Phoenix (SW) Limited

Phoenix Care

Inspection report

Unit 3G, St. Peters Business Park
Cobblers Way, Westfield
Radstock
BA3 3BX

Tel: 01225481923
Website: www.myphoenixcare.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Phoenix Care is a service providing personal care to people in their own homes. This included older people and people with mental health conditions. Small teams of staff were allocated to each person. At the time of inspection 69 people were receiving the regulated activity of personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. Personal care is help with tasks related to personal hygiene and eating, we also consider any wider social care provided.

People's experience of using this service and what we found
People and their relatives were positive about the care they received from staff. Comments included, "They are very, very good", "My carer is very helpful to me", and "It is excellent, it really is."

However, we found improvements were required in several areas which placed people at risk of receiving poor and potentially unsafe care. Care plans lacked details, when regular staff were not available there was limited guidance for new or agency staff to follow. Risks had not always been assessed or mitigated. Medicines were not always managed in line with current best practice.

People, their relatives and staff felt staff were not rushed and had time to travel. Systems were in place to monitor missed calls and provide an on-call service for staff. However, recruitment of staff was not always in line with current legislation to protect vulnerable people.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Management systems were currently not effective to drive improvement and identify concerns as they arose. Reliance had been placed on external organisations and the structure of staffing needed to be embedded.

We made two recommendations around safeguarding and person-centred care planning.

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

Rating at last inspection
This service was registered with us on 20 December 2019 and this is the first inspection.

Why we inspected
This inspection was the first inspection based upon the registration date and was prompted in part due to concerns received about safe care and treatment, medicine management, recruitment and leadership and

management. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report. You can also see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to managing risks to people, recruitment of staff, decision making for people who lack capacity and management of the service at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Good

The service was 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.

Phoenix Care

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
This inspection was carried out by two inspectors and a member of the medicines team on site. An Expert by Experience made phone calls to people and relatives following the site visit. 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 did not have 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. Since the last registered manager left a new manager had been appointed. They were supported to run the service by the managing director and several other staff members based in the office.

Notice of inspection
We gave a short period of notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 2 June 2021 and ended on 17 June 2021. We visited the office location on 2 and 10 June 2021.

What we did before the inspection
We reviewed information we had received about the service since it had registered. We liaised with the local authority who had recently visited the service. The provider was not asked to complete a provider

information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who use the service and six relatives. We spoke with 10 staff including the manager and the managing director who was the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed face to face training occurring in the office and telephone calls with staff and people by members of staff in the office.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at recruitment records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We continue to review training data and quality assurance records. We spoke with two members of the local authority commissioning team.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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.

Staffing and recruitment

- Recruitment was potentially placing vulnerable people at risk because it was not in line with statutory requirements. For example, application forms lacked full employment records to allow for adequate checks on any gaps and suitability for care work.
- Pre-employment checks such as references lacked information to demonstrate they were from a reputable source. No authentication was sought by the management. This meant there was no evidence to show the referee was genuine.
- Recent criminal record checks were from previous employment and there was a gap prior to starting work. There was a risk a staff member could have committed a criminal offence prior to starting work with vulnerable people.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate staff were being safely recruited. This placed people at risk of harm. This was a breach of regulation 19 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported by small teams of staff who arranged the staffing rotas between themselves to ensure personalised care. A team leader or key worker oversaw the rota to ensure no gaps were in place. An electronic system alerted management if there were any missed calls so that they could be resolved.
- People and their relatives were positive about the small teams of staff that worked with them. Comments included that staff arrived on time and care never felt rushed because of these arrangements. One person said, "I like my carers very much. I feel very safe with them. Lovely ladies."
- Staff were positive about the way rotas were organised. They told us there was enough time to travel between calls and they never felt rushed. Whenever people required staff this was provided. Relatives said occasionally they offered to be the second staff member.

Assessing risk, safety monitoring and management

- People were placed at potential risk of harm by staff who were new or agency staff especially during a COVID-19 pandemic. Risks had not always been assessed or ways to mitigate them, found. Care plans were electronic and contained a variety of risk assessments. Some were incomplete for people and others lacked details or guidance for staff.
- Examples were found when a person had a specific way of having their food and medicine's administered. Although their relative did this, there was little guidance about how staff should manage the area of the device during intimate care. Another person was identified as at risk of infections. There was no information

about what staff should look for or how to prevent further infections. This placed people at risk of their health declining without staff recognising it.
● Environmental risks had been considered prior to supporting a person in their own home. However, these sometimes lacked detail of how to mitigate risks. For example, one person placed staff at risk when they became confused. Two recent incidents of this had occurred. The person's risk assessment had not been updated with these details. This meant new or agency staff could be placed at risk if they were unaware of this. The management were liaising with the person's family to prevent this from happening again.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff regularly working with people knew the various risks so mitigated them even when care plans lacked details. The managing director told us about how new staff were carefully inducted to a team by some team leaders to ensure knowledge was passed on. They understood the risks about lack of detail in care plans especially during a COVID-19 pandemic.

Systems and processes to safeguard people from the risk of abuse
● One person, was placed at potential risk of abuse. Three out of four staff supporting them had inadequate training in children's safeguarding. Children's safeguarding systems were not set up in line with statutory requirements. Following the inspection, the managing director informed us they had given notice on this package until they were better prepared to support children. They had not realised the differences between supporting children and adults.
● People felt safe with the support they received and commented on how good the care they received was. Relatives all felt their family members were safe. Comments included, "Yes, definitely safe with the carers" and, "Yes, [person] is safe with the carers. It is because they are nice, kind people. Lovely people."
● Staff knew how to keep people safe and recognised signs of potential abuse. They knew who to report to internally and felt concerns would be managed. However, not all staff were aware of external organisations such as the local authority safeguarding team they could report potential concerns to.
● Systems were emerging to manage safeguarding concerns. Examples were seen of how concerns were managed by the new manager and provider. It was too early to demonstrate the positive impact of these. However, the previous systems had failed to effectively manage safeguarding which was highlighted by the local authority.

We recommend the provider seeks advice and guidance from a reputable source about managing safeguarding in line with best practice and legislation and take action to update their practice accordingly.

Using medicines safely
● People were not always having their medicines managed safely or in line with best practice. Administered medicines were recorded on an electronic medication chart. However, one person's medicated cream directions on the medicines chart did not correspond to how it had been prescribed. There were not always clear directions on where creams and other topical preparations needed to be applied. This meant there was a risk of inappropriate administration by staff.
● One person was having their medicines distributed in a dosette box for them by staff which was not in line with good practice or the provider's medicines policy. The managing director stopped this practice and made suitable arrangements when they were made aware of this by the inspection team.
● Some people required time specific medicines to manage their health conditions. There were not always

appropriate arrangements to manage this type of administration.
● Protocols for medicines which had been prescribed to be taken 'when required' were available. Some lacked detail on the symptoms staff should be aware of for each person to ensure consistent administration from staff. This had also been recently identified in an external audit by the local authority.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate medicine was always managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives were happy that their preferences around medicine administration was followed. Comments included, "Medication is given at the right intervals through the day" and, "We are confident the medication is done safely." Staff understood the importance of administering people's medicines safely. They knew people well and their preferences for administration.

Preventing and controlling infection
● People were protected from infections spreading when staff provided their care. Comments from people and relatives demonstrated staff washed hands and wore personal protective equipment (PPE) such as masks. One person said, "They wear gloves, aprons and masks. They wash their hands at the sink when they come in the door."
● Systems were in place to ensure staff were tested for COVID-19 weekly in line with government guidance. However, the risk assessment around COVID-19 procedures did not match this.
● The provider had written a basic COVID-19 emergency plan and the managing director had an unwritten approach they talked us through. This would help keep people safe in the event of an outbreak. Following the visit, we spoke with the local authority who said they would arrange further support with this. We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● The management had informal ways of learning lessons when things had gone wrong. However, they were still developing more formalised processes. They had sourced a system to assist them with this.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

We checked whether the service was working within the principles of the MCA.

- People were at risk of legislation around decision making not being followed if they lacked capacity or had fluctuating capacity. Care plans were mixed in how many decisions were recorded, including the quantity, and often they referred to seeking advice from other professionals.
- Completed mental capacity assessments were not always decision specific. For example, one person with fluctuating capacity had an assessment titled, "General Assessment" with no specific decision.
- Another person had cognitive difficulties thought to be as a result of dementia. The decision listed was "Dementia" and then it was written, "I am not sure. Assistance from a medical professional is required." By not applying the MCA correctly people were at risk of having decisions not made in their best interest or being the least restrictive option.
- A third person had a decision documented in a capacity assessment; this person had the mental capacity to make the decision. The outcome of the assessment then stated, "I am not sure. Assistance from a medical professional is required" rather than allowing them to make a decision. This meant they had not followed the MCA for this person in supporting them to make a decision for themselves.

We found no evidence that people had been harmed. However, people who lacked capacity were at risk of not having decisions made in line with the MCA. This was a breach of regulation 11 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and their relatives were positive about being consulted when decisions were required. One person

said, "We talk through what needs to be done" and explained a friend helped them with other decisions. Comments included, "I'm involved in decisions every time", "They get consent for care. They talk things through", and "The family are included in decision making. [Person] is unable to make choices."

Staff support: induction, training, skills and experience

● People were supported by staff who received a range of training. However, there were times when this was inconsistent. For example, not all staff had completed Mental Capacity Act training or adequate safeguarding training for the age of people they were supporting.

● Some recent training decisions were a result of other social care professionals prompting them. For example, most staff had now received more appropriate training around medicine management and administration because the local authority had identified it as an issue.

● People and their relatives felt staff were trained. Comments included, "Yes, [they are] well trained in caring", "Team leader is on the ball with training", and "Staff are well trained."

● Staff were positive about the recent changes in training to be delivered in person. During the inspection, staff were seen attending training, they were engaged, and it was a lively experience. Training was led by a training manager who was one of six staff that had completed accreditation to deliver the training.

● New staff were now receiving a thorough induction prior to starting to work with people. This included working through four days of key information. Staff then shadowed experienced staff and completed the Care Certificate. The Care Certificate is a set of standards which all health and social care workers should meet working in the sector.

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

● People had their needs assessed prior to starting to receive care and support from the provider. When there were changes in need staff were informed. One person when asked whether they had an assessment prior to the care starting said, "Yes, a lady came. I have got a care plan. I am happy with it."

● Relatives confirmed they were involved in assessments as well. Comments included, "Care assessments have been ongoing", and "[Person's] care needs are adapted to meet need as things have changed."

● The managing director explained how they used these to inform which staff they matched to work with people. For example, if the person's preferred language was not English they would try and source staff who could meet their needs. They looked at age and interests as other ways to match staff to people.

● The manager told us they had developed a new format for assessing people. This would be more in depth and include relevant information for their care and support to be in line with their needs and wishes.

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

● People, who required it, were supported to eat and drink by staff. One person told us, "I can choose my own food. I ask the carer to get me ploughman's rolls. I buy them. I cut them in half and share the dinners with the neighbours."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to see other health and social care professionals by staff when it was required. One relative told us, "Carers have contacted the doctor. They organised cream to solve the problem at the time." Other relatives gave examples of how staff had worked with other health professionals.

● Care plans contained records of health professional involvement in people's care. For example, one person's care plan had records of physiotherapy exercises. Another person's care plan identified they had been supported to get to hospital following a fall.

● People's oral health had been considered and guidance was in line with individual needs. One relative said, "They see to their [person's] oral health."

Good

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were supported by kind and caring staff who knew them well and treated them with respect. One person said, "Carers are absolutely brilliant. Cannot fault one of them. [Staff name] is brilliant. More than a hundred percent. Cannot fault them. Others are really good." Other comments included, "I see the same carer most of the time. Mondays off then somebody else. Regular is exceptionally good", "I feel I have become great friends with the person who has looked after me", and "I like them very much. Very good girls. All lovely girls. I can assure you I love them all."
- Relatives spoken with were positive about the care people received. One relative said, "The carers are always cheerful and pleasant. [Person] gets on well with them. All carers are great to them." Other relatives told us, "Without exception cheerful and positive", and "[Person] gets on well with the staff."
- Staff all spoke about people in a caring way. They described how they felt compassion for the person and their family, which meant they would "Do anything" to help the person have a positive experience.
- The management led by example and set a culture of kind, caring, person-centred approach. When phone calls were made to people and their relatives during the inspection their ethos was witnessed in practice.
- People with specific beliefs or cultural differences were respected. For example, the provider was currently trying to employ staff who spoke the same first language as some of the people they supported. Other people told us about the staff recognising their religious beliefs. One relative said, "[Person], sees eight different carers. So far [person] enjoys the variety and ethnic diversity as they grew up in Africa."

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

- People were involved in decisions about their care. When they were unable to, those important to them were involved. One person said, "[Staff are] careful to get permission for care and ask how I would like things done."
- People were able to make choices and staff respected them. Staff told us they always offered choice to people. One relative told us, "[Person] is involved as far as they can be in care decisions."
- People were able to express their staff gender preferences for care. One relative said, "[Person] is happy with male and female carers. One male carer was adored."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was protected at all times. Comments included, "Privacy and dignity is respected all the time", "[Person] is treated with respect and dignity at all times", and "Staff do respect privacy and dignity."
- Staff ensured people were encouraged to be as independent as possible. For example, one person who was not able to communicate verbally since returning from hospital was encouraged by staff to talk,

resulting in the person saying "Morning".

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

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.

- People receiving care had a variety of different communication needs. The provider had started to consider how to meet the AIS following a visit from the local authority. However, the manager and managing director were still identifying ways to implement the standard.
- People had electronic care plans which started with a detailed pen picture of the person. However, guidance around peoples' different needs and wishes was mixed and often lacked details for staff to follow. For example, there were limited details for specialist methods for eating, drinking and medicine management.
- Contradictions were present in some care plans. Examples of this were seen when peoples' pen pictures mentioned people may have medical needs that were not reflected anywhere else in the care plan. There were also incomplete sections in some care plans.

We recommend the provider seek advice and guidance from a reputable source, ensuring care plans contain adequate information in line with current best practice and meet people's communication needs.

- People and relatives were positive about the personalised support they received. Comments included, "They all know what they are doing. They do not clock watch", "We went through the care plan with the team leader. It was all fine" and, "I get on well with my carers. We always have a chat. They know what to do."

Improving care quality in response to complaints or concerns

- People and their relatives knew who to raise complaints or concerns to. However, the systems to manage them were only emerging. Previous concerns and complaints had been actioned although not always following the provider's policies and procedures.
- People and their relatives raised no complaints or concerns during the inspection. Examples were provided about how previous issues had been managed. For example, changing staff if there was a personality clash.

End of life care and support

● People were supported to have a comfortable, personalised death which met their needs and wishes. One relative said, "[Person] was on end of life care. They [staff] pulled them along. Spent time with them, not looking at the clock. Really nice. A good team. Interaction is now really good, wonderful to watch." Another relative said, "Carers are very calm and reassuring at an uncertain time. Without exception staff are cheerful, positive and respectful."

● The manager explained there were a team of staff who specialised in end of life care. One staff member led this team. Staff chose to be part of this team. This meant staff had personalities which matched the type of care which was required.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Many of the systems to run the service were either not in place or robust enough to demonstrate safety and quality of care was effectively managed. The manager and managing director assured us they were making changes and new systems were being put in place. However, these were either emerging or not established.
- Audits were either not completed or unavailable at the inspection to determine how effective they were. For example, medicines audits were not available. We were told a new template had recently been developed of checks they were going to complete going forward. The same issues were found with the safeguarding systems.
- The management were unaware of all concerns identified during this inspection. For example, in relation to supporting children, recruitment issues and medicine administration.
- Policies and procedures were now being put in place. However, examples were found throughout the inspection of them not being followed. Such as with recruitment, capacity and consent, and medicines.
- Reliance had been placed upon external parties such as the local authority and the regulator identifying where improvements were required. The managing director explained there had been some management issues for the service. Now they were resolved they hoped moving forward this will no longer be the case.
- Action plans to resolve issues with specific timescales had not always been met. For example, an action plan shared with the local authority had missed deadlines in relation to recruitment and medicine management.
- The management team required support during the inspection to understand the current regulations and apply them to their service. Additionally, they were not always aware of current best practice in relation to parts of their service such as medicine management and assessing risks for people with health conditions.
- Confusion was shared amongst the management around the structure of staff and chain of command within the service. The managing director told us an emerging structure was key workers and team leaders running each team of staff. The management were yet to embed the new roles and responsibilities within the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that the service was effectively governed for quality and safety . This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Throughout the inspection, the management were responsive and wanted to work with us to make improvements. The managing director was transparent with us. They explained they were new to regulation and had learnt a lot since being registered and this was an ongoing process.

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

● The management led a culture which promoted people being at the centre of their care. Teams of staff were developed around people considering their interests, needs and wishes. Staff described the service as, "Person-centred. It is all about the clients", "So long as the clients are happy that is all that matters."

● The managing director explained how this culture extended to the staff. Training was focused on staff meeting people's needs. They made sure the training was face to face and within working hours. Staff who had English as a second language had additional support if it was required.

● Staff were positive about the support they received from the management. One member of staff said, "This is the best company I have ever worked for. Not stressed, relaxed." Other comments included, "Really good support", "Very supportive", and "Good management. Friendly. Always someone to speak to."

● Staff had regular supervisions with senior staff where they could discuss what was going well and if there were performance issues. It was also an opportunity for any ideas to be shared. Staff felt these would be responded to.

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

● The management believed in being open and honest when things had gone wrong. They talked us through examples of where this had been done. One person told us the manager was "Very open and helpful."

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

● People and their relatives told us they have regular contact with various members of management. The team leaders were providing hands on care. One person said, "I have spoken to the manager several times. Is a hands-on person. You can phone at any time except at weekends." They continued, "I needed them at short notice. Very accommodating. Made a lot of changes to get regular carer and the right care and people to help us."

● Relatives agreed with what we heard about from people. Comments included, "[Manager] is approachable and very helpful", "Manager does ring up and ask us how we are getting on", and "We have had reviews. They adjust the changes as needed."

● Staff told us they felt listened to and their suggestions were valued by the management. One staff member provided an example of where they had requested a change. This was respected by the management and they made appropriate changes.

Working in partnership with others

● People were supported by staff who worked in partnership with other health and social care professionals. Examples were seen of this during the inspection. Staff appeared to get them involved promptly when required. Once they had been involved copies of their guidance and reports were uploaded onto the system for staff guidance.

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 11 HSCA RA Regulations 2014 Need for consent People who use services and lacked capacity were at risk of decisions not being made in line with statutory guidance.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always being mitigated or recognised to ensure people received safe and consistent care. Medicines were not always managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to manage the service to ensure people received safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems to recruit new staff were not in line with legislation to protect vulnerable people.