London Care Limited

London Care (Raynes Park)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 August 2016 and was announced. London Care (Raynes Park) provides personal care and support to people living in their own homes and in two "extra care" housing schemes. These consisted of individual flats within staffed buildings with some communal areas. At the time of our inspection there were 382 people using the service.
There was 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.

Medicines were not always managed safely, because appropriate information about people's medicines was not included in people's files and in several cases records either showed people were not receiving medicines as prescribed or were not clear enough to show that they did. There were gaps in records and insufficient information about medicines to be taken only when required. There were procedures in place to ensure people did not run out of medicines and these were stored appropriately where applicable. Staff supported people to take medicines independently as much as possible and there were risk assessments to cover this.

People had risk assessments and care plans in place but these were not personalised enough for the provider to be sure they were assessing, managing and mitigating risks arising from individual needs such as people's health conditions and that they were meeting people's individual needs. People's risk of malnutrition was not always appropriately assessed. People's care was not always planned in a way that was personalised and met their individual needs. Information was missing from people's care plans about their preferences and how staff should carry out care tasks, and tasks that staff performed did not always correspond with the care plans, meaning there was a risk that people were not consistently receiving the care and support they needed.

There were not enough staff on duty to keep people safe and meet their needs at weekends and in the extra care scheme. However, the provider had taken appropriate steps to make sure that staff they employed were suitable to care for people. People felt safe using the service and the provider had appropriate procedures, staff training and monitoring to protect people from abuse and discrimination.

The provider used various checks, audits and a quality team to make sure the service was of good quality and continually improving. The provider's quality checks had identified the problems that we found, but when we visited the issues had not yet been resolved although work was taking place to address them. Poor record keeping meant that we could not be sure people were receiving the care they needed. Audits showed record keeping was improving but at the time of our visit this did not meet the standards required by the regulations that providers must comply with.

There were systems in place to record, monitor and learn from accidents and incidents. Staff were trained to

respond to emergencies.

People were happy with the way staff supported them with their meals. Staff were aware of the importance of respecting people's preferences and cultural needs around food. Staff helped people to stay healthy and to access healthcare services when they needed it.

The provider met the requirements of the Mental Capacity Act (2005). They followed appropriate procedures to ensure that decisions about the care of people who were unable to consent to them were made in their best interests. Staff obtained people's consent before carrying out care tasks. Some staff did not understand that they should not deprive people of their liberty without the correct legal safeguards in place but the provider was addressing this through staff training.

Staff were happy with the support and training they received. They had a comprehensive induction before starting work and they had supervision, appraisals and opportunities to attend staff meetings. The registered manager used a number of methods to help ensure staff received updated knowledge about best practice in care and the opportunity to discuss it.

People were happy with the care and support staff provided. They were treated with respect and dignity and staff worked with people to promote their independence. Staff provided people with the information they needed to make decisions about their care. This included providing staff who spoke the same language as people, where possible. Staff respected people's religious, cultural and other diverse needs.

Consistent staffing meant that people had the opportunity to develop positive relationships with the staff who cared for them.

People were able to raise concerns and complaints when they needed to. The registered manager made sure they responded to these quickly and resolved them to people's satisfaction. People were aware of the complaints procedure.

People and staff had opportunities to feed back and to be involved in decisions about how the service was run. The registered manager acted on their feedback and valued their opinions. People and staff felt that the service had a positive culture that enabled them to speak freely about their concerns and opinions. Staff were aware of the provider's values and considered these as part of their work.

We found breaches of regulations during this inspection relating to safe care and treatment, person-centred care, staffing and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. Medicines were not always managed safely. Staffing levels were not sufficient to meet people's needs at times. Risk assessments were not personalised enough to ensure that some risks were adequately managed.

Staff were appropriately vetted to help ensure they were suitable to work with people.

The service had robust procedures in place to safeguard people from abuse and to take appropriate action when abuse or ill-treatment was suspected.

Is the service effective?

Good

The service was effective. People were happy with the support staff gave them with meals. Staff made sure people were able to access healthcare professionals when they needed to.

Staff obtained people's consent before carrying out care tasks if they were able to do so. Where people did not have the capacity to consent, the provider followed the requirements of the Mental Capacity Act (2005) to ensure they fully considered people's rights in this area.

Staff received training and support to help ensure they had the knowledge and skills to provide high quality care in accordance with current best practice in social care.

Is the service caring?

Good

The service was caring. Staff treated people with respect and understood the importance of considering people's privacy and dignity at all times.

People felt comfortable with staff and had the opportunity to establish good rapport with them as they had visits from the same staff most of the time.

People received the information they needed to make decisions about their care. This included being cared for by staff who spoke

the same language as them where possible. Staff respected people's religious beliefs and cultural differences.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Care plans were not person-centred and did not take into account individual differences such as health conditions. Care plans were task-based but did not take into account the ways in which people required or preferred the tasks to be completed.

People received information about how to complain and were able to raise concerns when they needed to. The registered manager responded appropriately to concerns and complaints.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Although the provider's quality checks were effective in identifying the problems we found, these had not yet been resolved at the time of our inspection. Poor record keeping meant we could not always be sure people received the care they needed.

The provider had plans for improving the service. The service had clear values that staff adhered to and there was a fair and open culture that enabled people, relatives and staff to feed back their views, be confident the provider would act on them and be involved in the development of the service.

London Care (Raynes Park)

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 August 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office. This was the first inspection carried out at this location.

The inspection was carried out by an inspection manager, two inspectors and a pharmacist specialist. Before the inspection we reviewed the information we held about the service. This included notifications the provider is required to send us about certain events that take place within the service. We looked at feedback we had received from people who use the service and their relatives. We also discussed the service with a local authority commissioner.

During the inspection we spoke with 15 people who used the service and eight relatives of people who used the service. We spoke with the registered manager and six senior members of staff including the area manager, quality and governance director and an extra care housing scheme manager. We spoke with 11 members of staff who directly provide care and support to people. We also visited an extra care housing scheme to review the service being provided at the scheme by the provider, looked at 20 people's care records including care plans and medicines records and reviewed other records including four staff files.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the staff who provided care to them. One person told us, "[Staff] are kind and caring. I feel safe and confident with my carers." Another person said, when we asked if they feel safe, "Yes I do, at least you get the help here [at the extra care scheme] if you need it" and a relative told us, "My [relative] is safe with the carers. The carers are all good and helpful."

Three relatives told us during the inspection that they were concerned that the service did not manage people's medicines safely. We looked at nine people's medicines administration records (MARs) and all of these contained gaps where there were no signatures to show people had taken their medicines. For one person, 14 out of 31 daily doses that they were due to take one month were not signed for and for another, 18 out of 30 doses in one month were not signed for. Some MARs were missing information about what medicines people took, the dosage or when people should take medicines. For another person, although one medicine was prescribed to be taken at night there were no signatures to indicate the person had taken it at night, although there were eight signatures in the morning on one chart and these had been crossed out with no explanation.
At the extra care scheme we did not see appropriate, up to date protocols in place which covered the reasons for giving "as required" (PRN) medicines, what to expect and what to do in the event the medicine does not have its intended benefit. This meant we could not be sure that people received their medicines when they needed them. One person had been prescribed a medicine to take once daily but records showed that this person had received the medicine twice daily for 15 days in one month. Taking medicines more often than prescribed can cause people serious harm. There was no evidence that these errors were reported or that staff had contacted a doctor or pharmacist to ask for advice about the overdose and whether the person required medical attention.

There were moving and handling assessments in place for people who required physical assistance to mobilise or stand or were at risk of falling. These included assessments of specific risks such as rising unaided from chairs or using stairs and details of the measures taken to reduce the risks, such as use of stair lifts and other equipment. Each person's file also contained an environmental risk assessment so staff were aware of potential risks arising from people's home environments and how to protect people, and themselves, from these risks. However, we found that where people had specific medical conditions risk assessments were not always in place to help manage the risks. For example, where people had urinary catheters, there were no risk assessments or detailed care plans about what staff should do if the catheter became blocked or was not draining appropriately. This meant there was a risk that staff would not know when to alert the district nursing team to complications that could be harmful to people.
Where someone had diabetes, there were no risk assessments or management plans to address the complications of diabetes and the signs that staff should be observing if people's blood sugar became too high or too low, and the action to take in these circumstances. Some people had malnutrition risk assessments on file, but these were either not done or incorrectly completed for six people who needed support with meals. This meant staff did not always have the information they needed to keep people safe from avoidable harm because the provider had not assessed risks and set out management plans for these.

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

Nine people, two relatives and seven members of staff we spoke with felt there were not always enough staff to keep people safe, especially in the extra care housing schemes and at weekends. Comments from people included, "They are well intentioned but they are sometimes short staffed", "There never seems to be [a member of staff] when you need one", and "The staff are overworked. If they go home they are called again to cover for others". Another person told us, "My usual carer was on holiday and no one came to help me on Saturday" and three other people also reported missed visits although they said when staff came they were usually on time. Five members of staff told us they had problems getting to all their scheduled visits on time at weekends as not enough travel time was allocated, fewer staff were available and they felt more staff were needed. Records showed there were days when staffing levels were below the planned numbers at the extra care scheme, usually at weekends. For example, in one week there was one shift where there were five staff instead of eight and another where there were seven instead of eight. People told us they sometimes had to wait longer than expected when they needed help. This was concerning as it meant there was a risk that people would not receive prompt attention in emergencies.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained information about how much support people required to take their medicines. Where people took medicines independently risk assessments were in place and staff had access to information about their medicines in case this was required for medical purposes. We checked medicines storage and supplies at one of the extra care schemes run by this service. All prescribed medicines were available at the service and were stored either within the locked cupboard in the manager's office or in locked cabinets inside people's rooms. Controlled drugs were stored safely and securely in line with relevant professional guidance and there were arrangements in place to ensure people did not run out of their prescribed medicines.

Staff told us they received training in safeguarding people from abuse and we saw evidence that they had the opportunity to discuss safeguarding procedures at staff meetings. They were able to describe different types of abuse, their signs and how they would report any suspicions or allegations of abuse, including the whistleblowing procedure that they would use to escalate concerns if necessary. We saw evidence that managers took appropriate action to investigate allegations or suspicions of abuse and report them to local authority safeguarding teams. This helped to ensure that people were protected from the risk of abuse and that potential causes of abuse and avoidable harm were promptly removed from people.

There were systems in place to monitor accidents and incidents. Office staff used an electronic system to record accidents, incidents, allegations or suspicions of abuse, missed visits and other information that could indicate safety issues. Each record required staff to note what actions were being taken and timescales for completion and we saw examples of these. We saw reports that the system produced monthly showing summaries and possible trends that could alert managers to safety problems. It also sent alerts to senior managers when accidents and incidents were reported. Staff had training in emergency first aid and were able to describe what they would do in a variety of emergency situations. The service had a business continuity plan in case of events that prevented the service from running safely. This showed the provider had taken appropriate steps to keep people safe in the event of emergencies.

Processes were in place for office staff to monitor whether people received their booked visits on time. The provider used an electronic monitoring system for some people using the service. Office staff could use this

system to check whether staff had arrived promptly at people's houses when scheduled and had stayed for their allocated time. The system alerted them if staff missed calls. For other people, the registered manager told us they checked timesheets that people signed for each member of staff to show their allocated tasks were complete. We saw evidence that senior staff regularly asked people if staff arrived on time and records showed that people they had asked were happy with staff punctuality overall.

We looked at checks that the provider carried out to make sure new staff were suitable to work with people using the service. These corresponded with documentation we found in staff files, which included criminal record checks, references from previous employers, proof of identification and right to work in the UK and records of relevant qualifications.

Good

Is the service effective?

Our findings

People told us staff prepared a variety of nutritious food for them, where this was part of their care plan. One person said, "They cook food of my choice." Another person told us staff "cook the type of food I like to eat." Staff told us how they supported people's nutritional needs by helping them choose a variety of healthy meals that met their cultural needs. This included giving people choices about what food they prepared for each meal or asking them what they wanted to eat. We saw evidence that staff had discussed signs of malnutrition and the increased risk of dehydration in hot weather at a recent team meeting, to ensure people received the level of support they required to stay safe and well.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). 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. We saw staff explaining what they were doing or about to do and people agreeing to this, which helped to ensure people understood what they were agreeing to and did not receive care they had not consented to. Staff understood what mental capacity meant and what they should do if they thought people did not have capacity. They confirmed they had training on this and we saw evidence that they had discussed this at a recent staff meeting. People's care plans contained information about their mental capacity so staff supporting them were aware of any issues around their ability to consent to their care. People who were able to do so had signed to indicate that they consented to the care that was planned for them, but knew how to withdraw their consent should they wish to do so.

However, whilst senior staff at the extra care scheme we visited were clear about issues in relation to mental capacity and deprivation of liberty, two staff were not familiar with these. One said, "If X wanted to go out, we'll stop her." This meant there was a risk that staff could be depriving some people of their liberty, and thus compromising their right to freedom, without the appropriate legal safeguards in place. The quality and governance director we spoke with told us they were in the process of developing special training to educate staff about the impact of not meeting the requirements of the MCA. We saw posters and examples of flashcards that managers had given staff with information about the main principles of the MCA, to help familiarise staff with this important information.

We saw evidence that new staff completed an induction before working with people unaccompanied. The induction included classroom-based training days, assessment workbooks to ensure staff had learned from their training and on-site supervision and shadowing with more experienced staff to help new staff learn how to apply their training in practice. Managers told us they met each member of staff when they had completed their induction to assess whether they were competent. After this, staff received quarterly one-to-one supervision and annual appraisals. This helped to ensure that staff did not care for people unless they were equipped with the right level of knowledge and skills.

People who completed the provider's satisfaction questionnaire fed back that they were happy with the

level of knowledge and skill demonstrated by staff. Staff told us the training and induction were good and that they were able to access support to achieve relevant qualifications and additional training when requested. Senior staff told us about weekly meetings they attended to discuss best practice and current research in areas relevant to their work. They told us they passed this to staff via supervision, spot checks and meetings.

The registered manager told us that where they identified poor practice or gaps in staff knowledge, they asked staff to attend a themed supervision meeting to discuss the problem and provide brief retraining. We saw evidence that these sessions included assessments of competence to check staff had understood the material covered. Staff told us they had found these sessions useful, particularly when they were run as group sessions to allow staff to discuss good practice, ask questions and learn from one another.

Staff gave people the support they needed to access healthcare services. One person told us staff had contacted their GP on their behalf when they were feeling unwell. Staff told us they often liaised with other professionals such as GPs, district nurses, dentists, opticians and a continence service to ensure people received the support they required with their health needs and to obtain further advice for example in relation to pressure ulcer management and catheter care.

Good

Is the service caring?

Our findings

People told us they had good relationships with the staff who supported them and said they were "friendly" and "kind and caring." One person said staff were "really good and helpful" and a relative said staff were "fantastic" and "all very caring." Another person said, "My carer is splendid. [They] are like a friend and they take me shopping." Although five people and relatives said they did not consistently have the same staff visiting them, most people told us they did. One person said, "I know all the carers as you get the same ones each day. We know each other well." We looked at records staff made of the care provided to eight people and found that those people consistently received visits from the same members of staff. Staff told us this meant that people and staff had the opportunity to get to know each other and to build positive caring relationships. One person told us, "[Staff] talk to you. It's good to have some social contact."

We spent time observing staff engaging and interacting with people during a coffee morning at an extra care scheme staffed by this service. We also saw staff engaging with people when they attended to people in their flats. Staff were pleasant and talked with people appropriately. We observed staff taking the time to listen to people and to answer them in a polite manner.

People received the information they needed to help them make decisions about their care. Before people began using the service, they signed to indicate they had read and understood information about the service. This included how to complain and how to make changes to their care plan if people wished to do so. There was information in care plans about how to support people to make choices for themselves. Staff told us they worked with people to determine how they wanted their care to be delivered.

A relative told us, "The [member of staff] was matched with us as she can speak [the person's native language] which helps with communication." Staff also told us the agency tried to match people with staff from the same cultural or religious background or those who spoke the same language to help ensure staff understood people's needs and to facilitate communication. There was information in care plans about how people communicated, for example whether they had any sensory impairments, concentration difficulties or did not speak English as a first language. There was also information about what staff should do to facilitate communication with each person, for example by speaking slowly and clearly and making sure they were patient when people had difficulty understanding or communicating. This helped staff ensure people understood information they gave them about their care or when supporting them to make decisions.

As part of the provider's quality checks, senior staff asked people about whether staff treated them with respect, promoted their privacy, dignity and independence and supported them in line with their cultural background and religious beliefs. Staff carrying out these checks also asked how people wished to be cared for, if different from their current care plans. The records we saw showed that people were happy with all of these aspects of their care. We also saw that staff discussed equality and diversity at team meetings, as part of discussions about treating people with respect.

Staff demonstrated that they understood how to support people in ways that protected their privacy and

dignity. They described how they did this, including using towels to cover people when supporting them with personal care and talking with people as they worked to ensure they were respecting people's wishes and that people knew what was happening. We saw questionnaires that people had completed, saying the staff treated them with dignity and respect. Care plans contained some information about what people could do for themselves, such as taking their medicines or washing specific parts of their bodies. This helped staff to support people to remain as independent as possible.

Requires Improvement

Is the service responsive?

Our findings

People told us the staff were flexible and responsive to their needs. They also told us they had care plans in place, which staff adhered to. People's care plans contained information about their life histories, family relationships, interests and values. This included information about any social activities they participated in regularly. People's goals that they wished to achieve from their care, such as regaining a certain level of independence, were recorded so that staff could assist people to achieve these.

The service created care plans using a standardised template. While this helped to ensure that basic information and significant assessment paperwork were included, it also meant that the care plans were not always sufficiently personalised to ensure the service was responsive to people's individual needs. For example, one person's assessment stated that they were living with a mental illness but there were no details about the impact this had on their life, any support they received or required around coping with the illness or signs and symptoms that would indicate to staff that the person's illness was worsening and what they should do if this happened. Similarly, we saw care plans did not have this information for people living with other mental health needs, dementia and other cognitive problems and diabetes. This meant there was a risk that people's needs were not always met because care plans did not contain the details staff needed to be aware of.

The care plan template also meant that people's care plans were focused on tasks, such as what meals staff needed to prepare, any domestic tasks that needed to be completed and what type of personal care support, such as bath or shower, that they required. We did not see any information about how staff should perform these tasks or what help people needed to complete their personal care and some tasks staff completed did not correspond with care plans. For example, records showed that staff had assisted one person to use their commode at least eight times in one month, but there was no mention of the commode in the person's care plan or what support they needed to use it. There were no details about individual differences in people's needs such as those arising from identified risks, health conditions or cultural background. In some cases, there was no information in care plans about people's preferences with regard to how they wanted their care delivered. People told us staff knew what their personal care needs were and were good at meeting them, and staff were able to describe how they got to know people and their individual needs. Despite this, the lack of information in care plans presented a risk that staff who were new or working with people they were not familiar with were not consistently responding to people's individual needs.

Although people's life history and social and recreational needs had been captured as part of the assessment of their needs, these were not incorporated in people's care plans to make these person centred so that all of people's needs had been considered as part of the planning and delivery of care. All people who spoke with us at the extra care scheme told us that their social and recreational needs had not been fully considered as part of the delivery of the care. There were planned activities such as film nights and coffee mornings but not everybody was able to take part in these because of different levels of ability.

The paragraphs above show that there was a breach of regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

There were procedures in place to ensure the service was responsive to people's concerns and complaints. Staff documented when people raised concerns about the service they received. We looked at records of quality checks carried out by senior staff and found that where people raised concerns, managers followed these up and asked people about their concerns at the next quality check. The records we saw showed that people's concerns were quickly resolved to their satisfaction.

An effective complaints process was in place. People were aware of how to make a complaint, and managers told us they offered to visit people who had made complaints if they wanted to discuss them further. There was a complaints policy, which covered who would deal with complaints, timescales and resolution of complaints. We also saw evidence that regional managers reviewed how complaints were handled to ensure the process was followed appropriately and complaints were resolved to people's satisfaction. We looked at records of complaints and found these were managed appropriately.

Requires Improvement

Is the service well-led?

Our findings

There were processes in place to review the quality of service delivery and help ensure that people were satisfied with the service. Through these processes the provider had identified a number of shortfalls, which corresponded with the evidence we found at our inspection. We reviewed the action plan in place and discussed with the registered manager what action was being taken to improve service delivery.

In regards to staffing, the registered manager was negotiating with commissioning authorities to obtain funding for a "floating care worker" to cover the additional support needed in extra care schemes. They were in the process of recruiting more staff to cover weekend work and had an incentive scheme for existing staff to introduce friends and family who were looking for care work.

An organisational review, a themed audit about medicines management and targeted training were undertaken to inform staff about the impact of failing to provide safe medicines management. Senior staff attended 'medication lead officer' training to raise awareness about what to look for when checking medicines management. Staff we spoke with confirmed that they had received additional training and competency checks that senior staff confirmed they carried out. They told us they now felt more confident about administering and managing people's medicines. The registered manager told us staff who had completed the training were better at completing medicines records and more likely to report errors made by colleagues. We saw that a detailed discussion about good practice in medicines record keeping took place at a staff meeting six weeks before our inspection. However, when we carried out our inspection, this work was still in progress and we found several examples of poor record keeping in relation to medicines and other records of people's care.

Accurate and up to date records about people's care were not maintained to demonstrate that people received care in line with their care plans. One person's care plan stated that staff should support them with personal care and meals twice a day. We looked at the daily records staff kept for this person and found there was no mention of personal care, which meant we could not be sure the person was being cared for as planned. Staff were instructed to support another person with personal care daily but on 26 of 30 days they had not recorded having done so. Where we found poor record keeping in two people's care notes, we saw this had been identified by quality checks and the members of staff responsible had been asked to attend themed supervision sessions to address the problem. However, we also noted that one of the staff in question had previously attended the same session, which showed that the supervision may not always be effective. We also found similar information missing in another four people's records that had not yet been audited. For example, staff had not filled in repositioning records for one person who needed to be moved regularly to prevent pressure sores and where other people's care plans stated their food and fluid intake should be recorded this had not been done.

We looked at the records of a further three people who were at risk of malnutrition and found that staff did not record how much they ate or in some cases what they ate. The lack of accurate record keeping meant there was a risk that staff would not notice any changes in people's eating or drinking habits that indicated they were not eating enough to keep them healthy.

The above issues showed that, while the provider had taken measures to address shortfalls in the quality of the service, these were not always as effective as they needed to be or took a long time to put into practice.

The above paragraphs show that there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider employed a quality assurance team. We saw reports showing that the quality team carried out an internal audit every three months, or more frequently if they identified significant problems. Since the provider had become aware of problems with medicines management and record keeping, the quality visits placed more emphasis on medicines audits, records and staff competency assessments and the audits showed these had been improving since the provider had identified the problem.

Meetings were held with the managers across the provider's services to review key performance data, including the outcome of audits, and learning from incidents. This enabled managers to share good practice and learning across services.

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People told us they had the opportunity to participate in a survey about the quality of the service. We saw examples of completed questionnaires, which contained positive feedback. The registered manager told us they contacted each person who used the service at least once every three months, either by a telephone call or a visit from a senior member of staff, to ask their opinions about the service. There was evidence that the manager took action in response to people's feedback and had identified a need to involve people more in decisions about how the service was run and to keep them informed about developments within the service. They planned to start producing a newsletter to address this. The quality and governance director we spoke with told us that people were involved in some aspects of quality improvement work, such as policy review and using people's feedback to make changes in how the service operated, such as introducing staff uniforms after people said they would like to see them. They also told us about plans to introduce a quality advisory panel that involved people using the service. This demonstrated that the provider valued the views and opinions of people who used the service and wanted to improve so they provided the care people wanted.

Staff told us they were well supported by management to do their jobs and the registered manager told us they had enough support to ensure staff received the supervision they required. Staff knew who they should approach if they had a specific problem or query about their work. They said managers listened to them and acted promptly on any concerns they had. Managers asked staff for suggestions about what aspects of the service they could improve and they acted on these. For example, when staff fed back that communication within the service was poor, managers introduced a regular coordinators' meeting and weekly one-to-one meetings with supervisors. We saw some questionnaires that the manager had asked staff to complete and they had fed back positively about their interactions with managers and office staff. Staff we spoke with felt the service had improved overall over the last year and that the service had a positive, open and supportive culture so they were able to speak their opinions freely.

Staff told us they found unannounced spot checks by supervisors helpful as it helped them identify areas for improvement in their practice. They said senior staff were good at supporting them to improve. One member of staff told us they were surprised by how low their scores were in one particular area but they had received "really good support" and were now confident they were working in line with best practice.

We asked staff whether the provider had a clear vision and values that all staff should work towards. They told us they were expected to maintain high standards of care, treat people as individuals, respect people and their diverse backgrounds and to promote people's independence. We saw evidence that this was

discussed at a staff meeting to help ensure staff were aware of the standards and values they should be working towards.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs and reflect their preferences. This was because the registered person did not design care and treatment in such a way as to achieve service users' preference and ensure their needs were met. Regulation 9 (1)(b)(c)(3)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not assess the risks to the health and safety of service users and do all that was reasonably practicable to mitigate such risks. They did not ensure the proper and safe management of medicines took place. Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively in terms of improving the quality and safety of services provided and mitigating risks which arise from the carrying on of the regulated activity. The provider did not maintain an accurate, complete and contemporaneous record of the care and treatment provided to each service user. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy sufficient numbers of staff to meet the requirements of these regulations. Regulation 18 (1)