Meadowvale Homecare Ltd

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Inspection report

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11 October 2019
15 October 2019
17 October 2019
22 October 2019
23 October 2019

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27 November 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Meadowvale homecare is a domiciliary care agency which provides personal care and support to people who live in Redcar and Cleveland. The service supported adults and older adults living with physical and mental health conditions, including dementia. At the time of inspection 98 people were using the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of inspection 50 people received personal care.

People's experience of using this service and what we found
People said their overall level of care had improved since the last inspection. They were clear that there were still areas for continued improvement, however they had confidence in the service to carry these improvements out.

Quality assurance process remained ineffective. Repeated concerns had been identified. Record keeping in all areas needed to be improved. Full oversight by the provider was required. The culture of the service had improved. The staff team had been working together to raise the standard of care at the service.

Staff were more responsive to risk, however records for risk needed to be improved. Robust processes to ensure lessons were learned needed to be implemented. There were mixed reviews about the timeliness of calls. We made recommendations about medicines records, infection control and systems for ensuring lessons were learned because the right procedures were not always followed.

The quality of which people received had started to improve. Care was more dignified. Continued improvements were needed when communicating with people. People were involved in their care and said staff respected their decisions.

People said they did not experience good care when calls were rushed. Mixed reviews were received about staff knowledge of people. The quality of care records had improved, however not all had been reviewed. Care plans and training in end of life care had not been put in place. Complaints had been investigated appropriately.

Further improvements were needed to the support which staff received. Mixed reviews were received about staff training. People were supported with their health and well-being needs, however records needed to be improved. People were supported with their dietary needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was inadequate (Published 29 June 2019).

There were multiple breaches of regulation.

The service had been placed into a serious concerns protocol with Redcar and Cleveland local authority. As part of this process, the provider shared an action plan each month and met with stakeholders (including the Care Quality Commission) to demonstrate the improvements which they had been making.

At this inspection we found improvements had been made in some areas. In other areas further improvements were needed. This meant the provider was still in breach of regulations in some areas.

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadowvale homecare on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the care which people receive, staffing levels and support for staff and the quality of the service and the support in place for staff at this inspection.

Please see the action we have told the provider to take at the end of this report. 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.

At the last inspection we recognised that the provider had failed to notify the Commission of incidents taking place at the service. This was a breach of regulation and we issued a fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Meadowvale Homecare Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector, one pharmacist inspector and two Experts by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. We needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 11 October 2019 and ended on 23 October 2019. We visited the office location on 11, 15, 17 and 23 October 2019.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used the information shared with us as part of our attendance at serious concerns protocol meetings. We also contacted

stakeholders with the Redcar and Cleveland serious concerns protocol forum to provide feedback. This included the chair, safeguarding team, commissioning and contracts team and South Tees CCG. We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people using the service and 13 relatives via telephone. We visited a further three people at their home. We spoke with the provider, who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the registered manager, deputy manager, recruitment manager, client liaison officer, two care co-ordinators and six care staff.

We reviewed 19 people's care records. We looked at three staff recruitment and induction records, six supervision and appraisal records and the training records for all staff. We also reviewed records relating to the day to day running of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider and registered manager to validate evidence found. We looked at quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Improvements were needed to ensure all risks were recognised and appropriate documentation was in place. There were gaps in some risk assessments reviewed and some information within them was not accurate. Where situations involving risks occurred, staff were responsive.
- Records did not accurately describe behaviours which challenge, and the support required. Incidents involving behaviours were not consistently recorded. Staff were not appropriately trained to deal with people who displayed behaviours which challenge.

The risk of potential harm to people remained. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to have safe recruitment procedures in place and did not ensure safe staffing levels. This was a breach of regulation 18 (Staffing) and regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18. The provider was no longer in breach of regulation 19.

- We received mixed reviews about staffing. Comments included, "Carers always turn up on time." And, "Carers (who walk to calls) are often late." And, "Rotas don't always allow enough travel time."
- People said care could be late, particularly where two staff were needed. Comments included, "Carers do not turn up one time. One is always late, leaving the other carer waiting." And, "We get two carers. The first one gets things ready. The other comes within 15 to 20 minutes." Staff confirmed this, citing travel time and delays at previous calls.
- People raised concerns about the consistency of carers involved in their care. Comments included, "Sometimes we have so many different care workers, it can be a little problem."
- Call monitoring systems had not identified the concerns raised from people and staff.

Further improvements were needed to ensure safe staffing levels. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements had been made to recruitment procedures. This has led to more suitable staff being recruited. Risks relating to the recruitment of staff were more safely managed.
● Recruitment records required further improvement. The recruitment manager had started to address these during inspection.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to safeguard people from abuse. This was a breach of regulation 13 (Safeguarding people from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Staff were more proactive in raising safeguarding concerns. Records relating to safeguarding needed to be formally recorded. Analysis of safeguarding incidents was not sufficient. Where safeguarding alerts had been upheld for abuse, staff had not followed the correct procedures.

Failure to have strong systems in place to manage safeguarding increases the risk of potential harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People said staff made them feel safe. Comments included, "I have no problems with safety when the carers come. They are really good with me." And, "The carers talk to me, they always make me feel safe."
● Staff reacted quickly when safeguarding risks to people were identified. As a result, people were protected from potential abuse.

Using medicines safely
At our last inspection the provider had failed to oversee the risks relating to medicines. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● The level of support that people had with their medicines was documented. Records were not always updated when changes took place. Body maps were in place to support the application of creams.
● Records relating to medicines administered were completed correctly. Records in-line with national guidance were not in place where people were prompted with their medicines
● The medicines policy needed to be updated to ensure it reflected current practice. The registered manager had put a system of checks in place for medicines records. These needed to be embedded.

We recommend the provider takes action to ensure that medicines records are completed in line with guidance where medicines are prompted. They should also ensure support with medicines is detailed in the care plan and is updated when changes take place.

Learning lessons when things go wrong

At our last inspection the provider did not have robust systems in place to deliver a safe service. This was a

breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had not carried out a lesson's learned exercise to examine the failings of the last inspection. Although improvements had been carried out, this had led to gaps in the quality of the service.
● Records to review incidents taking place need to more detailed to identify patterns and trends. Information recorded as part of incidents and investigations need to formally recorded.
● Staff were more vigilant and willing to raise concerns in a timely manner. They were able to give some examples where lessons had been learned. However, they had not been formally recorded.

We recommend the provider continues to embed the systems in place to ensure lessons are learned.

Preventing and controlling infection
● Staff had access to equipment to manage the risks of infection control. These were reviewed by senior staff during observations of staff practice.
● Some people said staff did not always following the correct procedures to manage the risks of infection.

We recommend the provider take action to review staff practices in managing the risks to infection control.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection staff were not supported to carry out their roles safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider was still in breach of regulation 18.

- The induction policy was not clear about the support available to staff during their probationary period. Staff had received an induction which included training. Not all care staff had completed the care certificate.
- Concerns had been raised about the knowledge of new staff. Comments included, "New carers need to communicate a little more. They do need training."
- Staff had been supported with supervision. However, this was not in line with the supervision policy. The shortfalls in staff appraisals had been largely addressed.
- Staff training in most areas was up to date. Training was still needed in behaviours which challenge and end of life care. These areas of training had not been identified by the provider.

There were gaps in the provision of support for staff to deliver safe care. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care

At our last inspection people were not consistently supported in-line with recommendations from health professionals. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People received the care which they needed. However, information relating to hospital admissions was not consistently recorded within people's care plans.
- Care records did not determine if peoples care needs required review after discharge from hospital.

Incomplete records increased the risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection the provider did not have good systems in place to meet people's needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● The right information was sought before people received care. People said they were asked about the care which they needed before using the service.
● Staff prompted people to use their equipment to manage their care. This also supported people with their independence.
● Staff needed to be aware of recognised guidance to support the delivery of care.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the risks to people with nutritional needs were not well managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● People were supported with their nutritional needs. Risks to people, such as dehydration were clearly identified. Recommendations from dieticians had been followed.
● Records were in place to show how to support people with behaviours, where this affected their nutritional intake.
● People said staff made sure they had enough to eat and drink before they left.

Supporting people to live healthier lives, access healthcare services and support

At our last inspection people were not consistently supported with their healthcare needs. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Care records had been updated to include recommendations from health professionals. Staff supported people in-line with these recommendations.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

At our last inspection staff did not work in-line with the MCA. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough

improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● Staff knowledge of mental capacity had improved. Staff had completed training and answered questions during meetings to check their competency.
● Consent records were in place. These had been mostly completed. Where gaps in records existed, they had not been identified during quality assurance checks.
● Certificates to show people did not wish to be resuscitated were available within people's records. These were up to date and staff understood the purpose of these certificates.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection people did not receive dignified care. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

- People said their dignity was compromised. This was because there were so many different staff involved in their care. Comments included, "There is no continuation of carers. That really does make a difference."
- There were mixed reviews about people receiving the assistance they needed. Comments included, "Carers lack knowledge about my needs. One watched me struggle to put my coat on and didn't help."
- People said some staff did not always communicate with them during their care. Some did not display the right attitude during care. They felt newer staff concentrated on the tasks they needed to do and forgot to talk to them. This was deemed to be a training issue. Comments included, "Some [staff] just do a job though and [there is] little communication." And, "Some [staff] do not even communicate at all. They just do a job."
- There were many people who said their dignity was maintained. Comments included, "They [staff] always give me dignity and respect. They are always kind towards me." And, "We have a wonderful relationship. Carers are kind and caring. They are always wanting to do more for me."
- People said staff encouraged them to be independent. This included prompts to use equipment, such as walking aides. Staff also assisted people to use technology, such as using mobile phones and addressing issues with tablet devices.

Ensuring people are well treated and supported; respecting equality and diversity

At our last inspection people were not treated in a person-centred manner. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

- People said staff were kind and caring. Comments included, "Carers make an effort to build a relationship with me. This makes me comfortable and safe." And, "The carers know what I like. They have a good laugh with me."
- Choices and cultural beliefs were respected by staff. Comments included, "They [staff] are always respectful. They allow me to have choices. This means a lot to me."

● Staff acted quickly when people were unwell. People said staff showed compassion. Comments included, "They [carers] are very kind and compassionate towards me. I look forward to seeing them."

Supporting people to express their views and be involved in making decisions about their care

At our last inspection systems were not in place to raise and respond to people's feedback about their care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● People were involved in their care. Reviews of care had been completed more frequently. Where concerns had been raised by people, they had been addressed through supervision and training with staff.
● Staff communicated with relatives and professionals when needed. There was flexibility in people's care to change calls to suit their needs. People said they were encouraged to be independent.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider did not ensure people received person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- Care plans were in the process of being updated. Some records contained detailed information to support staff to deliver care. Some required further review to ensure they contained accurate and up to date information.
- Some people said staff did not know enough information about them. This meant they were not always provided with the right care. Comments included, "New carers don't know anything about me." And, "The new staff don't know about me or what I need. They were supposed to read the care plan when they first come, but no one has asked where it is."
- There were mixed reviews about the quality of care. People said they experienced poor care when calls were rushed or where the second staff member was late. This led to gaps in the care which people received and did not lead to positive outcomes for them.

The lack of strong systems to make sure people consistently received the care they needed meant there was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- People receiving end of life care got the support they needed. Care plans for end of life care were not in place. Staff training to deliver end of life had not been completed.

This failure to address the systems in place to deliver end of life care has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Communication needs were identified within people's records. People were provided with information in a format of their choice.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Some people were supported into the community. This included shopping, areas of interest and to attend planned activities. The provider organised coffee mornings for people to attend.

Improving care quality in response to complaints or concerns

● People knew how to raise a complaint. Records in place demonstrated they had been investigated. Records relating to complaints needed to be more formally recorded.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has improve to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection, the provider did not take action to deliver a safe service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Leadership had started to improve. Changes were led by the registered manager and not the provider. The values of the service had started to be embedded. Further development was needed to ensure the quality of the service improved.
● The culture of the service had changed. Staff were committed. However, people and staff gave mixed reviews about the visibility of the management team. Comments included, "I don't know who the [registered] manager is." And, "The [registered] manager is great."
● All staff needed to have a shared understanding of current risks and challenges to ensure a continual quality driven process is in place.

Risks still remained at the service because leadership and oversight needed to be further strengthened. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection, the provider and staff did not work in-line with the policies in place to deliver a good service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● A registered manager was in post. They had developed a working action plan to make improvements to the service. They required appropriate support to continue with the planned improvements.
● Some policies required review. A formal process to review policies needed to be implemented.

● The provider had increased their oversight of the service. This was not sufficient to lead continuous improvement at the service. Although improvements had started to take place, a level or risk remained. A shared understanding of risk needed to be embedded.

Leadership needed to be further developed to ensure a good service was in place. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection, the provider did not manage the risks in place at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● A quality assurance system was in place. However, it remained ineffective. The current processes were not routinely identifying areas for improvement. There were gaps in audits themselves. Some audits were checklists rather than audits.
● The provider needed to increase their knowledge of the quality assurance process. This would help to embed and drive change to further reduce the risk of potential harm.
● Staff needed to further understand the requirements of their roles. As a result, repeated concerns had been identified and policies had not been consistently followed.

Systems remained ineffective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, the provider failed to notify the Commission about two incidents which took place at the service. This led to a breach of regulation 18 Care Quality Commission (Registration) Regulations 2009. The provider was issued with a fixed penalty notice and this was paid in full. The registered manager has put a new system in place to make sure all incidents are reported.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection, the provider did not have good systems in place to drive improvement. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Feedback was more regularly sought. Staff meeting minutes need to be formally recorded. There was no clarity about how minutes were reviewed by staff who were unable to attend meetings. Where actions have been identified during meetings, it is unclear if they had been addressed.
● A survey for people and staff had been completed. Overall, there were much more positive comments about the quality of care delivered. Where areas for improvement had been identified, the action plan did not accurately reflect them.
● Communication at all levels still needed to be improved. People said they wanted to be kept informed about planned changes to the staff attending their calls.

● Staff said they were supported in their roles. They were confident in raising concerns. Not all felt they would be listened to.

Engagement needed to be further developed to contribute to delivering good care. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At our last inspection, there was no evidence of improvement This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

● Increased resources had been put in place to drive improvement. This had resulted in some positive changes taking place. Additional resources were needed in places, such as to increase knowledge of the quality assurance process and embedding the new systems in place.
● Further improvements were needed to make sure the service continued to learn from events taking place at the service. Quality assurance measures needed to be strengthened to allow a culture of continual quality improvement to be embedded.

The framework for learning needed to be further developed to ensure the level of care which people received was consistently improved and led to positive outcomes. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The provider had asked the local authority commissioning team for support to make improvements. This support had been given and the service had a working action plan in place. This was continually reviewed during serious concerns protocol meetings where feedback was given.
● The service shared information with professionals when needed. They also sought advice from professionals when people's needs changed.