

Care at Home Services (South East) Limited

Margaret House

Inspection report

Lealands Drive
Uckfield
East Sussex
TN22 1FH

Tel: 018257010003






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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

Margaret House 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 or partially owned, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service. The building is owned by Saxon Weald and has a restaurant on site that provides a midday meal to everyone living at Margaret House under their service agreement. Communal areas are available on site where activities are provided.

Not everyone living at Margaret House receives the regulated activity. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection, there were 21 people receiving the regulated activity.

This was the first inspection of the service since their registration with the CQC in March 2018, following a change in provider. Staff and the care manager (branch manager) were based in an office within the 'extra care' housing.

This inspection took place on 14 and 18 of September 2018. It was an announced visit, which meant the service was given 48 hours' notice, to ensure staff were available to facilitate the inspection.

The service had an acting manager who was a registered manager at another service within the same organisation, and who had applied for registration as Manager of Margaret House with the CQC. 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.

Feedback that we received from people about staff and the service provided was very positive. However, the provider had not ensured all aspects of the service were safe or that the quality of the service was monitored. Systems and records did not support the safe management of medicines. Accidents and incidents were not recorded in a consistent way and did not demonstrate that they had been used effectively to reduce risks. They had not been reviewed or evaluated. Staff had not been trained on fire safety. Management systems had not been fully established to ensure suitable, accurate records were maintained in all areas. This included records relating to, accidents, medicines and 'best interest' meetings. We also found that the service had not notified CQC of all significant events which had occurred in line with their legal obligations in a timely way.

People were supported by staff they liked and who knew them well. Staff understood people's needs and preferences. People were visited at times they wanted and staff stayed the correct amount of time to meet their individual needs.

There were enough staff working with the right skills to respond to emergency calls and people's assessed needs. Staff had a good understanding of the procedures to follow to safeguard people from the risk of abuse and to protect people's individual rights. People's choices were assessed and staff delivered care in a person-centred way that reflected people's wishes.

Staff recognised when people's needs changed and staff ensured health and social care professionals were involved in regular reviews. Packages of care were updated as required and staff worked flexibly to respond to people's needs.

People were supported by staff who were caring and kind and took account of people's privacy and dignity. Where required, staff supported people to have enough to eat and drink and maintain a healthy diet.

There was an induction programme in place and rolling programme of essential training was being established. Staff were trained in the principles of the Mental Capacity Act 2005(MCA) and understood the importance of gaining consent from people. The management team knew the correct procedures to follow when people lacked capacity to make decisions.

People were asked for their view on the service and support they received and were aware of how to make a complaint. There was an open and positive culture at the service which had clear aims and objectives. Staff told us they felt supported, listened to and valued.

This is the first time the service has been rated Requires Improvement. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

Some aspects of the service were not safe.

Systems and records did not always support staff to manage medicines or accidents and incidents safely.
Staff recruitment practice was safe.

People told us that they felt safe with the staff that supported them.

Staff undertook training and procedures were in place to protect people from abuse.

There were enough staff working to meet the needs of people who used the service.

Is the service effective?

Good ●

The service was effective.

New staff completed an induction programme and staff undertook essential training to support them to meet people's needs. Staff were trained on the Mental Capacity Act 2005 (MCA) and understood its principles.

People's nutritional needs were reviewed and they were supported to receive enough to eat and drink.

Staff knew people well and recognised when they may need to be referred to an appropriate healthcare professional.

Is the service caring?

Good ●

The service was caring.

Staff treated people with kindness, and had a friendly caring approach to people.

People were treated with dignity and respect by staff who took the time to listen and communicate with them.

Staff understood the importance of confidentiality, so that

people's privacy was protected.

Is the service responsive?

Good ●

The service was responsive.

People knew how to make a complaint.

People received care and support that was responsive to their needs and reflected their individual wishes. Care plans were kept under regular review to ensure they were appropriate.

The provider offered activities that could be attended by people living at Margaret House.

Is the service well-led?

Requires Improvement ●

Some aspects of the service were not well-led.

The leadership and quality monitoring systems did not ensure best practice in all areas. Some records were not accurate or completed in a consistent way to support safe and effective care.

There was an acting manager in post who had applied to be registered with the CQC.

People felt the management of the service was effective and available.

Staff told us the management and leadership of the service was approachable and supportive. There was a clear vision and values for the service, which staff promoted.

Margaret House

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.

This inspection took place on the 14 and 18 September 2018. We gave the provider 48 hours' notice of our inspection because we needed to be sure staff would be available to support the inspection process. The inspection was carried out by an 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.

Before the inspection, we reviewed the completed Provider Information Return (PIR) which the provider had sent to us. The PIR is a form that asks the provider to give some key information about the service such as, what the service does well and improvements they plan to make. We also reviewed information we held about the service such as notifications. A notification is information about important events which the provider is required to send us by law. We contacted the local authority before the inspection to obtain their views about the care provided.

During the inspection process, we spoke with 11 people who used the service, and one relative. We spoke to six staff members that included the operations manager, care manager and four care staff.

We reviewed four care records and risk assessments. We looked at four staff recruitment files, staff supervision and training records, the service user guide, staff meeting minutes, audits and quality assurance checks. We looked at medicines records, accidents and incidents reports and a range of policies and procedures.

The inspector visited three people with a staff member in their own accommodation to gain their experiences of the care provided and to review relevant documentation. We were able to observe the support provided and interactions between people and staff.

Following the inspection visits we contacted professionals involved in caring for people who used the

service, including a commissioner of the service and two social care professionals, who could provide their direct feedback on the service.

Is the service safe?

Our findings

We found some practice at Margaret House was not always safe. Although there was a system for recording accidents and incidents, these were not recorded in a consistent way and did not demonstrate that they had been thoroughly investigated, reviewed and evaluated so that any risk of repeated accidents or incidents was reduced. Not all accidents or incidents were recorded on allocated documentation. Evidence of action taken to reduce risks associated with accidents and incidents was not clearly recorded. For example, two incidents relating to medicine errors had not been fully recorded and associated investigation into the incidents were not documented. The investigation did not include an interview of staff involved or a review of records or other factors that may have impacted on the incident. The management had ensured appropriate immediate actions had taken place to ensure people's health and safety. They had also notified the local authority as necessary.

Systems for handling medicines did not ensure staff always administered or supported people to take their medicines in a safe way. Although staff received training on the medication, staff did not routinely have their competency on safe practice assessed before providing this support to people. Specific medicine procedures to guide staff on how to safely administer and support people handling their medicines were not in place. For example, a procedure to guide staff in relation to the safe and consistent handling of medicines prescribed 'as required' was not available.

The medicine administration records (MAR) charts were not completed in a consistent way and did not always record what medicines had been taken. We found when topical creams were prescribed, when and how these were to be applied was not recorded clearly. When people were prescribed 'as required' medicines staff did not have guidelines on when these were to be given. This is particularly important when people have poor memory and need support with taking these safely. The care manager was aware 'as required' and topical cream records were not suitable and was taking steps to improve these.

Staff had not completed fire safety training. The care manager had identified this training as a priority to ensure they were all confident with actions to be taken in the event of a fire.

The lack of thorough review, investigation and monitoring of accidents and incidents, robust fire safety arrangements and safe systems for the management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew people well and had a good understanding of risks associated with their care and support. People and any associated risks were assessed and managed safely. Risk assessments provided staff with information and actions to reduce the risk that related to the individual and the environment. For example, moving and handling assessments that confirmed the correct equipment and practice were followed. Medicines risk assessments were also in place and described the risks associated with people administering their own medicines.

People told us they felt safe living at Margaret House and with the care and support arrangements. They told

us they felt safer now that a new provider was supplying the staff who were always available, night and day. They felt they knew the staff now and who to expect when they arrived to provide any care or support. One person said "New staff are better. I feel safe and secure. There is someone here at night and that makes me feel safe. Call bells are attended to quickly." Another said, "It is a very safe environment. I know I am well cared for and I have a call bell. I think it is better now."

People were protected against the risk of abuse or discrimination because staff knew what steps to take if they believed someone was at risk. Staff received training on safeguarding people and understood their responsibilities to protect people from the risk of abuse. Where concerns had been raised these had been reported appropriately to the local authority to ensure appropriate actions were taken to protect people. A visiting social care professional confirmed any safeguarding concern identified had been dealt with sensitively and appropriately.

There were enough staff to provide the support people wanted. There was a system to identify and review the support hours required for each person, each day. The care manager reviewed the staffing levels and availability to ensure all care visits were suitably covered. The staffing arrangements ensured two staff were working at Margaret House each day with a waking staff member working at night. Additional care staff were also scheduled to cover care and support visits. There was an emergency call facility in each person's accommodation which was used to call for additional assistance outside of the visits arranged. This ensured people's needs could be responded to in a flexible way. There was an on-call system to ensure staff had access senior staff and management if required. People told us there were enough staff and scheduled care visits were always completed. One person said, "Staff come when they are meant to and we get a sheet each week to say who the carers are."

The provider had safe recruitment procedures which enabled them to check the suitability of staff to work within the organisation. The provider had a dedicated recruitment team that progressed recruitment on an on-going basis. A range of pre-employment checks were completed before confirming staff employment. This included two references and a Disclosure and Barring Service (DBS) check. The DBS restrict people from working with vulnerable groups where they may present a risk and provide employers with criminal history information. Applicants had completed an application process, which included a telephone interview, completing an application form and attending an interview.

People were protected from the risk of infection. Staff followed good infection control practices when supporting people. For example, washing their hands before administering one person's eye drops. Staff had easy access to personal protective equipment (PPE) on site such as, gloves, aprons and hand sanitizers. Infection control training was part of the provider's induction programme.

The housing provider was responsible for maintaining the building and individual flats along with all its facilities and fire safety. The care manager worked well with the housing provider to ensure essential checks, such as emergency call systems and lighting, fire alarm and fire-fighting equipment, were undertaken regularly.

Is the service effective?

Our findings

People and their relatives were confident that staff at Margaret House had the skills and abilities to look after people effectively. They were pleased that the use of agency staff had stopped and there was now enough regular staff working to cover visits and shifts in the building. One relative said, "I know when I am not around the staff can take care of everything she may need." A visiting professional were impressed with how quickly the new provider had replaced agency staff with regular staff employed by the organisation. They told us this had ensured people received a consistent level of care from staff that knew them. This was supported by feedback that the professionals had received from people using the service.

People were given choices and asked for their consent before staff provided any care or support. One person said, "Staff always ask me if I agree to any care." Observations confirmed staff understood the importance of ensuring people were at the centre of their care and in control of the care and support provided. They consistently asked people for their consent and agreement throughout their visits.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Senior staff understood what constituted a deprivation of liberty and how Deprivation of Liberty Safeguards (DoLS) were authorised through the Court of Protection.

We checked whether the service was working within the principles of the MCA. Staff had received training on the MCA and DoLS. Staff demonstrated understanding of involving people in decisions and asking their consent before providing care and support. Staff also understood that it was assumed that people had capacity to make decisions. When there was a concern about people's capacity to make a specific decision a mental capacity assessment was completed. Relevant people including family, staff and health professionals were then involved as necessary to make a best interest decision. For example, when a sensor mat was used to monitor a person's movement out of their flat.

Systems for ongoing staff training and development were being established by the new provider. A training manager was in post and they, along with the management team had reviewed the training needs of staff. They recognised that some essential training was overdue and were taking steps to address this. A training scheduled was provided to CQC following the inspection which identified key areas for staff training to be provided as a priority to ensure essential training was available to all staff on an ongoing rolling programme. This included, equality and diversity, communication and documentation training all to be given before the end of October 2018.

New staff employed by the provider completed a three-day induction programme. The induction

programme was based on the 'Care Certificate', a common induction framework. This is a set of standards that health and social care workers follow. It helps to ensure staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. New staff also completed a shadowing period, working alongside senior staff, where they were supported in understanding people's individual needs and had their skills assessed before working on their own.

The provider worked with staff to develop their individual areas of interest and skills. For example, the care manager was being supported by colleagues and relevant training to develop her managerial role. Staff told us they felt well supported by the staff team and the management. One staff member told us, "My induction was very good and the support here is good, I have never had such good support from the manager." Another told us, "During my interview I was asked what aspirations I had and work opportunities were discussed." A supervision programme was in place which included one to one supervision and spot checks. Spot checks were undertaken by a senior care staff member or one of the managers who observed staff when visiting people. Staff were given the opportunity to raise and discuss any issues with managers on a regular basis within a supporting environment.

When needed staff supported people to maintain a healthy diet including adequate drinks. A restaurant was on site at Margaret House. The restaurant was run and overseen by Saxon Weald who provided a lunchtime meal as part of the tenancy agreement. For people who were not able to attend the restaurant or who were unwell, staff ensured a meal was provided to them in their own flat. During the inspection process a staff member noted one person was feeling 'frail'. They asked if they wanted their meal on a tray and duly ensured it was collected and provided. One person told us, "The carers help me get my lunch and tea and that is good." The assessment process took account of people's known dietary needs and risks. These were recorded and responded to within the care documentation and shared with housing provider to ensure specific dietary needs were attended to. For example, one person said, "I'm allergic to beef and they know about this." Staff were able to support people with food preparation and monitored dietary and fluid intake when this was an identified risk. For example, one person was not eating adequately, staff were monitoring their weight and encouraging an additional hot meal in the evening rather than a snack.

An assessment of people's needs was completed before a new service was offered or agreed upon. The purpose of this pre-service assessment was to determine if Margaret House was the right environment for people and the level of care and support that people required. Staff knew each person well and responded daily to people's needs and identified when people had any changing need, affecting their health or well-being. They were vigilant and took appropriate action when things changed. One person told us "They called the GP out for me last week and it all went smoothly." Staff had regular contact with each other, this included a formal handover at any change of staffing. They were constantly reporting back to the senior care staff who were working in Margaret House each day. The management team including the care manager had a very good oversight of people's needs and were involved in discussions around people's needs. For example, one person was seen by an optician and a change in treatment was recommended, staff contacted a pharmacist to ensure this treatment was given in the correct way. The care documentation and assessment process ensured when health and social care professionals were involved in the support of people this was clearly recorded. The care manager and senior care staff contacted professionals involved to ensure they worked together to enable people to live in their flats safely. Visiting professionals confirmed a close working relationship. A social care professional told us "Staff are easy to work with and they flag up things with us as needed."

Is the service caring?

Our findings

People told us the staff were kind, polite and caring and they liked them. One person said, "Carers are marvellous. If you need anything you only have to ask." Another said, "The care staff are lovely. I couldn't complain at all. Very kind, very nice." A third said, "Staff are kind and caring and look after me beautifully." A relative and visiting professionals were confident staff were attentive and caring. A relative told us, "Staff treat people like they would their own parents. They are always very helpful."

People enjoyed the company of staff and each other and interactions were positive. Staff engaged in every day conversations with people and listened to what they had to say. Staff demonstrated a genuine interest in people and a fondness. For example, staff talked about supporting a person who had been bereaved. A staff member told us "All staff are checking on them, giving them cuddles and sitting with them so they do not get too lonely." This demonstrated a genuine concern for people's well-being.

Staff were respectful of people and protected their privacy, dignity and rights. Staff ensured people's flats were only entered with people's consent and they respected they were visiting their home. Care records recorded how people liked staff to enter their flats, including calling out when entering. People could choose if they preferred personal care to be provided by a specific gender or age to protect their dignity. One person told us, "I have a choice of gender for carers and I'm dealt with dignity". Another said, "I'm can to choose gender of carer especially for showering because I'm old school." A third person told us, "I had an issue when my legs were so bad that I didn't want a young person to see them and help me, they were good and adapted to this."

Staff had a very good knowledge of the people they supported, including their life histories, the things they liked and did not like. The assessment process encouraged people to share their requirements and wishes and individual plans of care were developed with people. One person told us, "I was involved in the care plan otherwise I wouldn't have signed it." In this way staff were enabled to support people in a personalised way that was specific to their needs and preferences. Another person said, "I'm treated properly. I was involved with the care plan."

Staff understood everyone had different ways of living and made choices that must be respected. In this way peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs, choices and preferences. One staff member told us, "You have to be polite and respectful of people's beliefs, and accepting of how they wish to live." A staff member described how they had supported one person who had a strong belief about not impacting on the environment. This was very important to this person and this view was fully supported. People told us they were treated as individuals and encouraged to be as independent as possible. One person said, "I am treated as a 'person' by care staff."

Staff told us they felt they were valued as a team member and supported as a person. The provider promoted caring principles throughout its service and this included support for staff. There was a relaxed atmosphere between all staff including the managers as they shared information and discussed people's care. Staff told us they liked their work and one staff member said, "I would strongly recommend it as a

somewhere to work."

The care manager demonstrated a caring approach to staff. For example, one staff member had some family concerns and she ensured they had time off to deal with these. They said, "How can I expect my carers to care for our clients if I do not care about them." Other staff benefitted from this approach. For example, one staff member who lacked confidence in writing records was provided with extra support in this area to reduce their anxiety.

Confidential information was handled appropriately by staff. People's information was only recorded with their consent and kept confidential. This information was only shared with staff within the organisation who were required to know. There was a policy and procedure on confidentiality and confidential records held in the office were locked in cabinets. The staff training programme included handling information, and staff had a good understanding of how they maintained confidentiality.

Is the service responsive?

Our findings

People told us they got the support they needed in the way they wanted it. They told us they were fully consulted and involved in the planning of any care and support provided. One person said, "The care plan is just as I want." Visiting professionals told us staff were responsive and were in regular contact with them for advice and to review packages of care provided.

A social care professional said, "They are using a new model of staffing that allows flexible responsive care that ensures the correct support plans are followed." Another told us, "Staff have asked us to review the number of hours provided for one person who has increasing needs, but wants to stay in their own home. Staff have worked very flexibly with the time allocated to enable the person to be cared for in a safe way. However, they also encourage and promote their independence with some short visits." The management team were confident that their knowledge and understanding of people's needs was up to date with regular feedback from staff. This information was then used to inform the care package. People's needs were constantly under review, and additional visits and time was provided when needed.

The provider had reviewed all the care documentation since taking over the service. This had given the opportunity to review each package of care along with each person to ensure people had the correct call times and level of service. Each person had a copy of their new care plan, which they retained within their flats. One person said, "Everything is written down and I can see what and when they are coming." People were offered the opportunity of having another care agency provide their package of care if they wanted.

The provider could now offer a core team of staff to provide people with consistent staff. This was important to people who wanted to see regular staff who they knew, and who knew them, and their individual needs. One person said, "It is much better now with staff I know." Each person was given a schedule which recorded the planned visits along with the allocated staff member who would be attending. People told us staff attended when expected, stayed the correct amount of time and ensured they had everything they needed. One person said, "The staff always make sure to ask if I need anything else."

From 1 August 2016, providers of publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Although staff had not received AIS training they were attentive to people's communication needs. Communication was part of the individual assessment process completed for each person. Through this people's identified communication needs were responded to. For example, staff supported people to use hearing aids and glasses when needed. One person came to the office and staff took the opportunity to clean their glasses to ensure their sight was as good as possible. The care manager told us documentation would be produced in easy read format including large print if assessed as appropriate.

People could raise a concern or complaint if they needed to. People told us they had no cause for complaint but would know who to talk to if they had a concern. One person said, "I would go straight to the head office if there was a major problem." Systems were in place to record and monitor complaints when made. The

PIR confirmed staff were encouraged to highlight any feedback from people to the care manager so any concerns were resolved quickly. A suggestions box was also available for people to raise issues anonymously if they wanted.

Staff promoted social and leisure opportunities for people. People told us there was an improvement in the activities recently which they appreciated. They told us, "We had an outing last Sunday which I enjoyed," "Activities are very good," and "I'm enjoying the new range of activities." The provider recognised the importance of enjoyable activities which impacted on people's level of well-being, and provided varied opportunities for people living at Margaret House. A flip chart recorded activities available and these included bingo with prizes and a film club.

At the time of inspection, no person required support with end of life care. The care manager explained that should end of life care be required, they would work with the person, their families and health professionals to support them appropriately. Staff were sensitive when talking to people about end of life care and when they expressed wishes they recorded these within the care records. This included people's choices and decisions around resuscitation which were recorded appropriately.

Is the service well-led?

Our findings

The service was not always well led. We found the management arrangements and leadership of the service did not ensure safe, effective care in all areas. The management systems had not been fully established to ensure suitable, accurate records were maintained in all areas. For example, not all care records were signed and dated appropriately to ensure an appropriate audit trail of decisions made. This included records relating to accidents and 'best interest' meetings. This could impact on people's care and support, and lead to people not receiving the best care possible. Quality and auditing systems had not been used to ensure appropriate records had been maintained in all areas. This included those relating to the management of medicines.

The lack of effective quality review and monitoring is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that the service had not notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations in a timely fashion.

This lack of appropriate notification is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

There was no registered manager in post at the time of the inspection. However, there was a clear management structure with identified roles and responsibilities within the services. An application to register the acting manager had been received by the CQC and was being progressed. The acting manager was also a registered manager of another location within the organisation. A care manager carried out day to day management of the service and had taken up post in August 2018. As the management arrangements were new the operations manager was also working alongside the managers in a supporting role.

People told us their care and support was well managed. They told us the managers knew them and responded quickly and effectively to their needs. They were satisfied with the service provided and were comfortable with any contact made with the staff in the office. One person said, "I know the manager well and she does my paperwork." Another said, "I feel that I am listened to when I go into the office." The social care professionals we spoke with were confident the new provider was establishing a management team that they could work with effectively.

The care manager worked from the on-site office each day. They had regular contact with people and staff and had a clear understanding of people's needs and the skills of staff. She took an active role in developing and reviewing the packages of care with staff and people. In this way she could review the attitude and approach of staff to ensure it reflected the culture of the organisation. For example, staff demonstrated through conversations that they genuinely cared about people and worked in such a way that supported them in the best way possible. One staff member said, "We use kind thoughts, kind words and kind actions, to give the best care we can." The aims and values of the service were clearly recorded within the documentation shared with people and staff. Staff were clear that their aim was to provide a high-quality

service to improve the quality of people's lives and support their independence. This in turn enabled people to live in their own home.

Communication between all staff was well established and staff told us there was a good team spirit. Staff were welcomed when they came to the office and senior staff made themselves available and approachable. The atmosphere in the office was relaxed and friendly. One staff member told us "Staff morale is very good. We know where we are now and have a good manager." Staff felt well supported and valued for the work they completed. Any compliments received were shared with staff and the managers thanked staff for the work they undertook. The acting and care managers provided a 24 hour on-call telephone service for staff to contact in an emergency and for advice. The care manager confirmed she was also had access to senior managers within the organisation at any time. Staff meetings were held regularly and staff were kept up to date on changes to the organisations and the running of the service. For example, meeting minutes showed that staff had been informed of changes in procedures and staffing.

There were systems to gain feedback on the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People were contacted routinely to check on the standard of the service received. People were also encouraged to provide feedback through a monthly meeting held within Margaret House. One person told us, "There are regular resident's meetings and minutes."

The provider held regular meetings with the commissioners to support good working relationships that had been established. One commissioner told us, "It is a pleasure to work with them." The provider also held senior management meetings to share experience, learning and knowledge across the organisation. Managers were encouraged to share experiences and to listen to each other regardless of their position. The care manager told us they found these meetings informative.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured effective management and review, of accidents and incidents, or systems for the safe management of medicines.</p>

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Management systems that included quality monitoring had not always ensured safe and best practice was followed in all areas. The provider had not established systems that identified and responded to poor record keeping.</p>