BELGRAVE CARE LIMITED

Belgrave Care

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

Summary of findings

Overall summary

This inspection took place from the 3 May 2018 to the 14 May 2018 and was announced.

This service is a domiciliary care agency that provides personal care to people living in their own houses and flats in the community [and specialist housing]. It currently provides a service to older adults. Not everyone using Belgrave Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection we were informed that 43 people received regulated activity.

The service had a Registered Manger who was registered on the 09 February 2017. 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.

We found that some improvements were required to the service in regards to management, staffing and quality oversight which meant that there was a breach of the regulations.

You can see what action we told the provider to take at the back of the full version of the report.

The management team were open and approachable in the way they managed the service. There were quality monitoring processes in place but these were not robust enough to fully address all aspects of the service such as monitoring the time, length and reliability of calls. Staff felt under pressure as they were not always given travel time in between visits.

The registered provider was in the process of recruiting staff fill their current vacancies. In the meanwhile, this meant that people were not always supported by a consistent group of staff who arrived on time or knew them well. Processes were in place to ensure that staff recruited was of suitable character but references were not always available or concerns acted upon. We made a recommendation that processes around recruitment are reviewed to ensure they comply with the regulations.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, decisions were sometimes made by people who did not have the legal authority to do so which was not in line with the Mental Capacity Act. We made a recommendation that this practice was reviewed.

People received safe care delivered by staff who understood their role in safeguarding the people in their care. Risks to people's safety were assessed and a management plan put in place to keep them safe. People

who received medicines were supported in a safe way as staff had the necessary training to administer medicines safely.

Care plans were comprehensive and person centred. Staff had the right information available to ensure that they provided care in line with a person's needs and wishes.

Where people were supported with their nutritional needs, staff showed a good awareness of their dietary needs and where to get further support should this be required. Staff worked with people, their relatives and health professionals to manage people's health needs, making appropriate referrals for advice when necessary.

People told us that the staff were caring and kind. People commented that they were treated with dignity and respect and their privacy was maintained. When staff supported people at the end of their life, they worked to ensure their wishes were acted upon and supported their relatives during this time.
People were aware of how to raise concerns and complaints. Not all complaints were recorded and a record kept of actions taken.

The staff had knowledge of the Equality Act and did not discriminate against people in their care. Staff was supported with a robust induction and regular training in all aspects of their role. They also received regular supervision from the registered manager

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.

People did not always get their support on time and there was a lack of contingency planning for late or missed calls.

Recruitment processes were not always robust as staff started work without the required references being in place or without appropriate risk assessments.

Staff had an understanding of safeguarding and risks inherent in providing a persons care and support were assessed and managed.

Is the service effective?

Good

The service was effective.

People received care that met their needs and kept them well. Staff ensured that they sought the help and advice of other professionals in order to keep a person safe and well.

People were encouraged to make decisions about their care and were consulted in how they wished they care to be delivered. Where a person was felt unable to make a decision this made by others in their ' best interest'. However, others consented to things on a persons behalf without the legal authority to do so.

Staff received an induction, training and on-going supervision that assessed their competence and confidence in their day to day work. People felt assured that staff had the right knowledge and skills.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive care from a consistent staff group and on occasions received support from staff to whom they had received no introduction.

People and their representatives said that the staff were kind,

considerate and caring. They felt that their dignity was upheld and they were respected.

Peoples individuality was acknowledged and their support tailored to their needs.

Is the service responsive?

Good

The service was responsive.

Care plans were thorough and detailed and demonstrated that staff had got to know people well over a period of time. This meant that staff had the information their needed to provide personalised care.

People were supported to maintain links with family, friends and the local community.

Concerns and issues were directed to the registered manager and registered provider. People had a varying opinion as to how these were responded to.

Is the service well-led?

Requires Improvement

The service not always well led.

The systems in place to plan staff's rotas were not robust and this meant that people did not receive care from a consistent group of staff or at a consistent time.

Checks were in place but they did not address the issues with the quality of the service found at this inspection.

The management team were visible and accessible to staff and people whop used the service. Opportunity was made available for feedback to be given on the service received.

Belgrave Care

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 checked 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 was the first inspection of the service since it was registered on 7 February 2017.

Inspection site visit activity started on 3 May 2018 and ended on 14 May 2018. The visits were announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Over the course of the inspection we spoke to eleven people who used the service over the phone or in their own home. We gathered feedback from twelve of their representatives by phone, face to face meetings or email. We also spoke to six members of staff about their work.

We visited the office location on the 3 and 14 May 2018 to see the registered manager and registered provider. We reviewed eleven sets of care records, daily records and medication administration record sheets. We also looked at policies, procedures, complaints, audits, training records and four staff files.

The inspection was carried out by one adult social care inspector.
We used information the registered provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make . We also reviewed information we held on the service such as statutory notifications, questionnaires, complaints and compliments.

We also had feedback from four professionals that came in contact with the service and this was positive.

Requires Improvement

Is the service safe?

Our findings

The registered provider informed us that in recent month's staff had left the service at short notice. This had impacted on the staff available in order for them to achieve the consistency of staff and timing of calls. This was reflected in the feedback we received from people who used the service and their relatives. Comments included: "There have been a number of missed calls recently", "Carers more recently have not turned up at the times that we had agreed' and "I have worried of late that the staff may not go and my [relative] would not be able to tell anyone". The Registered Provider was in the process of recruiting new staff but told us they wanted to be sure that those they employed had the right attitude and skills. In the meanwhile, the registered manager and the registered provider had to carry out a substantial number of the care calls themselves.

Rotas and daily records confirmed this. For example: one staff rota indicated a variation in the time of call from 8.35 to 10 am for one person whose care plan indicated their preferred time was 8.45. On other occasion the staff rota indicated a call time of 10am but the daily records indicated that staff had visited at 8.45 and on another the rota indicated a 19.30 visit but the daily notes confirmed it was at 20.20.

Some of the people who used the service lived alone whilst others had a degree of cognitive impairment. This meant that they may be particularly vulnerable if visits were late or missed. One staff member had failed to let the office know that they would not be at work and so calls were very late or had to be cancelled. Another family member told us that they would have no idea if the staff failed to attend as their relative would be unable to tell them or to report this to the office. This had already occurred on two occasions recently.

This meant that there were insufficient numbers of staff to meet people's needs in line with their care plans. There was a lack of procedure in place to follow to make sure that sufficient staff were available to cover both emergency and routine work.

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

Following the inspection, the registered provider sent to us a policy document that outlined how they would respond to any missed calls which would take into account the risks to each individual.

Staff were aware of safeguarding adults and what it meant for them in their day to day work. They were aware of the nature of concerns that they would need to report and were clear on how to do this. The Registered Manager had raised concerns with the local authority where it they had been it appropriate to do so.

The Registered Provider had processes in place to help ensure that staff recruited was suitable for the job. Staff completed an application form with their previous employment and experience. They also had an interview which covered core skills and knowledge. References were also obtained and verified from

appropriate sources. However, where issues in previous employment had been brought to their attention, there was no risk assessment in place to demonstrate that the concerns had been discussed with the person and assessed as not impacting on their suitability. Some staff had commenced employment ahead of all or any references being returned . Checks had been undertaken with the Disclosure and Barring Service to ensure that staff were of suitable character.

We recommend that the registered provider review their selection and recruitment processes to ensure that they fully comply with the regulations.

Staff provided support with medication management and administration. We checked medication records and medicines available for two people and found these to be correct. There was a list of the medication required for each person and this was updated with any additions or omissions. This also had a description of the medication required, any brand names, storage requirements, dosage instructions as well as side effects. This assisted staff in recognising medications that were in blister packets or not stored in original boxes. Where a person took a medication 'as required', there was information for staff as to what this was for and when it may be offered to ensure consistency of administration.

There were systems and processes to protect people against the risks of infection. Staff had received training in infection control. They told us they wore gloves when supporting people with their personal care. Staff told us and people who used the service confirmed that aprons were rarely used during personal care. This meant that staff did not always minimise the risk of spreading infection. The registered manager confirmed that supplies were available and would address this concern with all staff. Infection control was addressed within care planning. For example: where people used flannels for personal care, staff were guided to encourage the use of different coloured flannels for different parts of the body. There was also direction for staff in giving medication or applying creams to minimise the risk of cross infection.

There were a range of risk assessments in place to help advise staff how to keep themselves and people who used the service safe. An environmental risk assessment was undertaken in order to ensure that risks within a property were minimised. There was information for staff on the products used by means of a COSHH (Control of Substances Hazardous to Health) assessment. This assessment concentrates on the hazards and risks from substances in the workplace.

Risk assessments were in place for tasks that staff undertook such as moving and handling. Risks to a person's safety had also been identified such as where a person had a risk of falls. These assessments and management plans looked at key factors such as health conditions, medications, sight, diet and environmental factors. Some people had health conditions or took medications that came with specific risks. For example: some people took Warfarin that placed them at risk of bleeding and bruising whilst others had diabetes. There was detailed information and a risk management plan for staff to follow. This meant that staff had information available to them in order to take action to minimise the risks to a person's health and wellbeing.

Good

Is the service effective?

Our findings

People's needs were assessed prior to care visits commencing. The registered manager used a range of assessment tools to determine people's needs. These included meeting with people to discuss their preferences around their personal care routines. They also reviewed information from assessments by social workers or health professionals. This helped ensure people's needs were fully assessed and the service had the right skills and resources in order to provide appropriate care.

People told us that they felt confident that the staff had the skills required to support them safely and effectively. They told us that staff 'new to care' were always supervised by another more experienced staff member when they first joined the company. Staff joining undertook an induction programme that they told us prepared them for their roles. This included information relevant to their employment such as policies and procedures. They also undertook basic training in core subjects such as safeguarding, food hygiene, moving and handling, medication administration and infection control. This face to face training was followed up with an assessment of their skills and competency whilst delivering care and support. This induction followed the standards of the care certificate. The Care Certificate is a nationally agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Staff had to complete a six month probationary period over which their performance was monitored.

Staff had on-going support and direction from the registered provider and registered manager. Each person had a one to one supervision at regular intervals throughout the year as well as the opportunity to meet with colleagues at team meetings. Where concerns had been raised about a staff member's performance, additional supervision sessions or observations were seen to take place.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA.

Staff received training in the Mental Capacity Act 2005 and understood the need to seek consent before providing care. The registered manager ensured that people had read and understood their care plans in order to consent to their care where they were able. Where necessary, the registered provider consulted the person's representative. However, we saw that, on occasion, 'consent' had been given on behalf of the person but there was no evidence that this person held a valid lasting power of attorney for health to make decisions in the person's best interests.

We made a recommendation that the registered provider reviews decision making in the light of the MCA and its code of practice.

Mental capacity was addressed implicitly within care plans starting from a premise that a person had capacity unless proven otherwise. They clearly indicated the decisions people could make but also those situations where staff may need to act in their best interest. It was also recognised that people had the right to refuse: for example, it was written for one person" I need encouragement (with medication), explain to me what it is for and why I need to take it but respect my right to refuse ensuring that you documents my reasons". It was also recognised that a person's capacity to make a decision could vary on the time of day: for example, one person liked to sleep in the afternoon and when they woke could be disoriented to time and place. It was clear for staff that this was not the best time of the day to address important issues with the person.

Care plans addressed in detail health conditions that a person had: there was a comprehensive list for each person along with an explanation as to what the condition or illness was, how it affected them, any associated risk and how support was to be ultimately provided. For example, there was information for staff on the implications of diabetes, acquired brain injury, dementia and epilepsy.

Family members also felt that staff were good at recognising when someone was not well and seeking prompt advice. A compliment had been sent to the registered manager about a member of staff stating that without their prompt intervention a person could have ended up in hospital but this was avoided much to their relief.

Dietary likes and dislikes were also documented to assist staff where they supported with food and fluids at the visit or where they left food and drinks ready for consumption later on in the day. Staff had also recognised where adapted cutlery or aids could be useful to promote independence and raise this with the relevant people for purchase Staff kept records, where required of weight and/or food and fluid consumed in order to assist other professionals in the assessment of a person's intake Staff also had clear direction as to how to ensure good food hygiene with storage and preparation.

The registered manager had a good working relationship; with other professionals such as the community nurses, social workers and therapy staff. They accessed support as required to ensure that a person received the care and treatment they required. Professionals we spoke with were complimentary about the effectiveness of the service. One told us it had been initially it was very difficult to get a person to engage with care staff but the staff had worked hard and built a rapport with the person and this had allowed them to remain at home for as long as possible. It was also reported that staff kept professionals updated regularly with any progress or concerns via email which was useful.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their relatives told us that they did not get a rota and so were never sure who was going to come and when. One person said 'I have no idea who is coming or when these days to be really honest with you". The registered provider told us that they did not send a rota to everyone as on some 'rounds' the staff could change and this could cause more confusion or upset. They did agree to revisit this matter and preferences with people who used the service and their representatives.

The Registered Manager tried to ensure that a consistent team of staff attended but this was not always possible with staff turnover of late. Whilst people felt comfortable and confident with the staff that came they commented that they were not always informed in advance if a new staff member would be visiting. One person told us that they had been woken up in the morning by a new staff member and it had "Scared them" as they had not known who they were. This meant that the service did not always make sure that schedules were organised so that people received care and support from familiar staff.

Preferred gender of carer was not always taken into consideration which for some people was an issue. One male told us they felt more comfortable with a female carer but of late a male had come without prior notice. Likewise, a female person told us that the office had told them in advance that a male would have to come as they were now covering the area but they would not accept this. The registered manager informed us that they would revisit this matter with all people upon review.

The staff were given the training and support needed to provide care and support in a compassionate and personal way.However, rotas, schedules and practical arrangements were not always organised in a way that allowed staff time to listen to people due to a lack of travel time and a congested schedule.

Some calls were only 15 minutes long which was contrary to the NICE guidance but these calls were as the people who used the service wanted them. The registered manager assured us that where staff felt this it did not suffice it was discussed with the person and their representative.

People and their representatives were complimentary about all of the staff and felt that they were caring and considerate. Comments included "You do over and above the call of duty and I appreciate it more than you can imagine" and "Thank you for all you do for my [relative]. They are thrilled to be back home and I know that they would not manage without you".

Staff understood people's backgrounds and important events or relationships in people's lives. Care plans contained information about people's family and life histories including employment and hobbies. Staff told us these acted as reference points for conversation with people as it gave them common ground to talk about. This demonstrated that staff understood the importance of respecting people's background and life history.

Care plans were written in a way that encouraged staff to respect a person's dignity and choice. For example: one recognised that a person was 'fiercely independent' and did not want staff to 'come in and

start doing things for me or to me". Instead, it reminded staff of the importance of including the person and working with them in order to get things done and to resolve problems. Issues around dignity were raised in supervisions as well as team meetings. A session about recording reminded staff that "notes need to reflect the person as a whole and not just a set of body parts to be washed and dressed".

Staff demonstrated a clear understanding through the planning and delivery of care about the requirements set out in The Equality Act to consider people's needs on the grounds of their protected equality characteristics. The Equality Act is the legal framework that protects people from discrimination on the grounds of nine protected characteristics, such as, age or disability. There were polices to ensure people's specific care needs were considered and staff's knowledge was further bolstered by training in equality and diversity.

Good

Is the service responsive?

Our findings

A thorough pre-assessment was undertaken in order to determine the level of help and support required. This assessment was then on-going as staff got to know a person better and got to know their likes, dislikes and how they wanted their care to be provided. A professional told us that "They are a flexible care agency that 'thinks outside the box' – they are creative with care calls not just providing care in the traditional sense in particular with people with dementia".

People's care plans were detailed around the support people required from staff in order to meet their needs. People had a copy of their care plan in their home and one was stored in the office and on the computer system. Staff told us that they did not always have the time to read a care plan and sometimes they knew very little about a person before they arrived at a call. This mirrored some of the comments from people and relatives who explained that sometimes they had to guide staff as to what was required which could be frustrating. The provider information return indicated that this had been identified and that a 'one page' profile was to be introduced to give a brief overview of a person's needs.

Each care plan folder in the office was prefaced with an image that represented something of importance to that person: for example a cat, a music symbol, a crown and a football club badge.

Care plans were comprehensive and person centred. This gave new staff a very clear picture of the person and what was required. For example: care plans gave a step by step guide as to how to assist with personal care: what someone could be encouraged to do for themselves, what staff needed to help with and how, the type of toiletries to be used, where they were located etc.

Care plans reflected the level of support required by each person and any special instructions. For example one person did not like to take their tablets as they 'left a nasty taste' in the mouth so there were clear directions for staff to ensure that a fresh glass of water was provided at the time. Another person liked to have their medication placed on a dark coloured plate so that they could see it more clearly before taking.

There were occasions where a person required a short term change to their care plan maybe following a fall or an admission to hospital. There was evidence of temporary care plans being in place to address these changes. For example: a person had reduced mobility following a fall and required additional care staff. A care plan was put in place to encourage independence but also to address a new risk for pressure care and skin breakdown.

As well as addressing personal care tasks, care plans addressed a person's emotional and mental health issues. Care plans gave clues for staff as to when a person may not be feeling well or at their best. For example, one person could be 'low in mood' and when they felt like this they exhibited certain behaviours such as being unwilling to cooperate. Staff were advised to be calm and to use lots of positive reinforcement. Another person had some behaviour that a staff new to them might interpret in the wrong way: there was guidance to let the staff know that the person liked to talk to themselves and might indeed tell the staff that they 'talk gibberish' or 'had gone mad'.

Where a person had communication issues due to sight, hearing or memory loss, this was addressed in the care plan with alternative strategies for staff to follow. This included enlarging text, repeating information, writing it down, using facial expression, gestures or objects. Another person had difficulty on processing information and staff were directed to ensure that they used closed questions as the person could respond better in this way. Staff also made use of other techo9logy: for example, one person had a ' text to speech' reader which enabled them to listen to documents such as care plans or service user guides.

Care plans were reviewed annually or more frequently if there had been a change in need. The registered provider was also intending to introduce a ' learning log' so that staff could document any changes to needs or wishes that needed to be incorporated into the overall care plan.

Staff also supported people to maintain links with the community and to continue to participate in hobbies and interests. One person, for example, had a love of music and staff helped them to attend a local singing group. Another person was taken to places where they could paint and draw as this was a chosen hobby.

Staff were aware of people's 'end of life' wishes and this was addressed in care plans. Records reflected where a person had a 'Do not attempt cardiac pulmonary resuscitation' order place so that staff would not do anything to ignore the person's wishes.

There as a complaints policy in place that directed people to appropriate organisations should they feel that their concerns were not addressed by the registered provider. We saw that a log of 'formal complaints' was kept and that these were investigated and reported on. The registered manager gave an outcome on each element of the complaint along with their rationale. However, one significant concern that was brought to our attention had not been documented. There was no evidence of an investigation taken place and the actions taken were not clear. We spoke with the registered manager and registered provider about the need to maintain a record of all complaints, outcomes and actions.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. 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.'

There was a range of policies and procedures in place for staff to refer to. Staff were provided with key polices for their reference. Polices were last reviewed in December 2016 and some were now out of date and needed revision to reflect changes around best practice and legislation. For example: the infection control policy did not make reference to the HSCA 2012 code of practice and the medication policy did not ensure compliance with the NICE guidance in regards to medicines management. Neither the registered manager nor the registered provider was aware of these changes. This meant that they had not kept up to date with changes to guidance and practices relevant to the service.

The statement of purpose provided to CQC indicated that support could be provided to those both over and less than 18 years of age. The registered provider had not ensured that staff had the required checks, training or experience in order to do this. The registered provider informed us that they had no intention of supporting anyone under 18. We asked that they immediately review and submit a new statement of purpose to reflect this. At the time of completing this report it had not been done.

The checks in place to monitor the quality and safety of the service were not robust enough to address all aspects of practice and management.

There was no policy or plan in regards to responding to missed or late calls such as how it will be communicated to the person or their carers, the contingency arrangements or an assessment of the potential risk. This meant that there was a risk that person may not remain safe and that their carers would not be informed if a visit is going to be missed or delayed.

Systems in place to check that staff had visited at the right time, stayed for the required period or had not missed a call were not effective. This meant that there was a risk that themes and trends with missed, short or late calls were not recognised.

The systems in place to arrange staff work schedule were not robust and did not ensure that people received their care in line with their wishes.

Staff had not always been given travel time which meant that calls would be later than anticipated and staff felt under pressure. For example: rotas confirmed that calls were sometimes planned ' back to back'. On occasion the travel time in-between calls was estimated more than 10 minutes with no traffic but no time had been allowed. Another staff member was not allocated travel time but the journey time between the calls could be up to 15 minutes and they were due to meet with another carer for a 'double up call'. This meant that there was a risk that two staff might not be available as required. One rota indicated that seven

calls were planned back to back for a staff member from 10.55 through to 13.55. This meant that those calls would not be on time.

Staff did not complete a weekly time sheet and the registered provider was reliant on the information contained within the daily notes to verify the time and length of call. This information was returned to the office and checked up to a month after invoices for care delivered were sent out. This meant that there was a risk that people could be charged for care that had not been received. These issues had not been highlighted through the audits of the daily records.

The systems and processes in place for informing staff of their work schedules or access arrangements to properties did not support the confidentiality of people using the service and contravenes the Data Protection Act 1998. Rotas and access arrangements were sent and stored on a staff members personal email account via their computer or mobile phone. This meant that there was a risk that this information was not kept secure and accessed only by those persons authorised to do so.

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

Following the inspection, the registered provider took action to update their policies and procedures to reflect current guidelines. They also implemented additional checks to help them monitor and verify the time and length of each call".

The registered provider also informed us that they had met with their information technology team and an alternative secure method of passing on information was to be implemented in the forthcoming weeks.

The content of daily records was reviewed to ensure that there was a meaningful record of the support that had been provided. It was positive to see that the registered manager also looked at how staff recorded interventions to ensure that appropriate language was used. For example: a staff member had used inappropriate language to describe a person's mood and behaviours: This had been picked up though the audit process and addressed with the staff member concerned via discussion and supervision.

People who used the service and their representatives were aware of who the registered manager and registered provider were. They told us that they had lots of contact with them as they currently provided some of the care and support. A professional also commented " The owner has always been a visible leader of the company and will attend meetings with clients and families to seek solutions when required".

Staff came together on a regular basis for a team meeting and minutes were recorded so staff unable to attend could have note of the discussions. These meetings covered a wide range of topics such as those relating to employment, concerns around practice as well as individuals. For example: a session was held on dealing with conflict following an incident to ensure that staff understood the importance of being confident and consistent in their approach.

The registered provider had not yet carried out a survey in order to gather the views of people who used the service, professionals and staff. This was because the service had been getting established. Their provider information return outlined to us what they intended to do over the next few months by way of meetings and questionnaires.

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 17 HSCA RA Regulations 2014 Good governance The registered provider did not operate effective systems and processes to assess and monitor the service. Systems and process's did not support keeping personal information safe.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not have sufficient numbers of staff to meet peoples needs in line with their wishes and preferences..