Care Outlook Ltd

# Care Outlook (West London)

**Inspection report**

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## 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? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

We undertook an announced inspection of Care Outlook (West London) on 16, 17 and 23 June 2015. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

Care Outlook (West London) provides a range of services to people in their own home including personal care. At the time of our inspection 400 people were receiving personal care in their home. The care had either been funded by their local authority or they were paying for their own care.

The provider met all of the regulations we inspected against at our last inspection on 24 July 2013.

We spoke with the people using the service, relatives and care workers to obtain feedback about the service provided.

# Summary of findings

The service had a registered manager. 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 and associated Regulations about how the service is run.

Care workers had not received training identified by the provider as mandatory to ensure they were providing appropriate and effective care for people using the service. Also care workers had not received an annual appraisal.

A process was in place to record accidents and incidents but the care workers were not following the procedure. Care workers were not completing the record and identifying any actions taken.

General risk assessments were carried out but care workers were not provided with information on the possible risks relating to specific medical conditions.

Support plans were task focused and some plans did not refer to the person receiving care by name. We saw the support plans were up to date and people had been involved in their development and review.

Staff received training in the safe administration of medicines but records were not always completed as required by the provider. We have made a recommendation in relation to the recording of medicines.

People using the service and relatives we spoke with told us they felt safe when care was provided by staff in their home. The provider had policies and procedures in place to respond to any concerns raised relating to the care provided.

The provider had an effective recruitment process in place and the number of care workers required for a visit was based on an assessment of a person's needs.

People using the service and relative gave mixed feedback relating to the punctuality of care workers.

People we spoke with felt the care workers were caring, called them by their preferred name and treated them with dignity and respect while providing care.

The provider had systems in place to monitor the quality of the care provided and these provided appropriate information to identify issues with the quality of the service but some audits had not been completed during the previous year.

We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to identifying risk and staff training. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Some aspects of the service were safe. The provider has a process in place for the recording of incidents and accidents but the staff did not comply with it. Staff were not provided with information relating to specific risks.

Processes were in place for the recording of medicines but some staff did not always follow them.

People using the service and their relatives felt safe when care was being provided in their homes.

**Requires improvement**

**Is the service effective?**

Some aspects of the service were not effective. Care workers had not received the necessary training they required or appraisals to deliver care safely and to an appropriate standard.

People using the service and relatives gave mixed feedback relating to the punctuality of care workers.

**Requires improvement**

**Is the service caring?**

The service was caring. People we spoke with felt the care workers were caring, called them by their preferred name and treated them with dignity and respect while providing care.

People using the service spoke positively about their care workers and that they were aware of their care and support needs.

**Good**

**Is the service responsive?**

Some aspects of the service were not responsive. The support plans were up to date but were focused on the care tasks and not the person receiving the care.

Initial assessments were carried out before support began to ensure the service could provide appropriate support. Care workers completed a record of the care provided after each visit.

**Requires improvement**

**Is the service well-led?**

Some aspects of the service were not well-led. People gave mixed feedback in relation to the administration of the service. Some people had a positive experience when communicating with the provider while other people gave negative feedback.

The provider had a range of audits in place but some had not been carried out regularly.

**Requires improvement**

# Care Outlook (West London)

**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 was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service for people in their own homes and staff might be out visiting them so we needed to be sure that they would be in.

One inspector undertook the inspection. An expert by experience carried out interviews with people using the service and their relatives. 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 had expertise in relation to home care services for older people.

During our inspection we went to the office of the service and spoke to the registered manager and the recruitment manager.

We reviewed the support plans for 18 people using the service, the employment folders for 12 care workers, the training and supervision records for all 161 care workers employed and records relating to the management of the service. After the inspection visit we undertook phone calls to 12 people who use the service, eight relatives and received feedback via email from three members of staff.

Requires improvement

# Is the service safe?

## Our findings

The provider had a procedure in place for recording incidents and accidents but staff were not always following this. The director of operations explained that care workers should complete a form if an accident or incident should occur. An outcome form should also be completed indicating what action had been taken by the care worker or manager and if the support plan had been updated.

During the inspection we looked at 16 records for incidents and accidents that had occurred during 2015. We saw eight incident and accident forms had been completed in full. The remaining eight records we looked at included five records which consisted of a copy of an email. These provided brief details of the incident and identified that further action should be taken. In one case this stated the incident should be referred to social services due to an injury but there was no record that this had occurred. We saw an outcome form had been completed for another incident but an incident and accident form had not been completed. This meant that the outcome had been recorded for an incident but why those actions were required was not identified. The other records we saw had not been completed with the information required by the providers reporting process. This meant that the provider was unable to ensure appropriate actions were taken in response to an incident or accident to reduce the risk of it happening again.

Staff were not given guidance on how to safely and appropriately reduce any identified risks in relation to the person receiving care. We saw a general risk assessment was carried out during the initial needs assessment that was reviewed annually and these were up to date. This risk assessment included electrical and gas equipment, medication storage, access to the person's home and the safety of the care worker accessing and providing care in the property. There was also a section that identified any issues related to the person receiving care which included if the person had a physical disability, any medical conditions, whether they required assistance with personal care and if the person had any continence problems.

We saw that the support plans and the general risk assessments identified specific issues in relation to the person's medical or support needs but no separate assessments were carried out. Guidance was not provided for care workers on how to reduce possible risk and respond to these issues. The range of issues identified included epilepsy, diabetes, increased risk of pressure ulcers due to mobility and continence issues and use of oxygen. This meant that care workers were not provided with appropriate information on how to reduce possible risks in relation to specific health conditions.

The above paragraphs demonstrate a breach of Regulation 17 (2) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nine of the people using the service or relatives we spoke with confirmed the care worker administered their medicines and one other person was supported in catheter care. We received mixed comments from people regarding the medicines support which care worker provided. People using the service mostly felt that this was going well. A relative said "It was mainly set up for the medication, and it works. They remember to come earlier when my relative is going to the day centre." Another person told us 'The care worker gets my tablets and does my eye drops for me." Another said, "They do the tablets, but not the morphine ones. I do those.' A person using the service who used oxygen said that they helped with it if they needed them to. One person did tell us 'Sometimes at weekends, they are too late for the medication'. The director of operations explained that all care workers received training on the administration of medicines as part of their induction. The support plans indicated if the care worker should prompt, support or administer the person's medicines or if the person self-administered their own medicines.

Although systems were in place to manage medicines safely, some staff did not follow these systems and processes and did not complete records appropriately. We saw medicine monitoring audits completed during March and April 2015 for 10 people that indicated issues has been identified in medicines administration records (MAR) charts for four people. We looked at the related monthly MAR charts for these four people who had between two and four visits per day. We saw care staff had not signed off the administration of medicines during four visits on two charts, five visits on one chart and seven visits on the final MAR chart we looked at. We saw that the care workers had recorded the administration of the medicines in the daily record for each of the visits that had not been confirmed on the MAR chart. The operations director explained that these staff had been transferred from other providers with

# Is the service safe?

different recording systems for medicines. We saw that these care workers had received additional guidance on the recording system and further monitoring checks had been completed that did not indicate any further errors.

All the people using the service we spoke with said that they felt safe when their care workers were in their home, and all also felt that the carers respected their homes and personal property. All the relatives we spoke with also agreed that they felt that their relatives were safe with the care workers. One relative said "Absolutely. We hear all the bad press, but there's nothing like that." Another relative told us they had experienced some problems with the care provided when they started to receive care from the provider but this was all resolved and they felt their relative was now safe. One person using the service had also experienced issues with their care but this had been resolved "All my ladies now make me feel quite safe." Another person said "Safe? Oh God, yes." Another relative explained, "She's safe with them, yes, it's when she is on her own that I worry." Another person using the service "Of course I feel safe, or I wouldn't have them in the house!" We saw the service had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. There were policies on safeguarding vulnerable adults which identified the responsibilities of managers and support workers. There was also a whistleblowing policy and procedure. The director of operations explained that care workers completed training on safeguarding vulnerable adults as part of their induction. We saw information relating to safeguarding concerns was kept in a folder with all related correspondence and the outcome of any investigation was recorded.

The director of operations explained that the number of care workers required for each visit was based upon the person's care needs that were identified during the initial assessments and in discussions with the local authority, the person and their relatives. Care workers were allocated based on their skill set, location and any preferences identified by the person using the service for example gender or language.

We found that the provider had an effective recruitment process in place. The recruitment manager explained that before a person was invited to interview they would discuss the role with them over the telephone and their previous experience, where they lived and their right to work. Before an interview the person would complete an application form and pre interview questions related to the role. As part of the recruitment process two references were requested and an interview was conducted with the prospective staff member. New staff could not start their role until a check to see if they had a criminal records had been received. In the staff folders we looked at we saw that the provider had received two suitable references for each member of staff, the references had been verified by telephone, notes had been taken during the interview and a check for any criminal records had been completed. This meant that checks were carried out on new staff to ensure they had the appropriate skills to provide the care required by the people using the service.

**We recommend that the service reviews the medicines recording system currently in place.**

Requires improvement

# Is the service effective?

## Our findings

We saw people were being cared for by staff that had not received the necessary training to deliver care safely or to an appropriate standard. The provider had identified four training courses they felt were mandatory for staff to complete so they provided safe and appropriate care. Three of the courses were safeguarding vulnerable adults, moving and handling and medicines management with care staff required to complete a refresher course every two years. The fourth course was first aid with staff completing a refresher course every three years. The director of operations provided a spread sheet identifying the training records for all 161 care workers. We saw that 40 care workers had been employed by the service long enough to be required to complete the mandatory refresher courses. 40 care workers had not completed the refresher course for safeguarding vulnerable adults of which five staff had not completed the course since 2011. We saw 36 care workers had not completed the refresher training for moving and handling including five people since their induction in 2011. There were 16 care workers who had not completed the medicines management refresher course with a further four staff who had not completed the course since 2011. We saw 20 care workers had not completed the first aid refresher course. This meant that these staff had not received appropriate training required for their role as identified as mandatory by the provider.

The director of operations explained that 49 care workers had been transferred from other providers during November 2014 when a contract was taken over by the service. There were no accurate records to confirm what training they had undertaken and when it was completed with their previous employer. The transferred care workers had not completed the induction when they started with the provider to provide basic training and information on how the care was provided.

The recruitment manager explained that each care worker should receive supervision once a quarter. The care worker would have one supervision meeting with their manager, an appraisal and two observations while they are providing care per year. We saw the supervision and appraisal records for 161 care workers and we saw that some staff had two observations on the same day and others had their supervision meeting and two observations within the same quarter. There were 62 care workers that had been working for the provider for more one year and we saw that 61 of them did not have a current appraisal in place. This meant that these care workers were not receiving appropriate support.

The above paragraph demonstrates a breach of Regulation 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff completed a four day induction course which included sessions on the principles of care, safeguarding, policies and procedures, confidentiality, medicines administration and moving and handling. The director of operations explained that they had developed the induction training sessions based upon the requirements for the new Care Certificate. New care workers would complete a short test at the end of each section of the induction to check their understanding and knowledge. Following the induction the new staff member would complete a period of shadowing an experience care worker. They would do an average of 10 hours shadowing and then work with another care worker on visits requiring two staff. Feedback would be provided by the experienced staff about the new staff member's competency.

The provider had a policy and procedure in place in relation to the Mental Capacity Act 2005 (MCA). The MCA is law protecting people who are unable to make decisions for themselves and provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it was in their best interests and there was no less restrictive option by which to provide support. The director of operations explained that care workers received training on MCA as part of their safeguarding vulnerable adults session during their induction. The care workers we spoke with confirmed they had received training on the MCA. We saw on two support plans that the person had been identified as being unable to sign their plan as they were confused or had dementia. The director of operations explained that this was based on the assessments carried out by the local authority. They told us that if they identified that a person had problems with making decisions about their care and wellbeing they would record any information and inform the local authority so they could assess the person.

We received mixed comments from people using the service and their relatives relating to the punctuality of the care workers. 12 of the people and relatives we spoke with said that their care workers arrived more or less on time or

# Is the service effective?

that they felt it was not an issue. One person said, "Yes, usually on time, but there can be traffic of course." Another person said, "As on time as they can be, some come by bus! They are never too late." Some people did confirm that weekend or holiday care workers can be late. One person said, "Sometimes they come late, or not at all. I'm on oxygen and I got upset." People also said "Weekends are not as good as they could be" and "They are erratic at weekends. I think they are short staffed at the weekend." The other eight people and relative we spoke with were not happy with the timings. They told us that the care workers sometimes turned up late or missed calls and they are not informed. One person said "They are sometimes late and sometimes they don't come at all. This is not too often (the latter) but it has happened."

Most people we spoke with said that care workers stayed for the time that they were scheduled for. One person using the service said, "Yes, they stay and do everything for me.' Another person said "They stay and chat away to me. It's lovely." One person told us "They log in by phone, and they sit there for ten minutes, to make up the half hour if they've finished, and chat, saying that they don't get paid if they leave. I had a lady spot checking, and she said they don't have to stay, so I am confused." Relatives told us "Some have not stayed the full amount of time if my relative has said no to getting up" and "They always stay and sometimes give extra time!"

The director of operations explained that a logging system was used where the care worker would call to record when they arrived at a person's home and when they left. This provided a report showing the scheduled time of arrival, the actual arrival time and the duration of the visit. The director of operations told us that as part of the contract with one local authority for providing care there was a permitted two hour window around the stated start time in which a care worker could arrive. There was no similar agreement in relation to the contract with the other local authority. During the inspection we reviewed the visit records for 12 care workers over the same seven day period. The records were for six care workers from each local authority area. We saw the majority of visits occurred within 15 minutes of the scheduled time. It was recorded on the visit report if the care worker had forgotten to log in and out during the visit or if the office had been advised of a delay. The director of operations told us that these records were reviewed and if delays to visit times were identified it was discussed with the care worker to see if there were any issues that could be resolved.

The support plans we looked at provided the contact details for the person's General Practitioner (GP). We saw when care workers identified any concerns with a person's heath they informed the office and the relevant healthcare professional would be contacted. This was recorded in the records made by care workers following each visit.

12 people using the service and relatives told us that care workers were involved in preparing food and/or drinks as part of the care they received. This included helping with a percutaneous endoscopic gastrostomy (PEG) feed where a person receives foods and fluids using a thin tube directly into their stomach through their abdominal wall. This aspect of care drew mostly very positive comments, although the relative of one person with the PEG said 'The first carers pulled the PEG out'. One relative said of the carers, 'They help my relative to drink so well, it is excellent care'. A person using the service said "The care worker prepares the breakfast of my choice, simple fare.' Another relative said, 'At lunchtime the meal of my relatives choice goes in to the microwave and later they have tea and cake.' Other people using the service told us 'They cook my dinner in the evening, it works well' and 'They make breakfast, my porridge and toast, then lunch, then sandwiches, because I can keep those for later if I want to.' All mentioned that the choice of what exactly to eat was theirs. Just one relative mentioned some concern that 'Her relative gets worried when they are late. They have no drink until they come.'

We saw the support plans identified if the person using the service required support when eating and also included information on what food and drink the person preferred. The director of operations explained that care workers received training on how to support people with eating and drinking as part of their induction. If the use of a PEG feed was required the director of operations told us that the care workers would receive specific training from a healthcare professional. We saw from the training records that staff who provided support for a person using a PEG feed had received training.

Good

# Is the service caring?

## Our findings

People we spoke with felt the service was caring. They told us that care workers called them by their preferred name and all said the carers were polite and respectful. A person using the service said “They are always polite. I have never had a nasty carer. Even if I am sharp with them, they have never walked out!” A relative said, “They are more like family now. They make a lot of difference. My relative is relaxed with them, he knows them and they know him.’ Another person using the service said, of their carer, “He has become a friend now. I don’t know what I would do without him really.” A person said “I had one for over two years as my main one. She was a friend. Then they moved her so I don’t see so much of her. But they are all lovely girls.” Other people said “I need them to help me and they do. They try hard” and “I look upon her as a friend now, my long term carer.”

All the people using the service and relatives we spoke with agreed that care workers maintained the person’s dignity while providing care. One relative said “If anyone comes in, like the nurses, they close the door.” Another person said “There are no problems with my dignity.” A relative of a person using the service said that “Dignity was mentioned when the care was first set up.” We asked staff how they maintain the dignity and privacy of the person they are providing care for. Some of the care workers told us “I respect every service user independent of their colour, religion or beliefs and “While giving personal care I will always cover the person with a towel or their clothing.”

We saw the support plans identified the person’s ethnicity and religion as well as what name they preferred to be called. The support plans identified how the person maintained their independence by identifying when the person receiving care required support and when they were able to complete tasks on their own.

People we spoke with told us that the regular care workers were aware of the care and support they required and spoke positively about them. One person said “They know what to do, they are regulars. The others, I have to explain more what to do. The only problem is when the regulars are off.” Other people said the care workers were good and all okay. A relative said that at least one carer “was not getting my relative up if she said no. She was not attempting to coax or use persuasion at all’. Another relative told us “Some of the carers are excellent.” A person using the service said “If they don’t know the routine, I tell them. They learn quickly. There are more good than bad, and some are brilliant.’

Requires improvement

# Is the service responsive?

## Our findings

People we spoke with confirmed they had been involved in the development of their support plan.

The director of operations explained that the support plans were reviewed annually or sooner if the person's care needs had changed. The director told us that as part of a new contract with one local authority the support plans for people being funded had to be reviewed after six weeks of the care starting. When asked about the review of support plans people we spoke with said "It is due for a review soon, they have said" and "She visits and checks the support plan regularly." Another person said they recalled a recent review of their support plan, when a change in timings had been suggested, which they declined. We saw the support plans we looked at were up to date and the person or their representative had signed to agree with the plan. A person who had recently started to receive care from the provider said "There have been no changes as yet." The support plans included information on personal care, continence management and nutritional support. We looked at the support plans for 18 people using the service. We saw they were task orientated and the actions identified were focused on what staff had to do and not how the person wished their care to be provided. In some of the support plans the person receiving care was not referred to by name but as S/U or service user for example S/U will be in bed. The plans focused on the tasks and used wording such as "change pad and transfer to bed" to describe the support required by a person in the evening. We saw some people had an additional support plan which included a section on background information but this was a summary of the initial assessment and a description of the care to be provided. It did not provide any information on the person's background for care workers. The director of operations explained that this style of support plan was previously required as part of a local authority contract and was not developed for everyone using the service.

We saw assessments were carried out by the service before the person started receiving care in their home. The local authority also provided detailed assessments when arranging the person's care. When the service received a new referral the co-ordinator would arrange to visit the person and their relatives to discuss the draft support plan. The assessment was used to identify if appropriate care and support could be provided. The completed assessments identified the person's individual support needs including mobility, social and health issues. An assessment was also carried out in relation to the person's medicines. This assessment identified if the person had been prescribed any medicines, if they were time critical, who was responsible for ordering the medicines and if the care worker was required to prompt or administer the medicines. This information was used to develop the support plans and risk assessments.

Care workers completed a record for each visit to the person they provided care for. We saw copies of completed daily record forms were collected each month and were stored in the office. The daily records were appropriately detailed, reflected the needs outlined in the care plan but we saw some used repetitive wording related to the care provided.

People using the service and their relatives we spoke with did not comment in the complaints process. There was a complaints policy and procedure in place. We saw a folder for each local authority area was used to store any complaints received. The director of operations explained there had been an increase in the number of complaints received from one of the local authority areas. This was following the transfer of the contract to provide care for a larger number of people funded by the local authority. If it related to a person whose care was being funded the complaint would be initially received by the local authority who then passed them on to the provider with a date they required a response by. People who were funding their own care could complain directly to the service. During the inspection we looked at 13 complaints that had been received in 2015 which related to missed calls and issues with the standard of care received. We saw each record had a copy of the initial complaint, details of any investigation and evidence that had been gathered with the response to the local authority.

People using the service and relatives we spoke with were either sure they had not received or were not sure if they had received a questionnaire. The director of operations explained that a questionnaire had been sent to people using the service in April 2015 and the results were being analysed by their head office so the results were unavailable. We saw a copy of the questionnaire that had been sent out which included questions on quality of care, time keeping, contacting the office and the training of the care workers. There were also boxes for people to write

Requires improvement

# Is the service responsive?

their own comments relating to what they thought was good and suggestions for ways to improve the service. The director told us these comments were passed to the quality monitoring officer and if any issues about the care were identified they would visit the person to discuss their concerns. We saw the covering letter that was sent with the questionnaire which confirmed that the results would be sent to people using the service once analysed. We also saw that people could provide feedback through monitoring visits that were carried out when care was being provided. We saw completed monitoring forms which included comments from the person about the care worker and the care they received.

Requires improvement

# Is the service well-led?

## Our findings

We received mixed feedback from people using the service and relatives relating to the administration of the service. Some people had very little contact with the office with one person saying "I haven't rung them since Xmas." Another person said, "The only problem is that I cannot always get through to the office, but when I do, they are okay." A relative told us "The office are helpful, they apologised for a late call, they try their best to help". Five people we spoke with had quite negative things to say about the office and/or the organisation. One relative said "It is the worse service I've ever encountered. If they are off sick, no one communicates. They never phone me and I am left hanging around." Other relatives commented on the lack of communication, being unable to contact the office, disorganisations and problems with invoicing. When we asked care workers if they felt supported by their manager and of the service was well-led we also received mixed comments. The care workers said they felt supported to do their job by their manager but had differing views on the service. They said "Yes the service is well-led and we can share our views", "I think the organisation must be more organised when they make the rosters. Every day they alter the planned route and we have not always the same service user" and "I am not really happy the way the company is led by the owners." The director of operations explained that since the transfer of contracts the service was now providing support for 400 people and there had been issues during the transitional period as the additional workload was managed. To resolve this issue, at the time of the inspection, the provider was in the process of opening a new office to specifically manage the care being provided for people in one local authority area.

The provider had a range of audits in place to monitor the quality of the service provided but some of these had not been regularly carried out over the previous year. The director of operations explained that due to work pressures following the transfer of additional contracts from a local authority some audits were not regularly completed.

The director told us that a client file audit should be carried out every six months which involved a review of a random selection of support plans, risk assessments and other paperwork in the person's support folder. Each co-ordinator was responsible for carrying out the audit of the folders for a specific group of people using the service. The director of operations told us that this audit had not been carried out during the last year but they had restarted the audit in May 2015. We saw a copy of the May 2015 audit which identified any support plans and risk assessments which were overdue for review as well as when the last quality monitoring visit was carried out. Any actions were recorded on the audit and completed on the same day.

The recruitment manager showed us an audit of staff records which were regularly checked. This included checks to ensure all the required recruitment paperwork was in place for example two references, the date any work visas ran out and when a new criminal record check was required. The recruitment manager confirmed that she monitored the files for new staff and ensured relevant paperwork was provided by the care workers. This ensured that care workers had all the required information on their staff file and requirements such as work visas and criminal record checks were up to date.

We saw medicine monitoring audits were carried out monthly to check the completion of medicine administration record charts. These audits were given to the local authority as part of their monitoring system. We also saw medicine monitoring forms were completed when the paperwork relating to the recording of medicines was checked in the person's home. The quality monitoring officer would record if any errors were noted on the medicines records and these were discussed with the care worker with additional support or training organised if required.

We saw new care workers were given a code of practice during their induction identifying the expected standard of behaviour. The document included sections on protecting the rights of the person using the service, developing trust and protecting people from harm. There was a clear role description in place for care workers identifying the main responsibilities and also the personal specifications for the role.

Meetings for the care workers were held quarterly in cluster groups due to the large number of staff employed. During the inspection we saw notes from these meetings that were circulated to care staff. There were also meetings for the administration team. The director of operations told us that informal discussions also took place when care workers visited the office.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The registered person did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying out of the regulated activity.<br><br>Regulation 17 (2) (b) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The registered person did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate training and appraisal as is necessary to enable them to carry out the duties they are employed to perform.<br><br>Regulation 18 (2) (a) |