

Pentlow Community Care Limited

Ashridge Community Care

Inspection report

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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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Ashridge Community Care is a domiciliary care agency owned by Pentlow Community Care Ltd providing care and support to people living in their own homes in Bexhill-on-Sea and surrounding area. Although separately registered with CQC, Ashridge Community Care is a small service integrated into the day to day running of Pentlow Community Care from the same offices in Eastbourne.

The inspection took place on the 8 and 9 February 2016 and this was an announced inspection.

We informed the registered manager two days prior to our inspection to ensure that there was someone available to meet us at the office when we arrived. This also allowed the manager time to contact both clients to inform them of our inspection and seek permission for us to contact them.

Ashridge Community Care provided personal care to two people at the time of our inspection. Some people were living with illness or other long-term health related conditions, but lived reasonably independent lives and Ashridge Community provided care or support to help them maintain their independence and be able to stay living in their own homes.

Ashridge Community Care had a registered manager who was also the registered manager for Pentlow Community Care and both services were run jointly from the same offices in Eastbourne. 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.

The manager was in day to day charge of the service, supported by a deputy manager and an administration team of care co-ordinators and care staff. Staff told us that they felt supported by the registered manager and knew that there was always someone available to support them when needed. Staff told us that the manager had made a number of positive changes.

Staff knew about people and the medicines they required. However, medicines procedures were not followed and documentation was not clear. This meant that medicines were not always administered in a safe and consistent way.

Systems were in place to assess and monitor the service however these had not identified some of the areas of concern found during the inspection. Including MAR charts, medicine procedures and documentation.

Staff told us they had a good understanding of how to support people. However we found that care information in peoples homes and support plans did not contain all the information staff needed to look after people.

All staff were committed to providing a high quality service for people in their own homes. Staff told us they liked helping people remain independently in their homes. People using the service spoke highly of the staff and the service they received.

Staff had a good understanding of the risks associated with the people they looked after. However, the risk assessments did not reflect all the identified risks and actions taken when concerns when noted were not always documented.

Staff had a good understanding of safeguarding procedures and what steps they would take if someone was at risk of abuse or harm. There were enough staff who had been safely recruited to meet the needs of people who used the service.

Staff had an understanding of MCA and the importance of consent when providing care and support in people's homes.

Staff and people were supported by a registered manager who was committed to improving the service to ensure they were consistently providing a high quality service that met people's needs. Feedback was gained from people this included questionnaires and reviews and a complaints procedure was in place. The registered manager told us there were no on-going complaints.

We found a breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions 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?

The service was not consistently safe.

Medicines were not always administered in a safe and consistent way.

Information around people's changing health needs and wounds was not clear to ensure they received safe care at all times.

There were a range of risk assessments in place however these did not reflect all the individual risks for people.

There was an on-going recruitment plan in place. Systems were in place to ensure safe and effective recruitment for new staff.

Staff understood what to do to protect people from the risk of abuse.

Requires Improvement ●

Is the service effective?

The service was effective.

There was an induction programme in place.

Staff received effective training and support to meet people's needs.

Staff and management had a good understanding of MCA. People were involved in day to day decisions and consent gained before care was provided.

Good ●

Is the service caring?

The service was caring.

People told us staff were kind and caring.

Staff knew about people's care needs and they respected people's privacy and dignity.

Good ●

People were encouraged and given support to maintain their independence when possible.

Is the service responsive?

The service was not consistently responsive.

Although care plans were in place, these had not been kept up to date.

When people's health needs had changed actions taken by staff were not clearly documented.

Documentation in people's homes did not tally with information held at the office.

People were made aware of how to make a complaint.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Systems in place to assess and monitor the quality of service provided had not identified areas of concern in relation to medicines and documentation.

Not all staff attended meetings or visited the office regularly. Recent changes with regards to how staff access and return documentation needed to be clarified.

There was a registered manager in place who was supported by a deputy manager and administration team.

The registered manager had an action plan which was in progress to continually develop and improve service provision.

Requires Improvement ●

Ashridge Community Care

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 which took place between the 8 and 15 February 2016. We visited the agency offices on the 8 and 9 February 2016. This was an announced inspection. This means the provider was given notice due to it being a domiciliary care provider and we needed to ensure someone was available to talk to us. The inspection involved visits to the agency's offices and telephone conversations with people and staff.

The last inspection took place in January 2014 where no concerns were identified.

Before the inspection we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports and any other information that has been shared with us.

Before the inspection, the provider completed a Provider Information return (PIR). A 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. We used the PIR to help us focus on specific areas of practice during the inspection.

Ashridge Community Care is a domiciliary care company owned by Pentlow Community Care Ltd. Ashridge provides privately or local authority funded care and support to older people in their homes in Bexhill and the surrounding area. Although separately registered with CQC, Ashridge Community Care is a small service integrated into the day to day running of Pentlow Community Care from the same office in Eastbourne.

People receiving care from Ashridge Community Care were able to tell us about their experiences. We looked at care documentation and daily records, risk assessments and associated daily records and charts for people. Medicine Administration Records (MAR) charts and medicine records were checked. We looked at supporting computer systems based at the office and read information completed by staff, policies and

procedures, accidents, incidents, quality assurance records, staff memos and meeting minutes. Recruitment files were reviewed for three staff and records of staff training, supervision and appraisals.

Ashridge Community Care currently provides personal care to two people. There was a small care team comprising of three care staff. We spoke to both people receiving care and support and received feedback from all three staff members. We also contacted health professionals who have contact with the service on a regular basis.

Is the service safe?

Our findings

People receiving care and support told us they found staff supportive and helpful. People knew when visits were due and this gave them peace of mind. People felt that the help and assistance they received enabled them to remain safe in their own homes. One person told us "I tell them what I need help with and they do it."

Despite this positive feedback we found that people receiving support with medicines did not always receive their medicines appropriately or in accordance with documented instructions. One person had a prescribed a pain relieving cream. The Medication Administration Record (MAR) chart in the persons home stated this was for application to one specific area of the body. However, we saw that over some considerable period of time daily records completed by staff clearly showed that this cream had been applied to a second area. There was no written information in the persons care folder or in the office to support this decision or to show that this had been done on the advice of the persons GP. Staff were also administering eye drops and providing eye care three times a day. This had been requested by the persons daughter, however, information in care files did not explain the reasons why this was being done, or any risks staff should be aware of in relation to this treatment. MAR charts had handwritten instructions to administer eye drops into both eyes, however no name or description of the eye drops was included and there was no information to show if this was a prescribed eye drop. This meant that people may receive medicines that had not been prescribed or may be unsuitable.

MAR charts had hand written entries which had been continued for over a month. This included information regarding new medicines and how these often these should be administered. However, this information had not been updated in the office to ensure that MAR charts were correct. Handwritten entries on MAR charts which remain unchecked could result in medicines being given incorrectly if information is not written clearly or correctly. Systems were in place to identify and review medicine practices, these included competency assessments, however, these areas of concern had not been identified to ensure people received their medicines safely and accurately as prescribed.

Information for one person stated that staff were prompting the person with regards to their medicines. However, MAR charts and daily records clearly showed that staff were administering medicines to this person on a regular basis. The manager and care coordinator told us that this varied from time to time; however, this information was not clear from the medicine documentation in place. This was updated during the inspection.

A full assessment was carried out before people began receiving support from care staff in their own homes. Risk assessments were in place for personal and environmental risks. These included information about how people mobilised for example whether they were independent or used walking aids. Environmental risk assessments identified, any aspect of the person's home which may present a hazard to them or staff. For example, safe access to the persons home. However, risk assessments were not in place for all person specific risks. For example, one person had a specific health condition. This meant that they may become unsteady and needed to walk with the use of a frame. Daily records clearly showed that this person's

condition fluctuated and there were times when they became quite unsteady and shaky. However, no specific guidance or risk assessment was seen to be in place in response to this. This meant that they may be at risk of receiving unsafe care.

All these issues meant that the provider had not ensured people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to help protect people from the risk of harm or abuse. The registered manager and staff were aware of the correct reporting procedure for any safeguarding concerns. A safeguarding policy was available for staff to access if needed. Staff had received safeguarding training and demonstrated a good knowledge around how to recognise and report concerns. There was a 24 hour on call system in place with a designated person available to be contacted by staff and to pick up any messages regarding peoples care. The 'on call' person had all emergency support and contact details for staff, people using the service and other emergency contacts in relation to people's safety and care needs.

The manager told us that there was an on-going recruitment programme; this included weekly recruiting advertisements, recruitment days and social media advertising. Care co-ordinators told us that when required, staff worked jointly across both agencies. All administration and management staff were able to provide care if required. The registered manager had a thorough recruitment system in place including an interview pack used during the recruitment process. Staff recruitment files showed relevant checks had been completed before staff began work. For example, disclosure and barring service (DBS) checks, a DBS check is completed before staff began work to help employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment and relevant references had been sought before staff were able to commence employment. Staffing levels were appropriate to ensure people received care visits at the designated times.

Staff had access to relevant and up to date information and policies, including whistleblowing and safeguarding. Policies were reviewed and updated when changes took place; this included the addition of new policies to incorporate recent changes to regulation and lone worker safety. Staff told us they knew where policies were stored and that they were informed during meetings and by memos when they needed to be aware of changes.

Incidents and accidents were reported and the registered manager had oversight of any incidents/ accidents or falls that had occurred, this meant that they were able to identify any themes in relation to incidents and respond appropriately. All incidents were logged onto the computer with actions taken for example, referral to district nurses, reported to local authority or no further action required.

Is the service effective?

Our findings

People told us that they felt staff had a good understanding of their needs and the support they required. People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when needed, this included GPs and district nurses. We were told, "If I need something from the GP they pick it up for me, or they ring to make me an appointment, they are happy to help."

The three staff currently employed by Ashridge Community Care had all worked for the service for some time. The manager told us when any new staff were recruited they were given a handbook. This contained relevant policies and procedures to ensure staff were aware of their role and responsibilities. An induction programme had been completed for all current staff this included mandatory training, observations and shadowing. Induction logs were completed with certificates in personal staff files showing training completed. The registered manager told us that any newly recruited staff would complete the new care standards certificate to support the induction process. The care certificate is a set of 15 standards that health and social care workers follow. It ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. A mandatory workbook training had been implemented to assess staff competencies.

Staff told us they received supervision. We saw that a programme was in place to ensure staff were regularly supported. Supervision and appraisals had taken place regularly and these were documented in staff files. Staff told us they felt supported. One told us, "There is always someone you can contact if you need support or help, someone gets back to you quickly I have never felt unsupported." And, "Yes we get supervision and we are kept informed of things by memos and meetings." Staff were in the process of being allocated email addresses and staff had been reminded over previous months to set these up to ensure that rotas, memos, care documentation and further information could be emailed to them on their work email system to improve communication.

There were systems in place to ensure staff received and attended training required. Mandatory training included key areas to ensure staff were adequately trained to meet people's care needs. All staff told us that they felt the training provided was appropriate and effective. All staff felt that their training needs were met; this included safeguarding and medicines training. The registered manager had completed external training to support them in their role. This included a level 5 in Adult Management Pathway in domiciliary care. All office and administration staff were also trained to provide personal care for people. This meant that they were able to support staff if needed and carry out visits to people to check that care was being provided to meet their needs.

The registered manager had a clear understanding of the Mental Capacity Act 2005 (MCA) and all staff demonstrated a good understanding around mental capacity and how this may affect people they provided care for. Staff were able to explain the process required if they felt that people were unable to make decisions to keep themselves safe and other professionals who would need to be involved in this situation. For example in a person became unwell and this affected their ability to make safe choices.

People said staff always asked for consent before providing any care. One told us, "They always ask me before they do anything." And, "I tell them what I want, they always listen to me." Initial assessments were completed before people started to receive care. During these assessments people's care needs and requirements were discussed. Each person had then signed to show they agreed and understood the care they would receive. When reviews or changes had occurred people had been asked to sign to show they consented to the changes.

People's health and wellbeing was monitored at each visit. Staff knew about people's day to day health needs and routines and how people liked their care provided. Some people required low level support to help them meet their nutritional needs. This included preparing and serving some meals. There was guidance in support plans informing staff of people's preferences. For example, one person liked cheese and biscuits left for them to eat when they were ready. Ashridge were not providing assistance for people with all their meals on a daily basis.

Is the service caring?

Our findings

People receiving care in their homes from Ashridge Community Care told us that staff were kind and caring. One person told us, "I have been receiving help for a few years, and the carers are always kind and helpful." And another told us, "I am more than happy with everything, they are always polite."

Staff told us that due to the small number of people receiving care they knew people very well. The same small core of staff provided care for people throughout the week. This only changed when a member of staff was on holiday or off sick. People told us that they received a list informing them who was going to visit them and what time they were due. People felt that staff respected their home and belongings when they visited people's homes to provide care. People were told each week who would be visiting them and were informed if this changed. They told us, "They are normally on time, but occasionally something happens at the last visit and they telephone to let me know they are on their way." And, "I know who is coming, and if it's not them the office rings me. Staff were aware of access information for people and any relevant access codes required.

Staff were able to tell us about people's likes, dislikes and routines. This meant that staff were able to ensure people had their care provided in a way that met their needs. Both people receiving care lived independently within their own home. Staff told us, "I enjoy my job, I feel privileged to be able to help people stay living in their own home. And, "Even if we are only popping in to do a few bits for people, if it means they can remain at home it makes all the difference." People felt that staff encouraged them to be involved in day to day choices and decisions. One person told us, "I choose what I am wearing,

A copy of people's care files were kept in their home, with another copy kept at the office with further information kept on the computer system. People were happy with the information stored in their homes and told us they had information on how to contact the service if they needed to. People felt involved in changes to their care and decisions made. If they wished to change a visit or cancel it, for example, they had another appointment to attend they were able to contact the office and arrange this. When people's care needs had increased we saw that this had been discussed with the person and applications made to the funding organisation if required to increase visit times. One person told us, "If I need anything different, like more help one day, or if I am tired staff are more than happy to help me."

The registered manager told us that the organisation had a policy not to provide designated care visits which were less than 30 minutes. When people required assistance with personal care, meals or other support this was not appropriate to be done in less than 30 minutes as this did not allow staff adequate time to provide care. Occasionally staff may be asked just to pop in to check on someone as an extra visit but rostered care visits were no less than 30 minutes. This meant that personal care could be provided in an unhurried manner which allowed people's dignity to be maintained and gave staff time to encourage and support people to remain as independent as possible.

Is the service responsive?

Our findings

People told us that staff knew them well and how they liked care to be provided. People were happy with the service as a whole and told us they had no concerns. People felt that staff listened to them and, "Knew how they liked things done," Staff told us they had got to know people's care and support needs, choices and preferences. Although care and support plans were in place these were not always up to date or completed accurately. For example, one person had information in their daily records regarding pressure area concerns. We saw that staff had documented that an item had been purchased for the person to treat this although the rationale behind this decision was unclear. There was no information in the persons care file to show if this concern had been reported to the appropriate health professional or whether the description of the pressure area was accurate. We saw further daily record entries documented by staff which showed that they were providing care in relation to this concern; however this information was not updated on the care plan. This meant that care being provided could be out of the scope of practice for the staff member for example a nursing need which should be referred to a district nurse or GP.

Another person's daily records highlighted a specific concern in relation to their health. Actions taken in response to this were not documented. We discussed this with the manager who was able to show us computer records which showed when care staff had contacted the office to raise concerns appropriately. However, designated communication sheets and other specified documentation which we were told by the registered manager should have been completed was not in place. This meant that it was not easy to identify follow up actions and how further assessment of people's needs had been identified. Staff told us, "There is very limited info about the client in their home, I sometimes feel it is out of date, but I've noticed more improvement here recently." Care records in people's homes were not accurate and up to date and current information did not tally with care files held at the office. Handwritten changes were seen in care files in people's homes, but it was not clear when these had been written. We recognised the service was small and therefore staff knew everybody well, however there was some reliance on verbal information when providing care. This put people at risk of receiving inappropriate care. We raised this with the registered manager during the inspection as an area for improvement.

Staff profiles were a new tool being used by the registered manager. These included information about the staff member what hobbies they had and any relevant background information. The registered manager told us that these would be useful to let people using the service know a little about the person coming into their home to assist them.

Staff told us they knew people well; however we found that documentation was not always updated promptly or revised care plans put in place in a timely manner. This meant that when care staff from the related service, Pentlow Community Care were covering annual leave or sickness, information may not be available in people's care folders to ensure care was provided in a safe consistent manner at all times. The manager told us that information in relation to wounds or injuries should be documented by staff on body maps. We saw that body maps in people's files were incomplete with entries not dated, information crossed out or additional issues added at a later date. This meant that information regarding people's current health and concerns were unclear. In daily records for both people we saw information regarding wounds and

areas of concern which did not have associated body maps in place. This included a foot wound which staff had documented as a possible pressure sore. It was unclear if the lack of up to date information documented in care files was due to up to date information not being collected from the office, or because staff were not aware of the correct documentation to complete.

People told us they received their visits at a time that suited them within reason, and they were aware that there were occasions when this would need to be flexible. When a change to visit times was requested this was considered and people were always informed if the timescale could be met or if they would need to arrange it slightly later or earlier due to high demand at specific times of the day.

People who used the service received a folder containing a copy of the statement of purpose which informed them what the service does and how it achieves this, pricing information if they are self-funded, along with details on how to make a complaint or contact the service.

A complaints policy and procedure were in place. The registered manager was able to evidence the process they would follow on receipt of any concerns or complaints. There were no current on-going complaints at the time of the inspection. People told us, "I ring the office if I need to, or staff do it for me, I have never had any concerns but if I did I would say so."

Is the service well-led?

Our findings

The registered manager had been in post for over a year. Administration staff told us they felt that the manager had made some very positive changes to the day to day running of the service. Care staff told us, "I get invited to staff meetings, however I have never been able to attend usually due to time constraints and distance. I would say we feel physically isolated from the wider team." Whilst another told us, "I feel fully supported, If I need anything I pop to the Eastbourne office. I have never had any problems, I feel well supported if I need anything." One staff member also told us they had not met the registered manager in person as they rarely visited the office where the manager was based.

All information including policies, procedures and computer records about people's care needs were stored at the Eastbourne office. It was noted that this was not the registered address for this service. We discussed this with the registered manager who told us that in relation to procedures, policies and practices, including staff training and support, Ashridge Community Care was integrated into the Pentlow Community Care service and as such staff were included in all staff meetings and training at the Eastbourne office. With regards to staff employment they were employed by Pentlow Community Care Limited and therefore were able to work across both services if required. However, for CQC registration and inspection processes Ashridge Community Care was a separate location registration and therefore all aspects of the service would be inspected as such.

Systems to return documentation to the office when they were removed from people's homes was not clear. Previously there had been a designated office space based within a nursing centre owned by the provider in Bexhill-on-Sea. This was no longer the case and staff told us that they did not visit the office on a regular basis. There was now a tray on the reception desk at the nursing centre. We saw that this tray was on the reception desk in the main entrance foyer. Information had been left in this tray and staff at the nursing home were unaware of this when we arrived to review it. Staff told us that information relating to people which needed to be returned to the office in this tray for collection and it was sometimes there for a number of days. This meant that information relating to people's care was left in an area that was accessed by the public throughout the day. This desk was not manned at all times. This was an area that needed to be improved. Staff also told us that the lack of a separate office meant that they had nowhere to store things safely, meet up if needed or access a computer. We discussed this with the registered manager who told us that there was a designated cupboard at the nursing centre for stores to replenish supplies and paperwork, although staff would be expected to inform the Eastbourne office when these supplies ran out and staff would be expected to attend the Eastbourne office for all other work related requirements. And weekly visits took place when a member of the administration team went to Bexhill to collect paperwork which needed to be returned to the office.

Two staff felt that communication could be improved as they felt that the lack of an office in Bexhill meant that they were not always kept up to date and updated documentation for people receiving care was delayed. We discussed this with the registered manager who was able to evidence that all staff were sent text alerts, memos and received regular spot checks in accordance with the organisations policies and procedures.

New channels of communication had been introduced to improve communication and help the two services work together. This included text alerts and information, weekly memos, a range of meetings, including care staff and team leader meetings. The team leader role was newly implemented, so a weekly review meeting took place in the form of a catch up to review whether this was proving successful and to iron out any minor issues. Team leaders also had allocated supernumery hours each week which would give them time to complete client reviews. On a daily basis there was a 9am meeting and an 11am 'on-call' feedback meeting at the office. A handover sheet was completed, this included details regarding any new people receiving care, new staff information, absences or sickness and any other relevant information for staff. This meeting was attended by the deputy manager or care co-ordinator. And a weekly office meeting took place every Thursday which was attended by all administration staff. Staff told us that they felt communication had improved over recent months.

The provider also gave staff the opportunity to feed back via staff questionnaires. This feedback was analysed in detail. Questions included feedback on working hours, future of the business, training opportunities, information about clients and whether staff felt praised, rewarded and informed about the future. Two questionnaires had been completed by staff and both were predominately positive. Care staff had spot checks completed whilst providing care in people's homes. Staff told us, "I have spot checks from team leaders at regular intervals, I find this helpful." People receiving care were also asked for their feedback and any changes they required were discussed at care reviews. For example, one person had required a longer visit when they had been unwell. Reviews of care meant that the registered manager had oversight of the service and regularly monitored the care delivery to ensure standards were maintained and care needs met.

The registered manager had a number of new pieces of documentation which they were in the process of integrating. They showed us new style support plans which were going to be used in the near future. The format for these was more person centred and included information about people and their lives. The registered manager had identified that current care folders lacked information about the person's background and needed to be more individualised. Hospital passports had recently been implemented. These were in place in the event that a person was admitted to hospital and included specific information about the person, their health needs, preferences, likes and dislikes.

There were systems in place to facilitate flexible hours for administration and care staff. We saw that staff were well supported when they had personal reasons meant they flexible working arrangements. Staff told us they felt valued as they received paid travel time between visits. This was calculated by a computer system which worked out distance between visits and the time this would take. Staff told us this worked well. On occasion when traffic was bad they contacted the office and the person expecting a call was contacted, but this did not happen very often.

The service prided itself on good community links. The registered manager attended regular management meetings, and had participated in media discussion around the provision of domiciliary care. Pentlow Community Care Ltd had an annual nominated charity and carried out fund raising events to raise money throughout the year.

There were system in place to assess and monitor the service provided. We saw that care reviews and audits had been completed, however, not all issues found during the inspection had been identified during audits. This included medicines and documentation.

The registered manager had written a detailed action plan of areas they had identified which they wished to change or improve. We saw that a number of these areas had been completed and others were on-going.

The registered manager had a clear direction for the service to take it forward and continually improve over the next 12 months.

Policies and procedures were available for staff to support practice. And were in the process of being updated and reviewed if required. Staff were aware of the policies and were aware that these underpinned safe practice. Policies and changes to procedure were discussed during supervision and at meetings to ensure everyone was aware if changes occurred. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice. The registered manager had a good understanding around 'duty of candour' and the importance of being open and transparent and involving people when things happened. Information was seen displayed for staff around safeguarding and their responsibilities. We saw that a newly devised lone working policy was in place. This meant that staff had access to relevant documentation to support them in their role. The registered manager told us that they were always keen to learn from incidents to improve future practice.

The registered manager had completed the Provider Information Return (PIR) and had provided us with detailed information about how they had made improvements and planned to take the service forward over the following twelve months.

Staff supervisions and appraisals were monitored and recorded. Systems were in place to review staff sickness. Staff disciplinary procedures were clear and when required these had been followed to address any concerns regarding staff practice.

All of the registration requirements were met and there were clear processes in place to ensure notifications were sent to us and other outside agencies when required.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way. The provider had not ensured people received safe care and treatment in relation to medicines. Regulation 12 (1)(2)(a)(b)(g)