

Prestige Nursing Limited

Prestige Nursing Swindon

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

SUMMARY

Prestige Nursing and Care Swindon provides domiciliary care and support services to meet a wide range of individual needs, including older people, individuals with physical disabilities, dementia and children and young people. At the time of our inspection 58 people were being supported by this service.

This inspection took place on 13 October 2015 and we spoke with people who used the service, their relatives and staff on the 13 and 14 October 2015. This was an announced inspection which meant the provider was

given short notice of the inspection. This was because the location provides a domiciliary care service. We wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf. At the last inspection on 5 September 2014 we found the provider was meeting all the regulations we inspected.

There was a new manager was in post at the service at the time of our inspection and they have applied to be registered with us. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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 accessible and approachable. Staff, people who used the service and relatives felt able to speak with the manager and provided feedback on the service.

People were placed at risk from unsafe medicine practices. The administering of people's medicines were not being recorded correctly. This meant that it was unclear if people were receiving their medicines when they required them. When there was guidance in place on how to help people manage their medicines it was not being followed appropriately or being recorded by staff.

Staff were not receiving regular one to one supervision with their line manager. This meant their performance was not being monitored effectively and feedback was not being provided. An action plan had been put in place, by the manager, to start supervising staff members and to monitor that this would continue to be done on a regular basis.

There were not effective systems in place to monitor the service. Information recorded about people's preferences was not always up to date. Support plans were not monitored or reviewed to assess their progress or their effectiveness. Staff told us that they were not informed of people's needs changing appropriately. People said the care plans that were in their homes did not reflect their current level of need and some reported they did not have a care plan in their home. The manager informed us the care plans need improvement and were going to be reviewed and updated in the next six weeks.

Staff sickness had been a significant concern for the company and this had resulted in missed visits for the people using the service. The manager had spent time addressing this area and preventative measures had been put in place to reduce the risk of people being left without care.

Safe recruitment procedures were followed and staff said that they undertook an induction programme which included shadowing an experienced member of staff. Staff were appropriately trained and told us they had completed training in safe working practices and were trained to meet the specific needs of people who used the service such as dementia care. The provider had undertaken recruitment checks on prospective new staff to ensure they were suitable to care for and support vulnerable adults.

People and relatives were complimentary about the caring nature of staff. Staff were knowledgeable about people's needs and we were told that care was provided with patience and kindness. People's privacy and dignity was always respected. Staff explained the importance of supporting people to make choices about their daily lives. Comments included, "carers are very nice, we have a laugh", and "carer is wonderful, very proud to have her, lovely so glad".

Staff had a good understanding of safeguarding and whistle-blowing procedures. They also knew how to report concerns and had confidence in the manager that these would be fully investigated to ensure people were protected. All of the staff we spoke with were knowledgeable about the requirements of the Mental Capacity Act 2005.

We saw records to show formal complaints relating to the service had been dealt with effectively. The manager was aware of their responsibilities in reporting notifications to CQC and these had been done in line with regulations.

People had opportunities to give their views about the provider and their care, including completing a survey and telephone and face to face opportunities. People and their relatives told us they are regularly given the opportunity to feedback their views to the service.

We found breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

This service was not safe.

Medicines were not always managed safely. Staff were not always signing the medicine administration records.

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse.

People were protected by safe recruitment practices in place.

People were not receiving consistent care and treatment. Staff told us there were missed visits. People and their relatives raised concerns about the changes of staff and the impact this had on people.

Requires improvement



Is the service effective?

This service was not always effective.

Staff did not have access to regular supervision and appraisal to support their personal development.

Staff were knowledgeable about the needs of the people they were supporting.

We saw that training courses were available in safe working practices and to meet the specific needs of people who used the service, such as dementia care.

Records completed for monitoring purposes were not being completed accurately or being reviewed to make necessary changes.

Requires improvement



Is the service caring?

The service was caring.

People were involved in making decisions about the support they received.

People and family members we spoke with gave us very positive feedback about their care workers and told us they were caring.

People said they were treated with dignity and respect. Staff told us how they aimed to provide care in a respectful way whilst promoting people's independence.

We found staff were knowledgeable about people's individual care and support needs. They were able to describe people as individuals.

Good



Is the service responsive?

The service was not responsive.

Requires improvement



Summary of findings

People may not be receiving care and treatment which met their current needs. Support plans were not evaluated or monitored to assess the effectiveness of the action plans.

There were systems in place to manage complaints. Everyone we spoke with was confident that any concerns raised regarding the service would be listened to and acted upon.

People's feedback was regularly sought by the provider by a range of methods.

Is the service well-led?

The service had not been well-led.

There are historical improvements to be made within the service that the new manager has identified. An action plan is in place to address those areas of concern.

The provider did not have effective systems to monitor the quality of service to ensure that they checked for any potential issues or risks and could respond in a prompt manner.

Communication from the management team that ensured people knew about changes in the service was not happening successfully .

Staff were aware of their responsibilities and accountability and spoke positively about the support they received from the management team.

Requires improvement



Prestige Nursing Swindon

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 checked 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 the 13 and 14 October 2015 and was announced; this meant the provider was given short notice of the inspection. The inspection team consisted of two inspectors. The service was last inspected on the 5 September 2014 with no concerns.

We did not ask the provider to complete a Provider Information Return (PIR). This 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. Before the inspection we checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We used a number of different methods to help us understand the experiences of people who used the service. This included gathering information by speaking with people who use the service, their relatives and staff members on the telephone. We spoke with four people, three relatives and six staff. We reviewed documents that related to four people's support and care, seven staff files, medicine administration records (MAR), survey and questionnaire feedback forms and other records relating to the management of the service. We spoke with the manager who was appointed recently, and is in the process of registering with us.

Is the service safe?

Our findings

Medicines were not managed safely or recorded properly. This was because records relating to medicines were not completed correctly placing people at risk of medicines errors. We viewed the medicines administration records (MARs) for four people. There were significant gaps in recording on people's MAR charts. Some staff had recorded in daily notes that medicines had been applied or given but had not filled in the MAR chart. One person's MAR chart had only been signed five times in one month. There was no other information to say why this medicine had not been received by the person. The Medication Administration Record contains codes which must be used when recording medication. We saw that in some instances the MAR chart had been filled in with an 'X', which did not represent a signature or the code stated at the bottom of the MAR chart. It was unclear to know if this person had been receiving their medicines. This meant the provider did not have accurate records to support the safe administration of medicines.

One person's care plan had a signed document to say that staff had been trained to administer a person's nasal spray, which was to be given first thing on a morning before the person's daily care commenced. There was no record that this was to be done on the person's care plan and there was no evidence of it being administered on the MAR chart or daily recording. We discussed our findings with the manager. They told us they were unaware of the gaps. This meant the provider did not have effective systems in place to ensure gaps in medicines records were identified and investigated quickly.

Where a person had been assessed as requiring support with taking their medicines, the support they required was included in their medication management assessment. This included information on the person's preferred method of taking their medicine and any difficulty they had around taking medicine. One person's care plan stated that they had been assessed as fully independent in managing and taking their own medicines, and did not require assistance, yet staff had recorded in the daily communication notes to say they were giving the medication and completing a medication record for this person. There were no dates or reviews in place to suggest this person now needed this level of assistance.

This was a breach of Regulation 12 (2) (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and relatives told us there had not been sufficient numbers of staff in place and this had resulted in missed visits. Comments from staff included "not enough staff, staffing a problem especially at weekends", "there have been missed visits, one person had no one over the weekend", "some care packages not being fulfilled as no staff to visit them" and "staff an issue, not good for staff or company". People told us they were often not informed of these situations "sometimes they are late, you have to ring them, they don't ring you", "Recently I was left without care as there was no one available, I understand I am not high priority but there should be a system whereby no one is left without care" and "it's all upside down, you never know who you're going to have, it's uncomfortable, I have to tell them what to do".

The management team informed us that staffing had previously been a significant issue for this service and staff sickness was the first problem the new manager addressed when starting employment with the service. Preventative measures had been put in place to ensure people would not be left without care and that they or their relative would be informed if their call was going to be late. Two of the office staff were also trained in supporting people and delivering care so they could be deployed if there was a shortage. A traffic light system was in place which identified people most at risk that could not have their visits missed under any circumstances, for example someone lacking capacity or who was bed bound. A list of staff had been put in place by the manager who did not mind if they were called in to work in an emergency.

Staff told us they had received training in how to protect people from abuse and avoidable harm. Through conversations with staff they demonstrated their knowledge and understanding of safeguarding, including how to recognise signs of abuse and report them. One staff member said "If I felt a staff member was acting inappropriately and putting someone at risk I would safely stop the person's care and seek advice from management." Any concerns about the safety or welfare of a person were reported to the branch manager who investigated the concerns and reported them to the local authority safeguarding team as required.

Is the service safe?

Each person had a personal profile risk assessment in place and people were kept safe by staff following the correct procedures. The service had a safeguarding vulnerable adult's policy and this was understood by staff with comments on keeping people safe including "I follow the guidelines and information from prestige", "there is online support available", "I look through the action plans and use my knowledge" and "people have a key safe or a relative lets me in, I always call out so people know I'm there".

Staff safety was monitored and systems were in place to protect lone workers. An ECM (Electronic Call Monitoring system) was used, so when staff arrived at people's home for a visit they logged in on the landline or could text. In people's care plans part of the assessment was around establishing any environmental risks associated with each individual location. Questions asked and observations conducted included if the person had any pets, trip hazards, if there was appropriate lighting and access to the property and if parking was available close by for staff.

The service had appropriate arrangements in place for managing emergencies. There were arrangements in place for staff to contact management out of hours should they require support. Staff told us they were aware of the procedure to follow in an emergency commenting "I would always act first and call 999, and inform manager immediately"

People were protected from the risk of being cared for by unsuitable staff. There were safe recruitment and selection processes in place to protect people receiving a service. Staff were all subject to a formal interview prior to commencing employment. We looked at six staff files to ensure the appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. Staff were subject to a Disclosure and Barring Service (DBS) check before new staff started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Is the service effective?

Our findings

Staff were aware of their roles and responsibilities. However regular meetings were not held between staff and their line manager to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people using Prestige services. Staff comments included “need to support staff better”, “no staff meetings”, “not told about changes in the office” and “meant to be a caring company but need to care about their staff too”. Staff we spoke with were not receiving the appropriate support through regular supervision. One staff member said “No supervisions I haven’t had one”. Another staff member said, “Only had one supervision in the early days of starting”. There were no records in place to show that staff had been having regular supervisions. The new manager told us this had not been maintained as it should have been and this was in the process of being addressed. We saw in the manager’s action plan they plan to bring all supervisions and appraisals up to date by December this year. This is going to incorporate an observational element with supervisions taking place on location.

This was a breach of Regulation 18 (2) (a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The recording charts we looked at for monitoring the health needs of people were not being completed properly or being followed correctly. One person who was unable to mobilise independently and remained in bed had a skin integrity assessment in place. The assessment stated that staff were to check this person’s skin on all calls and assist this person to change position in bed. The daily communication notes did not support the plan, it had not been recorded which position this person was being assisted to change from and too from, and on some visits nothing had been written in relation to this person’s repositioning. This lack of recording meant it was unclear to know if this person was receiving care in line with the guidance stated in their care plan and due to the fragility of their skin was at risk of potential pressure damage.

Another person had a bowel chart in place. There was no guidance for staff on how it should be completed and the recordings varied greatly, making it hard to understand. People had used signatures or numbers, and on one week it had been filled out with ‘x’s’. This meant it was not known

if this person had gone to the toilet that week. There was nothing in place to inform staff what action to take when this happened or that the situation was being managed. Staff we spoke with about monitoring people’s health needs told us they report all concerns back to the manager and the district or community nurses are also informed.

People were happy with the skills of the staff delivering their care. Comments included “staff are trained and have experience”, “staff training good, meets my needs, my carer is proactive and asks for training” and “staff are well trained, no problems there”. A relative described members of staff as “trained well, and well managed”. The manager informed us that staff are matched with people by their skills set. They gave an example of a person having dementia and matching them with a staff member that had specific training in the needs of people with dementia.

When we spoke with staff they felt positive about the training opportunities that were available. Staff commented “I have had lots of training, all up to date”, “offered all kinds of training, safeguarding, protecting vulnerable adults”, “been given PEG training by the district nurses”. PEG, percutaneous endoscopic gastrostomy is a procedure that allows nutritional support for people who cannot take food orally, by placing a tube through the abdominal wall into the stomach so liquids can be infused. During our inspection there was training taking place at the office for updates including manual handling training. The manager told us mandatory training was in place for all staff and then there is specialist training available depending on the needs of the person they support. We looked at the staff compliance record for training on the service’s computer system. The training for staff was up to date and the system flagged up any training for staff that was due to expire in one month’s time.

Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. We spoke with staff who had recently been employed by Prestige. They spoke positively about the support and training they had received during their induction period. Staff member comments included “The training has been really helpful to my role” and “Induction was good, informative, a lot of training involved, learnt a lot”.

Staff were familiar with the principles Mental Capacity Act 2005 (MCA). CQC is required by law to monitor the application of the MCA and to report on what we find. The

Is the service effective?

Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment.

We found support plans had records of assessments of capacity and what people were able to do independently and what areas they needed support with. Care plans showed relatives had been involved in best

interest decisions where appropriate. One member of staff told us “before I do anything I get their wishes to do something, I always try and get someone’s permission”. One Care plan stated a person may display some behaviour that may challenge. There was advice in the plan on what works best for that person in that situation. This included ‘staff being patient’ and stated that the person enjoyed singing and this would ease their anxiety.

Is the service caring?

Our findings

People and relatives we spoke with gave us very positive feedback about their care workers and told us they were caring. Comments from people included “very polite, always nice”, “carers are very nice, we have a laugh”, “carer is wonderful, very proud to have her, lovely so glad”, “carer is fantastic who comes” and “I have a good relationship with staff, very polite”.

The staff were knowledgeable about the people they supported and told us they were able to know people well by having regular clients. Staff said “continuity of care is really important, I support regular people”, “I build relationships through talking to people, listening to them and check on them” and “I support the same people, I do not move around”. The manager emphasised the importance of matching staff to people and a staff member commented “having carers that know what they are doing, the service matches carers and people well”.

Relatives felt reassured by the carers that came in to support their loved ones. One relative told us “individual care is good; carers make a bond with my relative”. Another relative said “we are all happy with the care”. The manager told us that if people’s relatives are going to be away the service are asked to be informed of this and to be provided with a second point of contact during this period of time.

People were being involved in decisions about their care. We saw in people’s care plans they had a section on

‘Outcomes I want to achieve’. One person had stated they wanted to stay at home as long as possible. Staff said they supported people to make choices, and adapted their approach in relation to people’s needs stating “I encourage people to do as much as they can themselves, assist where they need it”, “if I can get someone to do something themselves I will” and “let them do it if they can”.

People’s privacy and dignity was maintained. Staff explained how they maintained people’s dignity when carrying out personal care. They said doors and curtains would always be closed. They would always seek permission before doing anything and explain what they were doing. People told us they felt respected by the care staff commenting “does everything she can, and always asks before doing things” and “I’m very satisfied, always offers choice”. One staff member said how it was important to ensure, if they were supporting people with personal care, they covered the area they were not supporting the person to wash, with a towel or dressing gown to maintain their dignity.

Staff demonstrated insightful awareness for people’s feelings around having support and personal care provided commenting “I’m going into their home and that’s in the back of my mind so I try and understand their stress”. Staff files contained a signed confidentiality agreement protecting the people they supported and staff were knowledgeable about how to protect the confidentiality of the people they supported.

Is the service responsive?

Our findings

We looked at four people's care plans. Records were in the format of a risk assessment and support plan which detailed support required. This was also supported by a more detailed care plan. We found they did not always contain the most current information, required for staff to be able to care for people consistently. For example in one person's risk assessment and support plan it stated they liked to transfer into their wheelchair for a few hours during the day. However there was no information on how staff were to support this in their daily care plan. In the same person's risk assessment and support plan it stated that the person required their PEG (percutaneous endoscopic gastrostomy), to be flushed through. It did not contain any information on what fluid or quantity was to be used to flush the peg. There was nothing in the person's review to say that this was a change to their care plan. Another person's medication assessment stated they did not require eye drops yet we saw in daily records that eye drops were being administered each day.

Staff told us that care plans were not present in everyone's home. Information on how to support people and changes to their needs had been passed to staff by word of mouth and not properly documented. Staff comments included "I've never seen a care plan at the person's home that I support", "there is no paperwork in the house to support care", "no care plans in client homes" and "I go into clients blind, we need something in place so we know what clients' needs are".

People's care plans did not always have dates on them which meant it was difficult to know if this information was current and up to date. One person told us "there is a support plan in my home but it's not updated, things reviewed haven't been updated and amended and the details are not accurate". Another person said "my needs aren't reviewed; things are passed on between the carer, not with the service". A relative commented "the care plan is not updated, things are noted only in the communication log". Staff also reported this to be the case commenting "if the needs of people change we are informed by text message and daily notes" and "the office should react on things when clients need changes". This meant if somebody new went to support a person there would not be an up to date care plan in place identifying the level of support required to appropriately care for that person.

We spoke with the manager about the care plans not being reviewed and containing inconsistent and out of date information and they were aware of the improvements needing to be made to the documentation. The manager told us reviewing the support and need levels for everyone is the next focus in a six week plan. A plan is to be put in place for everyone to receive a telephone call every three months to discuss any changes, and a full review every six months unless someone has very complex needs and are in need of a more regular review. The manager informed us one page profiles are going to be developed in line with the care plan updates. These will contain essential information for each individual to assist staff in caring for that person, which will be easier to read quickly.

This was a breach of Regulation 9 (3) (a) (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were made aware of the complaints procedure. We were informed during our inspection that part of the initial assessment with people goes through the complaints process so that people are aware of how to make a complaint and to whom. People told us they were happy to raise a complaint if they needed too, "if had a complaint would talk to the manager, no problems with the service", "had a concern and asked for a chat, manager is going to come and speak with me, so that's good", "not happy before the new manager came in to raise concerns" and "only one complaint and dealt with properly, if I do have complaints I ring office".

Staff said they felt supported by the new manager and could raise concerns and would feel listened to. They also felt confident that the manager would take appropriate action to address their concerns, comments included "confident in manager to deal with concerns", "happy to report concerns", "new manager is much more approachable" and "can't fault the office, issues have been resolved" We looked at the complaints file log which showed a recent complaint that had been dealt with and responded to appropriately.

Feedback was sought from people in the form of telephone calls, homecare surveys or face to face visits. One person had fed back that staff "Make me laugh" and stated that they were "Extremely happy with carers". We looked at the survey feedback forms for this year and comments included "members punctual, very happy with all the carers", "feeling more listened to these days" "very satisfied

Is the service responsive?

with care”, had same carer for some time now to give me a short break, my husband looks forward to seeing her, very kind and caring”. People and their relatives that we spoke with said they are regularly asked to provide feedback and forms come through the door every three months.

Is the service well-led?

Our findings

A new manager was in post and has applied to be registered with us. The manager was available throughout this inspection. They spoke enthusiastically about their role and dedication to ensuring the care and welfare of people who used the service. The manager told us they promote an open door ethos so staff can ask for support and advice at any time. The manager spoke about encouraging staff to take on ownership for different roles. Staff said they felt able to approach the manager with suggestions they had for improving the service. One staff member explained how they recently discussed implementing a new system with the manager, to ensure that monitoring records were audited monthly.

Staff sickness had been very high in the service and this had been a priority for the manager in their three months in post, so people in the service were not left unsupported by missed visits. The manager informed us that for staff members repeatedly calling in sick an individual meeting was held between the manager and staff member. The aim was to re-establish stability in the service for people. This had been managed in the previous three months by the branch manager taking responsibility for the on call every weekend. The on-call system enables staff to seek advice in an emergency. Staff previously text to inform the office if they were going to be off sick, and the new system means they have to call in and speak to someone directly and it is logged onto the computer system. Back to work interviews which happen after a member of staff has been absent due to sickness are all now conducted by the manager.

People using the service and their relatives expressed concern over a lack of communication from the service saying “we were not informed about management changes”, “I did not know the new manager had taken over, it would have been nice to have been informed”, “I have spoken to the new manager but not met them or had a letter to say there is a new manager”. Plans were in place to address these concerns, feedback was highly encouraged by the management team, they wanted to be informed of areas needing improvements and the manager had taken over direct responsibility for different roles to see personally the route of potential concerns. A bridging service offered by Prestige, which is when a service is provided for people discharged from hospital and

supported at home so they can rehabilitate has been stopped. The manager informed us that this was stopped in order to narrow the focus of the service and then expand when the team is rebuilt and in a stronger focused place.

The provider did not have effective systems in place to assess and monitor the quality of the service and ensure that the care planned and delivered met the persons assessed needs. One person using the service commented “quality is being compromised”. Another said “the manager has a big task”. The manager told us that they were aware they needed to improve the quality monitoring of the service and have given us their action plan which identifies these areas of improvement. We were told that staff had been involved in putting the action plan together and had been allocated different responsibilities within it to promote a whole team approach to changes.

The Manager told us they felt supported by their senior management, the regional manager and the quality performance manager. In turn the manager said they were committed to supporting and establishing a strong staff team within the service. The manager was able to demonstrate some concerns they have addressed. One coordinator had been struggling with their workload so the manager reduced this and took over responsibility for a section of this. The office team have been recently established and are focused together on improving the service for people. Staff told us “manager did not have an easy task to take on, they are trying to make improvements”, and “new manager is good, turn office around”. We observed a map board in the office that identified people and staff locations which was being used to form cluster groups of individuals so staff could cut down on travelling time and support people closer together maximising visit time.

Areas that we did identify as needing attention and working on were historical problems that had been in place before the manager came into post. The manager has been open with us during safeguarding enquiries that have been raised and had submitted statutory notifications to the Care Quality Commission. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns.

Informal concerns were logged as well as formal complaints and if necessary were being fed back to the

Is the service well-led?

staff. Compliments were shared with the staff to promote morale. This was demonstrated by one staff member telling us the manager had recently fed back a compliment to them which had been nice to hear telling us “the manager is good at feeding back positive comments from clients and relatives”. The manager told us that feeding back is important and something that the service does well.

Staff understood the provider’s whistleblowing policy and procedure and would feel confident speaking with

management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff’s care practice. We looked at the whistleblowing policy in place which stated that all concerns were to be reported to the branch manager. One member of staff told us “I would not hesitate to report any concerns I had about staff’s working practices to the manager.

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
Nursing care Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from the proper and safe management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not receiving appropriate support in the form of regular supervision and appraisal. Regulation 18 (2) (a)

Regulated activity	Regulation
Nursing care Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not receiving assessments of their current level of need in order that appropriate care could be provided. Regulation 9 (3) (a).

This section is primarily information for the provider

Enforcement actions

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