Brendoncare Foundation(The)

Brendoncare Mary Rose Mews

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 3 and 4 May 2016 and was announced to ensure staff we needed to speak with were available. Brendoncare Mary Rose Mews provides extra care housing or 'Close Care' as the provider terms the service. The service is available to people who live in one of the 46 leasehold apartments located in the grounds of Brendoncare Care in Alton; if people wish to purchase a personal care service from the provider. People can also arrange care with external providers if preferred. At the time of our inspection 15 people were receiving personal care provided by the service.

The service did not have 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 2008 and associated Regulations about how the service is run. The provider has provided regular updates on their progress in recruiting a manager. They last wrote to us on 20 April 2016 to inform us that a peripatetic manager was overseeing the service and that a permanent manager had recently been appointed who was due to commence their role with the provider and register with CQC. Suitable arrangements had been put in place in the interim to ensure the smooth running of the service. The domiciliary care supervisor who had been in post since 22 June 2015, had responsibility for the day to day running of the service. They were unavailable during the inspection so we were supported throughout by a senior member of care staff.

The provider had carried out recruitment checks in relation to staff. However, they had not always ensured that applicants had provided a full employment history. They had not obtained photographic proof of identity for two care staff. Therefore, people might have been placed at risk from the recruitment of staff unsuitable for their role.

People were safe from the risk of abuse as staff had undergone relevant training and understood what action they should take to protect people from the risk of abuse.

There were processes in place to identify and manage risks to people. Staff were provided with relevant guidance and understood how to minimise the risks to people to ensure their safety.

People received their medicines safely from trained staff, although staff competency in relation to medicines management was not assessed following their medicines training. There was no evidence to demonstrate people had been placed at risk of harm as a result. The domiciliary care supervisor has since assured us that they will be introducing a competency assessment for staff and we have made a recommendation in relation to this. There were processes in place to ensure people received their medicines safely and relevant action was being taken to assess staff competence.

Staff received an appropriate induction to their role and were offered on-going training and supervision, to ensure they had the opportunity to update their skills and were supported in their role. People were cared

for by appropriately trained and supported staff.

People told us staff always sought their consent before providing their care. Although people were able to make decisions about their daily care, staff had undergone relevant training to ensure they could identify if a person lacked the capacity to make a particular decision when required.

Staff supported people to ensure they received sufficient food and drink. Risks to people associated with eating and drinking had been identified and managed effectively.

Staff ensured people had their healthcare needs met. Where people required supported to make or attend healthcare appointments this was provided.

People were consistently positive about the caring attitude of staff who were heard to speak with people in a warm and friendly manner. Staff understood people's likes and preferences about their care. People were proactively supported to express their views and staff supported people to make decisions about their care. People told us staff upheld their privacy and dignity when providing their care. Staff were aware that they were providing care to people in their own homes and were respectful of people's homes and privacy.

People told us the service was responsive to their needs. People's care calls and the duration of their calls were agreed with them. People could use the service if and when they required it. Staff supported people's independence and ensured they did not experience social isolation. People received care that was personalised to them and their care needs.

Processes were in place to enable people to make a complaint if they wished. People were provided with relevant information about how to make a complaint. When people had made a complaint their concerns had been investigated.

Staff were encouraged to speak out if they needed to about issues which could impact upon people's care. Staff told us there was a good team. Staff were observed to apply the provider's aims and values in their work with people.

People's views on the service were sought through regular questionnaires and coffee mornings. People also had the opportunity to meet with the provider's representatives at the annual general meeting and to give their views. Various aspects of the service were audited to identify areas which could be improved for people and action was taken as a result.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were supported by sufficient staff to meet their needs safely. Staff had undergone relevant recruitment checks; however, not all of the required evidence was available for each staff member to fully demonstrate their suitability for their role.

People were safeguarded from the risk of abuse.

Risks to people were identified and managed safely.

There were processes in place to ensure people received their medicines safely, however; staff's competency had not been assessed following their medicines training.

Is the service effective?

Good

The service was effective.

People received care from staff who had the knowledge and skills required to provide their care effectively.

People's consent was sought in relation to their care and staff understood their responsibilities if people lacked the capacity to make a specific decision.

People were supported by staff effectively to ensure they ate and drank sufficient for their needs.

Staff supported people to maintain good health and ensured they were supported to see healthcare professionals as required.

Is the service caring?

Good

The service was caring.

People experienced positive caring relationships with the staff who provided their care.

Staff supported people to express their views and to be actively involved in decisions about their care.

Staff ensured people's privacy and dignity were consistently upheld.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was arranged in consultation with them and which was responsive to their care needs.

People were provided with information about how to make a complaint and any complaints received were documented, investigated and people responded to appropriately.

Is the service well-led?

Good

The service was well-led.

The service promoted a positive culture amongst staff who felt valued and able to speak out if required.

The provider had ensured that a suitably qualified staff member was responsible for the day to day running of the service. They had taken reasonable measures to appoint a registered manager for the service.

Processes were in place to drive service improvements for people.

Brendoncare Mary Rose Mews

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 3 and 4 May 2016 and was announced to ensure staff we needed to speak with were available. The inspection was completed by one inspector.

Before the inspection the provider completed 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. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we sent 18 questionnaires to people and nine were returned. We sent 18 questionnaires to people's friends and relatives and two were returned. During the inspection we spoke with four people and visited a further four people. We spoke with the senior member of care staff, four care staff, the peripatetic manager and the nominated individual. A nominated individual is a person employed as a senior person of an organisation who has the authority to speak on the behalf of the service about how care is provided. Following the inspection we spoke with the domiciliary care supervisor and received positive feedback from a GP on the service provided.

We reviewed records which included three people's care plans, three staff recruitment and supervision records and records relating to the management of the service. We also attended a staff shift handover.

The service was last inspected in April 2013 and no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us there were sufficient staff to meet their needs. All of the people who responded to our questionnaire said 'I receive care and support from familiar, consistent care and support workers.' 'My care and support workers arrive on time' and 'My care and support workers stay for the agreed length of time.'

Staff told us, and records confirmed, that they had undergone recruitment checks. These included the provision of suitable references, to provide satisfactory evidence of their conduct in previous employment, a health declaration and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Two of the staff employment records reviewed did not contain photographic evidence of their identity or a full employment history. Therefore, people might have been placed at risk from the recruitment of staff who the provider had not fully assured themselves of their identity or suitability for their role.

The provider's failure to ensure that all of the required information was available in relation to each staff member employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and records confirmed that any staff who administered people's medicines had undertaken training which they were required to update every three years. The domiciliary care supervisor told us they did not assess staff competency to administer medicines following completion of their training. Although there was no evidence that people had experienced unsafe medicines administration as a result, staffs competency should be assessed, to ensure they could administer people's medicines safely. We spoke with the domiciliary care supervisor who told us they would introduce a medicines competency assessment for staff.

We recommend that the service seek advice and guidance from a reputable source, about the assessment of staff competence in relation to medicines management.

People told us staff supported them with their medicines where required. One person told us "I get support with medicines." People's records contained an up to date list of their medications and an assessment of the level of support they required with their medicines. If people needed topical creams applied for them, then they had a topical cream chart to provide staff with written guidance about where they were to be applied. People's medicine administration record (MAR) had a photograph of them attached, to enable staff to check that they were administering medication to the correct person. A staff member was observed to administer a person's medicines safely, telling the person what they were giving them before signing the person's MAR to confirm that they had administered their medicines. People's MARs reviewed had been signed by staff to demonstrate they had received their medicines. There were processes in place to ensure people's medicines were ordered for them when required and that unused medicines were returned safely to the pharmacy.

The senior member of care staff told us that there were two care staff rostered from 08:00-14:00, one care staff from 14:00-20:00 and there was a member of care staff on-call, on-site at night if required; records confirmed this. Staff told us they tried to cover any vacant day shifts between them if needed and that there was the occasional use of agency staff at night to cover staff holidays and sickness, which records confirmed. The domiciliary care supervisor was supernumerary and worked weekdays. In the evenings and weekends staff were able to use the on-call system to request advice from senior staff if required. People were cared for by sufficient numbers of staff to meet their needs.

All of the people who responded to our questionnaire said 'I feel safe from abuse and or harm from my care and support workers.' A person told us "I feel safe in staffs care." Staff told us they had completed safeguarding training, which records confirmed. Staff were able to demonstrate their understanding of safeguarding and their role and responsibilities. Staff supervision records demonstrated that safeguarding was an item that was discussed with staff at each supervision session to ensure they had the opportunity to raise any safeguarding issues. Staff had access to safeguarding policies, procedures and telephone numbers in the event they were needed. Staff were able to describe to us how they had sought guidance from Social Services who are the lead agency for safeguarding about a person's care to ensure their safety. Staff had completed body maps where they had identified any form of bruise or injury to a person. This ensured there was a record of when the injury had been noted. People were protected from the risk of abuse.

People had a health and safety risk assessment which assessed the risks to people associated with their home environment. People also had a moving and handling risk assessment, a personal risk assessment and a falls risk assessment. Where risks to people had been identified, measures were in place to manage them, such as the use of a walking frame. Staff were observed to follow the guidance in a person's care plan and ensured that they were provided with their walking frame to enable them to walk safely. If staff assessed that they could not safely bathe a person in their apartment, then they were offered the use of the facilities of the provider's nursing home which was located on the same site to bathe. This ensured people were able to enjoy a bath or shower safely with staff support.

If people experienced a fall then this was documented on an incident form which the domiciliary care supervisor reviewed and any action required to prevent the risk of repetition was taken to ensure people's safety. For example, a person was referred to the falls clinic following a fall. Processes were in place to minimise the risk of people experiencing further falls.

People's apartments were fitted with a call system on the wall which was tested daily so people could alert staff in an emergency. People could also have a pendant to wear, this was linked to the call system so that they could request staff support immediately. If people used a pendant then there was written guidance for staff in people's care plans to ensure people had their pendant with them. Processes were in place to enable people to request staff assistance in an emergency.

Staff were made aware of risks to people through their care plans, risk assessments, the staff handover and information on their daily handover sheet. Any information staff needed to be particularly aware of such as people's communication needs was noted in red or highlighted. Staff were able to tell us about specific risks to individuals and the measures they took to manage them safely; they told us about what equipment people needed to support them to be mobile. Staff understood and managed risks to people to ensure their safety.

Good

Is the service effective?

Our findings

All of the people who responded to our questionnaire said 'My care and support workers have the skills and knowledge to give me the care and support I need.'

Staff told us they had undertaken an induction to their role based on the industry requirements. No new staff had been appointed since the introduction in April 2015 of the Care Certificate as the industry standard induction for staff who are new to care. However, we were provided with evidence of the induction programme new staff were required to undertake which incorporated the requirements of the Care Certificate. Staff received an appropriate induction to their role.

Staff told us they underwent regular training. Records demonstrated staff underwent training in equality, dignity, skin integrity, nutrition, dementia care, moving and handling, food hygiene, health and safety, first aid, fire training, infection control and hazardous substances. Staff were required to undergo a range of training relevant to their role to ensure they had the appropriate skills to provide people's support effectively.

Staff told us that the provider had encouraged and supported them to undertake a National Vocational Qualification (NVQ) in Social Care; nine of the ten staff had completed a NVQ. Staff were supported with their professional development.

Staff told us they received supervision of their work, which records confirmed and felt supported in their role. Staff received one to one supervisions and support through staff meetings, the last one of which took place on 18 April 2016. Staff were sufficiently supported in their role.

People told us staff always sought their consent before providing their care. One person commented "Staff seek our permission." Staff confirmed that they sought people's consent for the provision of their care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Although no-one lacked the capacity to make their own decisions about their care staff told us they had completed MCA training, which records confirmed. Staff were able to demonstrate their knowledge of the Act. People's care records provided staff with guidance about seeking people's consent for particular aspects of their care. People's written consent had been sought for the sharing of their information with other agencies where required, in order to provide their care. A record reviewed showed the person had a Do Not Attempt Cardiopulmonary Resuscitation order in place. This had been correctly discussed with the person by the medical practitioner to ensure they were aware of it, in case they wanted to seek a second opinion. A person had granted power of attorney for finances to their relative and this was documented in

their records. The provider should have obtained a copy of this to ensure there was written evidence of this on the person's file. We discussed this with the senior carer who told us they would request a copy. People's consent for the provision of their care had been sought.

People who owned one of the Close Care apartments were all able to purchase a hot lunchtime meal if they wished from the restaurant located within the Brendoncare Care Centre; whether or not they used the Close Care service. Staff had written guidance about who needed their meals to be taken to them from the restaurant to meet their nutritional care needs. Staff also supported people by making breakfast and light snacks if needed. People were supported by staff where required to ensure they received their meals.

People told us their dietary needs were known and met by staff. If people had specific dietary requirements such as a gluten free diet, then this was documented in their care plan; staff demonstrated their understanding of people's dietary needs. Staff told us they were aware of how well people ate at lunchtime if they ate in the restaurant, as the restaurant staff provided them with feedback. If staff had any concerns about a person's weight, this was discussed at the staff handover. The person would be asked if they could be weighed in order to monitor their weight and to identify if any further action was required. Staff understood who was at risk from dehydration. People's care plans provided guidance for staff about how to manage any risk of dehydration to people and staff were seen to complete fluid charts where required to enable them to monitor how much people were drinking. Staff ensured risks to people associated with eating and drinking were identified and managed effectively.

People's records demonstrated they had seen a variety of health care professionals such as GPs, community psychiatric nurses, district nurses, occupational therapist, chiropodist, physiotherapist and the continence service. During the inspection staff called a person's GP to arrange a home visit for them as they had identified that this was what the person needed. Staff also accompanied another person to their GP appointment who required this support. People were supported by staff to access healthcare support as required.

Good

Is the service caring?

Our findings

People were consistently positive about the caring attitude of staff. Their comments about the staff included "Staff are polite and caring." "They are so patient and understanding" and "I couldn't praise them enough they are so thoughtful and caring." All of the people who responded to our questionnaire said 'My care and support workers are caring and kind.'

Staff were always heard to speak with people in a warm and friendly manner. They demonstrated a genuine interest in people, their lives and their welfare, asking after their health. People were observed to enjoy the company of staff and were pleased to see them. People experienced positive relationships with the staff who provided their care.

Staff demonstrated a good knowledge of people's care needs, risks to people and their preferences about how they wanted their care provided. Staff told us they got to know people and their preferences by reading their care plans and spending time with them. A staff member said "We always ask what people want." Staff demonstrated a clear understanding and appreciation of people's histories, likes and individual preferences in relation to the delivery of their care. They were able to tell us about people's favourite foods, interests and routines. We observed staff serving breakfast and saw the table was laid out with place mats and napkins and that the staff member brought a pot of tea and jug of milk to the table as per the person's preference. Another person's care plan specified the time they preferred their first visit and the support staff were to provide. We observed staff as they completed this person's visit at their preferred time and they provided the person with their breakfast. Staff told us there had been issues with obtaining an item of food that this person particularly enjoyed. Staff had taken the initiative to find out where else they could obtain this food, which the person confirmed. Staff had recognised the importance to this person of obtaining their preferred food and ensured they received this. People were cared for by staff who understood and respected their preferences and who appreciated what was important to people.

People were proactively supported by staff to express their views to make decisions. Staff told us they supported people to make decisions by giving them choices and listening to them. A member of staff was observed to ask a person if they were ready for breakfast. They then asked the person what they wanted and showed them the choice of cereal to support them to decide. Staff told us if people were dining in their apartment at lunchtime then they either showed them the menu or telephoned and discussed it with them. Staff were heard ringing people to tell them what the lunch time meal options were to enable people to make a choice. Staff supported people to be involved in decisions about their care.

People told us "We get good information." People were provided with a copy of the 'Residents Guide', which outlined their rights for example, to be involved in planning their care. People were kept informed of service events through letters and memorandums. People were provided with relevant information about the service.

People all told us that staff upheld their privacy and dignity when providing their care. One person commented "Staff always ring and wait for a response before entering."

People's care plans provided staff with guidance about how to uphold people's privacy and dignity. For example, by waiting outside the bathroom whilst people bathed if it was safe for the person to be left alone. Staff told us "I treat people like I would my granny." They were able to describe the measures they took to maintain people's dignity in the provision of their personal care, such as closing the door and ensuring the person remained covered. A member of staff was observed to discreetly support a person to the bathroom; then they ensured that the door was fully closed. Staff ensured people's privacy and dignity was upheld in the delivery of their care.

People's records showed that where staff held a master key the person had signed to agree the conditions for use of their key by staff. People had also been consulted about the process for staff entering their property. Staff were observed to knock and wait for a response before entering people's property. Staff appreciated that they providing care to people in their own home. A staff member told us "We are very aware that we are a guest in the person's home." Staff treated people's homes with due respect. We observed a person had to answer their phone during their care call. The staff member respectfully withdrew from the room so that the person could deal with their call in private. Staff respected people's right to privacy within their home.

Good

Is the service responsive?

Our findings

People and a GP told us the service was responsive. One person commented "Staff are very responsive if we need anything."

A person told us that the domiciliary care supervisor was "Wonderful in sorting my care" and that "It was all arranged very quickly." Another person told us that although they did not currently use the service they had used it during a period of ill health for the length of time they had required staff support. All of the people who responded to our questionnaire said 'I am involved in decision-making about my care and support needs.' People's records showed their care needs had been assessed to ensure staff could meet them and the content of their care plan had been discussed with them. People had signed their agreement to the care provided. People received care that was responsive to their needs and they were involved in their care planning.

The amount and duration of calls people received was individual to them. Some people required very little support whilst other people received a number of visits across the day of varying duration to monitor them and meet their care needs. Staff were provided with a handover sheet which gave details of the timing of people's calls, their duration and the support they required at each call. We observed on visits that staff provided the care as described in people's care plans and as documented on the handover sheet. However, they also asked people if there was anything else they needed before they finished, which gave people the opportunity to ask if they required anything else. During the staff shift handover a person came to tell staff they had locked themselves out of their apartment. A member of staff immediately went to assist the person and to locate their keys for them. Staff were provided with clear guidance about the care people required at each visit but were also responsive to their immediate needs.

All of the people who responded to our questionnaire said 'The support and care I receive helps me to be as independent as I can be.' People's care plans and risk assessments identified what they were able to do for themselves. One person's care plans stated 'Encourage [name of person] to do as much as possible." People's care plans provided staff with guidance in relation to them supporting people to undertake their exercises as prescribed by the physiotherapist; we spoke with a person who confirmed that staff did this. People were assisted by staff to retain their independence.

Staff encouraged people to attend the facilities and activities that were available within the Close Care apartments. These included coffee mornings, games and an exercise group; people could also attend activities in the nursing home. Staff enabled people to attend the hairdresser in the nursing home if they needed assistance to get to the salon. Staff told us that if people did not wish to do the activities then they encouraged and supported them to come out regularly for a brief walk, people confirmed this. Staff told us that they had time to spend with people as they provided their care; this was confirmed by people's care records. One person's care notes documented that staff "Had a chat" with them. Staff were observed to provide people's care at their pace and did not rush them. Staff ensured people did not become socially isolated and spent time with them as they provided their care.

People told us that their care was reviewed. A person told us "Staff review our care with us." People were each allocated a keyworker who was responsible for reviewing their care with them every three months and for updating their care plans as required for example, following any incidents. Staff completed regular reviews of people's care with them.

A person told us "I feel any concerns would be addressed immediately." All of the people who responded to our questionnaire said 'I know how to make a complaint about the care agency.'

People were provided with details about how to make a complaint if they wished to in the 'Residents Guide.' Staff told us that if a person had cause to make a complaint then they would ensure this was passed to the domiciliary care supervisor to address for the person. The service had last received a written complaint in October 2015. Records demonstrated this had been investigated and feedback had been provided to the complainant about the outcome. Processes were in place to enable people to raise any issues they had about the service provided.

Good

Is the service well-led?

Our findings

The aim of the Close Care service was to enable people to remain independent in their own home and to provide people with additional care and support where required. Staff told us they learnt about the provider's aims and values as part of their induction and this was confirmed by records. Staff understood what the provider's aims of the service were for people. Staff were observed throughout the inspection to implement the provider's aims in the course of their work with people.

Staff told us that the service had an "Open culture" and that it was a "Nice team." They said there were regular staff meetings at which they felt their views were heard; staff told us they felt valued. The whistleblowing policy was available to staff in the office and staff told us they were able to speak out as required. People were cared for by staff who were encouraged to raise any issues as needed in relation to people's care.

People told us "There is good contact with the manager," "It is well led" and "The manager is very efficient."

Although the service had not had a registered manager for over six months, the provider had taken reasonable steps to recruit one. They have provided us with regular updates throughout and had recently informed us that a manager had been appointed and that they were awaiting their start date. The nominated individual told us that the domiciliary care supervisor was responsible for the day to day running of the service and had been in their post since 22 June 2015. They were undertaking a National Vocational Qualification in leadership management. Staff told us that although the domiciliary care supervisor was responsible for the daily operation of the service they could also take any issues to the peripatetic manager for the site if required for support. Staff said there was an "Open door" policy if they wanted to go and see the peripatetic manager. They also said that the domiciliary care supervisor was "A good manager" who was quick to follow up on issues and that she "Visits people regularly." Another staff member told us the service was "Well-led." There were suitable management arrangements in place for the service.

The peripatetic manager told us that the domiciliary care supervisor was involved in the nursing home's daily meetings to ensure they were aware of issues across the two services that might impact on people's care, for example, if a person was receiving respite care in the nursing home. They also attended the weekly head of department meetings. The nominated individual and the peripatetic manager told us they were both available to support the domiciliary care supervisor in their role and gave an example of how they had supported them at a recent meeting. The service was well-led; the domiciliary care supervisor who was responsible for the day to day running of the service provided consistent leadership and direction for staff and were themselves appropriately supported.

A person told us "We get a questionnaire to fill in. They act on feedback." Records showed people and their relatives were sent a questionnaire every six months. These demonstrated a high level of satisfaction overall with the service. However, where people had not scored an aspect of the service so highly, it was not always possible to explore the reasons for this as the questionnaires were completed anonymously. We brought this to the attention of the peripatetic manager for their consideration.

The domiciliary care supervisor attended the Brendoncare Mary Rose Mews coffee morning on a fortnightly basis to meet with people and to hear their views. The peripatetic manager told us they had also recently met with people at the coffee morning. People's views on the service had been sought at the Annual General Meeting held on 25 February 2016. This was attended by the provider's Chief Executive Officer, the Chief Financial Officer the domiciliary care supervisor and the peripatetic manager to enable people to meet with staff including head office staff and speak with them directly about the service provided. Minutes demonstrated that no issues had been raised about the quality of the provision of people's care. People told us they had been invited to meet the applicants for the registered manager post prior to their recent interview, which records confirmed. There were processes in place at all levels of the organisation to seek people's views on the quality of the service provided and to involve them.

Records showed the domiciliary care supervisor completed a monthly check of the incident forms to identify if any further actions were required. There was evidence that where incidents had occurred, action had been taken to reduce the risk of repetition. A person had been referred to the falls clinic following a fall. Following another person's fall in the grounds, the provider had taken action and arranged for the paths to be tarmacked for people's safety. The senior carer told us people's medicine administration records were audited monthly which records confirmed. Records showed the domiciliary care supervisor audited whether people's reviews were completed with them on a three monthly basis as required. They also audited staff training records and where they identified staff were not up to date with their required training this had been arranged. The domiciliary care supervisor told us they also completed weekly maintenance fire risk assessment checks including escape routes, fire warning systems, lighting and equipment. Processes were in place to monitor the quality of the service people received and to drive improvement for people.

The peripatetic manager told us that following a recent incident which they had reviewed and discussed with the domiciliary care supervisor they had suggested the introduction of a log book to document all communications from people and their relatives in the same place to aid communication. We saw this idea had been introduced and that there was now a centralised record of people's communications and the actions taken in response. For example a person had contacted the service to request their care call was reduced and there was documentary evidence that this had been completed. The nominated individual told us they visited the site monthly including Brendon Care Mary Mews. If issues were identified then these were raised with the domiciliary care supervisor. There were processes in place to ensure that the peripatetic manager and the provider had oversight of the service and that this was used to drive improvements for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that all of the required information was available in relation to each staff member employed. This was a breach of Regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.