

Community Integrated Care Teeside Domiciliary Care Office

Inspection report

Room 4001, DBH Belasis Business Centre
Belasis Technology Park, Coxwold Way
Billingham
Cleveland
TS23 4EA

Tel: 01642345654






Date of inspection visit:
14 January 2016
15 January 2016

Date of publication:
09 March 2016

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?	Good 
Is the service well-led?	Good 

Summary of findings

Overall summary

We carried out this inspection on 14 and 15 January 2016 and it was announced. The provider was given 48 hours' notice because the location provided a domiciliary care services and we needed to be sure that the manager would be in.

The service had a registered manager who had been registered with the Care Quality Commission since November 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service also had a service leader who managed the day to day running of the service.

Teesside Domiciliary Care provides support to adults with learning disabilities both within supported living services and in domiciliary care settings. They provide personalised support packages tailored to meet the individual's needs 24 hours a day seven days a week. At the time of our inspection they were providing personal care for five people.

Due to people's communication needs we were unable to gain some of their views about the service and therefore we spoke with family members or other person close to them.

Risk assessments were not always in place for people using the service and care workers. Identified risks were not always acted on.

There were systems and processes in place to protect people who used the service from the risk of harm. Staff were aware of different types of abuse, what constituted poor practice and action to take if abuse was suspected.

Staff were trained and competent to provide the support individuals required. Although staff demonstrated an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, they had not received training in this area. Training was also needed in food hygiene. We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to show staff employed were safe to work with vulnerable people. Staff had now started to receive regular supervision and appraisals, these had not taken place for the majority of 2015. The service leader was aware of this and had put a system in place.

We found that appropriate systems were in place for the management of most medicines. People were supported with their medicines by suitably trained and experienced staff. We have made a recommendation regarding when required medicines.

The service had a system in place to monitor accidents and incidents.

The service acted in accordance with legal requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. At the time of our inspection no one was subject to a Deprivation of Liberty Safeguards.

The registered provider carried out assessments to identify health and support needs of people. Each person had a person centred plan which showed how they wished to be supported. We found that these would benefit by adding further detail. People were supported to maintain good health and have access to healthcare professionals and services.

From discussions with a relative and documents we looked at, we saw people who used the service or their families were included in planning and agreeing to the care provided at the service. People had individual support plans, detailing the support they needed and how they wanted this to be provided. Staff reviewed plans at least monthly with input from the person who was supported.

Staff demonstrated they knew; the people they were supporting, the choices they had made about their support and how they wished to live their lives. All this information was documented in each individual care plan.

People were supported to access activities of their choice.

A complaints procedure was available and people we spoke with said they knew how to complain, although no one said they had needed to. The service maintained records of compliments and complaints and recorded how these were resolved.

There were effective systems in place to monitor and improve the quality of the service provided.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered 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.

People were protected by the service's approach to safeguarding, whistle blowing, and arrangements for staff recruitment.

There were safe systems in place for managing most medicines. We made a recommendation about 'as required' medicines.

Risk assessments were carried out before providing a service to people. However some detail were missing and decisions to alleviate risks were not acted on in a timely manner.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff were now starting to receive regular supervision and appraisals. These had not taken place for the majority of 2015.

Staff had the knowledge and skills to support people who used the service.

Staff were able to update their skills through regular training although training was overdue in some areas.

People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Good ●

The service was caring.

Staff upheld the privacy and dignity of people using the service.

Relatives and people close to those using the service, told us staff were kind and caring.

People were involved and their views were respected and acted on. Staff were able to form positive relationships with people.

Is the service responsive?

Good ●

The service was responsive.

People's needs had been assessed and care and support plans were produced identifying how to support them with their individual needs.

People were supported to access activities of their choice.

The relatives of people knew how to make a complaint and complaints were responded to and resolved appropriately.

Is the service well-led?

Good ●

The service was well led

Staff were supported by their service leader.

The service had a registered manager, a service leader and supportive management structure.

There were effective systems in place to monitor and improve the quality of the service provided.

Teeside Domiciliary Care Office

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 14 and 15 January 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care services and we needed to be sure that the manager would be in. The inspection was undertaken by one adult social care inspector. At the time of our inspection there were five people receiving personal care.

The registered provider was not asked to complete a provider information return (PIR). The PIR 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.

Prior to this inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During this inspection we spoke with a quality and excellence partner, the registered manager, the service leader, one person who used the service, a relative and a personal advisor to one of the people who used the service. Teesside Domiciliary Care Office also sent a questionnaire to all 24 staff who provided personal care and we received three completed questionnaires. We also spoke with three members of staff after the inspection.

We reviewed care records relating to three people using the service and four staff files that contained information about recruitment, induction, training, supervisions and appraisals. We also looked at further

records relating to the management of the service, including quality audits.

Is the service safe?

Our findings

We asked one person who used the service if they felt safe when staff supported them. They said, "They [staff] good and I feel safe. They are there for me every morning." A relative we spoke with said, "I have no issues or worries, [my relative] is safe."

Care staff were able to provide a good explanation of what was meant by a safeguarding concern and the various forms of abuse, including financial, institutional and emotional abuse. All staff we contacted said they would report any signs of possible abuse straight away and had no worries about doing this.

We looked at files of people receiving care and each contained an individualised risk and management plans, completed with them and where appropriate their relatives. Care plans identified the risk and the actions required of staff to minimise the risk. The risk assessments seen covered areas such as social isolation, professional boundaries and moving and handling. There was also a 'My Safety and Security' support plan which covered what to do in the event of an emergency situation.

Moving and handling plans and risk assessments were also in place for each person. Where people needed specialist equipment, all information was documented. For example one person needed to use a sling, the moving and handling plan stated the type and size of the sling, how to use the sling and what the staff needed to observe regarding the sling, such as cleanliness, tears etc.

We did find that some risk assessments were missing or lacked detail. For example one person used a key safe and there was no information or risk around this. We discussed this with the service leader who said that the key safe number was never written down and staff were verbally told it. We discussed the need of a more robust risk assessment to cover use of the key safe. One person the service cared for had a dog but there was no risk assessment around staff entering the person's home. The service leader said they would update the risk assessments immediately.

One person's support plan had been reviewed in September 2015 due to their behaviour that challenges. A decision was made to incorporate ABC charts and scatter plots. An ABC Chart is a direct observation tool that can be used to collect information about the events that are occurring within a person's environment. "A" refers to the antecedent, or the event or activity that immediately precedes a problem behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence, or the event that immediately follows a response. The scatter plot is an interval recording method that can help discover patterns related to a problem behaviour and specific time periods. We saw no evidence of these in the care plan. The service leader said, "We have just started working with these." We would have expected to see some evidence of these being used since the decision was made in September. This meant that where systems were put in place to evidence possible risks they were not acted on in a timely manner.

One person who used the service had a feeding tube in place. Although a full manual of use was available on the care files, daily notes showed that on some occasions staff were setting feeds up but nothing was documented to say how much feed and fluids were needed. The service leader was arranging for this

information to be added.

This was a breach of regulation 12 (Safe care and treatment). The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service leader told us about some positive risk taking that had taken place. For example one person they support wanted more unsupported time, the service manager said, "We held a review with the person and their care manager to discuss the risks associated with this for example danger, fire safety, telephone training, assisted technology, Community Integrated Cares on call procedure and stranger danger. We agreed to meet and review this every four weeks. This has resulted in the person's support going from being 24 hours a day seven days per week to three hours per day unsupported and the person now travels independently." The service leader also told us about a person who wanted to go abroad for three months, they said, "We worked in partnership with Psychiatrist Care Managers and Continuing Health Care to plan and make this happen."

We looked at four staff files. There was evidence in staff files that new employees were checked before being allowed to commence work to ensure they did not pose a risk to people who used the service. The recruitment checks included proof of identity, two references, and employment history. The files also contained a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers to make safer recruiting decisions and also to minimise the risk of unsuitable people working with children and vulnerable adults. During interview potential staff had to answer a what would you do question. For example, a support worker was borrowing money from a person who used the service, what would you do? They would also be involved in a group interview.

The service leader said, "We recently held a recruitment day in Middlesbrough and two of the people we support took part in this for the full day this included handing out flyers having discussions about the job role and actively taking part in the interview process and selecting their own staff."

We looked at staff rotas and found there were sufficient staff with appropriate skills and knowledge to meet peoples needs. Each person's care file identified the amount of staff support needed and the majority needed two to one support when accessing the community. We saw that there were always enough staff on duty to cover this. All staff we contacted said there were enough staff. The service leader said that staffing levels are monitored daily to ensure people receive safe care. The service leader also said, "If person wanted the service to be on a different day, if possible this would be accommodated immediately, if not a date would be agreed for when this could happen."

We looked at a sample of medicines records, including records of medicines received, administered, and disposed of, medicines care plans, medicines audits. We found medicines were being managed safely. The service carried out a medicine assessment form to find out what support a person needed with their medicines. This information would form the basis of a medication profile form which documented the name, description, dosage, time of day and why 'I' take this medicine. There was also information on how people preferred to take their medicines. For example 'place the medicine in a small beaker, put the beaker into left hand and then hand a drink of water. Staff we spoke with said, "I always ask them if they want to take their medicines first, then offer it in a way they want them, such as on a spoon or in a measuring cup."

Appropriate arrangements were in place to record when medicines were received, used and disposed of and all prescribed medicines were available. Records showed that these were being given regularly and as

prescribed.

We looked at the records for people who were prescribed medicines to be given 'when necessary' or 'as required' for pain. We found there was no PRN protocol in place. We recommend that the service consider current guidance on giving PRN medicines to people and take action to update their practice accordingly.

We asked how the service was monitoring how medicines were managed. The service leader showed us regular monthly audits and a very detailed annual audit. Staff said, "We have a countdown sheet so we can monitor the amounts of medicine." Staff involved in the administering medicines had received appropriate training, and had regular checks of their competency.

The service carried out relevant safety checks of the premises such as portable appliance testing (PAT). The service had a business continuity plan which detailed what to do in the event of an emergency such as flood, fire or loss of electricity, in the first 24 hours, 24 – 48 hours, up to a week and up to two weeks.

The service had a system in place to monitor accidents and incidents. All accidents and incidents were inputted electronically, investigated and discussed with the relevant social worker. The service leader also said they would discuss any incidents with the psychiatrist and safeguarding if need be.

Staff we contacted said they had plenty of personal protective equipment (PPE) available to them.

Is the service effective?

Our findings

The relative and personal assistant we spoke with were happy with the care the service provided. The relative we spoke with said "I am very happy with this service." And the personal assistant said "We work very well together. They turn up when they should and stay for the time they should."

New staff were inducted to the standards recommended by Skills for Care under the Cavendish Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. The induction process lasted 12 weeks with two weekly performance reviews. New staff also shadowed existing staff into support packages where they were introduced to people they would support and their families. A record of these shadowing visits were made and these fed into the performance reviews.

We looked at staff supervision and appraisal. We saw that regular supervisions or appraisals had not taken place, with some staff having only received one supervision 2015. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The service leader had recognised this and put a plan in place to make sure people received their supervisions and appraisals. The service leader showed us this plan and we saw that as from November 2015 people had started to receive supervision and nearly all staff had received an appraisal in December and January. We saw records to confirm this. One staff member said they found the supervisions useful, saying, "I receive a supervision every few months, they are useful and at the last one I made the point of wanted to do my NVQ level three, I have now been enrolled on that." Another staff member said, "I have only had one meeting since I started last September." We asked this staff member if they had received meetings during their induction and they said "No." We asked the staff member how they thought the induction went and the support they had received, they said, "I found the induction boring, but I don't like sitting and listening I am more hands on, I did get support from staff when I went out though."

Staff completed a one page profile about themselves. This information included what is important to that member of staff, what do people like and admire about them and how that member of staff liked to be supported. The staff members one page profiles were discussed at their supervision and this provided them with an opportunity to update their profile so their skills could be best matched to the people they supported.

People were supported by staff who had the right skills and knowledge to care for them. Staff members were knowledgeable about people's individual needs and preferences and how to meet these. Staff had been trained to meet people's care and support needs in topics such as epilepsy, administration of Buccal Midazolam medicine and percutaneous endoscopic gastrostomy (PEG). Records showed all staff had received training in mandatory subjects, such as moving and handling, health and safety, safeguarding and first aid. Although staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) they had not received training in this. We could also not see any evidence of staff being trained in food hygiene even though they did support people with food preparation.

The service leader was arranging for this training to take place.

One staff member said, "I have had lots of training, such as first aid, dementia, behaviour that challenges and safeguarding." Another staff member said, "I have been supported to expand my knowledge and skills to enable me to support the people who used the service."

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. No one was being deprived of their liberty at the time of our inspection. The service leader manager was aware that if they had any concerns regarding a person's ability to make a decision they would work with the local authority to ensure appropriate capacity assessments were undertaken. This was in line with the Mental Capacity Act (2005) Code of Practice (MCA) which guided staff to ensure practice and decisions were made in people's best interests. Staff had not received training in mental capacity and DoLS. However staff that we contacted were able to explain sufficiently what MCA and DoLS were.

We saw people had provided verbal consent in care plans, For example consent to medicines or holding information about the person. We saw evidence in care files to show that staff checked with the people who used the service regularly to make sure they were still happy with the support being provided on a regular basis.

We saw evidence to show that healthy eating was promoted. Each person who used the service had an eating plan which included their food preferences It also included how to present the food for example, 'cut up into very small and add moisture such as gravy, a sauce or custard if a pudding'. One staff member said, "We need to cut the food up small as they have a tendency to overfill their fork, then put too much food in their mouth, this could be a choking hazard because they start talking straight away." One person who used the service said, "I love the food they make for me, it is hot and I my favourite is curry."

Is the service caring?

Our findings

The relative of a person who used the service said, "The carers are fantastic and I mean fantastic." And "They deserve a big pat on the back, they [person who used the service] loves them." A staff member said, "I have worked here for years, I love it." Another staff member said, "The best thing is seeing the client's face when I finish the support, they look so happy because we have had an enjoyable time, I love spending time with [person who used the service]."

Staff we spoke with knew the people they cared for really well. We asked staff what is important in terms of interacting with the people who used the service and what they value. One staff member said, "It is important to get their views and opinions on things."

Staff explained how they support people who used the service to live as independently as possible. Staff we spoke with said, "I always prompt them to do what they can." Another staff member said, "I promote independence by offering choice." One staff member said, "We are support workers, so we are there to support but not take over, I encourage people to do as much as they can, the person I support is really good at putting rubbish out, cleaning up after themselves but I am there for what they cannot manage."

One staff member told us that they person they support values commitment. They said, "I am committed to [the person] I work with their family and we are a team for them, we discuss concerns and find solutions together."

The service supported people to express their views and be actively involved in making decisions about their daily care and support. If a person struggled to make choices staff were trained to support them by offering different suitable options in a suitable format, for example, by using pictures or symbols if necessary. Support plans clearly recognised potential challenges to communication and provided clear guidance for staff about how best to support people. For example, one person who used the service had no verbal speech. Therefore, staff needed to be aware of facial expressions to show if the person was happy. The plan directed staff to look out for facial expressions if the person was to become unhappy, be in pain and discomfort. Unfortunately it did not explain what these facial expressions could be. We discussed this with the service leader who said they would update the care plan.

We asked management how they support people's human rights. We were told that the service supports inclusion and tackles discrimination. The service leader said, "We signpost people to organisations that can help and support them and offer advice." The service leader also said, "We identify people's individual needs and areas in which they require support, whether this is support with personal care or to maintain their home."

People and their relatives were aware of, and were supported, to have access to advocacy services that were able to support and speak on behalf of people if required. Advocates help to ensure that people's views and preferences are heard. No one at the service used advocacy at the time of inspection.

The service continually reflected on their practice and sought to make improvements for the people they supported. There were monthly joint meetings between the team and people who used the service, these were recorded and demonstrated that the team were consistently monitoring and reflecting on the service.

Is the service responsive?

Our findings

We looked at three people's care records. We saw assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. We noted that care plans were reviewed six monthly or sooner if needed. Records demonstrated that people and/or their relatives routinely discussed their support plans. Meetings were held on a monthly basis with the staff who cared for that person and the person was also included in the meetings. During these meetings they looked at what they were documenting about the person, whether further training could be introduced to match a new need and they also looked at things like staff time keeping. We were told they also checked that staff were correctly matched to people if a person's needs had changed.

Care records contained information about people's health and social care needs. Although the care plans were person centred, which meant they were individualised and relevant to the person we found a lot of blank paperwork included. The service leader explained that they were in the process of updating the care plans and the blank pages would be removed if they were not relevant to that person, they were there in the interim to add further detail if needed.

We saw people's daily notes and found these were detailed. The daily notes were outcome based and monitored whether required outcomes had been achieved. For example the daily notes were completed for social engagement, maintaining health and wellbeing and staying safe. For one person the outcome for social engagement had not been achieved due to the swimming baths being closed, it was then documented what they had done to try and achieve this outcome.

Care plans also documented things that were important to the person such as their computer, keeping to routines, shopping and television programmes. The care plans also documented signs if someone was becoming unhappy and what staff would need to do. For example one person's care plan said, 'If I get upset leave me for a bit.' Another highlighted what staff needed to do if the person got anxious. This meant that staff knew what steps to take and prevent further anxieties.

The person's assistant we spoke with said, "[person] is very happy and settled with the staff, they are happy in their life."

People who used the service were encouraged and supported to engage with activities and events outside of the home. For example, one person said, "I love going shopping and I also like a lie in, I don't get up till ten o'clock, it's great."

A staff member we spoke with said, "I support [the person] on their activity day, they choose what they want to do beforehand, but they usually choose shopping, going for a coffee and we must make sure we get the bus back, they love getting on the bus." Another staff member said, "When I first started supporting [the person] they were a blank canvas, over the years we have got to know each other and we now have a good structure built with their autism in mind so they have a meaningful day."

The service had a policy and procedure in place for dealing with complaints. People we spoke with knew how to make a complaint but said they had not needed to. We spoke with the service leader about the complaints procedure and were reassured the service took complaints seriously and acted promptly to address concerns. The service received nine complaints since April 2014 which included for example, late calls, missed call and inappropriate clothing. All information regarding the complaint had been documented although we could not see an outcome to show what the service had done was satisfactory for the complainant. The service leader said they would add this further information on going forward.

Is the service well-led?

Our findings

The relative and personal assistant we spoke with said they were happy with the management of the service. The relative said, "I have no worries they are always there when we need them." And the personal assistant said "They are very good at communicating with us."

Staff we spoke with said they were supported by the registered manager. One staff member said, "I talk to the service leader if I have any issues which is rare. They have faith in me." Another staff member said, "The manager is alright, supportive, but I don't speak to them much." And another staff member said, "We have a very approachable management."

The service had a clear vision and put values, such as respect, enable, aspire, deliver and include into practice. Staff understood these values and were committed to them. One staff member we spoke with thought the service had an open and honest culture.

The service leader said, "I promote a 'can do attitude' and hopefully motivate the staff team and I am very aware of and promote our values to become the UK's number one leading health and social care charity."

Staff meetings did take place although not very often. The only staff meeting we saw documented was for January 2015. Topics discussed at this meeting were rotas, conduct and performance, communication and training. The service leader said, "We find the individual meetings with the person being supported much more beneficial because we can tailor the meeting to them and their needs. It is difficult getting staff altogether as they are all out supporting at different times."

We asked staff about staff meetings and they said, "I don't get to many meetings but I always get the recorded minutes sent." Another staff member said, "I have only been to one meeting and it was boring, they told us stuff we already knew."

The service reflected on their practice and sought to make improvements for the people they supported. There were monthly joint meetings between the team and people who used the service, these were recorded and demonstrated that the team were consistently monitoring and reflecting on the service.

We asked the service leader how they gather the views of the people who used their service, their relatives and staff. The service leader said, "We gain the views of people who used the service via the monthly meetings and parents would call us if they had any issues. I am planning on incorporating monthly check phone calls, but this is not happening at present." The service leader provided examples of satisfaction surveys that go out to people and their relatives. These were also in picture format for people who could not understand the written word.

The service leader also said, "We use outcome focussed monitoring sheets which are person specific and comment on the outcomes being achieved for each support session. We use these sheets as tools during review process and give families and people we support the opportunity to look through these and add any

comments that they may have."

Community Integrated Care sent out a staff satisfaction survey and provided feedback for the whole group showing the positives and the negatives. A positive showed that 90% of staff were aware of the services values and what it meant for them. A more negative aspect showed that only 70% of staff received supervisions or appraisals.

The service had robust quality assurance processes in place. The quality and excellence partner explained the audit process. They said, "The service do an annual self- assessment, [service quality assessment tool] they have 249 questions to answer that match CQC's key line of enquires and they risk rate themselves, green for good, amber needs improvement and red action required immediately. The service has to then do themselves an action plan, this is all stored electronically and is visual to the quality and excellence team and will alert us if an action on the action plan has not been completed in the agreed time." We saw the self-assessment and an action plan the service leader was working through. We were told that once a service had self-assessed themselves they are visited by the quality team to do a service 'health check,' This health check looks at what the service has assessed and reviews the ratings. The service quality assessment tool covered support planning, risk assessments, nutrition, healthcare, caring, health and safety, environment, medication, safeguarding, staffing, training, quality and complaints. We were told that although this is annual the service need to keep it updated and if any risks are highlighted another assessment would be done.

The service also carried out 'peer reviews.' This is where a person they support become an expert by experience [someone with knowledge of the service] and do a quality of life audit. One person from Teesside Domiciliary Care Office did an audit in Gateshead and Newcastle. We were told they always went out of area so there was no conflict of interest. The person looked at the service and questions "Would I be happy to receive this service," etc. The quality assurance partner said, "Our peer reviewers look at things in a different way, in a more person centred way, we have learnt a lot from these reviews." this meant that people who had used the service were involved in monitoring and improving standards.

We asked what the plans were for developing the service and the service leader said, "We will continue to develop personalised services and look at what people want from the service and how we can deliver this make sure that all people we support have personalised rota's in place which are flexible and dictated by the person working in partnership with local authorities. Also to look at what the gap is in relation to what people want in a service and how we can meet this."

The service had links with the local community and organisations such as Shaw Trust, Shaw Trust was formed as a charity, in 1982, to ensure the most severely disabled people had employment opportunities outside sheltered workshops. The service leader said they also do community mapping of local areas, they explained, "We pass on information about what activities, events occur in areas that are local to people."

The service understood and complied with their legal obligations from CQC or other external organisations and these were carried out consistently.

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 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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Risks were not always in place or where risks had been identified the systems put in place to minimise the risk were not acted on. Staff were not recording the amount of feeds and fluids being set up for a PEG feed.</p>