SOS Home Care Limited

Willowmere

Inspection report

East Road, Middlewich, Cheshire, CW10 9HW
Tel: 01606 606236
Website: www.soshomecare.co.uk

Date of inspection visit: 24 February 2015 10 March 2015
Date of publication: 06/05/2015

Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 24 February and 10 March 2015. The inspection was unannounced on the first day but we gave 24 hours' notice of our second visit.

Willowmere is an extra care housing scheme which can provide accommodation for up to 79 people. People live in their own apartments either as owner occupiers or as tenants.

SOS Homecare Limited (the registered provider) provides a well-being service to all the people who live in Willowmere. The registered provider also provides further personal care (or home care) to some people who live there. Most of the personal care service is commissioned by the local authority.

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

People who used the homecare service felt safe and staff knew how to keep them safe. The staff were well-trained and the provider had made the necessary enquiries to make sure that they were suitable to work in providing personal care. Many of the staff had worked at Willowmere either since it opened or for most of the time since then and so there was good continuity of care. This

Summary of findings

was also helped by the close liaison which the registered manager maintained with other services and with the registered social landlord which provides the accommodation, as well as with the local authority.

Some care planning documentation was incomplete and we have recommended that the provider takes steps to remedy this. The registered provider had not maintained adequate records of complaints. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 because staff had a good understanding of safeguarding and knew what to do in order to keep people safe. People who used the service told us that they felt safe.

The provider used assessments to identify specific risks and to minimise or avoid them. Where staff administered medicines they knew how to do this, were trained and were checked from time to time.

Is the service effective?

Good

The service was effective because staff were well-trained. There were sufficient staff to provide the registered service to the people who used it.

Staff knew that it was important to gain people's consent to the care they were providing. The registered provider was taking steps to make sure that staff were trained in the latest developments in connection with Mental Capacity Act 2005.

Is the service caring?

Good

People told us that they felt that the service was caring and that the staff working in the service looked after them and treated them with dignity,

People were usually familiar with the staff who provided them with care and staff visited in time or apologised if they were late for any reason. People were allocated a key worker to take responsibility for their arrangements.

Is the service responsive?

Requires Improvement

The service was not always responsive because care planning documentation was not always signed or dated. The complaints log did not accurately reflect the small number of complaints there had been in the last year.

The service worked with other agencies so as to coordinate the service people received. Information was sought from other providers to make sure that the care was appropriate to people's current needs.

Is the service well-led?

Good

The service was well-led because there was a system of supervision, appraisal and spot checks all of which provided the registered manager with information about the quality of service.

The service was audited by the registered provider who made monthly monitoring visits. The registered manager made herself available to the people who used the service at a regular "surgery".

Willowmere

Detailed findings

Background to this inspection

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

This inspection took place on 24 February and 10 March 2015. The inspection was unannounced on the first day but we gave 24 hours' notice of our second visit. The inspection team was made up of two adult social care inspectors on the first day with one of these returning on the second day. The inspection team also included two experts-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 in this case for older people.

Prior to the inspection we contacted the local authority for any safeguarding or commissioning information they might have. We also contacted the local branch of Healthwatch.

Not all the people living at Willowmere and who received a service from SOS Homecare Limited received personal care. We therefore restricted our discussions to those people who did receive the regulated activity of personal care.

During the visits to the service the inspectors spoke with four people who used the service by visiting them with their agreement in their own apartments. We also wrote to 20 other people asking them if we could interview them by telephone. The two experts by experience made the telephone calls and spoke with 13 people who used the service and one of their relatives.

We talked with three members of staff as well as the registered manager and the head of operations. We looked at six care plans and risk assessments and three staff files as well as other documents relating to the management of the service. When we visited people in their own apartments we looked at the copies of care plans and medicines administration sheets which were kept there as well as the arrangements for the storage of medicines and for summoning assistance.

Good

Is the service safe?

Our findings

One person who used the service told us "I feel very safe with the staff coming in they are wonderful" and another told us "I feel safe when I am showering - I am a bit bossy and if I felt unsafe I would ring the alarm". Other people told us they felt perfectly safe with the staff coming into their home and they "had given permission to them to enter when they were not present". One person's care included shopping and they told us "I get the correct change when they come back together with the receipts from the shops". One person told us "You could trust them (the carers) with anything".

Staff gave us a good account of their responsibilities in relation to safeguarding. They described it as "keeping an eye out for anyone who might be in danger" and "Making sure everything is OK". Another said "I look out for any signs such as body language or communication". They were clear that any concerns would be reported to the registered manager and knew about the arrangements for whistleblowing if appropriate action from management was not forthcoming.

Staff told us they had no current concerns but were able to give us instances where a person's behaviour had caused concern about the effect for their health and how this had been dealt with as a safeguarding matter. A visiting professional told us that in the past they had raised concerns about a member of staff and was confident that the registered manager would deal with it. We looked at records of an investigation into and subsequent disciplinary proceedings against a member of staff. These had arisen out of concerns expressed by staff. We saw that the matter had been dealt with by the registered manager and recorded appropriately.

We saw that care plans contained risk assessments and that these had been recently reviewed. Staff told us that they referred to these when they were providing care so that they would be aware of potential risks and provide care in a way that would avoid or minimise these risks.

We checked that the registered provider took proper precautions and followed regulations to try to make sure that people recruited to work in the scheme were suitable to do so. We looked at the file of a member of staff most recently recruited to the service. We found that the file was up to date and contained all the relevant documentation. This included a check list of requirements, application form, two written references including one from the most recent employer, and information on qualifications. During the appointment process the provider had used a structured interview questionnaire which was detailed and comprehensive and recorded the responses to important quality issues around providing care to people, including questions on safeguarding.

There was also a Disclosure and Barring Service (DBS) check which showed that the provider took steps to verify any information about a criminal record or other restrictions. The provider had sought a new DBS check where a new member of staff had brought one from a previous job. This member of staff told us they were not allowed to work until the results from the new check had been received. These checks helped the provider to make safer recruitment decisions and may prevent unsuitable people from working with vulnerable groups. We looked at a further two staff files and found these had been completed to the same standard.

The local safeguarding authority requires local providers to complete either care concerns for less serious untoward incidents or if the matter is more serious a first response alert. We saw that the provider completed these returns appropriately and kept a log so that she could check progress in resolving them. We saw one example where concerns were raised where a person had refused personal care, another where there had been concerns about a carer's attitude and a third where the service had felt that inadequate hospital discharge arrangements had been made. Raising a concern in this way allows all the agencies concerned to agree appropriate responses to untoward or unexpected incidents.

We asked staff to describe the system for managing medicines. They each told us that medicines were delivered by the chemist in a monitored dosage system. This meant that medicines were pre-packed by a pharmacist into the correct doses for each time of day and supplied to the people for whom they are prescribed in a sealed tray. This reduced the risk of too much medicine being taken or medicine being taken at the wrong time.

Staff told us that for each delivery they also checked that the medicines contained in the pack corresponded to the person for whom it was intended and that the medicines were as recorded on the medicines administration record for that person. Staff all confirmed they had had recent

Good

Is the service safe?

medicines training. They were all very clear about the arrangements for the safe administration of medicines and would refer any discrepancy for example in the medicines received with what was prescribed to senior staff. They were equally clear that they would not give over the counter medicines to people.

We saw that medication competency assessments had been undertaken on all staff 2014 and 2015. We saw that recent observational checks had been made to make sure that staff were dealing with medicines appropriately. These included a series of scenarios such as what the carer would do if medicines were refused or if an error was discovered. In each instance the carer had said that they would report the matters to their senior.

Staff described the way in which finances were recorded where they had to handle money on behalf of a person who used the service say to go shopping for them. They told us that they had to record everything on a finance log sheet and provide receipts. These logs were checked in front of the person using the service by the senior staff.

Good

Is the service effective?

Our findings

One person told us “These are well trained girls, they are very good company” and another person reiterated this with “They are very well trained girls”. A third person said “Well trained girls, they do what I want” and “Excellent service. I have a lot of complicated care. They are so good”. One relative told us “They go the extra mile - it makes all the difference”. Another person told us “(The carers) are good - some are better than others”.

Fifteen care staff were employed at the scheme together with two senior carers and the registered manager. The registered manager explained that staff were organised on a “rolling rota” which meant that as far as possible the same arrangements would apply from one week to the next. Staff told us that they thought there were enough staff to cover this rota.

The provider relied on a “bank” system for holidays and sickness which meant that existing staff were given the opportunity to work extra hours to fill in. We were told that because there was a long-standing staff group working at the service that there was an established routine of staff covering one another’s’ shifts where necessary. As well as rostered visits staff might have to respond to other demands made through the call system in which case they would be directed towards this via a mobile phone call from the office. However the registered manager told us that a member of senior staff was always based in the central office and would respond if necessary.

Some staff felt that they did not always get sufficient time to complete everything that was required on a call. One said “Sometimes you do and sometimes you don’t get enough time”. One member of staff told us that if there was a real need to stay longer on call than the time allotted then they felt confident that they would be reimbursed for the time. There was no need for staff to be allocated extensive travelling time between calls as would be the case in a conventional service of this type since all the people who used the scheme lived in the same building.

However we were told that no allowance was made at all for the time taken to get from the end of one call to the next apartment for the next call. We estimated that the time taken to walk from one part of the building to another could be as much as 10 minutes and this would allow no time for staff who might meet a person on the way and exchange pleasantries, or for unscheduled alarm calls, or for the additional tasks undertaken by staff such as securing the building. This meant that staff would become progressively later and later as their shift progressed. The registered manager told us that currently the time taken to go from one call to the next was included within the call time itself but that when a new scheduling system was introduced this would allow some time for travelling between calls.

We saw that each week each person who received care from the service received a programme to provide an overview for the following week. This provided people who used the service with relevant and important information to them about the staff on duty each day and so who might be visiting them. This meant that people could be confident that they would receive care and support from regular carers and feel safe knowing the person who would be visiting them. Any sudden changes such as might be caused by staff sickness or other unforeseen absence were notified to people via the intercom system installed within the building. Because both people who used the service and their carers and the registered manager of the scheme lived and worked in the same building any difficulties could be resolved immediately by the manager or senior person visiting the person.

Staff were available at all times including at night and at the weekends. At night there were two staff one of whom “slept in” and the other who provided personal care. The “sleep in” staff provided a back-up to the waking staff and ensured that a safe response could be made to people who needed assistance and who used the call system to summon this. In addition we saw that a member of senior staff was available by telephone.

The registered manager told us that all staff training was provided “in house” through two training officers employed by the company which owned the service. The registered manager maintained a training matrix and we saw that this allowed her to check when staff had completed training and whether they were in need of update or refresher training. Where a need was identified then this was sent to the training department who would arrange to meet the need.

We looked at the training records and saw that all staff were up to date with their training. In addition most of the staff had completed a National Vocational Qualification at level 2 or level three. NVQ qualifications are

Good

Is the service effective?

competence-based which means that people learn practical, work related tasks designed to help them develop the skills and knowledge to do their job effectively. We saw that when staff had completed courses and in-house training they had completed a written test that checked and provided evidence that the carer had understood the learning objectives. This meant that people who used the service could be confident that staff had received training relevant to their roles and had understood the training content.

Since the staff team at the service was relatively small it was possible for training to be provided locally and in small group settings. The registered manager told us that staff were responsive to the availability of training and this was confirmed when we talked with them. Staff could recall the most recent training they had undertaken (which was usually quite recent) and were enthusiastic about extending their knowledge and skill base. Staff confirmed that where they prepared food they had received food and hygiene training and where they were involved in medicines administration they had been trained and had had their competency checked in this.

We saw that most of the training was provided at annual intervals. This included health and safety, moving and handling, medication and safeguarding, principles and values of care, food hygiene, continence and stoma care and first aid. Staff had also undertaken dementia training as well as a course in values and principles in care both of which included the topic of mental capacity. We saw that the entire staff group had been scheduled to undergo training in the Mental Capacity Act 2005 in the week following our inspection. We saw that the provider had recently introduced payments to staff for the time spent on training. The head of operations explained that this was in recognition that the registered provider considered attendance at training to be mandatory.

We asked staff how they could be sure that they had the consent of people when they were providing them with care and what they might do if people refused important care such as washing or medicines. They told us “We would not force anyone to do anything” and “I would not push (a person) to do something they didn’t wish to” and “I can’t make anybody do anything if they refuse”. They told us that they would “Use our knowledge of (the) people (who used the service) to find a solution if people refuse something” and “I would offer alternatives even if they might take a bit longer” and “I’d find ways around (refusal). But if it is a point blank refusal then that is final”.

In the case of providers such as Willowmere and SOS Homecare Limited relevant applications under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards arrangements must be made to the Court of Protection. No such orders were in place at the time of our inspection.

Good

Is the service caring?

Our findings

One person told us "They (the carers) are very good - they're very careful – they're lovely". This person showed us their pendant alarm and said "I only have to press this and they come quickly. They come as quickly as they can". This person told us that they were forgetful particularly about their medicines and that they would call the carers for reassurance. Another person told us "Coming here is the best thing that ever happened to me – I was going downhill. When I use the pendant (alarm) it's only a couple of minutes at most (before they respond) – I have had a couple of falls but they (the carers) came to me quickly – bless them. They (the staff) are all very nice – they treat me with respect".

A third person we visited in their apartment told us "It's fantastic. The carers are out of this world – they are angels. I love them all". A fourth person said that "the carers are very caring and treat me with dignity and respect when showering me" but added "They (the carers) sometimes listen to me but they are very busy". We were also told that "They (the carers) are expected to be here, there and everywhere. They have no time to take a break or walk from one place to another". One person summed up the consensus view when they said "The staff are always very busy".

We asked about the punctuality and continuity of the carers. We were told "They are more or less always on time" and "Sometimes they are late but they do apologise". One person said "If it is not the usual carer then it will be one I have had a visit from before" and "A new carer started recently but she is a regular now". This person told us that the new starter had visited with a more familiar carer at the beginning.

We saw that the registered manager held a monthly "surgery" when she made herself available to the people who used the service at a central point within the building. We saw that this was advertised around the building and on the monthly activity programme. This ensured that people who used the service had an avenue to access information, raise concerns and meet directly with the provider to discuss these.

We saw notes going back each month to August last year but these meetings had been poorly attended. On the other hand we saw minutes of the Residents' Association convened by the housing provider which made reference to the personal care service provided by the registered provider. It is possible that people who used the service did not draw a sharp distinction between the two agencies. People at Willowmere had a number of activities available to them although these were organised by the housing provider.

We saw that people who received the service might be allocated care according to four levels which had been defined by the local authority which commissioned the service from the provider. The minimum level was known as a "wellbeing service" which meant that people could rely on the provider to respond to any call they might make for assistance at any time. The remaining levels (low, medium and high) equated to between less than 2.5 hours of personal care and more than 10 hours per week. The level was set by the local authority according to their assessment of people's needs. Additional care could be arranged over and above these levels and we saw that the provider initiated requests for this where they thought it necessary as a result of their experience of providing care to people.

The registered manager described Willowmere to us as ""A community with a roof on it". Because all the people lived in their own apartments with a relatively small group of staff but within a single building there was the opportunity for a good deal of familiarity between the people who used the service and carers. We saw when we were introduced by staff to people who used the service that there was a positive relationship between them. Because of this people welcomed us into their private apartments once the purpose of our visit had been explained by the staff and people had consented to our visiting them.

We asked staff how they made sure that people were treated with privacy and dignity. They said "We give people respect and offer them choices. We have had training which mentions this". Because the apartments in which people lived were either owned or rented by the people who lived there they could control access and therefore their privacy by using a remote control. When we visited people we used the intercom system to contact them and if they were willing to see us they were able to open their door to us and close it when we left using their remote control.

We saw that there was a list in the staff room which allocated each person who used the service to a named member of staff who was described as their key worker. We

Good

Is the service caring?

asked staff what this role included and they told us that it included a monthly check to make sure that the pendant and other call systems were working and to check overall satisfaction with the service.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they felt that their comments and opinions were taken into account. One person said "I can talk to them and they can talk to me" and another said "I've got nothing to complain about". A third person told us "I complained about something when I first came here. They've put it right now". Another person said that they "Had minor complaints but it does no good, the seniors take notice but not above them - they take no notice".

Care plans were kept in the main office as well as a copy in each person's apartment. We looked at a number of care plans in the office. We found that they contained a comprehensive check list on the plan enabling staff to check that all the appropriate information was available on the files and that they were complete. The files contained relevant documentation including risk assessments and took a person-centred approach to care planning where the person who used the service was consulted about how they wanted to receive care and support. Person-centred plans help providers and their staff to find out what matters to a person so that they can take account of their choices and preferences. Individual contracts and service agreements were in place so that people knew about the service they could expect to receive.

We were told that reviews of care plans took place every 12 months but more frequently if required. Staff told us that they were instructed to report any significant changes in a person's care needs and if necessary a request for a change would be sent to the funding or commissioning authority. We saw such a request being processed during our inspection. The provider had alerted the authority to a change in a person's circumstances and an assessor had visited the person to look at the situation with them.

We confirmed that regular reviews were taking place. We saw on one file that the last review had taken place within the last week. This had included looked at any changing care needs and the provider had then updated the care plans accordingly. Health and safety and environment updates were included along with reviews of moving and handling requirements. The updated plan included a record of discussion with the person about how they wanted to receive care and support. This included consideration of what the person wanted to achieve and how the person might do this together with an agreed support routine. The registered manager told us that because of proposed changes in the range of services commissioned from them that all local authority commissioned care packages were about to be reviewed.

We were told that a copy of the care plan, risk assessment and hospital admission form was kept in people's own apartments with log sheets. When we visited people in their apartments they allowed us to look at the copies of the plans which were kept in a green folder. We saw that the care plan included a service user guide which provided information for people on key policies and procedures that affected them including how they could provide feedback to the service. We saw that log sheets were maintained by the care staff and completed after each visit. This included a check that the medicine administration records were up to date including where PRN (as required) medicines were involved. The log of each visit confirmed where appropriate that the person had their call bell in reach. None of the people we talked to said that they looked in their care plans but all knew of their existence and what they were for.

When we looked at care planning documentation in the service we saw that this was not consistently always signed or dated by the person who used the service to show that they agreed with the care plan. The registered manager showed us a new form of care planning documentation which was currently being introduced. The introduction of this new documentation would provide the opportunity to make sure that people's agreement to their care plan was documented.

In each care plan we saw that there was also a copy of the service user guide which provided people with clear information about how to make a complaint. The service had a complaints and compliments file in place which included a comprehensive complaints policy and a complaints log book. However we saw that there were had been no recorded complaints in the last year although several positive comments had been received. In the course of our inspection however we became aware of three complaints which had been raised in the last year but these had not been recorded. Some incidents which had been logged as care concerns also constituted complaints but had not been recorded in the complaints log. This meant that the provider did not have an effective complaints system in place. This was in breach of

Requires Improvement

Is the service responsive?

regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of each of these incidents and agreed that anything similar would be recorded in the future. In one instance we spoke with the complainant who did not feel that they had received a complete response to their concern. We raised this with the registered manager who agreed to visit the person and try to resolve the matter. The head of operations told us that the provider was also going to develop systems to include minor complaints that were managed on a daily basis. This could assist the service with closer monitoring and looking at patterns to help them to continuously improve.

The registered provider maintained a log of calls made by the call bell system. These were calls made in addition to any tasks or routines included in the care plans. We saw that such requests could be made for the purposes of getting support with making a cup of tea or queries about whether medicines had been taken.

We asked staff how they knew about what had been happening to people in between their shifts. They told us that they looked in the log sheets in the care plans which were kept in each person's apartment and that there was a communications book in the staff room which had to be signed at the end of every shift. We looked at this book and saw that staff added key information to it such as appointments and information which other members of staff needed to be aware of such as if a particular person was unwell or if laundry required attention. We saw that staff passed through the staff room at intervals and so could readily refer to or add to the communications book.

On both days of our inspection we saw local authority staff visiting the apartments and calling into the office to discuss matters with the registered manager who made herself available to them. A visiting professional told us that they were confident that the care provided by the service was appropriate to the person they were visiting. We saw records which confirmed that the service worked with other community services such as the district and incontinence nurses and occupational therapists. We saw evidence that showed that the provider sought and received information about changes in the health of the people who used the service such as following a hospital stay and used this information to adjust the service with the person.

We recommend that the service introduces arrangements to make sure that all care planning and risk assessment documentation is signed and dated by people who use the service or their representatives or a reason recorded why this was not possible.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place who spent two days a week at Willowmere and the remainder of the week at a similar development at which she is also the registered manager.

The registered manager had a number of processes and procedures in place to support her in monitoring the service delivery and these formed part of the quality assurance systems. We saw that members of the senior management team of the registered provider visited the service and provided feedback reports. The registered provider had its own quality auditing system and a separate manager was in place specifically to undertake this. The last audit report had been completed with the last three months and identified several areas for attention including around management meetings, records, audits and communication. We saw evidence that action had been taken to address these areas.

We were told that a quality questionnaire was sent out annually. This last took place in November 2014 and the analysis was available for us. People who used the service were consulted and asked to provide feedback on a wide range of issues which included times and length of call, staff attitude, staff approach, staff performance in carrying out their duties, staff appearance, response of staff or office staff in respect of any concerns or complaints raised, staff delivery of care task in ensuring that care was provided in a way that was respectful and supported people to maintain their dignity. People were asked to provide their overall opinion of the service and given the opportunity to make suggestions and recommendations.

On completion of the survey, the agency analysed the finding and produced a briefing which we were told was circulated to the people receiving the care. Seventy-one questionnaires were sent out and there were eight responses. The analysis of these responses found that staff attitude was good and that staff respected people's privacy and dignity. The report identified areas for improvement which were in relation to call times and duration.

The report provided evidence which showed that the service had tried to be proactive in responding to these concerns by consulting with people. Where people had provided their names we saw that the service had undertaken reviews to address their specific concerns.

There was an action plan produced as a result of the findings which stated that all care packages would be reviewed and that there would be a focus on looking at the log books and that spot checks would be undertaken to check call times. We saw logs from the call system which could be compared with other information so as to provide an audit trail and check performance.

This action taken by the service provided evidence that the service took feedback seriously and that the registered manager responded positively by taking the necessary action to improve service delivery.

Records showed that spot checks were undertaken on staff every three months and these were found to be current and up to date. The spot check proforma included all aspects of performance whilst delivering personal care and specific tasks and included a check that paperwork had been completed, confirmation that staff had read and understood the care plan, and that staff had made appropriate entries on records and signed them accordingly. Checks were also made on staff competencies when managing medication to make sure that they were following the correct procedures and protocols. The checks also looked at staff attitude and communication skills when working with people.

We were told by the manager that a spot check provided opportunities to link any findings to training and supervision. We were told that when an issue of concern was identified this triggered an action plan which included further training if appropriate and increased supervision and monitoring.

We saw that that the service carried out weekly audits on the medication. We sampled one audit and saw that it provided checks that the person's name was clearly identified, all recordings were in black ink, instructions were legible and were clear as to the time of medicines were to be given, that signatures on medicines administration chart (MAR) were evident, and that any gaps in recording were explained. A senior member of staff told us that when a problem was identified on the action plan a supervision meeting was triggered either with the individual member of staff involved or as a team meeting event as appropriate.

We saw evidence that all staff received supervision every three months together with an annual appraisal. Records

Good

Is the service well-led?

confirmed that supervision and appraisal were up to date for 13 out of the 15 staff. It was explained that two staff had been on leave and had missed their scheduled supervision session, but this was being addressed.

We looked at the supervision format and found that it covered key aspects of good care practice. This included care practice issues, training and continuous professional development, safeguarding, medication procedures and updates. There was a section on feedback from observations, spot checks, and monitoring. Observation feedback meant that there was provision for staff to reflect on their practice and potentially learn from mistakes or issues of concern identified through this process. Appraisals were documented and showed that staff were provided with the opportunity to discuss their learning and performance for the rest of the year and identify any training needs. When we spoke with staff they confirmed that they received supervision at regular intervals and that they had also received appraisals.

We saw that regular staff meetings were held with senior staff and the care staff team and that the most of recent of these had both taken place within the fortnight preceding our inspection. These meetings were documented and issues of concern were discussed and plans put in place to address these with any specific tasks allocated out for action

We saw that the service had comprehensive policies and procedures were in place. These included policies relating to complaints, confidentiality, equality and diversity, health and safety, medication, safeguarding and whistleblowing. They had all been reviewed and updated within the last nine months.

We saw that members of the senior management team of the registered provider had visited the service. We saw records of visits for each of the last four months.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered provider did not have an effective complaints system in place.**