Hales Group Limited

Cecil Gardens

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21, 22 and 23 August 2018 and was announced. This was the first inspection since Cecil Gardens was registered with the Care Quality Commission (CQC) in July 2017. We gave the provider, Hales Group Limited, 12 hours' notice of our inspection. This was because the location provided a domiciliary care service and we needed to be sure the registered manager and staff would be available to support the inspection process.

Cecil Gardens provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

There are 95 individual flats in Cecil Gardens. Not everyone living there receives a regulated activity. The CQC only inspects the service being received by people provided with 'personal care', for example, help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of the inspection, 71 people were receiving the regulated activity of personal care from Hales Group Limited. There were also 63 people who lived in the surrounding area who also received calls for personal care from Hales Group Limited. Most were older people who had a range of needs, which included physical difficulties and those people who were living with dementia. However, there were other people who had mental health needs and a small number of people who had a learning disability.

The service had a registered manager in post, although a new person had been appointed as a 'care manager' and was in the process of applying for registration with CQC. The registered manager was to 'de-register' for this location once the process of registration with the care manager was completed. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Act 2008 and associated regulations about how the service is run.

During this inspection, we identified shortfalls in relation to medicines management, gaps in recording and quality monitoring of the service. These issues were breaches of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found people had not always received their medicines as prescribed. There had been some administration errors and also recording omissions, which made it difficult to check if people had actually received them. Staff received additional training and competency checks. The recording errors had persisted although were reducing. This meant people remained at risk of harm as the provider could not be assured people were receiving their medicines in line with the prescribing instructions.

There was a quality monitoring system and audits had identified some shortfalls. However, the system had not identified other recording issues. These included mental capacity documentation, missing dates and signatures on important assessments, the lack of an important care plan update following a significant change in one person's needs, no monitoring charts for pressure relief for a person at risk and some elements of risk identification. The quality monitoring had not identified a lack of time in-between care calls within Cecil Gardens.

Staff knew how to protect people from the risk of abuse and had completed training. They knew who to contact if they had concerns. Risk assessments were completed and steps put in place to minimise risk. Some risk assessments could have more information and guidance for care staff, which was mentioned to the care manager to address.

Staff supported people to meet their health and nutritional needs. They contacted health professionals when required and put in place plans to support people to make, and when required, eat their meals.

People told us staff supported them in a kind way and respected their privacy and dignity. They maintained confidentiality and ensured personal information was stored securely. People were supported to make their own decisions as much as possible. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff were recruited safely and employment checks were in place before they worked with people who could be vulnerable. There had been some issues with staff retention and the care manager told us recruitment was an ongoing process. The staffing levels had started to be more constant but were affected by issues such as long-term sickness and school holidays. The care manager told us the employment of 'bank staff' used when required to fill in gaps had helped the situation.

Staff had access to induction, training, supervision and support. The team leaders and care manager carried out spot checks of staff practice and assessed their competence in specific areas such as medicines management and moving and handling.

Staff described the registered manager, care manager and regional manager as supportive and approachable. They also described the culture of the organisation as open and willing to listen.

Staff were provided with personal protective equipment such as gloves and aprons, which helped them prevent the spread of infection.

The provider had a complaints policy and procedure, which was given to people when they moved into Cecil Gardens and received a service from Hales Group Limited. People told us they felt able to raise concerns.

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.

Some people had not received their medicines as prescribed.

Staff had received safeguarding training and knew what to do if they had concerns people were at risk of abuse. Risk assessments were completed. On one occasion, a person's significant health change was not reflected in records. This was quickly addressed by staff.

Staff were recruited safely and they were sufficiently deployed to meet people's needs. The registered manager monitored call times to ensure these were within an appropriate timeframe.

Staff had access to personal protective equipment, which helped them prevent the spread of infection.

Is the service effective?

Good

The service was effective.

Staff knew how to gain consent before delivering care to people. Staff had an understanding of mental capacity legislation and had completed training. However, records regarding best interest decisions could be clearer and include a discussion on the least restrictive option.

Staff supported people to meet their health and nutritional needs. They contacted health professionals for people as required.

Staff had access to induction, a range of training courses, supervision meetings and ongoing support from management. This helped them to feel confident when supporting people.

Is the service caring?

Good

The service was caring.

People told us staff had a good approach and delivered care and support in a kind way. People's privacy and dignity was

respected.

Staff supported people to be as independent as possible. They had completed training in equality and diversity and were aware of people's diverse needs.

Staff were reminded of the need to maintain confidentiality in the staff handbook and during induction. People's personal information and staff personnel records were stored securely.

Is the service responsive?

Good

The service was responsive.

People who used the service had their needs assessed and plans of care had been developed to guide staff in how to meet them in an individual way. Staff knew people's needs well.

The provider had an end of life policy and procedure; people were supported to remain in their home for end of life care if this was their choice.

The provider had a complaints policy and procedure. Complaints were recorded, investigations were completed and people were informed of the outcome.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although there was a quality monitoring system of audits and checks, some shortfalls re-occurred each month. There were also some shortfalls with records.

The provider had an open culture, which encouraged staff to be honest about mistakes and to learn from them.

People who used the service and staff described the care manager as approachable and available when needed.

Cecil Gardens

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 site visit took place on 21 and 22 August 2018. We gave the service 12 hours' notice of the inspection site visits because the location is a domiciliary care service and we needed to ensure someone would be in the office. We made telephone calls to people on 23 August 2018.

The inspection team consisted of one adult social care inspector, an assistant inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used the PIR and all the intelligence CQC held, to help inform us about the level of risk for this service.

We contacted the local safeguarding and contracts and commissioning teams to request their views of the service. We received information from two health and social care professionals involved with supporting some of the people who used the service. We spoke with reception staff at Cecil Gardens employed by Riverside.

During the site visit, we spoke with eight people who were tenants in Cecil Gardens and one of their relatives. We spoke to an additional seven people by telephone, five of whom lived in the surrounding areas and received support from the community team. We looked at care records for 12 people and other important documentation including medication administration records (MARS) and monitoring charts for food and fluid intake.

We spoke with the registered manager, the care manager and the regional manager. We also spoke with two

team leaders and five care staff who worked within Cecil Gardens. Additionally, we spoke with the care coordinator for the community service and four care staff who delivered care to people in the surrounding areas. We looked at recruitment files for five members of staff, staff supervision, appraisal and training records, as well as other records used in the management and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the staff who provided a service. Comments included, "I feel really safe; there is always somebody around and I have this [pendant alarm]", "I do feel safe; I would tell someone if it wasn't right", "They come in and put the brakes on the chair and help me. They make sure I am safe, one in front of me and one behind; that makes me feel safe and cared for" and "I feel safe the majority of the time; the staff are really nice and very caring." One person told us staff reminded them to use protective equipment necessary for their safety.

Medicines were stored in people's own homes and there were care plans and medication administration records (MARs) for staff to follow. Some people had not received their medicines as prescribed. Audits had also identified there was a large amount of recording errors, which made it difficult to check that people had received their medicines as prescribed. There were various reasons why staff had not administered medicines. Staff had not given one person specific medication for a two week period which impacted on their health. The medicine had not been reordered so had not appeared on the new MAR and had been overlooked. Some people's prescribed creams did not have clear directions so staff omitted them and staff were unable to locate some medicines or they were out of stock. There were gaps in recordings with no code to detail why the medicine was omitted. There were no clear directions for staff when some people's medicines were prescribed as and when required. Two family members also confirmed they had concerns about the management of medicines for their relatives.

Not ensuring the safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff had been vigilant and contacted the dispensing pharmacy when they noted discrepancies in labelling a person's medicines; this helped to prevent a potential error. The care manager told us they were monitoring the management of medicines closely and had taken actions such as completing additional staff competency assessments. They told us the number of medicines errors was reducing and they were continuing to monitor to ensure everyone received their medicines as prescribed.

There was a policy and procedure for safeguarding people from the risk of harm and abuse. In discussions, staff confirmed they had completed safeguarding training and they were knowledgeable about the types of abuse and the action they must take to report incidents. We saw the care manager reported incidents to the local safeguarding team.

People who used the service had assessments completed to identify potential risks. Those risk assessments seen included nutrition, dehydration, choking, infection leading to confusion, medication, falls, self-neglect and health related issues such as diabetes and alcohol dependency. A risk assessment had been carried out on people's home environment to identify issues such as fire hazards. There were also risk assessments for the use of equipment such as bed rails, hoists and the shower. However, there were some instances when people's risk assessments required updating in a more timely way, when changes in their needs occurred. For example, one person recently had a fall and their mobility needs changed significantly. Their risk

assessment and care plan had not been updated to reflect the change. In discussions with staff, they all knew about the changes and how to support the person with their moving and handling needs. The risk assessment and care plan was updated during the inspection.

People had personal emergency evacuation plans (PEEPs), which gave directions for staff should they need to support people to leave the building in emergency situations.

There were sufficient numbers of staff deployed in the service but there were mixed comments from people about the timeliness of calls with some stating there had been an issue lately with calls being late. We spoke with the care manager about this and they confirmed there had been some staffing issues over the school holidays but there was a constant recruitment drive to rectify this. There were three vacancies at present and existing staff completed shortfalls. Staff confirmed there had been some staffing issues especially when people phoned in sick at short notice but management tried to address this and staff completed additional shifts to ensure care calls were not missed. Comments from people who used the service included, "They haven't been on time lately; they were half an hour late today" and "Sometimes they are late; they will ring if they are going to be very late." People were happy that staff stayed for the correct length of time for the care call.

There were two team leaders on duty 24 hours a day for emergency calls for anyone who lived in the service. These calls could be requests for assistance in-between planned care calls or from people who did not receive a commissioned service. The team leaders may attend people together if two staff were required to assist people. This meant there could be a delay in answering the phone or requests from district nursing teams to access the building out of usual working hours but was unavoidable. Other people received calls commissioned by the local authority in line with their assessed needs. Staff told us they could report the need for additional calls to commissioners and these would be increased. The care manager told us there had been a large staff turnover since the service was registered with the Care Quality Commission in July 2017, which had impacted on the consistency of calls for people. This in part had been due to local public transport issues for some staff. However, they told us staff turnover was more settled now.

Staff were recruited safely. Application forms were completed so gaps in employment could be explored; where there were gaps, these were discussed during interview. Two references were obtained where possible but always one from the person's last employer. A check was made with the Disclosure and Barring Service (DBS), which indicated any criminal convictions or cautions and helped employers make safer recruitment decisions. Staff were issued with uniforms and identity badges following their recruitment so people who used the service could check their authenticity.

Staff were provided with personal protective equipment which helped to prevent the spread of infections. People who used the service confirmed they saw staff using the equipment such as gloves and aprons.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do this for themselves. The MCA requires, as far as possible, people make their own decisions and are helped to do so when this is needed. When they lack capacity to make particular decisions, any made on their behalf must be made in their best interest and as least restrictive as possible.

People's initial assessment indicated whether they had capacity to make their own decisions and there was evidence they had signed agreement to their care plan when they were able to. The care manager told us most people who used the service had capacity to make their own decisions. However, three people may meet the criteria for DoLS and the care manager had been in touch with social services to discuss their changing needs and whether an application for DoLS was required. They had capacity assessments and some level of restrictions, although documentation to support decisions made in their best interest could be improved and include comments about whether they were the least restrictive options. This was mentioned to the care manager who told us they would address this straight away. Staff had received training in MCA during their induction.

In discussions, staff described how they ensured people gave consent prior to care tasks. Staff comments included, "We ask people, everyone is able to say what they want" and "Always ask people, check out their care plan and see what approaches are best." People who used the service confirmed staff sought consent before carrying out care tasks. They said, "When they [staff] come in they say, 'Are we having a shower?'" and "They always ask my consent before doing things."

Staff supported people to access health professionals when required. They made appointments for people if requested, contacted relatives if they had concerns about people and telephoned GPs or emergency care practitioners as needed. Health professionals told us staff could check people's skin on more frequent occasions throughout the day for sore areas, however, staff told us the amount of calls provided to people was determined by the assessment completed by the local authority. They did contact commissioners of the service if they felt care calls needed to be increased.

Staff supported people to maintain their nutritional needs and prepared meals for them when part of the care plan. There was also a café in Cecil Gardens and some people chose to eat their meals there. People had care plans and task sheets, which described the support staff completed with meals. This ranged from prompts, heating up prepared meals, making a meal or assistance to the café. Staff told us they monitored people at nutritional risk and daily notes showed staff made people drinks, encouraged them to drink more and supported them to make meals. People who used the service confirmed staff supported them with their nutritional needs when required. Comments included, "They get my meals ready", "They are always telling me I don't drink enough; I try to drink more" and "I do them myself. I go down stairs and get a meal in the restaurant."

Training records showed staff completed a five-day induction. This covered training considered essential by

the provider and was in alignment with the Care Certificate. New staff also completed shadowing shifts and competency-based learning for moving and handling and medicines management before working with people unsupervised. There had been some concerns with staff repeating medicines errors, particularly recording errors, even following additional competency tests. The care manager told us these had reduced and they were monitoring it closely with supervision meetings with specific staff. Staff spoken with felt they received sufficient training. Comments included, "The induction was very interesting with lots of information and booklets to test us" and "There are refresher courses." Some staff commented that moving and handling training using equipment such as a hoist could be improved. This training used a specific hoist to train staff but they told us they encountered a range of hoists and types of slings. Some staff told us that although they had received training in epilepsy management, they required more in-depth follow up. These comments were mentioned to the care manager to discuss with training officers.

Staff confirmed they received supervision and felt supported by team leaders and management.

The office space and equipment provided for staff was sufficient for their needs. They also had access to a staff room with kitchen area, lockers and toilets.

Good

Is the service caring?

Our findings

People who used the service were happy with staff approach and the way they received care. They said staff had time to talk to them and show an interest in them. Comments included, "[Name of staff] is excellent; very experienced and they are nice girls", "I can't fault the staff, they are nice and kind", "I'm satisfied with the carers; they are good people and look after me well", "They are very caring and gentle; I don't really know what I would do without those two [pointing at photos of two staff]; they are my friends and I wait every day for them to come in and help me" and "They make me a cup of tea and see that I am alright."

Most people confirmed they were introduced to new staff when they were part of the team supporting them. Comments included, "Only this morning I was introduced to a new carer. It was their first day today and they were coming around with the carers" and "They always make sure that I know who is there. I have difficulty seeing them and get an idea of who is there." One person said, "They [staff] are all friendly and caring. The carers make it relaxing and friendly when they come. They make me feel at ease with their friendly nature."

People told us staff respected their privacy and dignity. Comments included, "They do [respect privacy], for instance when they take me through to the bathroom, they would put a towel over me, that sort of thing", "Absolutely, I think they respect me because they ask first and always tell me what they are doing; they would always knock on the door", "They never push and they treat you as a human being" and "When they come in, they cover me up with a towel; we see each other as friends and that is where the respect comes in." One person did say they would prefer to have the same carer, as it was difficult to get undressed in front of different carers each time. However, they did realise there had been some changes in care staff.

Staff had a good understanding of how to promote privacy and dignity. They said, "We close curtains and doors and keep people covered [during personal care]", "We don't have fobs now so can't just walk in [the flat] apart from those people at risk who can't answer the door themselves and we have codes for their locks" and "We speak to people in a non-patronising way." The care plans reminded staff to maintain people's privacy and dignity and staff had received training in equality and diversity during their induction.

Professional visitors to the service did not have any negative comments about staff approach. One person raised a concern with us about a specific incident and we spoke with the care manager about this. They were fully aware of the incident and it was in the process of being dealt with.

People who used the service all lived in independent flats but all required some level of support or oversight to ensure their safety and wellbeing. This support ranged from emergency cover only to several calls a day from care staff. Some people were very independent and others required physical assistance to meet their needs. Staff described how they supported people to be as independent as possible and how they encouraged people to do tasks for themselves.

Staff were aware of the need to maintain confidentiality. People's personal care records were held in their own homes and copies held securely in the main office. Staff personnel files were held securely. There was an office so the registered manager or team leaders could hold telephone conversations in private. Review

meetings to discuss people's care were held in their own flats. Computers were password protected to ensure only appropriate staff had access to them.

Good

Is the service responsive?

Our findings

People told us staff knew how to care for them in ways they preferred. Most said they had regular carers who knew them well. Comments included, "They fluff up my duvet for me", "They make a sandwich for my dinner and ask me what I want for breakfast", "They do what I want them to do" and "Any extra and they do it like emptying bins especially on dust-bin day."

People had assessments of their needs before they received a service from care staff. The initial assessment was completed by social care professionals from the local authority. This assessment determined whether people's needs could be met within an extra care facility and the scope of the care package required to support people. This assessment process highlighted the number of care workers required for each care call and when people's needs changed, the new manager or team leaders liaised with the local authority to increase the package of care.

The care manager and team leaders completed their own assessments of people's needs. They were in the process of transferring information from old style assessment and care plan documentation to the new style ones. The new style 'My support plan and assessment' was more detailed and provided staff with prompts to complete the document in a person-centred way. For example, it had sections for 'About me', 'My future' and 'My daily routines'. The assessment identified family contact information and the names and details of health and social care professionals involved with people's care. The assessment also identified needs and how they impacted on people, for example in relation to health, communication, continence, washing and dressing and how medicines were managed. There was also a risk assessment completed on each person's home to identify potential hazards.

The information from all assessments were used to formulate plans of care. Most of the care plans we assessed had good person-centred information. For example, one described in detail how the person could be very anxious and they required lots of prompts. It described what the person liked to eat for breakfast and that staff were to be mindful of not deskilling them by completing tasks for them that they were able to do themselves. The care plan indicated the person's call times were adjusted following a review and in response to changing needs. Advice from health professionals had been recorded in the care plan.

A second person's care plan was very detailed and covered their life history, their current wishes and goals, key important health information and daily routines. There was also information detailed in a positive behaviour support plan from a health professional, which was colour-coded and described the signs for staff to be aware of should the person experience escalation of their anxiety. This was very detailed and provided staff with good information to provide support in an individual way.

A third person's care plan described how they knew the risks of a specific activity but chose to take the risks and staff were to monitor and contact health professionals if required. The care plan for management of their skin gave a description of issues such as pressure, friction, moisture and shear so staff knew how to prevent them. However, although the person was at risk of pressure ulcers, they did not have a monitoring chart in place. This was mentioned to the care manager to address.

A fourth person's care plan described what they could do for themselves, how they liked support to be carried out and what made them agitated or angry. They also had a colour-coded positive behaviour support plan to give staff guidance when assisting the person at home. However, there was no information for staff on what to do if the person had agitated behaviours when out in the community. This was mentioned to the care manager to address.

One member of staff described how team leaders had responded when they told them care calls needed adjustment. They said, "They listened to us; the last call at night was 6pm but the person was very incontinent next morning so we put in later calls."

People could remain in their homes for end of life care if this was their choice. Support would be provided by local district nursing teams. The provider had an end of life policy and procedure, which referred to people's choice on where this care would be delivered and the development of a specific care plan to meet their changing needs and support for relatives.

People were supported to access facilities within Cecil Gardens such as the café, the computer room and planned activities. Some people had social support planned into their package of care such as shopping and trips into the community.

The provider had a complaints policy and procedure. People were provided with information on how to make a complaint when they started to receive a service from the provider at Cecil Gardens. There was a concerns and complaints form for staff to record issues and log the action taken. The form also prompted staff to consider whether the issue constituted a safeguarding concern and whether it required a notification to the Care Quality Commission. The complaints log showed there had been minimal complaints between 25 October 2017 and 9 July 2018. The care manager sent acknowledgement letters to people, completed investigations and informed complainants of the outcome. People who used the service told us they felt able to raise concerns if required. Comments included, "I would ring the office or [Name], the manager", "Touch wood, I have never had one but I'm sure it would be dealt with if I had one" and "They would look straight into it and see what could be done about it." In discussions, people confirmed they had been provided with a telephone number to ring if they had any complaints. Most knew the name of the care manager or quoted the names of other members of staff they felt confident in talking to.

Requires Improvement

Is the service well-led?

Our findings

People who used the service knew either the care manager's name or the care coordinator who oversaw the community domiciliary service. They told us they felt able to contact them if required and had been given the office telephone number.

Although the service had a registered manager, this was in the process of change. A new person had been appointed as care manager and was applying to the Care Quality Commission for registration. As soon as this is completed, the current registered manager will de-register for this location, as they are already the registered manager of another service within Hales Group Limited. The registered manager told us they visited the service one day a week and was in regular contact by phone to support the care manager. The regional manager provided support to the care manager when required.

There was a quality monitoring system in place which consisted of audits and checks of records, surveys to obtain people's views and spot checks of staff practice. There were also competency assessments for moving and handling and management of medicines. There were sections of the quality monitoring system that required improvement.

Each month there were audits on a selection of medication administration records (MARs) and daily recording logs. The audits of MARs and log books between January and March 2018 had recurring themes each time of missed signatures, staff not recording the times they logged in and out of a person's home and unclear directions on creams. The issues continued to occur each month through to July 2018, although they were decreasing.

The gaps in medication administration records were being identified in audits but they continued. When we assessed this more fully, it was noted care staff were told not to apply creams and ointments unless there was full guidance but 'as directed' appeared on a lot of the prescriptions issued by GPs. The care manager told us care staff would be expected to contact the person's GP to check the directions before application of the cream. However, this could take time and call times were limited, which impacted on whether people received application of their medicine. This system accounted for a large number of documented medication omissions and errors. The care manager confirmed they were to liaise with the local authority commissioners and a partnership organisation responsible for medicines support regarding this issue.

There were also surveys for people who used the service and for staff. On most occasions, there was action taken regarding the result such as a memo to staff to inform them of findings. The monthly staff survey in March 2018 recorded staff as stating they required more time in-between care calls within Cecil Gardens. During the inspection, we asked to see staff phones, which detailed their schedule; there was no time between calls on many of the ones we assessed. This had not been identified as part of the quality monitoring system and the new manager told us they were unaware there was no time between calls.

There were some concerns with recording elements of care and reporting on follow-up action. For example, there was important information from a psychologist about some people's care needs and although this

was included in the care file, selective information could have been included in the actual care plan, which staff could read. Another person had an informative care plan for management of their skin, as they were at risk of developing sores but there was no risk assessment and no monitoring chart; the latter was put in place during the inspection. We saw gaps in medication administration records and completion of mental capacity assessments and best interest decisions. Although risk assessments had been completed and risk identified, some of them needed more information to guide staff. The daily notes staff completed were limited at times and did not give a full picture of the support provided, especially when the person who used the service had anxiety and raised concerns about their mental health. There were dates and signatures missing from people's assessments. These issues had not always been identified and rectified via the quality monitoring system.

How staff completed the risk assessments led to confusion about the risk score before and after control measures were put in place. For example, staff recorded the initial score for a person at risk of falls as low when in fact they were a high risk. Following the introduction of control measures, they were scored a low risk. There were several risk assessments completed in the same way. The care manager told us they would update existing risk assessments and ensure staff understood how to complete them.

Not ensuring a more robust system of governance and full and complete records was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service confirmed they were asked for their views. They received phone calls and were asked what they thought of the care delivered and the members of staff who provided care. Comments included, "A senior asks questions every now and again", "We sometimes we get a sheet through the door or one of the senior carers comes and asks if everything is okay" and "I think every quarter we are asked for feedback." There was also an annual satisfaction survey, which had taken place in July 2018. The results had been collated and an action plan produced. The action plan was to be monitored by the care manager and regional manager to ensure it was completed.

Staff confirmed they attended meetings and also received memos for reminders and information about improvements that were required. They said communication was good and they could contact the office if required for support.

Staff described the care manager as approachable, easy to talk to and supportive. The care manager told us the culture of the organisation was open and encouraged staff to be honest about mistakes. There were different levels of management within the organisation and tiers of support for staff. There were meetings for managers within Hales Group Limited in order to share ideas of good practice. Staff were provided with a handbook, which provided information on specific core policies and procedures and expected ways of working.

Staff in the community told us their care routes had been reorganised and sometimes they had to retrace steps for care calls. The care manager told us there had been some issues regarding 'care rounds' due to staff sickness and confirmed staff had been switched from permanent rounds to cover shortfalls. This had been due to temporary staffing issues which recruitment had rectified.

There were incentives for staff to remain working for the provider and an 'Employee Portal' for them to access which provided information about benefits and news. There was a Hales Hero Award given for staff meeting specific criteria of reliability, providing quality care and being professional. Those nominated were entered into a monthly draw and had the opportunity of winning £1000. This was a good example of the provider valuing staff and recognising and acknowledging positive achievements. Other benefits included

child care vouchers, access to store discounts and remuneration when staff 'refer a friend' which results in recruitment.

The management team had developed relationships with other professionals involved in people's care. Health care professionals told us they had difficulty accessing the building when Riverside reception staff were not on duty. The care manager told us they would discuss this with health care professionals, Riverside staff and the Hales management team to try to resolve the issue. Team leaders told us joint working could be difficult at times. As people had group practice for GPs, it had been difficult to ensure for one person that all were aware of specific risks. For example, the person was at risk regarding their medicines and it had been agreed prescriptions were to be left with team leaders. However, this had not happened and the person was issued with the prescription despite staff highlighting this with the surgery. Staff now monitored this more closely. Management had built up good relationships with the dispensing pharmacy and contacted them for advice when required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not ensured medicines were administered accurately and in accordance with the prescriber's instructions.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not always ensured there was an effective system of governance and quality monitoring in place. There were shortfalls in some recording systems. The registered persons had not consistently ensured complete and contemporaneous records were maintained.