Eleanor Nursing and Social Care Limited

Ealing Office

Inspection report

Eleanor Nursing and Social Care Limited
157 Uxbridge Road, Hanwell
London
W7 3SR

Tel: 02085793233
Website: www.eleanorcare.co.uk

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ealing Office is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. The majority of people had their care funded by either the London Borough of Ealing or the London Borough of Hounslow. At the time of our inspection 107 people were using the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
During the inspection we found risk assessments were not always robust enough and medicines were not always managed safely.

The provider had systems in place to record safeguarding alerts, complaints, and incidents. However, the quality of the information input was not detailed enough and there was a lack of identified learning to help mitigate future incidents and improve service delivery.

The provider had care plans in place, but these were not always updated appropriately to meet service user needs.

The provider had systems in place to monitor, manage and improve service delivery, however these were not always effective.

The provider had systems in place to safeguard people from the risk of abuse and followed safe recruitment procedures. Staff followed appropriate infection prevention and control practices.

Staff were supported in their roles through induction, training and supervision. The provider assessed people's needs to ensure these could be met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were respectful, provided care in a dignified way and provided day to day choices for people.

People, most relatives and staff reported managers were available and responsive.

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

Rating at last inspection
The last rating for this service was requires improvement (published 15 May 2019) and there were multiple breaches of regulation. The provider completed an action plan after the inspection to show what they would

do and by when to improve. On 15 May 2020 we carried out a targeted inspection of the four key questions of safe, effective, responsive and well led to check whether the provider was meeting the regulations we found them to be in breach of at the March 2019 inspection. The service remained in breach of regulation and has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

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 safe care, person centred care, deployment of staff and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Good

The service was 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.

Ealing Office

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
The inspection was conducted by two inspectors and two Expert by Experience who made phone calls to people and their relatives after the site inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including the action plan the provider sent to us following the previous inspection saying what they would do and by when to improve. We also sought feedback from the local authorities who work with the service. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
We spoke with the operations manager and consultant and we reviewed a range of records. This included five people's care records and multiple medicines records. A variety of records relating to the management of the service, including audits were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also spoke with ten people who used the service and 11 of their relatives about their experience of the service. We emailed 70 staff and had responses from ten staff.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection we found risk assessments were not always robust enough and were not always person centred. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

• At this inspection we found risk assessments were not always detailed enough to provide staff with guidance for safe care. We saw one person had a pressure sore identified by a safeguarding alert in June 2021 but it was not recorded in their skin integrity plan which put them at risk of further skin degradation as staff did not have adequate guidance in the care plan for meeting the person's needs around skin care.
• Risk assessments were generic and therefore not always person centred. For example, one person smoked. Their risk assessment indicated they should try and smoke outside, but this was not appropriate as they were bedbound. It also acknowledged the person used flammable creams and required their sheets and bed clothing to be changed to prevent a build-up of flammable substances. However, the risk assessment did not record how often or by who and there was no record in the daily log of sheets and clothing being changed. Smoking in bed in sheets and bed clothes soaked in flammable cream put the person at serious risk of harm. After the inspection, the operations manager confirmed the care plan had been reviewed to address this.
• The falls risk assessment for the same person indicated staff should use equipment to help the person stand but they were bedbound and their moving and handling risk assessment indicated they could not weight bear which meant the guidance was incorrect.
• One person's care plan recorded a pressure mattress was used but there was no guidance for how to make sure it was set correctly. The person also required repositioning in bed to help prevent pressure sores but there were no repositioning chart to confirm this was being done.
• COVID-19 risk assessments for people that used the service and for staff were not personalised with COVID-19 indicators such as ethnicity and age to help assess people's likelihood of becoming ill with the virus. Additionally, staff did not have risk mitigation plans to help address their risk of COVID-19.

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

Staffing and recruitment
At our last inspection we found the provider did not always follow safe recruitment procedures. This was a breach of regulation 19 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

• The provider followed safe recruitment procedures to ensure new staff were suitable for the work they were undertaking. These included checks on staff members' suitability for the job and criminal checks.

At the last two inspections the local authority provided information indicating care workers were sometimes late for care calls and at other times missing them altogether. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 18.

• The provider did not deploy a sufficient number of suitably qualified, competent, skilled and experienced staff to meet people's care needs or have effective procedures to follow in an emergency, such as a staff shortage, to ensure sufficient and suitable staff were deployed to cover both the emergency and the routine work of the service.
• There was an ongoing issue around late and missed care calls and it was not always clear what action was taken to address this in a timely manner, or what preventative measures were put in place to help prevent it happening again. The provider's system was not effectively monitoring late and missed calls which meant they could not respond effectively and safely.
• As at previous inspections we found that the actual times of calls made to people did not always reflect the time recorded in the care plan. We confirmed this remained the case by reviewing four people's electronic call monitoring records. We identified for the week of 12-18 April 2021 one person had care workers arrive up to an hour and half early to up to two and half hours later than what the planned call time was. This meant people might not have received the care they needed in a timely manner and according to their preferences
• The systems the provider had in place were not always effective in monitoring care calls which meant they were not responding quickly enough when things went wrong, including when care workers were not arriving to scheduled home visits on time.
• While some people and relatives were happy with the consistency and punctuality of calls others were not. People told us, "They are very bad at timekeeping. It can be up to one and a half hours late and there is no proper manager to talk to", "Their timekeeping is not bad. [Person] is supposed to have a double up call, and last week only one of them showed up", "In the first couple of weeks, the timekeeping was a little lax", "They are nearly always on time. I have no complaints at all" and "I haven't seen any lateness. They come on time and stay for the agreed time."

This was a repeated breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The operations manager told us they felt the main issue around late calls was their staffing levels, as they had recently lost a number of staff members. To address this, they were recruiting and had reduced the number of hours they accepted from the local authority.

Using medicines safely
• Medicines were not always administered or recorded safely. A relative told us, "We've made numerous complaints about medication."
• During the inspection we saw medicines administration records (MARs) were not always signed correctly. For example, one person received a medicine once a month, but the MAR had been signed daily instead of monthly. This meant we could not be sure people were receiving their medicines as prescribed. This person's MAR also indicated one medicine was to be given at night, but it was given in the morning and they did not have as required (PRN) medicines protocols in place.
• Another person had medicines crushed to be administered. However, this information was not included in the care plan which meant care workers did not have guidelines for the safe administration of the medicines.
• A third person's daily logs recorded cream was applied but there was no record of what cream in the care plan or MAR.
• One person's care plan stated they self-medicated but the care package changed in March 2021 to staff supporting them with medicines. The care plan had not been updated which meant care workers did not have the correct information to administer medicines safely.
• Staff administering medicines had completed annual theoretical training but there was no evidence of annual competency testing to help ensure staff had the skills to administer medicines safely.
• Medicines audits were not effective as they had not identified the above.

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

Learning lessons when things go wrong
• The provider had systems in place to record safeguarding alerts, complaints, and incidents. However, the quality of the information input was not robust and there was a lack of identified learning to help mitigate future incidents and improve service delivery.
• For example, we saw the local authority had raised a safeguarding alert for one person. The provider's investigation was not robust as it was mainly statements from support workers and the conclusion was there was not enough evidence to support the allegation. Part of the complaint was about support workers not remaining the full time of the care call, but there was no indication electronic call monitoring records had been reviewed as evidence. Nor did the investigation indicate what the local authority's findings were. Additionally, there was no analysis and no learning outcomes to help prevent future incidents and improve service delivery.
• A safeguarding alert was raised for another person because of a missed visit. The outcome was recorded as 'an error' but there was no investigation or supporting documents or evidence the call monitoring records had been reviewed. Nor was there a record of what the learning was and what had been put in place to help prevent it happening again.
• We also found that incidents were not always recorded. We reviewed one person's daily logs and found a support worker had called an ambulance and paramedics had attended to the person. However, this was not recorded on an incident form and it was not recorded in the care plan that the person was seen by paramedics or what the outcome was. A second person's daily log recorded the person was smoking in bed and almost set fire to themselves, but an incident form was not completed about this. As there were no formal records of the incidents there had been no opportunity to put in preventative measures to mitigate the risk in the future.

Preventing and controlling infection
At our last inspection we found the provider did not always follow safe procedures for preventing and controlling infection. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 12.

• The provider had systems in place to help prevent and control infection.
• Staff completed training about infection prevention and control and there was enough personal protective equipment (PPE) such as masks, gloves and aprons to help protect people from the risk of infection.
• Spot checks of care workers carried out in people's homes checked that they were wearing and disposing of PPE correctly.

Systems and processes to safeguard people from the risk of abuse
• People and relatives told us they felt safe with the care they or their relative received. Comments included, "Yes quite safe. They make sure everything is tidy and clear of things so I can get about safely", "Very safe. I have a double up call as I need lifting. I have a hoist. They do this very safely and correctly when lifting me" and "I do, they check on me to make sure I am ok, that gives me peace of mind and makes me feel safe."
• The provider had systems and processes to safeguard people from the risk of abuse, including safeguarding adult policies and procedures in place. However, we found that these were not always followed as the provider had not always notified CQC in a timely manner, when a safeguarding had been raised.
• Staff had up to date safeguarding training to help ensure they had the skills and ability to recognise when people were at risk of being unsafe and knew how to respond.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At our last inspection we found people's initial assessments had not always been completed in a timely manner and call times identified in people's care records were not always updated on the provider's call monitoring system to reflect the times people wanted to receive their care at. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• The provider was in the process of addressing call times as part of their wider review of how care calls were monitored.
• People's needs were assessed prior to starting the service to confirm their needs could be met by the provider. Assessed needs included various levels of ability such as mobility, communication and health conditions. These assessments formed the basis of people's care plans.
• Care plans were reviewed but were not always updated to reflect people's current needs. For example, we were told by staff that a healthcare professional had visited one person several weeks ago and left notes in the person's home to add thickener to their drinks, but the care plan was not updated with this information.
• Care plans included details of people's background history and preferences. People's cultural and religious needs were also recorded.
• People told us they were involved in discussions about their care and how it was provided. Comments included, "Yes they are very helpful and always ask what I want before starting", "They always ask how I am feeling when they come in and what order I would like to have things done" and "Definitely [they ask how I want to be cared for]. They won't do anything without a chat first."

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.

At our last inspection we found information in the care plan about people's mental capacity was not always consistent, stating at different places in the mental capacity section that people had and did not have capacity.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

• The provider had an MCA policy and staff received training on the principles of the MCA.
• People and relatives told us they were involved in making decisions about people's care and support.
• When someone lacked capacity, the provider had an assessment to complete and understood a best interests decision needed to be taken around the specific decision to be made. Consent to care forms were signed appropriately, either by people who were able to sign their consent to care form, or by someone who had the legal authority to do so.

Staff support: induction, training, skills and experience
• People were supported by staff who were trained to meet their needs. Two relatives felt staff were not as skilled as they needed to be but people receiving a service were more positive and told us, "All well trained and skilled I would say", "Yes all fine. I have not seen any training deficiencies", "All very good and trained. You have to be to be able to know how to move me safely with the hoist" and "Carers are all marvellous and well trained in what they do."
• Care workers were supported to provide effective care through induction, training, supervision and spot checks to monitor staff competency when delivering care. New members of staff completed an induction and their Care Certificate, so they knew how to work safely and effectively at the service. The Care Certificate is a nationally recognised set of standards that gives staff new to care an introduction to their roles and responsibilities.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to have enough to eat and drink. When people were supported with meals they were happy with this and told us, "They will do me cereal or toast, whatever I decide on, and in the evening make me a sandwich of my choice" and "Yes they get all my meals for me and hand them to me then I eat myself."
• Care plans included information about people's dietary needs and meal preferences.

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 access other healthcare services if needed and care plans included information about health and social care professionals involved in people's care.
• The provider worked with other professionals including the GP and community services such as the occupational therapist. A social care professional said, "When I have queries regarding any initial problems with emergency care packages, it is attended to immediately and responded to appropriately in timely

manner."

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

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 and their relatives generally spoke positively about the care they received. One relative said, "Some of the newer [care workers] need more training in my opinion but they are all polite and friendly but don't always listen to [person]." People told us, "I found them all very good, happy and helpful and caring", "I find them to be very polite and caring and compassionate as I need quite a bit of care from them" and "They are lovely, like I said I wish now I had them earlier to help me instead of waiting until April. Very caring and compassionate all of them."
• The provider had an equality and diversity policy and people's needs such as religion and personal history were recorded. This helped to ensure they received care according to their wishes and needs.
• People's preferences for how they liked personal care was respected and they confirmed they were given the choice of a male or female care worker.

Supporting people to express their views and be involved in making decisions about their care
• People and relatives told us they were consulted in decision making and received care in their preferred way. Comments included, "We have a talk when they arrive, and they will do what I ask of them" and "They always try to find out [person's] likes and dislikes".
• Care workers confirmed they asked people how they would like their care and provided choices.

Respecting and promoting people's privacy, dignity and independence
• Care plans had guidelines for how to complete personal care tasks and staff told us they maintained people's privacy and dignity.
• People and their relatives indicated they were cared for respectfully and with dignity. They said, "Yes [dignity is maintained] and they are very respectful. They close the door and draw the curtains when tending to me", "Privacy and dignity is good and handled well" and "I think they are very aware of [person's] dignity. They don't make you feel like a bother at all".
• People were supported to maintain their independence where they were able. One care worker explained how they supported someone to mobilise and walked with them at the person's pace.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has improved to good.

This meant people's needs were met through good organisation and delivery.

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

At our last inspection we found care plans were not always person centred so that these reflected people's current needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• However, further improvements could be made as we found some records were generic. For example, one person had a risk assessment for falls which included information about the person's health condition. There was generic information about the condition and the reasons people with this condition might fall but it was not specific to the person's individual needs.
• Care plans contained information about people's backgrounds and current preferences, which provided staff with context when providing support to people.
• People were supported by the same staff to provide consistency.
• Regular reviews were held to update people's records and help ensure they received care appropriate to their needs.

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

• Care plans included information about people's communication needs, including if they required assistive aids such as glasses or a hearing aid.
• The staff spoke a range of languages and the provider was able to match people to care workers who spoke their preferred language.

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

• The provider helped to prevent social isolation by providing information in the care plan about people's backgrounds, families and interests. This helped to ensure staff engaged with people about things that were of interest to them.

Improving care quality in response to complaints or concerns
• The provider had a complaints procedure and systems in place to respond to any complaints received. However, the investigation into the complaint was not always effective as although there were actions taken to address the immediate concern, it was not clear what lessons were learned to avoid future repetition and improve service delivery, for example late care calls.
• People and relatives we spoke with said they knew how to make a complaint. For most people who had made a complaint, they said it was dealt with appropriately.

End of life care and support
• At the time of the inspection, no one was being supported with end of life care. The provider had recorded people's wishes and preferences for care at the end of their lives in the event they required this support.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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
• The provider did not always notify the Commission of notifications in a timely manner. This was demonstrated by a safeguarding incident that CQC were not notified about until 28 July 2021 three weeks after the incident on 03 July 2021. We are considering if we need to take further action regarding this.

Continuous learning and improving care
At our last inspection we found shortfalls regarding the governance of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

• Quality assurance systems such as audits were not being operated effectively as demonstrated by a number of shortfalls identified during the inspection. These included the quality of risk assessments for people using the service, medicines audits, personalised care plans and up to date medicines competency testing for staff.
• Late and missed calls was an ongoing issue over the last three inspections but the provider did not have an effective monitoring system in place to identify issues as soon as they happened so immediate action could be taken, nor was there an effective investigation process to analyse what went wrong and put in preventative measures.
• Incidents and accidents were not effectively investigated and lacked learning outcomes to improve service delivery. Some incidents and accidents were not recorded at all, for example, when a care worker had called an ambulance to a person's home.
• People's records did not always contain correct and up to date information about them. For example, the person who changed from self-administering medicines to requiring support or the person whose occupational therapist's notes were not recorded in their care plan.

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

• Medicines and daily log books were audited monthly. The consultant had last audited people's files in June 2021 and had an action plan to address shortfalls identified in the audit. The consultant had also been holding workshops with staff to provide practical advice, for example, writing effective risk assessments.

• The operations manager felt some of the issues identified during the inspection had resulted because the service was at times short staffed. At the time of the inspection the provider was actively recruiting new staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and relatives told us overall the provider promoted an open culture and responded to people using the service and to staff.
• Relatives generally spoke positively about the service and the care provided. Comments from people included, "For anything at all if I need to contact them they listen to me and act", "They are only a phone call away and if I ever called them I found them polite and helpful" and "Yes they do listen and act, like when my carers kept coming late."
• Feedback from care workers indicated they were happy working for the provider and confirmed they received the support they needed to carry out their role. One care worker stated, "Yes I do [feel supported]. If there is something needed or we need any kind of support they are always there."

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 provider had policies and procedures in place to respond to incidents, safeguarding alerts and complaints and knew who to notify if things went wrong.
• People and their relatives knew who to contact if they had a concern.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider contacted people using the service and their relatives for feedback about their experiences.
• There were spot checks in place to monitor staff competencies and telephone monitoring calls were made to get feedback from people using the service about the care and the support provided.
• People's diverse needs such as culture, religion and language spoken were considered as part of the assessment process.
• Team meetings were held to share information and give staff the opportunity to raise any issues.

Working in partnership with others
• The provider worked in partnership with various other health and social care professionals.
• Where appropriate they liaised with other relevant agencies, such as the local authority and community health care professionals to ensure people's needs were met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always assessed or done all that was reasonably practicable to mitigate the risks to the safety of service users. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)

The enforcement action we took:

We imposed a condition requiring the provider to send us a monthly report.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)

The enforcement action we took:

We imposed a condition requiring the provider to send us a monthly report.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled experienced persons were deployed to meet the needs of service users. Regulation 18 (1)

The enforcement action we took:

We imposed a condition requiring the provider to send us a monthly report.