Nestor Primecare Services Limited

Allied Healthcare Sutton

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

This inspection took place on 20 July 2016 and was announced. We gave the registered manager 48 hours' notice to give them time to become available for the inspection. This is the first inspection of this service since it was registered in November 2014.

Allied Healthcare Sutton provides personal care and support to people living in their own homes. At the time of our visit there were approximately 250 people using the service. The service had a registered manager in post. 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 had individual risk assessments and risk management plans to help staff keep them safe but some of these were not detailed and were missing key information about risks such as choking. In these cases, staff did not have the information they needed to keep people safe from foreseeable harm.

Medicines were not always managed safely. There were no clear instructions for when staff should administer some medicines prescribed to be taken only as required. Medicines that were prescribed to be taken no more than every four hours were given more frequently, which can be dangerous. Medicines administration records were incomplete or unclear in several cases, which meant we could not always be sure people were receiving their medicines and that there was a risk that others involved in people's care did not have the information they needed about what medicines people received and when.

People told us they felt safe using the service. The service had safeguarding policies and procedures in place and staff were aware of these. This meant staff were able to recognise and report signs that people were being abused or mistreated. Record showed that the provider took prompt action to address any safeguarding concerns that were raised.

The registered manager had taken action to address problems with staffing. This included recruiting new staff and assigning supervisors to monitor staffing levels more closely. This meant there were enough staff to cover all visits and keep people safe. The provider vetted new staff thoroughly to ensure they did not recruit staff known to be unsuitable or unsafe.

There were appropriate policies and procedures in place to keep people safe from the risk of infection and staff were aware of these.

Staff had the skills and knowledge to carry out their roles effectively because they received training, supervision and guidance about best practice in caring for people. The provider used several methods of sharing this knowledge with staff on a regular basis. Staff were able to access extra support if they needed it.

The provider adhered to appropriate legislation and guidance to ensure people only received care they had consented to or, if they did not have the mental capacity to consent, decisions about their care were made in their best interests.

Staff were aware of the importance of ensuring people had enough to eat and drink. The provider carried out assessments of people's risk of becoming malnourished, but did not always follow up where a high risk was indicated. We recommend that the provider seeks advice on current best practice around meeting people's nutritional needs in domiciliary care.

People told us staff were friendly and caring. Staff took time to get to know people and their individual communication styles to enable communication and help people feel at ease with them. People and their relatives were involved in care planning and some people's preferences and what was important to them was included in their care plans. However, this was not consistent as other care plans were based on completing tasks and did not contain this information. We recommend that the provider consider the use of current best practice guidance around the use of life histories in person-centred care planning.

Each person had a care plan but these were not always sufficiently personalised to ensure the service was responsive to their individual needs. Some assessments, such as those around continence, allergies and the use of bed rails, were not completed when they were relevant to people so there was a risk that people's needs were not met in these areas. Some assessments and care plans were not updated to reflect changes to people's care and this meant there was a risk that people were not consistently cared for in a way that reflected their current needs.

People's care plans were designed to meet their emotional, social and cultural needs. There was information about how staff should support people to remain in contact with loved ones or to access the local community.

People were aware of how to complain and told us the provider regularly contacted them to check they were happy with the service. There was a robust complaints policy that helped to ensured the provider responded promptly to complaints and concerns that were raised.

We found that the provider was not submitting notifications about certain events that happen within the service and which they are required by law to tell us about.

People were not sure who the manager was, but the manager was aware of this and was working on an introductory letter to send people. People were familiar with office-based staff and spoke positively about them. People, relatives and staff fed back that the service had an open and supportive culture with a clear vision and values.

The provider used feedback from people, their relatives and staff to help them assess and monitor the quality of the service. Where they identified improvements to be made, they put action plans in place and discussed these with staff so they were aware of the changes that needed to be made and how the service was progressing. The provider carried out a number of spot checks and audits to check that care was being delivered to a high standard. However, these were not always effective as they had not identified the issues that we found during our inspection.

During the inspection we found breaches of regulations in respect of sending statutory notifications to the CQC, ensuring the safe care and treatment of people, making sure people received personalised care and good governance. You can see what action we told the provider to take at the back of the full version of the

report. Full information about CQC's regulatory response to the breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 which we found during the inspection is added to the report after any representations and appeals have been concluded.

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. Some risk assessments did not cover key risk areas.

Medicines were not managed safely. People did not always receive their medicines as prescribed and recording of medicines was not always clear or complete.

People felt safe using the service and there were robust safeguarding procedures in place. There were enough suitable staff to care for people safely.

People were protected from the risk of infection because staff followed policies appropriately.

Is the service effective?

Good

The service was effective. Staff were supported with a range of training, supervision and good practice information to enable them to carry out their roles effectively.

The provider adhered to relevant legislation to ensure that people only received care they had consented to or that was in their best interests.

The provider assessed people's nutritional needs and staff made sure people had enough to drink.

Is the service caring?

Good

The service was caring. People said that staff were kind and caring. Staff knew about the importance of using different communication styles that were right for each person.

Staff helped people make decisions about their care on a day to day basis.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not always sufficiently personalised to ensure their individual needs were met and some assessments were missing or out of date.

Care plans considered people's emotional, social and cultural needs.

People knew how to complain and the provider responded appropriately to concerns and complaints that were raised.

Is the service well-led?

Requires Improvement

The service was not always well-led. There was a range of audits and checks but these did not effectively address the problems we found with care plans and medicines management. The provider did not submit notifications that they must send to us by law.

The service had an open and supportive culture with a clear vision and values. People, relatives and staff were comfortable expressing their views and the provider sought feedback from them regularly to help them improve the service.

Allied Healthcare Sutton

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.

The inspection took place on 20 July 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure there would be someone available at the office.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who carried out this inspection had experience in using services for older people and caring for family members living with dementia.

Before the inspection, we reviewed information we held about the service. This included questionnaires received from people using the service and healthcare professionals, notifications about events the provider is required by law to tell us about, feedback submitted via our website and a provider information return (PIR). The PIR is a document we ask providers to submit before our inspection about how they are meeting the requirements of the five key questions and what improvements they intend to make.

During the inspection, we spoke with 10 people who used the service, two relatives of people who used the service and five members of staff. We looked at care records, including care plans and medicines records, for 10 people who used the service. We also examined five staff files and other records relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "I feel very secure with [the member of staff who supports me]." Another person told us they would call the office if they felt unsafe, but they had never needed to do this. A third person told us senior staff had come to visit them to make sure they felt safe using the service.

People had risk assessments, which covered risks specific to them. Some assessments we saw outlined people's individual risk levels and what was in place to reduce these, such as pressure relieving cushions for people at risk of developing pressure ulcers. The falls assessments included a separate assessment of the safety of the person's home environment. This helped to ensure that people and staff remained safe in people's homes. Where people required assistance with mobilising, there was a moving and handling assessment including information about what support was needed, how many staff and the equipment that was required for each task.

However, information about risks was sometimes missing. For example, one person had a breathing assessment, which indicated some actions staff should take to help prevent the person having an asthma attack but not what to do if they did. One person was recorded as having diabetes but there was no information about warning signs that the person's blood sugar was too high or low or what staff should do if this was the case. Another person, who had a history of frequent seizures, did not have a choking risk assessment. There was no information about how staff should respond if the person experienced a seizure while eating, which could lead to the person choking on food or drink, although there was more general information in their care plan about the warning signs that they were going to have a seizure and what staff should do. A fourth person had been diagnosed with swallowing problems and a speech and language therapist had recommended thickened fluids, mashed foods and for staff to check the person's mouth after eating. This information had not been incorporated into the person's care plan and they did not have a choking risk assessment, meaning staff may not have been fully aware of these risks and how to reduce them. Care records showed that staff gave the person food that was inconsistent with the recommendations, such as firm-textured cakes.

People had assessments of their risk of developing pressure ulcers, but these did not include information about how often they should be reviewed. One person had been identified as being at high risk three months before our visit and another person, who had a history of pressure ulcers, had been identified as being at high risk in February 2015 but there was no information about how often this needed to be reassessed. This meant there was a risk that people's care did not always reflect their changing needs. For example, if risk levels rise over time people may need extra support to stay safe, or if risk levels fall people may be able to stay safe with less restrictive care.

Staff did not always record in people's medicine administration record (MAR) charts when they gave medicines. There were MAR audits on file and these covered the information that should be present on the charts. One person's care records included a statement staff had written that there was no MAR chart available, but they had not added details of whether or how they had recorded the administration of the

person's medicines. This person's MAR chart from two months later also had gaps on three days where no administration of medicines had been recorded and there was no explanation for this. A third person's chart contained no record of whether they had received their medicines on five out of eight days and there was no explanation given for these gaps. The lack of clear records meant we could not be sure that people were receiving their medicines as prescribed. There was also a risk that other providers involved in people's care, such as doctors and ambulance staff, would not be able to confirm what medicines people had taken and when if they needed to do so.

Although people told us they were happy with how staff managed their medicines, this was not always done safely. One person's care records showed that they had a medicine to take only when required. However, there were no instructions for staff about when this should be given. We looked at the person's MAR charts and found that staff appeared to be giving the person this medicine twice every day. However, it was not clear whether this was the case because dates were not always written clearly, the chart skipped two weeks' worth of records and on five out of seven rows of administration records there were no details about which medicine was being given as the chart included records for two different medicines. We also noticed that the person was not receiving one medicine in accordance with the pharmacist's instructions. The medicine was prescribed to be taken no more than once every four hours, in line with national medicines guidance. However, according to the records, the person frequently received the medicine less than four hours after the previous dose and sometimes as little as three hours passed between doses. This can be dangerous and demonstrated that people did not always receive their medicines as prescribed.

The above issues indicated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at safeguarding records and saw that the provider had appropriately documented concerning information about alleged abuse and neglect and this was reported to the relevant authorities. Investigations took place in a timely manner in line with the provider's safeguarding policy. We saw evidence that whistleblowing was discussed at a recent staff meeting to make sure staff were aware of their duties and how to report any potentially abusive behaviour from other staff. Staff we spoke with knew about the different types of abuse, their signs and how to report them. Staff had a handbook containing information about keeping people safe. This included the safeguarding and whistleblowing procedures, dealing with emergencies and safe medicines management. Staff were able to give examples of how they would respond in an emergency, such as a fire in someone's home or a person collapsing. They also knew when they needed to report potential safety hazards to the agency office to protect people and staff from harm.

People told us staff were "regular and reliable" and they had no concerns about staff being late or not carrying out visits. Three members of staff told us they felt staffing levels could be improved, however. We discussed with the registered manager a number of comments we had received before the inspection from people who used the service about unreliable and late staff. The manager was aware of these concerns and told us about action they had taken to address them, including reallocating responsibilities for senior staff to cover visits to people when staff were absent, and recruiting new staff. There was a system that staff used to "log in" when they reached a person's home. The system raised an alert if a member of staff did not log in so office staff were aware of any missed calls and were able to take prompt action.

We looked at the provider's recruitment processes and saw how they used application forms, interviews, fitness checks and probationary periods to make sure staff were suitable to carry out their roles. There was a compliance checklist to ensure that all staff supplied documentation required by law before they were allowed to start work. We checked five staff files and found all the required information was present. This helped protect people from the risks of being cared for by unsafe or unsuitable staff.

Staff told us people's care files were colour coded according to how much support they needed with their medicines, so for example if they saw a red file in a person's home they knew they needed to administer medicines and complete MAR charts. Staff we spoke with said they had regular training on administering medicines.

People we spoke with were satisfied with the standards of hygiene and cleanliness demonstrated by staff. Staff followed a personal protective equipment (PPE) policy which stated that staff needed to wear PPE when supporting people with personal care to reduce the risk of infection spreading. Staff told us what PPE they used, such as gloves and aprons, and this was in line with policy.

The service had infection control policies and procedures for staff to follow to help them work safely and reduce the risk of people becoming exposed to potential sources of infection, including sharps and other hazards. Staff we spoke with understood these and gave examples of precautions they took to protect people from the risk of infection. We saw evidence that supervisors checked that staff were complying with these policies and where they were not, they reminded staff of the correct procedures and monitored compliance.

Good

Is the service effective?

Our findings

People told us staff were able to do all the tasks they were assigned. One person told us, "My carer helps me lead my life." Staff we spoke with were satisfied that they had the knowledge and skills they needed to care for people and that the training they received was of good quality. We spoke with a member of staff whose role was to provide training to care staff. They told us about the different training methods used by this service, including coaching, support networks and classroom-based training. They gave examples of specialist training they provided for specific health and care needs such as diabetes and epilepsy. The registered manager told us that where people had such specific care needs, staff who had been trained to care for people with that condition were assigned to them.

We saw evidence that the provider shared current research and best practice with staff through meetings. At recent branch meetings, the team had discussed deafness and hearing loss, allergies and allergic reactions, dementia and various health conditions staff might come across in their work. The registered manager told us supervisors tested the knowledge of staff by asking questions at spot checks. Staff told us they also received reminders via text message, for example if it was a hot day they would be reminded to make sure people had plenty to drink. The trainer told us about their own training updates, conventions they attended and Care Certificate standards they adhered to in order to ensure the training provided was up to date with current best practice guidance.

Senior staff told us that care staff had two spot checks, one office supervision session and one annual appraisal per year. Aside from this three-monthly structured support, staff told us they were able to access informal support whenever they needed to by contacting the office to speak to a supervisor or the registered manager. Staff records we saw confirmed that staff received regular supervision and support.

People told us staff obtained their consent before carrying out care tasks. We saw that people or their family members had signed a form to declare they consented to staff carrying out the care that had been planned.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The provider had gathered information to help ensure that people's care would be in line with their wishes should they lose the capacity to consent. Where people had advance directives or had assigned power of attorney, there was information about this on file. An advance directive is a decision that a person can make in advance to refuse certain treatment at a point in the future when they may not have the capacity to make that decision. Where people did not have the capacity to consent at the point of using the service, the provider gathered information from family members and appropriate health and care professionals who knew them well, so that they did all that was reasonably practicable to ensure decisions about people's care were made in their best interests.

Each person's initial assessment included a screening tool to assess their risk of becoming malnourished. However, where a high risk was indicated, we did not see evidence that this was followed up appropriately. One person's assessment in March 2016 and another person's in February 2015 stated they were at high risk. According to the assessments, this should have triggered a letter to each person's GP but we saw no evidence of this, repeat assessments or details of food preferences to help encourage these people to eat enough. This meant the provider could not be sure the risk of malnutrition was being appropriately managed.

Care plans contained information about how to support people with their meals, for example by offering choices. We saw one person had seen a dietitian and their recommendations were included in the care plan to help ensure staff supported them to eat suitable food for their needs. Staff were aware of the importance of making sure people had access to adequate fluids, especially in hot weather.

We recommend that the provider seek advice on current best practice around meeting people's nutritional needs in domiciliary care.

Good

Is the service caring?

Our findings

People we spoke with commented positively about the caring nature of staff and told us they got on well with them. One person said their regular member of staff was a "very caring person" and another person told us the staff were "really friendly people."

Staff told us they encouraged people to talk about themselves and their interests, or they spoke to people about things they were interested in if they were not able to communicate verbally, to help them build up positive relationships. They described different ways of communicating with people non-verbally according to their needs. Examples given included a person who relied heavily on eye contact, aperson who liked to have in-depth conversations and another person for whom touch was an important part of communication. The fact that staff were aware of these diverse communication needs showed that they took time to get to know people and build relationships with them.

We saw evidence that the service was starting to send birthday cards to people who used the service. This was to help people feel valued and important.

People told us staff supported them in a way that enabled them to remain as independent as possible. Care plans contained information about people's strengths and what they could do for themselves. This helped ensure that staff allowed people the level of independence that was right for them. Staff demonstrated an awareness of the importance of keeping people informed about their care and giving them options such as food and clothing choices. They told us that because everyone was an individual they should be treated as such, because everyone has different needs and preferences.

We saw evidence that staff had discussed privacy, dignity and choice and how to promote these at a recent staff meeting. Staff gave examples of how they did this, for example by telling people what they were about to do and making sure people's bodies were covered as much as possible when supporting them with personal care. Staff received training that covered promoting people's privacy and dignity and supporting them as individuals.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan that was completed after an initial assessment. The assessment was designed to highlight the needs for any further assessments. We found that some of these were not complete. For example, one person's initial assessment showed that they needed further assessments around communication, memory and the use of bed rails but these had not been completed. Because the initial assessment identified these needs but the provider had not followed them up, there was a risk that people's needs were not being met.

The provider had a set format for care plans, which was designed to ensure that all the necessary information was included. However, this format meant that care plans were sometimes not appropriately personalised to take people's individual needs into account. For example, records staff made of the tasks they completed for one person showed that staff regularly assisted them with catheter care but their care plan did not mention use of a catheter and there was no continence assessment. Although the person's care plan stated that they only needed their incontinence pads changed at night, care records showed that staff changed the pads in the morning and throughout the day. This meant there was a risk that staff were not supporting them in a way that consistently met their needs as the person's needs in this area were not clear. This would be especially risky if staff who were not familiar with the person visited them.

Another person's personal information stated that they had a food allergy. However, the member of staff completing their assessment had ticked "no" to answer the question of whether the person had any allergies and an allergy assessment was not completed as a result of this. There was a risk that this contradictory information could lead to the person being cared for either unsafely or more restrictively than necessary depending on which statement was correct.

One person's relative told us they were involved in care planning because a member of staff had visited to discuss their relative's care plan in detail. We saw evidence of this in some people's care plans, which contained information about people's preferences, such as preferred washing routines, and what was important to them including outcomes they wished to achieve. However, this was not consistent as the information was absent in other people's care plans, which were based on tasks rather than people's preferences, and so there was a risk that these people were not supported in line with their preferences. We did not see information about people's interests and life history, which are important for staff to know about when planning care that suits people's individual personalities and preferences. Staff told us it was sometimes difficult to get information about people's interests, life histories and preferences especially if they did not communicate verbally but they got to know the person and how they preferred to be cared for over time. The care plans we saw had not been updated to reflect this, however.

There was not always evidence that care plans were regularly reviewed and up to date. Two care plans we looked at had not been updated for over a year. One person had an infection control assessment dated January 2014 that stated they had high needs in this area due to incontinence and a history of urinary tract infections, but there was no review to ensure the information was up to date. The same person had a moving and handling assessment dated January 2014, which stated that the person did not require support

from staff in this area. We saw evidence that the provider had carried out a "quality review" in October 2014 and had noted that new moving and handling equipment was in place after an assessment by an occupational therapist and that staff had been instructed how to use this. However, the care plan was not updated to reflect these changes. Because the care plan was not updated immediately after this significant change to the way the person was cared for, there was a risk that they were not being consistently supported in a safe way that met their needs.

The above issues indicated a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans took into account their emotional and social wellbeing and how staff should support them to promote their wellbeing and protect them from social isolation. For example, one person's care plan stated that they needed regular contact with their family and to watch TV channels in their native language. Another person's care plan set out how staff should support them to access their local community and attend activities outside their home.

The provider worked to match staff with people in a way that met their needs, for example with regard to language and culture. One person told us they had expressed a preference to be supported by male staff and the agency had fulfilled this request. The provider employed staff from a wide range of different backgrounds and staff told us this helped them to meet the diverse needs of people who used the service.

One person told us, "Every three months or so the Agency contact me to ask if I'm content and if there is anything they can help me with. They are really friendly people." We saw evidence that people and their relatives had completed questionnaires about the quality of care and feedback was positive. However, for two people whose records we checked there was no evidence of these being carried out within the last three years.

People we spoke with knew how to make a complaint but had not needed to do so. People told us any concerns they raised were dealt with to their satisfaction. Staff were familiar with the complaints policy and when to direct people to it.

The registered manager told us they analysed feedback from surveys and used it to learn from people's concerns. For example, if people regularly fed back that staff were arriving late for visits, they assigned a field supervisor to monitor staff timekeeping and establish whether the lateness was because of poor timekeeping or unmanageable rotas. We saw the system they used to ensure that each complaint, concern or incident was assigned to a specific person to deal with and they entered information about what the service had learned from the complaint and how it was resolved to the person's satisfaction. Dates on these records showed that the provider responded to complaints within the timescale given in their complaints policy.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with said they did not know who the manager was. They said that although their relationship with care staff was open and supportive, the provider or manager had not asked for their feedback about the service. However, people also told us that they occasionally spoke with office-based and administrative staff and spoke positively about their interactions with these staff. The registered manager told us they were aware that people did not necessarily know who they were and that they were preparing a letter to send to each person using the service to explain who they were, including a photograph.

We found that the provider did not send us the notifications they are required by law to send to us about abuse or allegations of abuse of people who are using the service. Since the service was registered, we had received no abuse notifications but the manager confirmed that several allegations of abuse were received by the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw evidence that the provider audited people's care records and noted issues of concern. However, they were not very effective as they had not identified several of the issues we found so these could be rectified. For example, where information was missing from care plans and records, and these had not been updated with comprehensive information about risk assessments and management plans.

Although the provider carried out audits of people's medicines records and these identified some of the problems we found, the audits were not fully effective as we found a number of inadequacies that had not been identified by audits. We saw evidence that staff had received training and competency assessments in this area. Managers had discussed the correct completion of MARs with staff in a team meeting and fed back that this had improved, but the records we found about MARs that were not correctly completed had been made after the date of that meeting and the competency assessments we saw. The provider had not identified why staff were still not completing records correctly despite the action they had taken to improve this.

This above shows that the provider's quality assurance systems were not very effective in bringing improvements at the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were able to speak up about any concerns they had and that all staff were treated equally. One member of staff told us about a problem they had reported to the manager and the action the manager was taking in response. Another member of staff said the manager had introduced a comment box so that comments could also be made anonymously. In general, staff said managers were approachable and we saw evidence that staff were able to raise concerns at meetings. This helped to promote a positive culture within the service.

Staff were able to describe the vision and values of the service and told us these came through clearly in training and discussions within the service. They included promoting dignity and respecting people.

The service had a leadership structure with clear lines of accountability. The registered manager had recently put in place a system in which field care supervisors were allocated to staff and people using the service on a geographical basis. They told us this helped the service to cover visits to people when staff were absent and enabled senior staff to keep track of staff performance and the quality of the care people received.

We saw the results of a staff survey the provider had carried out at this location and other local branches of the agency. Responses were positive and staff fed back that they received adequate training and support to do their jobs well. They understood the vision and values of the service and more than half believed that the provider would take action as a result of feedback from the survey. Other aspects of leadership the provider asked staff about included communication, management of change, continuous improvement, support from managers and integrity shown by managers and leadership. All of these received more than 50 per cent positive responses from staff.

The service had action plans in place for improving the quality of the service. Managers discussed these with staff at team meetings, including the progress they had made and what staff needed to do differently. Although we had received some negative comments and concerns about the service before our inspection, the registered manager was aware of these concerns and had plans to make improvements in these areas.

The service had meetings where the registered manager discussed with staff areas of good practice such as thorough record keeping. The registered manager told us there were audits of care notes and medicine records every three months. We saw evidence that the provider adhered to a disciplinary procedure where staff were not performing to an appropriate standard to help ensure that people were cared for by appropriate staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that the care and treatment of service users met their needs and reflected their preferences. They did not fully assess people's needs and design care and treatment in a way that met these needs and reflected people's preferences. Regulation 9(1)(b)(c)(3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always provide care and treatment in a safe way. They did not ensure that risks to the health and safety of service users were assessed and that they did all that was reasonably practicable to mitigate such risks. The provider did not ensure medicines were managed safely. Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not effectively operate systems to assess, monitor and improve the quality of the service. Regulation 17(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of any abuse or allegation of abuse in relation to a service user. Regulation 18 (1)(2)(e)

The enforcement action we took:

Warning notice