Unicare (London) Limited

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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

This inspection took place on 14 and 16 January 2019 and was announced.

We last inspected Unicare (London) Limited on 8 June 2016 and rated it 'Good' overall with the key question of safe rated as 'Requires Improvement'. This was because we found that the service had not obtained criminal record checks and references for all care staff at the time of their induction.

At this inspection we found that the service had made the required improvements in relation to this, however we found a number of concerns around risk assessments, medicines management and administration and the management oversight processes of the service.

This means that the service is no longer rated 'Good' and has been rated as 'Requires Improvement'.

Unicare (London) Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people and people with a range of physical and sensory disabilities as well as people living with dementia.

This service also provides care and support to people living in one 'supported living' setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Not everyone using Unicare (London) Limited receives a 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 take into account any wider social care provided. At the time of the inspection the service was providing care and support to 33 people.

A registered manager was in post at the time of this inspection. 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.

Although care plans identified people's risks associated with their health and social care needs, the service had not assessed specific risks associated with people's health and medical needs. This meant that care staff were not provided with direction and guidance on how to minimise the identified risk to keep people safe and free from harm.

Medicines management and administration processes were not always safely followed. Gaps in recording, incomplete information about medicines and lack of instruction about the level of support people required with their medicines, meant that people may not always have been receiving their medicines safely and as

prescribed.

Management oversight processes in place did not identify the issues and concerns that we found especially around the lack of appropriate risk assessments and medicine administration and recording.

Care staff were supported to carry out their role through induction, regular training, supervision and annual appraisals. However, competency assessments completed to assess staff understanding and knowledge in areas such as medicines administration had not been completed appropriately.

Assessments of people's care and support needs were carried out before they started using the service to confirm that the service could meet their needs effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People had consented to their care and support and where people were unable to consent, relatives had been involved in the care planning process where appropriate.

Care plans were person centred and recorded peoples, likes, dislikes, preferences, cultural and religious requirements and background history. This enabled care staff to provide care and support that was responsive to their needs.

Care plans were current and reflective of people's needs.

People and their relatives confirmed that they felt safe with the care staff that supported them. The registered manager and care staff demonstrated a good understanding of safeguarding and were able to describe the steps they would take to protect people from abuse.

The service carried out a variety of checks to ensure that only those staff identified as safe to work with vulnerable adults were recruited. There was enough staff available to meet people's care and support needs.

People were also supported with their nutritional and hydration requirements where this had been identified as an assessed need.

People and their relatives told us that they were happy with the care and support that they received and that care staff were caring and kind with whom they had developed positive relationships with.

People and their relatives knew who to speak with if they had any concerns or complaints to raise and were confident that these would be dealt with appropriately.

People, their relatives and staff spoke positively of the leadership and management of the service.

At this inspection we found the provider to be in breach of Regulations 12 and 17 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.

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. Risks associated with specific health conditions were not always assessed and guidance had not been provided to care staff on how to support people with those identified risks to keep them safe.

Medicines management and administration recording was not always safe.

People and their relatives confirmed that they received care and support from regular care staff were generally always on time.

Safe recruitment processes were followed to ensure only those staff assessed as safe to work with vulnerable adults were recruited.

People and their relatives felt safe with the care and support they received. Care staff knew how to protect people to be free from harm or abuse.

Is the service effective?

Good

The service was effective. Care staff were supported to carry out their role through induction, regular training, supervision and annual appraisals. However, competency assessments completed to assess staff understanding and knowledge in areas such as medicines administration had not been completed appropriately.

People's needs were assessed prior to the service providing care and support to ensure that the service could meet appropriately meet the person's needs.

People received the appropriate support with their nutritional and hydration needs.

People were supported to access health care services where this was an identified and assessed need.

Consent to care had been obtained in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People and their relatives were complementary of the care staff that support them and told us care staff were kind and caring.

People and their relatives received care and support from a regular team of care staff with whom they had developed positive and caring relationships with.

People were involved in day to day decisions about their care and support needs and care staff supported them accordingly.

People and their relatives told us that care staff were always respectful of their privacy and dignity. Care staff gave examples of how they upheld people's privacy and dignity.

Is the service responsive?

Good

The service was responsive. Care plans were person centred and detailed people's care and support needs and how care staff were to support them with those identified needs.

Care plans were current and reflective of people's needs and preferences and were reviewed and updated on a regular basis.

People and their relatives knew who to speak with if they had a complaint and were confident it would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led. Audits to check and monitor care provision did not identify any of the issues that we identified as part of the inspection process.

People and their relatives knew the registered manager and were complementary of them and the way in which they communicated with them and their relative.

The service encouraged people and their relatives to engage with them in giving feedback about the quality of care and support they received so that improvements and further development of the service could be explored.

Staff told us that the management were very supportive and were always available when needed.

The service worked in partnership with the local authority and

other healthcare professionals to ensure that people received appropriate care and support.

Unicare (London) Limited

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 14 and 16 January 2019 and was announced. We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the registered manager would be available to support the inspection process.

The inspection was carried out by one inspector and one 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. Their role was to telephone people using the service and their relatives to ask them their views about the service.

Inspection site visit activity started on 14 January 2019 and ended on 16 January 2019. We visited the office location on 14 January 2019 to see the registered manager and to review care records, policies and procedures. On 16 January 2019 we visited a supported living scheme at which the service provided the regulated activity of personal care to two people.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

During the inspection, we spoke with the nominated individual, the registered manager, a training consultant and seven care staff. We received feedback about the service from five people using the service, six relatives and one healthcare professional.

We reviewed the care records for eight people to see if they were up-to-date and reflective of the care which people received. We also looked at personnel records for six members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the

service, including complaint and safeguarding records, to see how the service was run.

Requires Improvement

Is the service safe?

Our findings

We asked people and their relatives if they felt safe and reassured with the support that they received from care staff from Unicare (London) Limited. One person told us, "Yes, my regular carer is lovely and makes me feel very safe and happy." Another person stated, "Yes, I used to work as a healthcare professional so I know what safe handling is and they are very professional. I have no concerns and if I did, I would say." One relative told us, "Yes, my [relative] gets regular carers which is very important so no strangers turn up."

The service identified risks associated with people's health and social care needs. Care plans contained risk assessments which identified the risk, how the risk affected the person and steps to be taken to minimise or manage the known risk so that people remained safe. Assessed risks included the environment, fire, moving and handling and behaviours that challenged.

However, for some people, we found that risk assessments had not been completed for specific health conditions and associated support needs that could place people at risk. For one person, who had been diagnosed with diabetes, a risk assessment had not been completed defining known risks such as high or low blood sugars, how this would affect the person and the steps care staff would take to support them manage the risk.

For another person who was being supported with the management of their urinary catheter, a risk assessment had not been completed to give guidance and direction to care staff on the known risks associated with the use of a catheter and how to safely minimise those risks. A urinary catheter is a tube that carries urine out of the bladder. This meant that people could be placed at risk of harm.

A medicines policy was in place to ensure people received their medicines safely, on time and as prescribed. However, we found that this was not always fully followed. We found a number of gaps and omissions in the recording of medicines. We looked at three people's Medicine Administration Records (MARs) for November and December 2018 and found that for two people, there were some gaps in recording where care staff had not signed to confirm the person had received their medicines. We looked at corresponding daily records for those people where we did note that care staff had recorded that medicines had been administered. This meant people were placed at risk of harm as it was not clear they had received their prescribed medicines?

Where care staff were noted to provide people with medicines support, a current list of their prescribed medicines had not always been recorded on their care plan or the level of support the person required with the administration of their medicines.

Care staff told us and records confirmed that they received training in medicines and that they had been observed by a manager when administering medicines to ensure that they were competent in doing so. However, competency assessments were not fully completed and did not define the practices observed and whether staff were competent. The forms were blank and had only been signed and dated by the care staff and the assessing manager. This meant we could not be confident staff were competent to give medicines safely.

The registered manager had processes in place to audit and check completed MARs so that issues and gaps in recording could be identified and addressed with the relevant care staff to ensure people received their medicines safely. However, the audits that had been completed did not identify any of the issues that we found as part of this inspection. The above concerns found during the inspection could place people at risk of harm and at risk of not receiving their medicines safely and as prescribed.

The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we showed the registered manager and the provider the issues we had found. Following the inspection, the registered manager sent us completed risk assessments for all people, where there was an identified risk associated with their health or medical needs and updated audits of MARs which took into consideration gaps and omissions in recording and the actions they had taken.

Relatives were positive in their feedback about their relative receiving their medicines. One relative said, "The carers always say what the tablet is for and give [relative] a glass of water." Another relative stated, "I have only seen them give [relative] their medicine a few times but every time they get a glass of water and I see them read the box before they got it out."

Care staff knew the people they supported well and could describe any known risks and how they would support people. One care staff member told us, "The care plans tell me all about my client, what they have, what they need and what to look for." One relative commented, "For example, she [care staff] was concerned that [relative] had a bit of irritation from the catheter so she let me know straight away, even though she had already phoned the district nurse, just to keep me informed."

Care staff explained their understanding of safeguarding people and named the different types of abuse that people may be subjected to and told us of possible signs of potential abuse. Care staff were clear that any concerns that they had would be reported to their manager. One member of care staff stated, "I would report it to my manager and in case he doesn't do anything about it I would go further. We don't accept abuse in our company." Staff understood how to whistle-blow and named professionals that they could contact such as the local authority, the police and CQC to report their concerns.

The service understood its responsibility and requirement to report any concerns of abuse to the relevant safeguarding authorities. Safeguarding concerns raised by the service or to the service were documented with details of the concern and the actions taken to ensure people were safe and free from harm or abuse.

At the last inspection in June 2016 we found that criminal record checks had not been in place whilst induction for new staff members was in progress which included shadowing experienced care staff at people's own homes. On some occasions we found that these staff members were also administering medicines during this time. During this inspection we found that this issue had been addressed.

Recruitment processes followed by the service included obtaining criminal record checks, references of conduct in past employment, proof of identification and right to work in the UK so that staff could be suitably assessed as safe to work with vulnerable adults. These were obtained prior to the person starting their employment with the service. However, we did note that gaps in employment and verification of references received were not always explored and verified. We highlighted this to the registered manager who assured us that going forward these enhanced checks and verifications would be carried out and documented.

People and their relatives told us that they were always supported by regular care staff who they had got to know and were comfortable with. Care staff generally arrived on time and where they were running late good communication from the office meant that they were always kept informed. Feedback from people included, "They are almost always on time", "They are hardly ever late but if they ever are, they let me know which is polite" and "They are very good to get here on time because I like to be up early." One relative told us, "They have been brilliant for the last two years, always on time and always stay for the whole half hour and they are busy the whole time. They don't just hang around for half hour to waste the time."

The registered manager confirmed that there were enough care staff available to meet the current needs of people the service supported. There had been no recorded missed visits. Rotas seen confirmed that people received care and support from a regular team of care staff. Travel time was allocated between calls and people's preferred call times had been accommodated.

There had not been any reported accidents or incidents recorded since the last inspection. Systems and processes were in place to record any accident or incident that care staff reported whilst delivering care. The registered manager explained that they would discuss with care staff any concerns or issues arising from any such accident or incident so that learning and further awareness could be explored.

Adequate supplies of PPE such as gloves, aprons and shoe covers were available for staff to collect from the office or were also delivered by the registered manager to care staff in the area where they were allocated to work.

Good

Is the service effective?

Our findings

People and their relatives told us that they felt care staff knew what they were doing and demonstrated skills and an approach that was caring. One person told us, "I don't know if they have training, they have never said, but they seem to know what they are doing." Another person said, "I can say they have the skills because they are caring people but that's all I can say." Relatives told us, "Yes the staff are very sensitive and I see them make sure [relative] is comfy" and "I have seen them wash and dress [my relative] and they are very gentle and kind and they seem to know what they are doing."

Care staff told us and records confirmed that they had received an induction when they first started work for the service. This was followed by a period of shadowing of a more experienced member of staff so that they could be assessed as competent and demonstrate confidence before they were allocated a package of care. We saw records confirming care staff received training in topics which included safe administration of medicines, MCA, safeguarding adults, dementia awareness, challenging behaviour and infection prevention and control.

However, where the service assessed staff members competency in areas such as medicines administration, safeguarding and skills knowledge these had not been completed effectively. Some assessments had nothing recorded on them other than a number or letter signifying competence, some were not dated and did not document who had overseen the assessment and confirmed competency of the particular staff member.
We highlighted this to the registered manager stating that these assessments did not assure or confirm competency of staff. The registered manager agreed to review these processes but did state that regular spot checks of care practices and quality of care, records of which were seen, gave them assurance that care staff were effectively trained and skilled to carry out their role.

We saw records confirming that care staff were regularly supported through supervisions and annual appraisals. Care staff spoke highly of the registered manager and other office staff who they stated were very supportive and always available when they needed. One member of care staff told us, "We talk about my work, how I am feeling and how everything is going. During my appraisal we spoke about me moving up. I am doing my level three qualification in care."

The service assessed people's needs effectively. Following any referral received by the service for the provision of care, the service carried out a client health and social care assessment to assess and determine people's needs to confirm whether they could effectively meet those needs. The assessment considered people's preferences and needs in relation to personal care, mobility and dexterity, mental capacity, skin integrity and any behaviours that may challenge. Information collated was formulated into a care plan which detailed the person's support needs and the ways in which care staff were to deliver the appropriate care. Care plans were reviewed every six months or sooner where a person's needs had changed.

People were only supported to eat and drink where this was an identified and assessed need. Care plans included information about the support people required with their meals and where people had specialist

requirements, including specialist diets or support with eating their meal, details and guidance around this had been clearly documented. People's likes and dislikes or choices in relation to food and drink were not always recorded, however, care plans clearly recorded that care staff should always ask what people wanted to eat and drink at the time of the care visit. One person told us, "The carers are lovely and always make me a nice cup of tea."

We saw records detailing communication between the service and a variety of health and social care professionals to ensure that people were supported to access these so that they could continue to maintain good health and positive well-being. Care staff documented daily their observations and tasks that they had undertaken for each person they supported so that information could be exchanged with other care staff, professionals and relatives.

For most people receiving a service, family members and relatives were involved in supporting the person with all their health care needs. Where required the registered manager and care staff worked in partnership with social workers, mental health services, district nurses and GP's. People and their relatives told us that care staff were observant and responsive to their health and gave examples of when care staff had called emergency services or health care professionals to raise their concerns. One relative told us, "When [relative] was poorly, they phoned for an ambulance straight away and let me know. They are good for that and don't hesitate if they are concerned."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. There were no people using the service that were subject to a judicial DoLS.

Care plans recorded people's consent and agreement to the package of care that the service provided. However, some care plans did not have the person's signature but a computer print of the person's name was used as a signature of consent. The registered manager said that as assessments and care plans were compiled on a hand held electronic device it was difficult to obtain physical signatures from people. The registered manager agreed to review their processes to ensure people confirmed consent to the care that they received. Where people lacked capacity to consent to their care, records confirmed that relatives had been involved in the care planning process.

Care staff demonstrated a basic awareness of the MCA and its key principles in supporting people especially where they were assessed as lacking capacity. Care staff told us ways in which they supported people especially where people were unable to make simple decisions about the way in which they received their care. One care staff member told us, "If in case they [people] don't have capacity you do things that are in their best interest. We ask them for their consent and we give them choice. When they refuse we try to

persuade them. We have got to know them."

Good

Is the service caring?

Our findings

When we asked people and their relatives if they found care staff kind and caring, the responses we received were overwhelmingly positive. One person told us, "They are very caring. They make time to talk." Another person said, "I worked in the healthcare and know what a good carer should be doing and they are definitely good, very kind, friendly and professional." Relatives comments included, "Yes, they are definitely and it's nice to get the same ones all the time so [relative] is very happy" and "The carers are very caring and [relative] likes them very much, which is very important."

People and their relatives told us that the care staff that supported them very well and always went the extra mile to ensure that they were safe and comfortable. People had established friendly and positive relationships with their care staff. People told us, "They are very good, especially [carer name]", "The carers are very friendly and do everything I need them to do" and "They make time for a chat and ask if they can do anything else for me before they go." One relative explained, "[Carer name] is brilliant. If she is concerned at all she comes and knocks on my door, I only live over the road, but she makes time to run over and let me know if she has any worries."

Care staff we spoke with demonstrated great dedication about their caring role. They spoke about the people that they supported with respect and compassion and it was clear that they had got to know the person really well. One care staff explained, "I care for my clients. I do it from the heart. I always go the extra mile to give them the best."

People told us that care staff always involved them in making decisions about the way in which they received their care. One person told us, "They always ask before they do things. I feel very comfortable with them." We received mixed feedback from people about their care plans. Some people knew of their care plan and confirmed they had been involved with compiling it. Other people could not quite remember or understand what a care plan was. However, relatives confirmed that they had been involved in setting the care plan. One relative told us, "I think we did it when [relative] first started receiving care. She gets the right care anyway so there must be a plan." Another relative stated, "Yes I was very involved. We all sat down together and everyone had their say."

People and their relatives gave examples of how care staff supported them in ways which upheld their privacy and dignity. People told us, "Oh yes, they are very private and they make sure I am all covered up" and "Yes, the carers help me with washing and dressing" Examples given by relatives included, "If I am there when they are dressing [relative] they always maintain her dignity even in front of me" and "Yes they are very good about things like that. They make sure [relative] is very clean and are very sensitive and gentle. It must be very embarrassing but they make the best of it."

When we spoke with care staff and asked them how they ensured people's privacy and dignity was respected, the examples they gave resonated with what people and their relatives had told us. One care staff member explained, "When I go to the person, I support them in private, I ask their permission, I give them choice and I let them know what I am doing." Care staff also told us about ways in which they supported

people to promote and maintain their independence. One care staff member said, "I always try and support them [people] with things they can do." Another care staff member told us, "I encourage the person to be independent."

Although care plans included only some basic information around people's diverse needs and requirements, care staff demonstrated a good awareness of people's identified needs and issues of equality and diversity. For example, recognition and acknowledgement of people's faith, culture, religion and sexuality. One care staff told us, "No, no it doesn't make a difference to me. I am a caring person and I am there to do my best for people. I don't see their culture or sexuality or anything. Everyone is equal to me."

Good

Is the service responsive?

Our findings

Care plans were person centred and gave information about people's health and care need, their likes and dislikes and how they wished to be supported. Care plans also included background information about people and their life history. This enabled care staff to understand people's needs and provide care that was responsive to those needs. Care plans were reviewed and updated as a minimum on a six-monthly basis or sooner where people's needs had changed.

Each person's care plan included a one-page person centred care plan which listed the person's needs and then listed the tasks that care staff needed to be complete in response to the identified needs. The plan also listed the timings and length of each call. One person's care plan recorded, 'I need my breakfast to be prepared and served between 8am and 9am'. We looked at daily records for this person and found that the person received their care call at that time.

Where people received support with activities, especially those supported by the service in a supported living scheme, details of their likes and dislikes, hobbies and interests and how they wished to be supported, were listed in the care plan. We asked one person about how they were supported to participate in activities. They told us, "I like doing my own thing. I can cook and I choose my own meals."

The providers complaints policy detailed the processes to follow to investigate and resolve any complaints received. Since the last inspection the service had only received one complaint, which was dealt with appropriately.

People and their relatives told us that they knew who to speak with if they had any concerns or issues to raise and were confident that the service would address their concerns appropriately. One person told us, "I would phone up if I had to and [Registered Manager] would sort it out". A relative said, "I haven't ever needed to complain but they would deal with it fairly I believe."

Requires Improvement

Is the service well-led?

Our findings

The registered manager showed us records of audits and checks that they completed to monitor and oversee the quality of care that people received. This included spot checks of care staff whilst delivering care and support, management and administration audits, client care administration audits and personnel audits. These were completed on a quarterly basis. However, we found that most recent audits of care plans, MAR's and daily records completed in November and December 2018, did not identify any of the issues that we found as part of this inspection. This included the lack of risk assessments identifying the risks associated with certain health conditions, gaps in medicine administration records and incomplete competency assessments, post medicine administration training, that care staff received.

Where the service had identified issues as part of their auditing processes and spot checks, these had been recorded, but detail of the actions taken, follow up of actions and timeframes of completed actions had not always been recorded. For example, an audit of daily records, highlighted issues with the quality of recording by care staff and an action was to discuss this at the next staff meeting. However, when we checked the minutes of the staff meeting following the audit, there had been no further discussion of the issue with care staff. Spot checks completed, identified that care staff were not always carrying their identification card when attending to care calls. However, there was not further detail of the actions taken by the service to address this.

Therefore, the service did not always appropriately monitor and oversee the quality of care that people received so that the required improvements could be made and further development of the service could be implemented. People may have also been placed at risk of receiving care and support that was not always safe and responsive to their needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These concerns and issues were highlighted and discussed with the registered manager and the provider throughout the inspection. Following the inspection, the registered manager sent us improvements that had been made to the issues we had found which included improvements to their management oversight and governance systems.

People and their relatives knew the registered manager and spoke positively about them and the way in which they communicated with them. Comments from people included, "The manager is very nice indeed and cannot help enough" and "He [registered manager] is a very nice man, very kind and polite." Relatives told us, "I met the manager when [relative] first needed care. He came out to do the assessment and was very nice, [relative] liked him straight away" and "The manager is a very nice man and I think the office is professional because they always try to help."

Care staff also spoke highly of the registered manager and told us that he was "a good manager" and "very supportive." One care staff member said, "He [registered manager] is very good. Whenever I need I call them

they are there, he is always available." Care staff told us and records confirmed that regular staff meetings were held in addition to other support mechanisms in place which gave them the opportunity to share experiences, learn and share their own ideas and suggestions. One care staff member told us, "We have team meetings every two months. We discuss what we do, what has gone wrong, we share experiences and we learn."

The registered manager had just recently introduced an annual award scheme for care staff which recognised their work and performance over the year. Nominations for the award was based on feedback about care staff received by fellow colleagues, people using the service and the office management. Care staff who had been selected were given a gift as recognition and acknowledgment of their hard work.

People and their relatives were asked to give their feedback about the quality of care and the support that they received every six months. This included the completion of satisfaction surveys as well as through regular feedback telephone calls made to people and their relatives. Feedback received was overall positive. When we asked people and their relatives whether they were asked for their feedback and comments, generally everyone confirmed that they were. One person told us, "I get asked for feedback regularly I think. They phone me." One relative said, "Yes, I get a regular questionnaire and telephone calls."

The registered manager told us that they worked in partnership with multiple local authorities to ensure that people received the care and support that had been commissioned. The registered manager explained that they also attended various meetings and training sessions organised by the local authorities and other care conferences so that they could use information exchange has a way of learning and further developing the service. The registered manager told us, "As a provider, we find ways of updating ourselves to learn." In addition to this the service also engaged with social workers, district nurses and GP's to ensure people received the appropriate care and support that they 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 Identified risks associated with people's health and medical needs had not been assessed so that staff could be provided with guidance on how to mitigate risks so that people were kept safe and free from harm. Medicines were not always managed, administered and recorded safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance audits that were being completed were not effective as they did not highlight concerns and issues that we identified as part of this inspection. This placed people at risk of receiving care and support that was not always safe and responsive to their needs.