisfied with the care received." We asked the relative what the issue was and they told us that one member of care staff, who had been recently allocated to their family member, was new to the role and had spent only one week shadowing a more experienced care worker. The relative told us, "The lack of experience meant that they didn't know how to use the key safe and didn't know what to do for [person] and I had to show [carer], which I did not think was acceptable." A 'keysafe' is an entry system which requires a passcode for entry into a person's home. The feedback from the relative, was received by the registered manager who took action to ensure the staff fully understood the procedures for using a 'keysafe'.

The registered manager told us that new care staff shadowed experienced staff for as long as needed. Staff that required or requested further shadowing experience were supported with this or were provided additional training. However, most new staff required only a week's shadowing whilst undergoing their induction training. They were able to shadow current staff to help them settle into their role providing personal care to people and learn. One staff member said, "I received an induction, training and did shadowing before I started. It was very helpful."

We saw there was an induction programme in place for new staff. This included reading through the provider's policies, procedures, codes of conduct, guidance, working with a 'buddy' whilst shadowing them and undergoing training. Staff had received training in safeguarding adults, record keeping and communication, infection control, basic life support, medicine administration, health and safety, infection control and managing challenging behaviour. Staff told us they were supported by senior staff and the training helped them to perform in their roles. Care Certificate standards was incorporated into the training. The Care Certificate is a set of 15 standards and assessments for health and social support workers who are required to complete the modules in their own time. Staff that completed the standards or a diploma received a certificate to show they had a qualification in health and social care.

Supervisions took place every quarter, where staff had the opportunity to discuss any issues or concerns with their line manager. Topics included communication skills, professionalism, punctuality, teamwork, decision making, personal care and any training needs. Annual appraisals were an opportunity for staff and managers to review their overall progress and ensure they had completed all their required training. Records confirmed that supervision meetings and appraisals took place. Staff were able to comment on their work performance over the past year. We saw that one staff said, "I am happy about the work I'm doing. I'm happy with the managers and my clients and look forward to moving forward." This meant that staff were monitored and their performance and skills to carry out their work were reviewed.

The provider received referrals from the local authority, who referred people that required assistance with personal care at home. Referrals were also received for people who were being discharged from hospital. The service provided support to people with differing levels of need. We saw assessments of people that required support which set out the needs of the person. Discussions were held with other health or social care professionals for further information.

Each person had a copy of their care plan in their home, which contained details of what support people wanted for each part of the day when a member of staff was scheduled to visit, such as in the morning or in the evening. Care plans were supported by a document compiled by the local authority, which contained background information on the person's health needs and history. People's physical and care needs were assessed by the provider before they started to use the service. The provider produced their own care plan based on the outcomes the person wished to achieve and ensured they were in line with recognised health and social care guidelines.

The plans were divided into sections, with each section detailing the specific needs of the person, such as assistance with their mobility, medicines, skin care, nutrition, night time requirements and any activities to assist them with their daily living. For example, one person's identified outcome was to "continue to live independently in the community with a good level of support to meet needs." Staff supported the person with their mobility, by using a full body hoist. They checked that all equipment they used was safe so that they could deliver effective care and support. Staff also reported any faults with equipment to the office.

Most care plans were reviewed and updated to reflect people's changing needs. However we saw that one person's care plan had not been updated following a change to their night time requirements. We addressed this with the registered manager and care coordinator, who assured us that they would make the necessary updates to the person's care plan.

Staff had received training in equality, diversity and inclusion. This helped staff understand how to treat people equally, irrespective of their race, sexuality, age or gender. They were respectful of and had a good understanding of all people's care needs, personal preferences and their religious beliefs.

People were supported to have their nutritional and hydration requirements met by staff. Care plans included details of the types of food they preferred and what they liked to drink. Relatives told us that staff helped with providing food and drink to their family member, when required. A staff member said, "I prepare food when needed. I might make them a cup of tea or warm their meals in a microwave."

People's care was planned and delivered to maintain their health. Records confirmed that people's relatives and their GP were informed of any concerns raised about people's wellbeing or any deterioration in their health. A relative told us, "The staff always look out for [family member] to make sure they are well." Staff were aware of how to respond to any concerns they had about a person's health. A member of staff said, "If we have a concern or notice the client is unwell, we will call the GP or district nurse right away."

Good

Is the service caring?

Our findings

People's relatives told us that care staff treated their families with respect, kindness and dignity. Comments received were: "The main carer does over and above"; "Carer seems to be fine, friendly; speaks Punjabi" and "We get on really well, really good with [care staff]."

People received care from staff who were familiar with their care and support needs. Their relatives confirmed they usually had the same staff providing care. This helped with consistency and enabled people to have a positive relationship with care staff. They felt comfortable with staff who visited them regularly. They enjoyed the company of staff because there was an understanding and familiarity between them. One relative said, "[Family member] gets on so well with her carer, they are like two kids laughing and joking; having [Carer] is a bonus. I have peace of mind." There were similar comments from another relative who told us, "We can have a joke and a laugh with the carers. We get on well."

Staff had a good understanding of all people's care needs and personal preferences. One relative said, "The agency has looked after [family member's] needs and have given Bengali speaking carers." Staff respected people's privacy and their homes. They entered people's homes, by ensuring they rang the doorbell before announcing themselves and greeting the person or their relatives. Some people had a 'keysafe' and care staff were given permission to access the code and enter the person's home at the required times.

Staff treated people with dignity and knew about their individual needs and preferences. One member of staff told us, "When giving personal care, I make sure there is privacy and no one else is around. I close the door and curtains to show them dignity and respect." Relatives told us staff were friendly and helpful. One relative told us, "Really pleased with the carers, they understand [family member's] needs; definitely couldn't fault them really great, go above and beyond. The carers understand my relative's behaviour and how they are." Another relative said, "The carers are kind and caring and treat [family member] with respect; happy with everything, they are fine."

People and relatives were involved in making decisions about their care plan when it was reviewed and updated. They had opportunities to have their say about the care they received from the provider. There was evidence in the care plans and through our discussions with relatives, that they and their family members were involved in their care planning.

People's care records identified their specific needs and how they were met. Although most people had limited mobility, we saw that they were supported to remain as independent as possible by staff. For example, we noted that one person's care plan said, "[Person] is able to change their own position in bed, day and night," although they required assistance from staff for most of their needs. This showed people were supported to do things for themselves as much as possible by staff but were assisted with other aspects of their personal care. It also helped staff to promote the person's independence to do as much for themselves as possible by identifying the areas the person required least support.

The registered manager was aware of how to access advocacy services to enable people to have a 'voice', air

their views and to ensure their human rights were protected. People's records were filed securely in the office, which showed that the provider recognised the importance of people's personal details being protected and to preserve confidentiality. Staff were aware of confidentiality and adhered to the provider's data protection policies.

Good

Is the service responsive?

Our findings

Relatives told us the service was responsive and said that they were satisfied with the care their family members received. Relatives were complimentary about the service and said their loved ones had regular carers and care arrangements. A relative told us; "The carers are very good, flexible, very helpful, work really hard, very happy with them, changed both of our lives."

The majority of the relatives we spoke with said that the carer's stayed for their allocated time. One relative said, "Sometimes they are late but it is only five minutes or so. We have the same carer all the time and they make sure everything is done before leaving." Relatives confirmed that there was a care plan for their family members and that there was a log book in which the carers made a record of the visit.

Relatives told us their family members had the same carers for the majority of the time. However should the service need to allocate a different care worker, relatives told us that they were always informed. One relative said; "Mostly the same carer but there is always a backup who introduces themselves and let me know who is coming; they work as a team."

People's care plans were personalised and included details on how the person wanted their care to be delivered, their likes and dislikes and some details about their spiritual and cultural requirements. For example, one person's care plan said, "[Person] likes to celebrate religious festivals with their family and worship at home." Another person's care plan stated, "[Person] enjoys spending time with family and watching television." This information enabled people to describe their interests and inform care staff about things that were important to them.

The registered manager and the care coordinator contacted people who used the service to check that they were happy with the level of care. This ensured that care was being delivered and people were satisfied with the service and their care worker. We saw records of assessments and observations of staff who provided personal care. We looked at daily records written by staff and found that they contained details about the care that had been provided to each person and highlighted any issues. This helped to monitor people's wellbeing and respond to any concerns.

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS). The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information will tell them how to keep themselves safe and how to report any issues of concern or raise a complaint.

We spoke to the registered manager about how people could receive information in a way that they can access and understand. Most people who used the service did not have English as their first language and the registered manager told us they were able to provide information to people that was translated into their first language. For example, we saw a welcome leaflet that was partly translated into Gujarati. People's communication needs were identified and recorded in people's care plans with guidance on how to meet those needs. The provider was in the process of producing newsletters to people every quarter to keep them

updated about developments within the service. The newsletters would be distributed by the end of the year.

Staff we spoke with were not fully aware of the AIS but told us they were able to provide necessary information by communicating with people and their relatives using the same language or by using simple phrases and signs. One relative said, "[Family member] gets on really well, really good with [staff]. Very nice, very happy with the carer, good carers, speak same language."

Where people were unhappy with the service, such as with times care staff arrived or lateness, people said they would contact the office or make a complaint. The registered manager addressed any concerns people had about times, occasional lateness and care provided at weekends. A relative said; "Usually on time and they stay for the allocated time, sometimes do extra to complete tasks; but they do not always have time to finish all their tasks, so sometimes they're rushing." The relative told us that they had discussed this issue with the care coordinator, who took action to remind staff of their responsibilities. The registered manager and records confirmed that action was taken.

A complaints procedure was in place. The provider dealt with any concerns or complaints from people and cooperated with external organisations, when required. Staff were aware of the complaints process and knew how to support people to complain. After a complaint was received, it was investigated by senior staff and a response was written to the complainant within two weeks, informing them of the outcomes of investigations. If the person was not satisfied, there was a second stage complaints process where a formal meeting was arranged with the registered manager. One relative said, "I have all the information and I know how to complain and who to speak to. I have no concerns at the moment. I previously had issues with carers but it's all been resolved."

Since the service registered with the CQC, the provider had received two formal complaints, one of which was still in progress. We saw that the first complaint had been investigated and an outcome was provided to the complainant. One relative told us they were not happy with the carer and the service and had written a complaint. We saw that this was currently in progress and a safeguarding investigation was being conducted by the local authority.

Good

Is the service well-led?

Our findings

Relatives told us the service was well managed and said they and were happy with the way the service delivered care to their family members. They told us the management team were available to speak to when required. We found that the management team worked well together and staff felt confident in being able to meet the challenges of their work.

Relatives said that they had received visits from senior staff, who made sure that their family member was being provided the care they needed. When we asked relatives if they were kept informed by the manager they confirmed that they were. Another relative said, "There's always a familiar face; I have had a few agencies; this is the best one for [family member]."

Providers of health and social care inform the CQC of important events which took place in their service. The registered manager notified us of incidents or changes to the service that they were legally obliged to inform us about. The service was managed by the registered provider, who was also the registered manager. We contacted the local authority for their feedback and they told us that the service was well led. They said, "The manager and the staff are professional and polite when dealing with them. They can demonstrate positive feedback from service users and their families." The provider worked with the local authority and complied with any recommendations to help further improve the service.

During our inspection, the care coordinator, who also had a senior role, was unavailable as they were going to be away for an unspecified amount of time. However, we were able to speak to them briefly on the telephone. Cover arrangements were in place while they were going to be away. The registered manager was taking on some of the care coordinator's workload and they had appointed and promoted current care staff to be team leaders. They told us, "Our values are to learn, develop and improve. We have to be caring and treat people like we would our own parents. I understand how our clients feel because of my own personal experience."

Staff said they were happy with the management of the service and were confident they could approach the management team with any concerns. One member of staff said, "All staff in the office are very supportive. The managers are very helpful and easy to talk to."

The management team monitored that care workers were following their individual rota at the scheduled times. The service was in the process of transferring from the current system of using timesheets and phone calls to a more technology based system. The registered manager told us, "I will be rolling out the new system in the new year. It will be a more effective way of monitoring calls."

Daily log sheets, which contained information on tasks that were carried out were completed, helped staff to follow up on any concerns and report on the wellbeing of each person. The logs were brought back to the office each month to be quality checked by senior staff, to ensure they were being completed appropriately according to the provider's policies. People and relatives were also invited to view the logs and complete a brief assessment of their own care. Comments included, "Carer is very good and always on time" and "Carer

is very caring towards [family member], helpful, understanding and well mannered. Does her best."

We looked at records of direct observations of staff practice and competency when carrying out personal care and saw that they were completed by the care coordinator. People's relatives confirmed their family members had been visited by the registered manager or care coordinator. One relative said, "The managers visit us and they are lovely. I can approach them 24 hours a day. Staff know what they are doing; they are amazing."

Staff attended team meetings where the management team discussed topics such as any safeguarding issues, feedback from people, concerns, supervision and person centred care. The meetings helped to keep staff informed of important information and provided them with guidance.

The provider used surveys, spot checks and phone calls to gain people's views about their care and support. People completed questionnaires and surveys which helped to ensure people were satisfied with the care and support that was delivered. Feedback from people, who were visited by senior staff was received and was positive. Results of surveys indicated people were happy with the service provided. One person wrote in their feedback, "[Carer] is doing a tremendous job. [Carer] is very responsible and helpful." The survey indicated that 90% of people were 'completely satisfied' with the service and the remaining 10% were 'satisfied'. We saw that the results of the survey were used by the provider to ensure further improvements were made, where necessary.

There were quality assurance systems in place to monitor and improve the quality of the service. The management team developed a Quality Improvement Plan to identify any shortfalls, what actions needed to be taken, by whom, when they needed to be completed and how any improvements will be measured and reviewed. For example, one area that was identified was to ensure staff had knowledge of each of the CQC's five key questions. Their knowledge was assessed during supervision meetings. Another area was to support staff with their own personal development. Incentives were introduced to encourage staff to perform their roles as carers professionally and respectfully. During our inspection, we identified other areas for improvement which had not been picked up by the provider, such as with their MCA (2005) procedures and updating of care plans. The registered manager told us they would make amendments to their quality assurance systems to ensure they were more thorough and drive further improvements. This showed that the provider was committed to developing and improving the performance of the service.