Phoenix Care Wakefield Ltd

Phoenix Care Wakefield

Inspection report

Unit 3, Thornes Office Park
Monckton Road
Wakefield
West Yorkshire
WF2 7AN

Tel: 01924377148
Website: www.phoenixcarewakefield.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 8 May and 10 May 2017 and was announced. Phoenix Care Wakefield provides personal care for a variety of people including older people and young children. At the time of our inspection Phoenix Care Wakefield provided personal care for 52 people, including four children.

Phoenix Care Wakefield was previously inspected in January 2014, and was meeting the Regulations. At this inspection we found the care records were not person centred and lacked detail regarding how a person's needs were to be met. There were some weaknesses in the management of medicines. We also found the provider's recruitment process was not a sufficiently robust process to ensure staff were of good character. The provider had not assured themselves that all checks were complete and satisfactory prior to letting staff deliver care. We established the provider did not have sufficient systems in place to assess and monitor the quality of the provision. We concluded these issues collectively constituted breaches of Regulations 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 spoke with six people who used the service and three relatives. Everyone we spoke with were very happy with the service provided. People told us the registered manager was approachable and dealt with any issues they had. They told us the registered manager had visited them prior to agreeing the care package and listened to what they wanted.

We found the care records were not person centred and lacked detail regarding how a person's needs were to be met. For example, the care records were written in the third person and had a check list to show the carer what was required for each call. This was task orientated. For example; 'assist [person] out of bed and to standing position.' Where people had diabetes, there was no diabetic protocol in place to provide information to staff about the signs and symptoms of hypoglycaemia and hyperglycaemia and what action staff should take in response to this.

Staff knew people well and staff had a regular client group, although there was a risk that if the documentation lacked detail people's needs may be overlooked in the event of staff sickness or new staff joining the organisation.

Staff confirmed they had received medicines training. They were aware of their responsibilities in relation to checking the person received the right medicine, in the right dose and at the right time. However, we found some weaknesses in the management of medicines. For example, the Medicine Administration Records (MARs) did not document which individual medicines had been given. It was therefore not clear whether all the required medicines had been given and whether any PRN ('as required') medicines had been

administered. We also found on one person's MAR it showed they were required to take a number of medicines at lunch and tea time. However, there were gaps on the MAR for more than seven days when it was not documented whether the person had received their medicines.

The provider's recruitment process was not a sufficiently robust process to ensure staff were of good character. The provider had not assured themselves that all checks were complete and satisfactory prior to letting staff deliver care.

There was evidence of staff induction and training and we saw training certificates in staff files. Staff completed the Care Certificate and we saw evidence of training undertaken in staff's individual workbooks. Training was mostly done online although there were practical elements where necessary, such as first aid and moving and handling. Records showed staff received regular supervision and staff said they felt supported in their role. The provider maintained an overview of supervision on a matrix which showed the last supervision date and the next one due. Records of staff supervision were kept on staff's individual files and there were action points discussed, agreed and recorded.

Staff understood the basic principles of the Mental Capacity Act (2005). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff members understood the importance of respecting choices people made, and people's right to refuse care and support. One staff member told us; "I give people choices and explain why care is needed." Another told us; "I encourage people to do what they can for themselves." We found evidence to show people had been involved with their care. For example, people told us the registered manager had visited them prior to agreeing the care package and listened to what they wanted. We saw initial assessments in people's care records prior to care being delivered.

There was strong evidence staff worked closely with other professionals to ensure consistency of care. Records showed staff attended meetings to review people's care when necessary. For example, staff attended a meeting regarding one of the children the service provided care for and this included family members, teaching staff, health professionals and social workers.

The provider gave details of their complaint and compliments policy in the service user handbook. This also provided details of external agencies a person could raise complaints or concerns with.

The provider was not always aware of the statutory notifications they needed to submit to the CQC. We found they had failed to notify us of two medication errors. The registered manager gave assurances they would look into this immediately and ensure they were fully aware of their legal duties.

We found the provider did not have sufficient systems in place to assess and monitor the quality of the service. For example, the provider carried out the MAR audits but had not considered whether specialist advice would benefit the process, such as from a pharmacist. Also the registered manager and provider were on occasions auditing their own work, such as recruitment paperwork. This meant it was difficult for them to identify shortfalls and areas where improvement could be made. Accidents and incidents were recorded individually, but there was no overview of these to establish if patterns or trends occurred.

The provider said they valued their staff highly and we saw evidence on staff newsletters they had been thanked for their hard work and professionalism. Staff told us they thought the service was run well and they felt valued by the management team. One member of staff told us; "If you have a query you can go to them

[the management]. There's always someone to talk to." Another member of staff said; "There is a very good support unit. They go above and beyond."

You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Care records lacked sufficient detail to ensure risks were assessed or mitigated.

The provider's recruitment process was not sufficiently robust process to ensure staff were of good character. The provider had not assured themselves that all checks were complete and satisfactory prior to letting staff deliver care.

We found some weaknesses in the management of medicines.

Is the service effective?

Good

The service was effective.

Staff told us they were well supported, and had regular supervision. Staff told us they received training. We saw training certificates which confirmed this.

Staff understood the basic principles of the Mental Capacity Act. Staff members understood the importance of respecting choices people made, and people's right to refuse care and support.

Is the service caring?

Good

The service was caring.

People's rights, privacy and dignity were respected.

People's independence was promoted well and they were involved and informed about matters relating to their care and support.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service, and we saw they were reviewed with people and their relatives. Staff told us they were alerted to any changes.

There were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We found the provider did not have sufficient systems in place to assess and monitor the quality of the provision.

We received positive feedback about the management of the service. Staff said they were happy to work for the provider and felt supported.

Staff and people were involved in the running of the service through meetings, regular contact and surveys.

Phoenix Care Wakefield

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.

This inspection took place on 8 May and 10 May 2017 and was announced.

The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The inspection team consisted of three adult social care inspectors.

We reviewed information we held about the service, such as notifications, information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion which gathers information about people's experiences of using health and social care in England.

The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, due to the provider moving location since the last inspection the PIR had not been completed.

During the inspection we spoke with six people who used the service and three people's relatives. We also spoke with four members of care staff, a director of the company and the registered manager.

We looked at a variety of documentation including; care documentation for three people, three staff recruitment files, meeting minutes, policies and procedures and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

People told us they had their needs assessed prior to care being delivered. One person said; "When I started they came out and spent three hours with me, and went through everything - all my needs and times. I have no problems what so ever." People we spoke with and their relatives were very complimentary about the level of care they received. One person said; "I'm very happy with the service. It's absolutely brilliant. I have a good rapport with the staff." Another person described the staff as; "Lovely girls; very good; they do a good job."

Staff we spoke with confirmed people had care documentation within their homes which they completed on each visit. Staff told us the care records were easy to follow and were kept up to date.

We looked at three care records which provided information regarding how people's needs were to be met. However, we found that although the care records provided a basic overview of people's needs they were not sufficiently detailed or person centred. For example, the care records were written in the third person and had a check list to show the care staff what was required for each call. This was task orientated. For example; 'assist [person] out of bed and to standing position' and 'wash and dry'.

We found further information was required within the care plan regarding what assistance was required to ensure people were safely assisted. Further information was also required regarding people's preferences on the level of help they required. For example, when bathing. In one care record it was documented the person 'cannot communicate'. There was no information regarding whether other aids to communication had been considered such as pictures or non-verbal cues. The part of the care record which stated 'gestures they may use and what this may mean' was left blank.

Where people had diabetes, there was no diabetic protocol in place to provide information to staff about the signs and symptoms of hypoglycaemia and hyperglycaemia and what action staff should take in response to this.

Although staff knew people well and staff had a regular client group there was a risk that if the documentation lacked detail people's needs may be overlooked in the event of staff sickness or new staff joining the organisation.

We concluded these issues collectively constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the event of an emergency the provider told us they had developed a flash card with key information about each person, so other professionals, such as ambulance staff would have easy access to be able to help someone quickly. Staff were clear on how to deal with emergency situations and had access to an 'on call' system if the emergency happened outside of office hours. For example, if a person was found to have fallen, staff were clear they should not move a person and call for an ambulance. Staff told us they would also make the registered manager or supervisor aware and would inform a person's family member.

We saw evidence the provider recorded accidents and incidents on an individual basis. However, the provider did not record the information in a central place which made it difficult for the provider to have a clear overview and for the inspection team to check whether these were responded to appropriately.

Staff completed training in safeguarding adults and children and we saw detailed information in the care certificate workbooks to enable staff to be alert to the signs of possible abuse and the action they should take. Staff we spoke with said they understood how to report any concerns if they felt a person might be at risk of abuse or if they suspected abuse. Staff gave examples of the different types of abuse. For example, if staff became aware someone had not received their medicines, they were clear they should report this to the registered manager and obtain medical advice.

The provider told us they had an on-going programme of recruitment and they made detailed checks to ensure the right staff were employed to work in the service. They told us candidates were invited for an informal conversation so they could get an idea about their suitability and then they were invited for a more formal interview. The provider said they liked to 'cherry pick' their staff because they wanted staff with the right skills and attitudes to provide care for people.

We looked at three staff files. There was evidence of interviews and any gaps in employment were discussed. We saw in two of the staff files two references had been obtained. However, in one file we saw there was a written reference that had no date or designation of the person. The provider told us this had been a telephone reference that was written up for the file. The other reference was provided by the candidate's relative and we questioned the objectivity of this. The provider told us the candidate had worked for their family business and so alternative references were not available. There was no record of the provider considering obtaining further references which would be impartial such as from the person's educational establishment.

The provider had a recruitment policy but this had not been kept under review. For example, the policy made reference to the obsolete Criminal Records Bureau, not the Disclosure and Barring Service (DBS). The DBS holds information about people who may be barred from working with vulnerable people, and making these checks helps employers make safer recruitment decisions.

We saw where new staff were appointed the provider commenced DBS checks but staff were routinely allowed to commence work before a full DBS check had been completed. The provider told us they ensured the adults first check was completed and staff were supervised until they were fully vetted. However, DBS guidance states this practice should only be used as an exception, rather than routinely. Also as the provider was offering personal care to children, staff needed to be fully vetted before working with children. We concluded these issues collectively constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider showed us the staff rota and where staff were allocated to work each day. They explained staff worked within a geographical location to minimise travel times between calls and we saw there were no overlaps of time from one call to another. The provider told us there was a call monitoring system newly in place. The provider told us staff were allocated sufficient time to complete the care tasks without needing to rush people and if more time was needed this was facilitated. The records of staffing levels showed these were managed to offer safe care to people. The provider told us they aimed to ensure consistent care staff were allocated to each person. This meant people received continuity of care and staff were able to easily identify if there may be a concern because they knew individual people well. The provider said they also were very involved in people's care and could cover in the event of a staff absence.

The staff we spoke with confirmed they work in specific geographical areas which helped with the travel time between calls. This also ensured continuity of care. Staff told us they felt people who used the service were safe and there were enough staff to meet people's needs. People told us they had regular staff who provided care and they usually arrived around the time that had been agreed. One person told us they did not always get the same carer but they did not mind this. Another person said; "Staff are usually on time and it's usually the same ones." One person commented; "They are always on time and always stay for the agreed time."

Staff completed online training and questionnaire booklets in the safe administration of medicines. The provider told us there was no other medicines training offered to staff.

We noticed in the care supervisors' information log books there were some recorded incidences of when people had not been supported effectively with their medicines. For example, one entry showed a person did not receive their evening medicine, and another showed a person had no paracetamol when they needed this. There was evidence of action taken and the provider told us they would refer to the person's GP or seek medical advice if there were concerns about medicines. The CQC had not been notified of the omissions in medicines and the provider said there were not aware to report this to CQC or to safeguarding. This matter is addressed under the well-led section of the report.

Staff confirmed they had received medicines training. They were aware of their responsibilities in relation to checking the person received the right medicine, in the right dose and at the right time. Staff told us they recorded any prompting or assistance with medicines on a medicines administration record (MAR) for each person. Staff were clear they would report any medicines error to their supervisor or the registered manager.

We looked at a sample of MARs. The MARs documented the medicines a person required and when they were required to be taken. However, the MAR used did not allow for the staff member to confirm they had given each individual medicine. It was therefore not clear whether all the required medicines had been given and whether any PRN ('as required') medicines had been administered.

We found on one person's MAR it showed they were required to take a number of medicines at lunch and tea time. However, there were gaps on the MAR for more than seven days when it was not documented whether the person had received their medicines. We spoke with the manager who assured us the person had received their medicines. They agreed the MAR looked like the medicines had been missed but explained this was because the person self-medicated at lunch and tea time. However, this was not clear from reviewing the person's MAR. We concluded these issues collectively constituted a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service effective?

Our findings

People told us they were happy with the staff. One person told us; "They do a good job." Another person said; "They do their job brilliant."

Staff confirmed they had received an induction which included shadowing a more experienced member of staff. One member of staff confirmed they had been assessed as competent to use a hoist. Staff told us they received supervision every three months and these were useful. Staff told us all their mandatory training was kept up to date in areas such as, moving and handling, safeguarding, medicines, health and safety and first aid. Staff told us they also had received training in areas such as dementia and autism.

There was evidence of staff induction and training and we saw training certificates in staff files. Staff completed the Care Certificate and we saw evidence of training undertaken in staff's individual workbooks. Training was mostly done online although there were practical elements where necessary, such as first aid and moving and handling.

Where staff needed specialist training this was completed and this enabled staff to provide effective care. For example, one member of staff had completed British Sign Language training to be able to support a person with a hearing impairment.

The provider told us they carried out spot checks of staff practice and they made sure staff were competent in their role before enabling them to work unsupervised. The provider said as well as carrying out monthly spot checks they worked alongside staff to assess their competence and monitor the effectiveness of training.

Records showed staff received regular supervision and staff said they felt supported in their role. The provider maintained an overview of supervision on a matrix which showed the last supervision date and the next one due. Records of staff supervision were kept on staff's individual files and there were action points discussed, agreed and recorded.

The provider told us they were responsible for overseeing staff training and we saw there was a designated training room for staff to complete training in. We saw computer desks for staff to complete online training, and the provider said this enabled staff to raise training queries or confer with colleagues and learn together. Although staff training information was recorded on individual files, there was no overview of staff training as a whole for the provider to see when training was due and if there were any gaps. The provider told us the information was held on the computer database but there were unsure how to manipulate the data to produce information in an overview format.

We saw a hoist which the provider told us was used to offer practical moving and handling training. There was no facility for staff to practice hoisting from bed to chair or vice versa and the provider said they improvised with this part of the manoeuvre by using the floor as a bed. We did not see any certificates to show staff had completed practical moving and handling training and the provider said they had maybe not

printed these. However, staff confirmed they had received this training and had been assessed as competent.

One person told us; "When we got a new hoist [the registered manager] came to make sure they were using it properly. I'd ring [registered manger] if I was worried about anything. I'm happy with the care and with everything they do. They are all very polite. It's much better than my last care experience."

Staff were aware of ensuring, where appropriate, people's eating and drinking needs were monitored. For example, one member of staff told us they were aware a person had begun to lose their appetite. After consultation with the registered manager, food charts were put in place to enable ongoing monitoring and to seek input from other healthcare professionals if required.

The provider told us staff meetings were held as well as newsletters to staff advising them of any key information. We saw care supervisors kept a log book of information to bring to their weekly management meetings. Records showed significant matters had been discussed, such as medication concerns, appointments for people and general information. There was clear evidence of staff working with other professionals and being aware of other professional advice to the people they supported.

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.

All the staff members we spoke with understood the importance of respecting choices people made, and people's right to refuse care and support. One staff member told us; "I give people choices and explain why care is needed." Another told us; "I encourage people to do what they can for themselves." Another staff member said; "If a person refused medicines, I would encourage them and talk to them. If they still did not wish to take them I would document this and report it to [the manager]."

The care records we looked at had considered people's capacity to be involved in administering their medicines. We found where a person was able to sign their care record, they did or a relative signed on their behalf. This demonstrated the care records had been discussed with the person involved and/or their relative.

Good

Is the service caring?

Our findings

People we spoke with confirmed staff respected their privacy and dignity. One person told us; "They are very polite. When they leave they check the door is locked. They know I'm vulnerable so make sure I'm safe. They are very, very caring." One person said; "I'm happy with the care and with everything they do. They are all very polite." Another person said; "Before they [carers] leave they say have you got everything you need or do you want anything else before we go. They know what they are doing." Although one person said; "There are some good ones [carers] and some can't be bothered." This person did tell us they could go to the registered manager with any concerns they had.

The relatives we spoke with were happy with the care their relative received. One relative told us; "It was important to us that we got the right care and we did. It's also important they leave things as they find them. I'm tidy, I expect it to be tidy and it always is."

The provider and staff we spoke with were passionate about providing person centred care and it was clear they knew people very well. One member of staff we spoke with said; "It's a really good company. It is fantastic. I would let a relative be cared for by them."

Everyone we spoke with was very happy with the service provided. People told us the registered manager was approachable and dealt with any issues they had. One person told us the care workers were "Very good. The timings are good and they never rush."

We found evidence to show people had been involved with their care. For example, people told us the registered manager had visited them prior to agreeing the care package and listened to what they wanted. We saw initial assessments in people's care records prior to care being delivered.

People were provided with service user handbooks which gave information on the care offered to people, how to make complaints/compliments and other agencies such as, the local government ombudsman and how to contact local advocacy services.

Staff provided good care and gave examples of how they ensured people's privacy and dignity were respected. Staff spoke of the importance of making sure care was carried out in private, people were covered and curtains were closed. Staff were clear that they respected people's wishes when delivering care.

Staff also spoke of the importance of maintaining independence for people who used the service. For example, one staff member told us they encouraged people to be involved in their own care by ensuring the person rubbed their ear in a circular motion to help with the administering of ear drops. Another person was encouraged to stir in a nutritional supplement into their drink.

We saw evidence to show the provider and staff were mindful of people's diverse needs. For example, one member of staff explained how she respected a person's religious and spiritual needs. The member of staff

said they were mindful that the person did not celebrate Christmas. In one person's care record it stated the person attended church and that the person liked to be dressed smartly for this.

Good

Is the service responsive?

Our findings

People told us the registered manager was approachable and dealt with any issues they had. They told us the registered manager had visited them prior to agreeing the care package and listened to what they wanted. One person said; "When I started they came out and spent three hours with me, and went through everything- all my needs and times. I have no problems what so ever."

There was strong evidence staff worked closely with other professionals to ensure consistency of care. Records showed staff attended meetings to review people's care when necessary. For example, staff attended a meeting regarding one of the children the service provided care for and this included family members, teaching staff, health professionals and social workers.

The provider said there were weekly care plan reviews and annual reviews of people's care, or sooner if required, such as if there was a change in a person's needs. They told us people had an initial four week care package which was then reviewed to ensure care delivery was responsive to their needs. One relative said; "[My relative] is absolutely fine with everything. Their needs have increased a little bit and the care plan has been changed." One person told us; "When we got a new hoist [the registered manager] came to make sure they were using it properly."

Staff were clear on how they would identify a change in a person's needs and what action they would take. For example, one member of staff told us they were aware a person had begun to lose their appetite. After consultation with the registered manager food charts were put in place to enable ongoing monitoring and to seek input from other healthcare professionals if required. Another member of staff described how they would identify a change in a person's mobility needs and that they would report the matter to a supervisor or the registered manager. They told us they were listened to when they reported a change in a person's needs and the care plans were adjusted accordingly. Staff told us they were alerted to any changes in a person's needs.

The provider gave details of their complaint and compliments policy in the service user handbook. This also provided details of external agencies a person could raise complaints or concerns with. We noted the provider had not made clear in the handbook that the CQC cannot investigate individual complaints, however people can make the CQC aware of concerns they may have.

We noted there had been one complaint recorded in the complaints file since the last inspection. We saw evidence to show this had been thoroughly investigated and the outcome clearly communicated to the person concerned. The registered manager told us low level complaints were recorded electronically in people's individual records. This meant we were unable to review these complaints. This matter is addressed under the well-led section of the report.

Staff we spoke with were clear what to do if a person made a complaint to them. Staff told us no one had made a complaint to them. The people we spoke with and their relatives told us they were able to speak with the registered manager if they had any concerns. We saw the provider kept a record of the compliments

people made, although some were undated so it was not possible to tell when they had been received. People commented how 'compassionate' the service was.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of the inspection. The registered manager had changed their surname and told us they would update their registration accordingly. It was clear the registered manager knew the people who used the service well.

We looked at the systems in place to assess and monitor the quality of the service. The provider told us they were responsible for completing the audits to check the quality of the service provision. There was no other oversight to verify the provider was auditing accurately or effectively. For example, the provider carried out the MAR audits but had not considered whether specialist advice would benefit the process, such as from a pharmacist. Also the registered manager and provider were on occasions auditing their own work, such as recruitment paperwork. This meant it was difficult for them to identify shortfalls and areas where improvement could be made.

Accidents and incidents were recorded individually, but there was no overview of these to establish if patterns or trends occurred. The provider was not always aware of the statutory notifications they needed to submit to CQC. We found they had failed to notify us of two medication errors. The registered manager gave assurances they would look into this immediately and ensure they were fully aware of their legal duties. We requested they retrospectively notify us of the incidents surrounding missed medicines and also report the matters to the local authority safeguarding team.

We found some policies and procedures had not been reviewed since 2010/ 2011, such as staff recruitment and the advocacy policy and procedure. Even though the safeguarding policy had been reviewed recently this referred to the obsolete Independent Safeguarding Authority instead of the Disclosure and Barring Service. This meant there was a risk that an outdated policy could be referred to or followed.

Although staff training information was recorded on individual files, there was no overview of staff training as a whole for the provider to see when training was due and if there were any gaps. The provider told us the information was held on the computer database but there were unsure how to manipulate the data to produce information in an overview format.

People's care plans and risk assessment review dates were recorded but the provider was unsure how to produce the information in an overview format. This meant the provider had to go into each file to check whether a review was required. However, we found no evidence to suggest a review had been missed.

Low level complaints were recorded within people's individual electronic records which meant there was no overview of complaints for the provider to pick up on any patterns and trends.

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were supervisory staff and a care coordinator in post to support care staff in meeting people's needs.

We saw care supervisors kept a log book of information to bring to their weekly management meetings to discuss concerns. The registered manager told us they went through the electronic logs to look for patterns/trends but this was done on a daily basis and not over a significant period of time.

The provider said they valued their staff highly and we saw evidence on staff newsletters they had been thanked for their hard work and professionalism. Staff told us they thought the service was run well and they felt valued by the management team. Staff told us they were supported in their role and encouraged to provide feedback on the service. One member of staff told us; "If you have a query you can go to them [the management]. There's always someone to talk to." Another member of staff said; "There is a very good support unit. They go above and beyond."

The provider undertook client surveys on an annual basis and analysed the results. We saw the results were shared in a newsletter to people who used the service. The majority of the feedback provided was positive. Some of the comments included: 'First class service' and '[Staff] all caring and pleasant.'

Following the inspection the provider sent the CQC additional information to inform us that they were taking action regarding the issues we had identified during the inspection.

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 There were weaknesses in the management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records lacked sufficient detail to ensure risks were fully assessed and mitigated. There were weaknesses in the systems and processes for assessing and monitoring the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The recruitment process was not robust enough to ensure staff were of good character. Appropriate checks were not always completed prior to staff delivering care.