

Ana Nursing & Care Services Limited

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Inspection report

166 Newcastle Street
Burslem
Stoke On Trent
Staffordshire
ST6 3QN

Tel: 01782833722

Website: www.ananursing.co.uk

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11 July 2018

12 July 2018

13 July 2018

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection site visit took place on 10 and 11 July 2018. Telephone calls to people, relatives and staff took place on 9, 10, 12 and 13 July 2018. The rating given at this inspection is Requires Improvement and this is the second consecutive time the service has been rated Requires Improvement.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older and younger adults.

There were 98 people using the service at the time of this inspection.

There was a registered manager in post at the time of the inspection. 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.

We identified breaches of regulations because people's risks and medicines were not always managed safely and systems were not operated effectively to monitor and improve the quality and safety of services provided. You can see what action we told the provider to take at the back of the full version of the report.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

People's needs were assessed; though suitable care and risk management plans were not always in place to guide staff.

Care staff received the training and support they needed to deliver effective care though some staff needed additional support to complete effective assessments.

People were supported to eat and drink enough, however nutritional risks were not always suitably managed.

Improvements had been made to staffing so that there were enough staff employed to provide safe and consistent care to people. The provider had learned and made improvements in this area since the last inspection.

People were safeguarded from abuse and the spread of infection.

People were supported to access health professionals when required.

People were supported by caring staff that protected their privacy and dignity. People had support to make

decisions and choices about their care.

People's preferences were understood by staff and recorded in their care plans.

People understood how to make a complaint and the provider had a suitable complaints policy in place. We have made a recommendation about responses to complaints to ensure they are consistent and in line with the provider's own policy and procedure.

Staff felt supported and listened to by management. The service had systems in place to gather feedback and plans were in place to improve communication with people about responses to feedback.

The service worked well in partnership with other agencies and were responsive to feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Improvements were needed to the way in which risks and medicines were managed.

Staffing levels had improved since the last inspection which meant that people received a more consistent service.

People were kept safe from abuse and protected from the spread of infection.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

When people were unable to make their own decisions, the relevant law and guidance was not always followed correctly to protect their legal and human rights.

People received support to eat and drink though risks to their nutrition and hydration were not always effectively managed.

Not all staff received the training and support required in order for them to effectively perform their role.

People were supported to access healthcare professionals when required.

Is the service caring?

Good ●

The service was caring.

People were treated with kindness and compassion by staff who knew them well.

People were supported to make their own choices and their communication needs were met.

People's privacy, dignity and independence was respected and promoted.

Is the service responsive?

The service was not consistently responsive.

Some people's care plans did not accurately reflect the support they were receiving from care staff including end of life care.

People told us they received personalised care that was responsive to their needs because staff knew people well, despite records not always being accurate. People were happy with their call times.

People felt able to complain if they needed to and the provider had a suitable policy in place to manage complaints.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

Improvements were needed to systems in place to check the safety and quality of the services provided.

People, relatives and staff felt the registered manager and provider were approachable and supportive.

People and staff were involved in the developments of the service and there was an open and inclusive culture.

Requires Improvement 

Ana Nursing & Care Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection activity started on 9 July 2018 and ended on 13 July 2018. It included telephone calls to people who used the service and their relatives on 9 and 10 July 2018. We visited the office location on 10 and 11 July 2018 to see the registered manager, provider and office staff; and to review care records and policies and procedures. This visit was announced. We gave the service 48 hours' notice of the inspection because we needed to gather information about people who used the service in order to consult them for feedback.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used the information we held about the service to formulate our inspection plan. This included statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with commissioners of the service to get their feedback about Ana Nursing & Care Services.

During the inspection, we spoke with twelve people who used the service and five relatives. We also spoke with the registered manager and provider along with six staff including a care co-ordinator.

We reviewed the care records of nine people to see whether they were accurate and up to date. These included initial assessments, care plans, daily care records and medicine administration records. We looked at records relating to the management of the service. These included five staff recruitment records, incident records, training information and quality assurance records.

Is the service safe?

Our findings

At the last inspection, the service was rated as 'requires improvement' due to issues with staffing and risk assessments not being updated. At this inspection, we found that improvements had been made in relation to staffing but further improvements were required to risk assessments and management of people's medicines.

People's risks were not always suitably assessed and planned for. When specific risks were identified such as pressure sores and diabetes, there were no specific risk assessments or management plans for staff to follow. For example, one person's care plan stated they had a pressure sore which they applied their own dressings to which were supplied to them by the district nurse. The provider told us that this person had very fragile skin and that staff were aware of this. However, there was no specific risk assessment in relation to the sore and no management plan to help staff understand what their role was in managing the pressure sore and reducing the risks of the person's skin breaking down further. The person's daily records referred to a 'pressure pad' which the registered manager confirmed with us could mean a pressure relieving cushion. However, there was no mention of this in the person's care plan as a means of reducing risks to the person's skin. Daily records also stated that staff had applied 'Proshield' to the person's skin. Proshield is used to protect intact or injured skin against moisture damage. However, there was no topical medicines administration record in place because staff were not planned to support with topical medicines as the person was deemed to be independent with this. This meant staff were applying topical medicines that they were not planned to support with and therefore not keeping an accurate record of the person's topical medicines application. Staff we spoke with understood their role in supporting people to minimise the risks of skin damage. However, there was no risk assessment or management plan in place which meant the person was at risk of receiving no support or inconsistent support to manage their risk of skin damage.

Another person's assessment stated that they had diabetes. However, there was no specific risk assessment for this and no guidance for staff to follow. It did not state what type of diabetes the person had, just that they needed "to follow a suitable diet" but there were no details of what a suitable diet may be. Staff we spoke with told us that diabetes had been covered in their training and some staff were knowledgeable about the condition and what would be considered a suitable diabetic diet. However, some staff were not aware whether the people they were supporting had diabetes and whether they needed any alterations to their diet. When a person experiences a hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) episode, immediate action can be required to prevent a person from becoming more ill. There was no guidance to help staff recognise deterioration in a person's diabetic condition. This meant there was a risk that people may not receive safe support in relation to diabetes as staff did not have all the information they needed to manage the risks.

People told us they got their medicines as prescribed when staff were required to help them with this, including topical creams. One person said, "[Staff] put the cream on my legs that the doctor has written up for me. Once they have done that they sign in my care plan to show they have done it." However, we found that systems in place to ensure medicines were managed safely were not always effective. A number of people required support to manage topical creams and we found that accurate and clear guidance was not

always in place for staff to follow. For example, one person's medicines administration record (MAR) stated, "Sorbaderm 'as directed.'" There was no body map to show where the person needed the cream applied and no further details as to what the cream was prescribed for or how often it was required. This meant there was a risk that people may not receive their creams as required as there was not clear guidance in place for staff to follow.

MARs were not always clear and up to date to show staff which medicines and creams were required to be administered and when. For example, one person had a cream discontinued by their doctor but their records were not updated so it was not clear to staff whether they needed the cream or not. Another person was prescribed a cream and a gel. Only the cream was detailed on the MAR, however, their daily records showed that staff were occasionally applying a gel but it was not clear which one as there was no MAR in place for the gel. Another person's daily care records said they had declined to have a cream applied to their legs. However, this cream was not detailed on their MAR so it was not clear what cream the staff member was offering to apply. This meant the service could not assure themselves nor us that people were receiving their topical creams as prescribed because medicines records were not accurate and up to date.

Some people were prescribed 'as required' medicines. There were no protocols in place to guide staff about how and when these medicines should be administered. For example, one person was prescribed a laxative 'as required'. There was no guidance for staff about when this should be administered, despite the service monitoring the person's bowel movements. This meant there was a risk that they may not receive this medicine safely and as intended.

We found that records of stocks of medicines were not consistently kept by staff and stocks of medicines was not considered as part of the medicines records audits. This meant the provider could not assure themselves nor us that people had received their medicines as prescribed.

The above evidence demonstrates that people did not always receive safe care. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about our concerns with risk management. They said, "I agree these risks should be assessed, there is no excuse, it should be better." They told us they would review people's records to ensure that suitable risk assessments and management plans were in place. We also spoke with them about our concerns with medicines management. By the last day of the inspection the registered manager had already started to work on changes to the medicines administration records and audit tools to help medicines be managed safely.

There were enough staff to meet people's needs. Since the last inspection, the provider had changed the way staff were employed and made changes to staff's terms and conditions. This had led to a much-increased retention of staff and therefore better consistency and safety for people. This showed that the provider had learned and made improvements when things went wrong.

People told us that missed calls were rare and that staff usually arrived on time. One person said, "In all the time I have had carers I don't think they have been more than five minutes late for a visit." Another person said, "The [staff] come when they are supposed to and I am never rushed at all. We have plenty of time to do everything I need. They are a cracking bunch." Staff told us they felt there were enough staff to safely meet people's needs. A staff member said, "It's much better now. They (managers) never harass me to do extra shifts like other companies I have worked for. I am happy with the rotas and have a consistent run so I get to know the people I support and they get to know me." There was an electronic monitoring system in place which allowed staff to log in and out of people's homes. This meant the provider could monitor whether calls were being delivered as planned and they were always aware of their staff's whereabouts to promote

their safety. We looked at the electronic monitoring of people's calls and found these matched what people and staff told us.

Safe recruitment procedures were in place and we saw that the provider checked staffs' suitability to work with people who used the service before they started to work. They requested references and completed a Disclosure and Barring Services check (DBS). The DBS helps employers make safer recruitment decisions. This meant that people were supported by safely recruited staff.

All the people we spoke with told us they felt safe when being supported by Ana Nursing & Care Services staff. People told us, "I have had carers for three months and from day one I have felt very safe with all of them. I know ninety percent of all the carers by now they are all so kind to me" and, "I feel very safe with all my carers. I have a key safe but my relative told them only to use it in an emergency, they knock on the door and call my name and then they come in." A relative said, "My [relative] has care twice a week to help them with personal care. We don't always know who is coming but they are all kind and respectful to us both and I know [my relative] feels very safe with whoever comes."

People were protected from abuse and avoidable harm. Staff we spoke with were knowledgeable about safeguarding adults' procedures and knew the different types of abuse which may occur, how to recognise signs of abuse and how to report their concerns. A staff member said, "I would tell the person that I can't keep this confidential and that I need to report it. I would report to the office or on-call staff and I'm confident they would act on concerns." Office staff understood their responsibilities in reporting concerns to the appropriate authority and the registered manager supported staff to ensure people were protected from abuse. This showed that staff were aware of the systems and processes in place and we saw this was working to ensure that people were protected from abuse.

People were protected by the prevention and control of infection. Staff had been trained to understand their role in relation to preventing the spread of infection and they were provided with personal protective equipment (PPE) such as gloves, aprons and antibacterial hand gels which they told us were readily available to them. People told us that staff always wore PPE when required.

Is the service effective?

Our findings

At the last inspection, the service was rated as 'requires improvement' due to the Mental Capacity Act 2005 (MCA) not being followed consistently. At this inspection, we found that improvements had been made in some areas but further improvements were required.

People were asked for consent to their care and this was recorded when people had the mental capacity to be able to do so. However, when people were unable to consent for themselves, the Mental Capacity Act 2005 (MCA) was not always followed consistently to ensure people's legal and human rights were respected. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Though staff were able to demonstrate an understanding of the MCA, we found it was not always followed effectively. Mental capacity assessments completed by staff did not comply with the MCA because they were not always decision specific. One person had a mental capacity assessment which stated they lacked mental capacity, though the decision being assessed was not clearly recorded so it was unclear what exactly they lacked mental capacity in relation to. When the person was assessed as lacking mental capacity, there was no best interest decision made which meant there was risk that staff were not acting in the person's best interests. Their care plan stated that they were not to know where their medicines were kept however, there was no specific mental capacity assessment in relation to medicines and there was no record of a best interest's decision to withhold this information from the person. This meant that restrictions had been imposed upon the person without the necessary permissions in place. The person had then signed their medicines risk assessment which did not include this information. This meant that the MCA had not been followed to ensure this person's legal and human rights were protected. The registered manager told us they would take immediate action to ensure this person's records and care were compliant with the MCA.

People told us they were supported by staff to eat and drink when this was an assessed need and that they were offered choices. One person said, "I only have the carers once a day to help me cook my tea. I can manage most of it but because I can't see I need someone to make sure I am safe, it keeps my family happy! Most of the [staff] can do most things but some [staff] don't really know how to cook so I can't always have what I fancy but on the whole we do ok. I tell them what to do and its usually ok."

Despite people being happy with the support they received to eat and drink, we found that nutritional risks were not always effectively monitored. One person was at risk of losing weight and staff completed nutritional charts to monitor the risk. However, these charts did not accurately record amounts of food and drink that had been given or consumed. For example, staff recorded that the person drank half of their coffee and three quarters of their water but it did not state how much of these fluids had been given so it was not clear what the person had consumed or been given. Additionally, these nutritional charts were not checked or reviewed by anyone which meant that any issues or concerns would potentially not be picked up and acted upon. This showed that risks to people's nutrition and hydration were not effectively managed.

Coordinators completed assessments of people needs including risk assessments and also created care plans. However, not all coordinators had received training and support in how to do this effectively. People's needs were assessed before they started to receive a service and a care plan was implemented. However, we found that some care plans lacked relevant detail to meet assessed needs which meant that support was not always planned for in line with current legislation and guidance. We told the registered manager about these concerns and they told us, "I'm seeing a pattern, we need more training." This meant that not all staff had received training and support to fulfil their roles effectively.

Staff told us they worked together well to deliver effective care. We saw that care staff communicated any changes to the office. However, information from care staff was not always used to update care plans which meant that some vital information was missing. For example, when a person's prescribed medicines changed, this information was communicated by care staff to the office but not updated in their care plans and medicines administration records.

Care staff were trained and supported to deliver effective care. People told us they were confident that care staff had the knowledge and skills to carry out the required tasks. One person said, "Every carer I have ever had has been well trained and has known exactly what help I need on a daily basis. [My regular carers] can always tell if I'm not so good when they come." A relative said, "I found it quite difficult to let someone else do things for [my relative] but the [staff] are so lovely and they really know what they are doing so I have real confidence in them." Staff told us that the regular training that was provided equipped them with the skills they needed and that they received support in the form of regular supervision, appraisal and spot checks. A staff member said, "We definitely have the right training. We also have regular supervision and appraisal which keeps a check on how we are doing and we get feedback on our performance." Another staff member said, "I have recently had an observation of my practice from a senior staff member, we get feedback and sign to confirm we are in agreement." During our conversations with staff they were able to demonstrate their competence. We viewed records which showed that staff had mostly attended required training and the registered manager kept an overview of staff training and arranged additional training for care staff when required.

People were supported to access healthcare professionals. People we spoke with told us they felt confident staff would support them to access healthcare service when this was needed. Staff told us about various occasions when they had contacted health professionals on behalf of a person including district nurses, doctors and Speech and Language Therapists (SALT). We saw that a staff member participated in a person's SALT assessment to ensure they got the correct modified diet. The staff member shared information about the person with the SALT to help them to effectively assess the person's needs. This showed that staff worked together across other organisations to achieve effective healthcare outcomes from people.

Is the service caring?

Our findings

At the last inspection, the service was rated as 'good' in this key question. At this inspection, we found the service continued to be caring.

People told us they were treated with kindness, respect and compassion. One person said, "I couldn't ask for better [staff]. I have two who come all the time and then I usually have another when they are off. It's like been looked after by my friends." Another person said, "I couldn't ask for better care. Everything I need is done for me by the [staff], they really, really care about me." A relative said, "I can hear the [staff] talking to [my relative] whilst in the shower, they are all very respectful towards [my relative]. I can often hear them laughing as though they are having fun." Staff we spoke with demonstrated respect for the people they supported. One staff member said, "I enjoy making a difference to people's lives." Another staff member said, "I enjoy banter with the ladies and gents I support. We have great relationships and we are like family. Their faces light up when they see me and one person told me, 'you are my medicine.'" This showed that staff were kind and respectful towards people.

People were supported to express their views and be involved in making decisions. When people had particular communication needs, these were assessed and met. For example, one person was hard of hearing and required a hearing aid. Their care plan directed staff to ensure they were wearing their aids and that they were working properly to ensure the person could communicate effectively with staff. Staff told us how they supported people to make their own choices. One staff member said, "I talk to people and encourage them to make their own choices." Another staff member said, "I inform people what their options are, such as food or clothes to wear, I show them examples." This meant that people were supported and encouraged to make their own choices.

People told us their privacy and dignity was respected. One person said, "The [staff] always make sure that I am kept covered when I have had my shower. It's to protect my dignity." Staff demonstrated how they respected people's privacy and dignity. One staff member said, "I make sure people are covered when having help with personal care. I close the doors and curtains."

People told us they were encouraged to be as independent as possible. One person said, "I only need help washing my legs and back, so I do everything else myself and then when I am ready the [staff] do my legs." Care plans were written in a way that promoted people's independence and staff told us how they promoted independence. A staff member said, "I encourage them to do what they can for themselves." Another staff member said, "I work in an inclusive way and support them to do as much as they can."

Is the service responsive?

Our findings

At the last inspection, the service was rated as 'requires improvement' due to people not always receiving consistent support from staff who knew them well because they often had different staff attending their care calls. At this inspection, we found that improvements had been made in some areas but further improvements were required.

People's care plans did not always accurately reflect the care and support they were receiving from staff. The registered manager told us that one person was receiving palliative care. We looked at their care plan and found no reference to this. This meant that the person's needs and choices had not been reassessed to ensure that any specific wishes for their end of life care were recorded. We saw that the service had worked with relevant professionals to ensure the person had the correct healthcare support, however their own care plan for staff to follow had not been updated to reflect the change in the person's needs which meant there was a risk of them not receiving personalised, responsive end of life care.

We found that some people's care plans did not contain accurate and up to date information. This meant staff did not always have the information they needed to be able to meet all of people's needs safely and effectively. However, staff told us they had access to information they needed to provide personalised care to people such as their life history, interests and preferences. We saw that this information was recorded in care plans so that staff had individualised information about people to help them to get to know people.

People told us they received personalised care that was responsive to their needs. People's needs, choices and preferences were considered before they started to receive a service including diverse needs relating to culture, religion and sexuality. One person said, "Before I started having care, [a staff member] from the office came and we had a really good talk about what help I would need and what I wanted the [staff] to do for me. It has worked really well from the start. I can't fault anything at all." We saw that people's choices and preferences were recorded and considered. For example, one person requested female staff only and their care records showed that their preference had been catered for.

People told us their call times suited their preference but where requested call times were difficult to fulfil, people were consulted about this and each person was happy with their call times. One person said, "When I started to have my care I was asked what time I got up so we could sort my call times to fit in. It has worked well from the start and the [staff] are never late." A relative said, "We would have liked the call a bit earlier but it was explained to us that it wasn't possible so we compromised and now we have got used to the time, I don't think we would like it changing."

People told us they had consistent care staff who knew them and their preferences. One person said, "I have had carers for years from Ana and they have all been lovely. In fact, one of the [staff] who comes now has been coming all the time." They told us that staff were usually on time and they were informed of any expected lateness or changes.

People told us they knew how to make a complaint or raise a concern if this was required. One person said,

"I know what to do if I need to complain, all the information is in my care plan." People and relatives said they felt confident to speak with care staff or office staff if they had any issues or needed to raise a complaint. We found the provider had a policy in place which identified how complaints would be investigated and responded to. We saw where concerns had been raised these were responded to and the information was used to share learning across the organisation. However, we found that one person had not received a written response to their formal written complaint, despite investigations having taken place.

We recommend that all formal, written complaints received by the provider should be responded to in the way directed by the provider's own policy and procedure.

Is the service well-led?

Our findings

At the last inspection, the service was rated as 'requires improvement'. This was because a system was not in place to check care records to ensure they were up to date and low staffing impacted on the quality of people's care and support. At this inspection, we found that improvements had been made in some areas but further improvements were required.

Systems were not operated effectively to assess, monitor and improve the quality and safety of the services provided. Coordinators were senior members of staff who were based in the office and had responsibility for assessment of people's needs and implementing care plans following these assessments. However, they had not completed any specific training in relation to these tasks and there was no system in place to check the coordinators competency. Audits of care plans and risk assessments were also completed by coordinators. The registered manager told us that coordinators should not audit their own care plans as they may not identify any issues with their own work. However, we found that coordinators had audited their own work. The issues we found during the inspection had not been identified despite care plans having been audited. For example, care plan audits had not identified issues with MCA assessments or the lack of suitable risk assessments for identified risks. They had not identified that a best interest's decision was not completed for a person who was assessed as lacking the mental capacity to make their own decision. Additionally, audits of medicines administration records were completed by coordinators and had not identified the issues we found during the inspection.

Systems were not operated effectively to assess, monitor and mitigate people's risks. For example, one person needed to have their food and fluid intake monitored due to risks of malnourishment and dehydration. This monitoring had not been implemented when the person started to receive a service and audits had not identified that this was not happening. Another person did have food and fluid monitoring charts in place but there was no record that these had been checked.

The audit tools that were used by coordinators were not robust in ensuring that thorough checks of care plans, monitoring charts and medicines were carried out. For example, medicines audits did not consider stocks of medicines or whether there was clear guidance in relation to 'as required' medicines. The registered manager confirmed with us that care plan audits were designed as a checklist to ensure plans were in place but they did not consider or assess the quality of the plans in place. This meant that audits had not identified the issues with the quality of care plans and risk assessments that we did during the inspection and therefore had not driven improvement.

The registered manager completed regular analysis of incidents and accidents, including medicines errors, to look for trends and take necessary action. However, this process was not always effective. For example, the medicines error data was taken from the medicines audits which did not effectively identify issues. This meant that the analysis completed by the registered manager was not a true analysis of medicines issues. This showed that systems were not operated effectively to assess the quality and safety of the services provided.

The registered manager and provider did not have suitable oversight of the systems in place to monitor, assess and improve the quality and safety of the service. This meant that they were unaware of the issues until we identified them during the inspection.

The above evidence demonstrates that systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We told the registered manager about the issues that we had identified. They agreed that records were not detailed enough and that audits were not effective. The registered manager told us they would take action to look at the systems in place to make the required improvements.

There were some effective systems in place to check the safety of the service. Staff used an electronic system to log in and out of people's homes. This was monitored closely by coordinators to ensure that people received their planned calls and action was taken if a staff member was late or missed or a call to a person. The system meant that the provider could be sure that people were receiving the required care and that prompt action could be taken if needed.

There was a registered manager in post, which is a requirement of registration with us. They understood their responsibilities of registration and were supported by the provider to complete what was required. People and relatives felt they could approach the office and registered manager at any time and that they would do their best to help them. Staff felt well supported by the registered manager and provider and felt they were approachable. A staff member said, "I feel respected as a worker by Ana." This showed there was an open and inclusive culture.

Attempts were made to engage people, relatives and staff in the development of the service. A questionnaire was sent to people and their relatives annually to gather feedback on the quality of the service provided. We saw that action had been taken to act on individual issues raised as part of this process. For example, one person requested a change to their call time and this was accommodated. However, if people had completed the questionnaire anonymously then there was no process to communicate actions taken in response to feedback. The registered manager told us they had learned from this process and were considering how they could effectively communicate any actions taken in response to feedback when the next quality survey was completed.

Staff felt engaged and involved in the development of the service. Staff told us they were in regular contact with office staff and the registered manager and felt able to share feedback with the management openly. A staff member said, "I can go to the office, no problem. The support is there. They are always respectful to me and I can vent if I want to because it is very open." The registered manager told us and staff confirmed that they were kept up to date with developments during supervision sessions and staff were asked for their feedback. Annual questionnaires were also sent to staff but there was not a high level of response so the registered manager implemented a suggestions box to try and encourage feedback from staff. They also offered regular drop in sessions and communicated with staff via a quarterly newsletter. This shared statistics to show improvements or areas which required improvement, to engage and involve staff with the service. This improved communication as attempts to organise staff meetings had been unsuccessful.

The service worked in partnership with commissioners and professionals. The registered manager told us that commissioners from the local authority had completed a quality monitoring visit and they had taken action to make some improvements in response to commissioners' feedback. The registered manager and provider were open and responsive and had a desire to work alongside other professionals and

organisations to make any improvements required to help people receive a quality service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not always suitably planned for and monitored. People's medicines were not always safely managed.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Suitable systems were not in place to effectively monitor the quality and safety of the services provided.