Kendrick Haylings & Jones Limited

Bluebird Care Hurley Office

Inspection report

Camp Farm Barn
Knowle Hill
Hurley
CV9 2JF

Tel: 07890541211
Website: www.bluebirdcare.co.uk

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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

We visited the offices of Bluebird Care Hurley Office on 8 March 2016. The inspection was announced. This was to ensure the manager and staff were available when we visited, to talk with us about the service.

Bluebird Care Hurley Office is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our visit the service supported 85 people. The service was last inspected on 10 April 2013 when we found no breaches of Regulations.

The service is required to have a registered manager in post. 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. At the time of this inspection, the service did not have a registered manager in post and had been without a registered manager since August 2015. There was a new manager who had been in post since January 2016, who was in the process of applying to become the registered manager.

People told us they felt safe using the service and staff understood how to protect people from abuse. However not all important events had been recorded, shared with senior managers for analysis or referred to appropriate agencies, during the period between August 2015 and January 2016. We found some identified risks to people's health, had not been recorded and assessed in full on their care plans. People received their medicines as prescribed, however there was no consistent process to identify medicine errors.

There were enough staff to deliver care and support to people, however some people told us staff were sometimes late. Staff received an induction and training to support them in meeting people's needs, however there were some gaps in staff training. Risk assessments and checks on staff to ensure their suitability to work with people who used the service, minimised risks associated with people's care.

The manager understood the principles of the Mental Capacity Act (MCA) and was in the process of providing staff with training and information on the MCA. Staff respected people's decisions and gained people's consent before they provided personal care. It was not clear on people's records if they required support to make decisions.

People told us staff were kind and caring and had the right skills and experience to provide the care and support they required. Staff treated people in a way that respected their dignity and promoted their independence.

Care was planned to meet people's individual needs and care plans were reviewed. Some care plans were not up to date and the manager was taking action to improve them. People were involved in planning how they were cared for and supported. Staff understood people's individual needs and information was shared about changes in people's care. People knew how to complain and were able to share their views and

opinions about the service they received.

People were satisfied with the service and felt able to contact the manager if they needed to. During the period where there had been no manager in place, the provider had not ensured all their responsibilities had been fulfilled. Systems had not been put in place to ensure information about important events was shared appropriately, so that some information about important events was not analysed by senior managers and learning could not take place across the service to minimise future risks. There were some processes to ensure good standards of care were maintained for people, however these were not all effective. The new manager had recognised these issues and had taken steps to make improvements since starting their role in January 2016.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff understood their responsibility to keep people safe and understood the risks relating to people's care. However not all important events had been recorded, shared with senior managers for analysis or referred to appropriate agencies, during the period between August 2015 and January 2016. Risk assessments and checks on staff to ensure their suitability to work with people who used the service, minimised risks associated with people's care. There were enough staff to deliver care and support to people, however some people told us staff were sometimes late. People received their medicines as prescribed, however there was no consistent process to identify medicine errors.

Is the service effective?

Good

The service was effective.

Staff received an induction and training to support them in meeting people's needs effectively. The manager understood the principles of the Mental Capacity Act (MCA) and was in the process of providing staff with training and information on the MCA. Staff respected people's decisions and gained people's consent before they provided personal care. It was not clear on people's records if they required support to make decisions.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring. Staff ensured they respected people's privacy and dignity, and promoted their independence.

Is the service responsive?

Good

The service was responsive.

Care was planned to meet people's individual needs and care plans were reviewed. Some care plans were not up to date and

the manager was taking action to improve them. People were involved in planning how they were cared for and supported. Staff understood people's individual needs and information was shared about changes in people's care. People knew how to complain and were able to share their views and opinions about the service they received.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People were satisfied with the service and felt able to contact the manager if they needed to. During the period where there had been no manager in place, the provider had not ensured all their responsibilities had been fulfilled. Systems had not been put in place to ensure information about important events was shared appropriately, so that some information about important events was not analysed by senior managers and learning could not take place across the service to minimise future risks. There were some processes to ensure good standards of care were maintained for people, however these were not all effective. The new manager had recognised these issues and had taken steps to make improvements since starting their role in January 2016.

Bluebird Care Hurley Office

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 8 March 2016 and was announced. We told the provider one day prior to the inspection that we would be coming, so they and the staff were available to speak with us. The inspection was conducted by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

We reviewed information received about the service, for example the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR reflected the service provided. We also contacted the local authority commissioners to find out their views of the service provided. These are people who contract care and support services paid for by the local authority. They had no concerns about the service.

Before our visit we contacted people who used the service by telephone and spoke with eleven people. During our inspection we spoke with the provider, the manager, a director of the company and the deputy manager. Following our inspection we spoke with five carers and a local authority worker who was supporting someone.

We reviewed four people's care plans to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe because they received care from staff they knew well and trusted. Two people told us, "Yes I feel safe, the carers are very good" and "Yes I feel safe, if I didn't I'd be on the phone."

People had different experiences of receiving care calls, some people told us their care calls were sometimes late and they had not been contacted in advance. One person told us carers could be, "As much as two hours late." However, some people told us staff contacted them if they were running late. One person told us, "It's very good really. They let me know if they are going to be late." We discussed this issue with the manager and the provider who were responsible for monitoring care calls were delivered safely. They told us care calls were monitored through a mixture of staff using clients phones with permission to log their call times and others by time sheets which clients signed on a weekly basis. Staff reviewed the electronic system to identify any issues during office hours. Outside of office hours, late calls were only identified if someone contacted the senior member of staff on call. The provider told us they analysed their systems to identify when calls were late, however there was no evidence that the reason for late calls was investigated to reduce future occurrences.

Staff knew what to do if concerns about people's safety were raised. A member of staff told us, "I would report straight to the office and the office would report to a social worker." They explained they had done this recently and were satisfied with the way the issue had been dealt with by their line manager. They said, "Action was taken straight away." Another member of staff told us they felt concerns were taken seriously by the manager. People who used the service told us they felt comfortable talking with staff if they felt unsafe.

The provider had an out of hour's on-call system when the office was closed. One care worker told us, "If I'm running late I report to the office or on call, then the office will ring the client." Staff told us they were reassured a senior member of staff was always available if they needed support.

Records showed that incidents involving people who received care from the service, such as falls and late calls, had not been recorded or shared with senior managers in the office during the period where there was no registered manager. Therefore during this period, incidents had not been analysed and learning had not taken place about how to reduce risks to people in the future. We saw staff had recorded events in people's care plans and that actions had been taken to minimise risks to people, however information about incidents had not been shared with the senior management team. Staff, including senior staff and carers told us they were not aware they should report incidents to the manager. Therefore there had been a lack of senior management oversight because there was no system in place to review incidents which had occurred within the whole service. We discussed this with the manager who told us they were aware information about incidents had not been shared and explained that they had arranged for all staff to receive training sessions in team meetings, in order to raise their awareness of how to follow the provider's process to report serious incidents and escalate them internally to their manager. They told us, "I want to get a pattern of frequency so we can assess risks and support people better." One member of staff told us, "[Manager's name] has gone through all the procedures with us." Staff were able to explain the procedure for reporting incidents to the manager, following the training they had received. One member of staff said, "[Manager's

name] has redone the incident form and there's a new process in place."

Records showed that not all events that might mean a person was at risk of harm, had been referred to appropriate agencies, such as the CQC, during the period where there was no registered manager. During this period the provider told us the senior management team had shared the responsibilities to provide the CQC with notifications about important events that occurred at the service and notify other relevant professionals about issues where appropriate, such as the local authority. We discussed this with the manager who told us they were aware there had been gaps where serious events had not been reported to external agencies and explained that they had developed a new system to track incidents to help them identify where improvements were required to keep people safe and to ensure events would be referred to the relevant external agencies as required.

There was a procedure to identify and manage risks associated with people's care. When people started using the service, an initial assessment of their care needs was completed that identified any potential risks to providing their care and support. When asked, staff knew about individual risks to people's health and wellbeing. Records confirmed that some risk assessments had been completed and most care was planned to take risks into account and minimise them. For example, a member of staff told us about one person whose physical health had deteriorated and they required increased support to eat and drink safely. They explained how they had involved health professionals to review the person's care and provide guidance about how they could be best supported. We saw the person's care plans had been updated with this advice.

We found some identified risks had not been recorded and assessed in full on people's care plans. For example, there was no assessment for the risk of swallowing for the person whose health had deteriorated. We found on some other people's files where they were at risk from falling, there were no assessment of risk recorded. This meant staff had not been provided with full instructions on how to support these people and reduce the risks to their safety. We discussed this with the manager who was aware that care plans were not all up to date. They explained they were in the process of reviewing people's risk assessments associated with their care. They said, "I think care plans should be fool proof, so anyone can pick it up and know what to do." The manager took action straight away on the day of our visit, to update people's care plans where concerns were raised.

Senior staff had completed risk assessments of people's homes, including any specific risks to people, such as using specialist equipment, to ensure they were safe in their homes. The manager told us they were in the process of improving these risk assessments to include more information about people specialist equipment.

People told us there were sufficient staff to meet their needs. One person told us they had regular carers, "Yes I do. [Name of carer] is like one of the family." People had mixed opinion of whether they received a rota to tell them the times of their calls and which carers would call. The manager told us, "We try to have consistent carers. Clients are on a run, they tend to have same carers at the same time, so people don't get rotas unless they ask for them." Staff told us they had enough time to attend calls. One carer told us, "We have regular shift patterns. We are seeing the same people so it is consistent."

The provider checked that staff were suitable to support people before they began working in the service, which minimised risks of potential abuse to people. Records showed the provider's recruitment procedures included obtaining references from previous employers and checking staff's identities with the Disclosure and Barring Service (DBS) prior to their employment. The DBS is a national agency that holds information about criminal records.

We checked how medicines were managed by staff. We spoke with one person about their medicines and they told us carers always remembered to support them to take their medicines. However they told us there were issues if carers did not arrive on time for care calls, as one of their medicines should be taken half an hour before food. We discussed this with the manager who took immediate action to review people's care plans and record where people's medicines were required at certain times to ensure their well-being.

Staff told us their competency was checked on an annual basis. Staff recorded in people's care plans that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this. We saw there were gaps in recording on some MAR sheets and it was not clear if some medicines were to be given on an 'as required' basis. Therefore we could not always see if medicines had been administered as prescribed. We discussed this issue with the manager who was aware improvements were required in recording and following our visit the manager introduced new MAR sheets. Two members of staff told us, "The new ones have been simplified. They are clear and they have a description of people's medicines" and "They're so much better."

A lack of senior management oversight during the period where there had been no registered manager in place, meant there had been no consistent system to identify medicine errors. The provider told us, "It seems the responsibility for checking MAR sheets got passed around and missed." The manager told us they were aware improvements were required and had put in place a new system where they would check MAR sheets regularly in future to reduce the risk of errors.

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to support them effectively. One person told us, "They do exactly what I want." Staff told us they completed an induction when they first started work at the service that prepared them for their role before they worked unsupervised. This included internal training from senior staff and working alongside a more experienced worker, before they worked on their own. The manager explained they were currently in the process of ensuring the staff training programme included the Care Certificate. The Care Certificate is a legal requirement and sets the standard for the fundamental skills and knowledge expected from staff within a care environment.

Staff received training to meet people's care and support needs. This included training in supporting people to move safely and medicine administration. Staff were positive about the training they received. We found there were gaps in some staff training, for example there had been no training on the Mental Capacity Act 2005 (MCA) for some staff. We raised this issue with the manager who told us they had recognised staff training required updating and had made improvements. For example, they had changed the induction programme to include information for new staff on the MCA, dementia and learning disabilities. They had arranged for all existing staff to receive a new training module during April 2016 to cover these areas. A member of staff told us, "The manager has just introduced new training which I've just signed up for. There are also different types of distance learning courses coming up." Staff told us they were supported to do training linked to people's needs, such as catheter and stoma care and had received training from the district nurse.

Staff told us their knowledge and learning was monitored through a system of supervision meetings and unannounced 'observation checks' of their practice. Supervision is a meeting between the manager and member of staff to discuss the individual's work performance and areas for development. Some staff commented their managers were busy and supervision had been delayed. One carer said, "I've not had supervision for ages. It would be useful to get an opinion on my performance." We raised this issue with the manager who told us supervision was not up to date for all staff, but showed us that it had been scheduled to ensure that all staff were seen by their line managers within the next three months.

Staff told us they felt supported by the provider to study for care qualifications. Two members of staff told us, "It's really good, work are supporting me to do qualifications" and "I've just finished my level 2 NVQ, work set it up for me." An NVQ is a national vocational qualification, which is a work based qualification achieved through assessment and training. The manager told us they would speak with staff during supervision and "Investigate who wishes to do qualifications and encourage them."

The 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. We checked whether the provider was working within the principles of the

MCA.

The manager told us there was no one using the service at the time of our inspection that lacked capacity to make decisions about how they lived their daily lives. We were told some people lacked capacity to make certain complex decisions, for example how they managed their finances, but they all had somebody who could support them to make these decisions in their best interest. We found there were no documented mental capacity assessments for these people, so their capacity to make decisions was not clear. We discussed this with the manager who agreed they would seek clarification on this issue and conduct assessments where necessary. Following the visit the manager has updated people care plans to include information about what support they require to make decisions.

We found that where people may not have had capacity to make complex decisions, they had been made in their best interests. For example a best interest decision about the best type of diet had been made for one person. The decision had been recorded in their care plan and involved appropriate people including health professionals.

Staff understood their responsibilities under the MCA and they told us how decisions were made in people's best interests where required. A member of staff told us, "We weigh up if people can make decisions, if they cannot, we would get other people involved to help make decisions." Staff knew they could only provide care and support to people who had given their consent. Two carers told us, "I ask for people's consent, for example if they want to have a wash or what they want to eat. If they changed their mind I'd stop and ask them what the matter was" and "I talk to people. If they don't want something, I won't do it." One member of staff told us how they gained consent from someone who was not able to communicate verbally. They said, "[Name] has a white board and communicates in writing with us."

Some people received food and drinks prepared by staff and some people were supported by staff to help prepare meals to support their independence. One person told us they received a variety of meals which they chose and they were happy with the service. Another person said, "We choose the food we want." People told us carers made drinks available to them.

People's health was monitored and where a need was identified, they were referred to the relevant healthcare professional. People told us staff supported them to attend health appointments. One person said, "If we need help, they'll [staff will] do it." A social worker we spoke with following our visit told us staff referred health matters to relevant professionals where required. They said, "They [staff] had taken the initiative and made a referral to an occupational therapist." The manager told us, "It is dependent on what people's wishes are. A carer may ring the GP or if it's more complicated they may refer the matter to the office. We were recently concerned about one person's medicines, so we set up a medicine review and informed the family." A member of staff explained how they monitored people's wellbeing. They said, "If someone's not well we contact the office or tell the family." Another member of staff told us, "I have called the GP, occupational therapist (OT), dietician and speech and language therapist (SALT) for people before." Records confirmed health professionals were involved with people's care when required, including district nurses, GP, OT and SALT and their advice was updated in people's care plans.

Good

Is the service caring?

Our findings

People told us staff treated them with kindness. Two people told us, "They are very caring" and "They're great, the girls are very good." A member of staff told us how they felt about their work, they said, "I love the clients, I love to chat with them." People told us they had regular care staff who supported them. Two people said, "[Name of carer] is like family" and "Yes I usually have regular carers." A member of staff told us, "I've got regular customers. They are happy with me, I know them well."

Staff told us they liked working at the service and they enjoyed helping people to be independent and supporting people according to their individual needs. One person told us, "They help with the things I need help with." A member of staff told us, "We encourage people to do things for themselves." The manager explained that staff were trained, "To do things with the client, rather than for them."

Staff told us the senior staff were caring and this made them feel motivated in their role. For example, one member of staff told us the office staff were kind, they said, "I can contact them when I need to." Another member of staff told us office staff were, "Really helpful."

People we spoke with confirmed they were involved in making decisions about their care and were able to ask staff for what they wanted. One person told us they were involved in planning their care, "From day one." Another person told us, "A manager came to do an assessment." The manager explained they involved people as much as possible from their initial needs assessment.

People told us they thought staff treated them with respect and dignity. Two people told us, "If the carer and the cleaning company are present at the same time, the carer manages the situation to preserve my privacy" and "They close the door and take 'precautions' as best they can." A staff member explained how they showed respect for people's dignity and privacy, they said, "A lot of clients sleep in their living room, so when we are supporting them to wash we shut the curtains and close the door. We lay towels over them." A member of staff gave an example of how one person's spiritual needs were met. They told us they removed their footwear in order to respect the person's beliefs.

Good

Is the service responsive?

Our findings

People told us they were happy with their care and that staff supported them to be independent. Two people told us, "The care is what I wanted from day one" and "They ask me what I want and they do it." Staff had a good understanding of people's care and support needs. For example, a member of staff told us how they noticed one person's mobility had declined. They shared this information with their line manager and supported the person to be reviewed by the local authority. As a result, the person received an increased amount of support and these changes were updated on their care plans, so all staff were aware.

Staff told us they had time to read people's care plans. Two members of staff told us, "I have time to read care plans in people's homes. If it's a new customer, I will read about medicines and if I'm not sure I will ring the office" and "If we are seeing a new person the rota gives basic information and we can look at the care plan in their home and marry that information with what's in the daily records." One member of staff said, "Sometimes I find care plans are not up to date." We discussed this with the manager who told us, "Care plans are a work in progress." The manager acknowledged that some care plans required more detail to allow staff to have sufficient information to meet people's needs. For example they told us senior staff were currently working with people to obtain more information about their preferences, so care plans could be updated with information for care staff.

People told us their care plans were reviewed by staff. A member of staff told us senior staff went to peoples home to review their care needs and updated care plans following reviews. They said they were notified by senior staff if there were any changes to people's needs. The manager told us reviews took place if staff notified them of a change in someone's needs. They told us if it was appropriate, relevant agencies such as the local authority would be invited to attend a review. A local authority worker told us they had a very positive experience with service. They said, "I urgently reviewed one person at their request. They were very helpful and attended the review and provided information. They shared their concerns and put measures in place to support the person. In this case they were very person centred, they knew the client well and clearly had a good relationship with the client." This showed changes were made to people's care when their needs changed.

Staff told us information was shared within their teams in different ways, including in people's daily notes and phone calls and texts on staff phones. A member of staff told us, "The office will phone if something changes in someone's care plan. They do this regularly."

Staff supported people to make choices. One person told us, "I've got total control." A member of staff explained how they knew what people's preferences were, they said, "I read the daily notes and listen to what people and their relatives tell me." Another member of staff explained how they helped people with their morning routines. They said, "I ask people if they'd like a wash or for example what they'd like to wear today. I ask people what they'd like to eat." Records showed people had been asked about some of their preferences. For example they were asked what name they preferred to be called by and about their religious and cultural beliefs.

People told us staff took time to listen to them and supported them to raise concerns. Two people told us they had raised issues with senior staff in the office and their concerns had been dealt with in a timely way and to their satisfaction. The manager explained they documented any comments, concerns, complaints and compliments raised by people. They told us, "I record what people's concern is and try to understand what they want and how to reach that goal. For example, if they don't get on with a carer the outcome is that we need to change the carer." Records showed evidence of compliments from people's relatives about the standard of care received. For example one relative thanked staff for their care in helping their family member to make progress in their home.

The provider's complaints policy was accessible to people in their homes. People told us they had the information they needed to make a complaint, in their customer information guide. The policy informed people how to make a complaint and the timescale for investigating a complaint once it had been received. It also provided information about where people could escalate their concerns outside the organisation if they were unhappy with how their complaint had been dealt with. Records showed there had been eight complaints in the last 12 months, which were dealt with in a timely way and in accordance with the provider's policy.

The manager explained there were several ways people could share their experiences of the service using, "Surveys, care reviews, or quality assurance meetings or phone calls." The manager had recently begun a new initiative of conducting quality assurance meetings with people, to obtain feedback and to help improve their care. We saw people's comments and compliments were recorded. The manager explained if there was a negative comment, they would investigate the reason for it and speak with staff as appropriate.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us they were satisfied with the service they received. Two people told us, "They are absolutely brilliant. I can't fault them, in any way and I tell everyone that" and "Yes I am more than satisfied, I'd give them 99/100." People we spoke with told us they were able to contact the office when required and people described the manager as, "Approachable." A member of staff told us, "I love working here because I know the company and I can point people in the right direction." Staff told us if they had any concerns they could go to the provider and the manager.

The manager was new and had been in post since January 2016, they were in the process of applying to become the registered manager. The previous long term registered manager had left in August 2015. During this period we found that the provider had not ensured that their responsibilities had been carried out. For example, not all notifications were sent to the CQC about important events that occurred at the service and systems were not in place to ensure that information, for example incidents of falls, were reported to senior managers to review and learn from. Some staff supervisions, spot checks and training were not up to date according to the provider's schedule. The provider told us, "Everyone in the office was taking on bits and bobs." The new manager had introduced new processes to ensure incidents were reported to the senior managers, to allow for analysis and learning from events and improvements to be made to the service. The manager had recognised where there were gaps in how the service was working under the MCA and had made improvements. The manager understood their ongoing responsibilities and were aware of the challenges which faced the service. They explained they had a number of areas to focus on for example, improving training and ensuring people's care plans were up to date. They told us, "I am prioritising the areas most needed."

Staff understood their roles and responsibilities. One member of staff told us, "We tell each other things. We work closely as a team. We have time to read care plans." Staff told us they felt supported by the manager and they felt confident about reporting any concerns or poor practice to their managers. Staff told us there had been improvements made to the service since the new manager had started. Staff told us the new manager was always available, one carer told us, "[Name of manager] speaks to you straight away." Another member of staff told us, "Since [name of manager] came, everything's going in the right direction." The manager showed us the staff newsletter, 'The blue parrot', which gave staff information about best practice, introduced new staff members and thanked staff for their work. The manager told us they wanted staff to feel, "Needed, wanted and valued." They said "Carers work independently, so they can feel isolated. I give carers feedback, I like to share compliments." Staff we spoke with told us they felt motivated.

Staff told us they felt listened to and could make suggestions for improvements within the service. One member of staff told us, "We are encouraged to make suggestions if there is a problem." They gave an example where one person's mobility needs had changed and they reported this to senior staff in the office. They told us, "It was addressed straight away." Another member of staff told us, "If I think something needs improving I will speak to the manager." This showed staff were encouraged to make improvements to the service.

Staff told us there had not been regular staff meetings, but they could request a meeting with the manager if required. Another member of staff told us they had attended a full staff meeting following our visit and said, "The meeting was useful, now I know what to do to report an incident." The manager told us there were weekly meetings, which were held between senior staff including the manager and the provider. They told us information about the service was shared at the meetings and they felt, "Happy to suggest improvements." They gave examples where they had made suggestions and these had been taken on board and changes had been made, for example a new system for monitoring incidents within the service. Records showed senior managers discussed a range of issues, such as audits, accidents and supporting staff with qualifications.

A lack of senior management oversight during the period where there had been no registered manager in place, meant there had been no consistent system to identify medicine errors. We discussed this with the manager who explained he was in the process of improving MAR sheets to make them clearer for staff to use. He told us people's MAR sheets would be checked on a weekly basis to identify any errors.

Since joining the service the manager had made checks on people's care plans and staff files to ensure they were up to date. However we found some checks had not been effective because some identified risks had not been recorded and assessed in full on people's care plans. For example, some people who had been identified as at risk of falling, had no assessments of risk recorded. We discussed this issue with the manager who took action straight away to further review people's care plans.

Checks on the service had been made one week prior to our visit, by the provider's franchise company. An extensive action plan of required improvements had been drawn up. We found the manager had begun to follow the action plan and had made some improvements. For example they had scheduled when staff supervisions, spot checks and appraisals were to be carried out and they had set up logs to record incidents and complaints.

People were encouraged to provide feedback on their experiences of the service by completing surveys. The director explained that questionnaires had been sent out to people in July 2015 and they had received 34 responses. Of those people, 24 rated the service as 'excellent', nine people rated it as 'good' and one person rated it as 'OK' .The director told us they had, ""Analysed the results and spoken with individuals."