One Housing Group Limited

Beaumont House

Inspection report

Apartment 1 – 61 (excl. 13)
Beaumont House, Arthur Ransome Way
Walton On The Naze
Essex
CO14 8FA

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22 November 2018

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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

This announced inspection took place on 13 and 22 November 2018.

Beaumont House provides care and support to people living in specialist 'extra care' housing. The property consists of individual rented flats in a shared building in Walton-on-the-Naze, close to local amenities and public transport. Care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing as the flats are people's own homes; this inspection looked at people's personal care and support service. People were able to purchase lunch in a communal dining room and take part in social activities. We did not inspect the provision of meals or activities.

CQC only inspects the service being received by people provided with 'personal care'; which includes help with tasks such as support with personal hygiene and eating. Where they do we also take into account any wider social care provided. There were 61 flats at the property. At the time of our inspection, 52 flats were occupied and 52 people received personal care.

This was the first inspection of this service since the provider One Housing Group Limited registered with us to provide personal care at Beaumont House in 15 June 2017.

There was a registered manager at the service. 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 also a general manager who had overall responsibility for the service, including the accommodation. During this report we referred to the general manager and registered manager as the 'management team'.

The registered manager and general manager had not clearly defined their roles and responsibilities. As a result, the overall communication and management of the service was not well coordinated and consistent. The provider had not effectively addressed these concerns at our inspection, however improvements were being introduced to resolve the issues we found.

There were a number of checks and audits on the quality and safety of the service. Whilst these had not addressed the key issues with the management of the service, the audits were detailed and were driving improvements in areas such as medicine administration and training.

When we gathered feedback about the service, everyone we spoke to was enthusiastic about the care staff provided. There was room for improvement in how the provider and management team communicated with key individuals and groups. People, families and staff told us they did not find the culture open and the registered manager and provider had not consistently gathered their feedback about the running of the service. Feedback from external professionals was also mixed, and was affected by the issues we found within the management of the service.

The provider and management team had plans in place to improve the safety of the people using the service, in particular to improve the support people received with their medicines and to focus on recruiting more staff. Whilst the measures to reduce medicine errors were not yet fully effective, skills and audits were slowly improving in this area. There was clear and detailed guidance to staff on the support people needed with their medicines.

There were enough staff to keep people safe however recruitment and retention of staff was an ongoing issue at the service. Agency staff were in use whilst the provider focused on increasing the staff team. Improvements were needed to ensure the registered manager had better oversight of the recruitment process.

Senior staff provided care staff with guidance outlining areas of individual risk. Staff raised concerns about people's safety where necessary and worked well with the management team and external professionals to minimise risk. Measures to reduce the risk of infection were effective. Senior and care took the necessary action when accidents and incidents occurred. However, improvements were required to ensure any lessons learnt as a result were shared across the service.

Staff had attended a number of mandatory courses, however they had not been consistently supported to develop skills to meet the more complex needs of people at the service. The provider was addressing this through additional courses and improved access to clinical guidance for staff. There was no care coordinator in post at the time of our inspection which had affected staff supervision and support, though this vacancy was being filled.

People at the service had the capacity to make decisions about their care. We made a recommendation to improve practice in the relation to the Mental Capacity Act.

Staff worked well with people, families and professionals to maintain people's health and wellbeing. They supported people to have enough to drink, though staff would benefit from developing their skills in supporting people with dementia in this area.

Support was flexible and personalised. Staff varied the care they provided depending on people's preferences and where people's needs changed. People felt they had input into the care they received. People felt able to complain, though there was some confusion about who they should speak to in the management team. Care plans took into account people's preferences around their end of life care.

People received a caring service and had a choice about their support. Staff developed warm relationships with people and families and treated them with respect and dignity. Improvements in recruitment would ensure people we supported by a stable staff team who all knew them well.

At this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

The service was not consistently safe.

There were processes in place to improve the administration of medicine, though these had not yet been fully implemented.

The provider was focusing on recruiting more staff. The registered manager did not have full oversight of the recruitment process.

There were effective measures to minimise risk.

Improvements were needed to ensure lessons learnt following accidents and incidents were consistently shared across the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff's knowledge around people's capacity was variable.

Staff had attended mandatory training but had not always been enabled to develop more specialist skills, in particular to meet complex health conditions and support people with dementia.

People were supported to have enough to drink and eat, though improvements in this area were needed when people had dementia.

Assessments of people's needs had been used to develop personalised care plans with detailed guidance to staff.

Is the service caring?

Good

The service was caring.

Staff developed warm relationships with the people they supported.

People were enabled to make choices about the care they received.

Staff treated people with respect and kept their information safe.

Is the service responsive?

Good

The service was responsive.

People received flexible and personalised care which responded to their changing needs.

There was a process in place to manage and respond to complaints, though people were not always clear about who to speak to about their concerns.

Care plans included details about people's preferences for end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Roles and responsibilities were not clearly defined in the management team.

People, families and staff did not always feel they could provide feedback about the service.

There were checks in place to monitor the quality of the service however this had not yet resulted in improvements across the whole service.

Beaumont House

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.

The inspection took place on 13 and 22 November 2018 and was announced. The provider was given 24 hours' notice because we needed to be sure the right people would be available to respond to our queries.

The inspection team consisted of two inspectors, an assistant inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of providing support to older people and carried out phone calls to 11 people who used the service and six family members. During our visit we also spoke with a further 10 people.

On the day of the inspection we spoke to the registered manager, who was the senior care coordinator, responsible for the provision of care at Beaumont House. We also spoke to the general manager, who was responsible for the whole scheme, including areas relating to the accommodation, which were not covered by this inspection. Throughout this report we referred to the registered manager and the general manager as the 'management team.' We also met with the provider's Head of senior living, who was responsible for a number of extra care services. We met with seven care staff during out inspection. This included accompanying staff on visits to people's homes.

We reviewed all the information we had available about the service including notifications sent to us by the management team. This is information about important events, which the provider is required to send us by law. We also looked at information sent to us from others, including family members and the local authority. We used this information to plan what areas we were going to focus on during our inspection.

We looked at five people's care records and three staff records. We examined information relating to the management of the service such as health and safety records, personnel and recruitment records, quality monitoring audits and information about complaints.

Requires Improvement

Is the service safe?

Our findings

Care staff, the management team and the provider were all committed to supporting people safely. We found however, that measures to minimise risk were not consistent.

Internal audits had highlighted concerns with the administration of medicines and the high number of medicine errors. The provider and registered manager had set up an improved process and action plan to address these concerns. Where necessary, staff received additional training after which their competency was re-checked. We found this system was proving effective in reducing medicine errors. A person told us, "The girls pull each other up for example if someone has forgotten to sign the medicine sheet; they go down and get them to come up and sign."

Each person had a medicine care plan which provided clear advice about the support they needed to take their medicines safely. This included their requirements for ordering and disposing of medicines and guidance about who was responsible for this. During one of our visits to a person's flat a member of staff became aware of a medicine error which had taken place earlier that day. They took the necessary action, such as phoning 111 for advice, raising the issue with the manager and recording the error. They also communicated openly with the person about the error. We found the member of staff expertly followed the registered manager's guidance in how to respond to a medicine error.

Despite this example of good practice, three relatives spoke to us with ongoing concerns about the administration of medicines. We noted that when the registered manager was absent for a month, checks by shift leaders had continued but limited actions had been taken when errors occurred. Whilst we were assured the registered manager was tackling the concerns in this area, further time was needed to ensure the improvements and new processes were effective and sustained. In the well led section of this report we outlined concerns with the leadership of the service which had impacted on how effectively errors in medicine administration were managed.

We reviewed the arrangements in place for the safe recruitment of staff. The initial stages of staff recruitment were completed by the provider's head office, which set up staff interviews at the service. The registered manager confirmed they did not always see application forms and references which meant they lacked overall oversight of the recruitment process. We discussed specific concerns regarding this arrangement with the registered manager. They assured us the system would be amended to ensure the registered manager was fully briefed when care staff were recruited in the future.

We found on the day of our inspection there were enough people to meet people's needs. People received a set number of care hours, which could be adapted in an emergency, after which the registered manager would review whether additional hours were required. The provider gave us examples where they had not accepted referrals from people's whose needs could not be met within the service. This demonstrated a commitment to people's safety.

We received feedback from people, families and staff that on some days visits were cut short as there were

not enough staff to carry out agreed visits. A person told us, "About six weeks ago, there were only three staff on and should have been seven. The other day, they said they could only do 15 minutes." Despite the concerns around staffing numbers, people told us their needs were met and call bells were answered promptly. The staff team worked together to minimise risk. A member of staff told us, "We are a good team and we muck in together to get it done."

The Head of Senior Living told us about how difficulties in recruiting new staff impacted on the staffing numbers and explained the actions they were taking to address this. Where necessary, agency staff were used to fill gaps in staffing numbers. Whilst the provider's actions demonstrated a commitment towards recruitment of new staff we found they were only starting to address the issues around retention of staff. A family member told us, "It can be a different carer each visit. There have been a lot of problems with staff with people leaving and lots of agency staff as they can't keep people."

Staff were vigilant about people's safety. Senior staff had carried out individual risk assessments and developed detailed plans to ensure people were protected from the risk of harm, for example, advice was given to staff to help people who used wheelchairs to transfer safely around their flat. Each person had a 'missing persons' form with key personal details which could be used, for example by the police if there was concerns about their safety.

The registered manager told us some reviews of people's needs had been delayed, as this was the role of the care coordinator, who was no longer in post. We noted, however, the registered manager had managed this process effectively. They had focused on people who were at greatest risk, for example where their needs had changed and care plans needed to be updated to provide correct advice to staff.

Staff had a good understanding of what to do if they were concerned about a person's safety. The provider had clear safeguarding processes in place and training had been provided to all staff. The registered manager worked with external professionals to investigate any concerns regarding a person's safety.

The general manager completed a log of any accidents and incidents. This log helped the management team ensure the correct actions were taken, for example when a person had fallen, staff had arranged with a family member for the GP to be called out. However, this system did not clearly track what further actions the manager had taken, such as any investigations. In our discussions with the registered and general manager we found it was not always clear who had responsibility for oversight of each incident, in particular where incidents related to the care or support people received. Whilst both managers spoke of examples where lessons had been learnt since the service had opened, this learning was not always communicated and coordinated effectively across the staff and management team.

Management and staff were effective in minimising the risk of infection. People told us, "The carers wear gloves and change them between different things they do" and "They always seem clean. They have been told off for wearing nail polish and they don't do it now and they have their long hair tied back."

Requires Improvement

Is the service effective?

Our findings

Staff worked effectively as a team to meet people's needs. However, we found the provider had not enabled staff to develop their skills to enable them to meet people's more complex needs, such as different health conditions.

There was also room for improvement in the understanding around people's capacity to make decisions. 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 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 checked whether the service was working within the principles of the MCA.

The registered manager told us all the people at the service had been assessed as having capacity to make decisions about their day to day lives. However, we noted a number of people were starting to present as having variable capacity as their needs became more complex. Throughout the inspection we observed staff asking people's consent before providing care. However, we found the staff we spoke to had a varying understanding of capacity. For example, staff did not always consider people's capacity when discussing whether to keep people's medicines locked. Staff had attended training on the MCA, however this learning was not consistent, in part due to high staff turnover.

We spoke to people who hoped they could live for many more years at Beaumont House. We did not find the service was effectively planning for how support might need to change when people ability to make decisions about their care declined. The impact to individuals at the time of our inspection was minimal, however we discussed this with the manager to ensure they started addressing gaps in staff knowledge.

We recommend the registered manager seek best practice guidance to enable them to plan and prepare for any changes in people's capacity to made decisions about their care.

All staff had undergone a period of induction and attended a number of mandatory courses, such as health and safety and infection control. Staff were positive about the training they had attended. New staff also shadowed more experienced members of staff prior to providing care. A senior member of staff told us, "The shadowing can be up to three weeks, all according to how we feel they are doing." There were a number of staff who were new to care and they had completed the Care Certificate, which is a national programme to ensure staff develop the core skills needed for their role. The registered manager had a log to check for any gaps in staff training.

People and families told us staff did not always understand more complex health care needs, such as diabetes and dementia. Two people told us, ""I don't think they really know about [my condition]. They only do whatever is in the book" and "I don't however think there are enough staff trained to deal with [my condition] and because of shifts I could be left with nobody trained on when I get ill." A family member told us, "There is a huge difference in ability. I am a bit concerned with their handling of dementia, they seem

inexperienced. They ask my relative lots of options and that confuses them."

Staff had demonstrated their commitment by requesting training to help them support people with specific needs. Staff had received intensive support to improve their skills in the administration of medicines, however there had not been a sufficiently robust review of other gaps in staff knowledge in relation to the needs of the people at the service. We discussed this with the Head of Senior Living and they advised us the organisation was in the process of recruiting a clinical lead, who would be available to provide staff with guidance on complex health needs. They also told us they were arranging a number of specialist courses. Staff said some courses were arranged away from the service which was difficult as they did not drive. The registered manager told us they planned to arrange a reflective workshop for staff on capacity, as this had been successful in improving staff skills around medicine administration. We found this to be a positive measure to develop staff skills.

The registered manager told us they had not completed some of the planned supervision sessions with staff and checks on staff competency due to limitations on their time. However, we noted that when they had worked with staff they had supported staff to increase their skills. The registered manager told us that once a new care coordinator was recruited staff would be fully supervised and monitored, as required.

The general manager or care manager carried out assessments of need prior to a person moving to the service. As well as meetings with the person and their family, assessments also included professionals such as physiotherapist and social workers. Care plans provided staff with detailed guidance about people's needs, as well as useful shorter plans which gave a summary of people's needs. Whilst there had been a lack of training to develop staff knowledge about different conditions, care plans did provide useful information, such as a description of different health conditions. Staff told us they found this information useful.

During our inspection, people told us they were dissatisfied with the meal provision at the service. We did not inspect this provision, but gave the provider feedback on the information we had gathered. Care plans included guidance around the support people needed to eat and drink. During one of the visits to a person's flat, we observed a member of staff serving food and drink in a specific way to a person, in line with their preferences. Two family members told us some staff's lack of understanding of dementia meant they were not skilled in ensuring people ate and drank as required. A relative told us, "They (staff) will ask 'What do you want to eat today?' and [person] will say but they lack the experience to determine whether what my relative is saying is fact or not and they don't ask supplementary questions." The registered manager assured us that they would address this area, when supporting staff to develop their skills further.

Staff supported people to access external health care professionals, as required. We observed staff chatting to people about their health care needs, in one instance gently reassuring and advising a person about a test which had been carried out. We noted staff communicated well about people's needs, for example, letting colleagues know about any planned hospital appointments, or sharing advice from health professionals such as occupational therapists. A person told us, "I was coughing all night so the night staff left a note so the day staff knew to look out for me." There was a handover after each shift which the registered manager used to follow up concerns and ensure any actions were carried out.

Good

Is the service caring?

Our findings

Whilst we had concerns with the overall management of the service, as outlined in the well led section of this report, the caring attitude of the care staff, ensured people received a caring service. We observed throughout our visit that staff were caring in their interactions with people, for instance a member of staff chatted reassuringly about having a flu jab with an anxious person.

People told us they had developed warm relationships with care staff at the service. People said, "They walk in through my door, they are walking into my home. They are my little ray of sunshine", "They are absolutely marvellous and regard me as a granny. We have a laugh together. I make a lot of jokes and they are very fond of me. If you can't be in your own home you wouldn't find a better place than this. They can tell if I'm feeling a bit down and give me a hug" and "The carers are kind and take me out for a walk which helps me keep going." A relative told us, "I find the carers pleasant and it's a nice place. I'm happy with it. There are some niggly little things but nothing big."

Staff told us they focused on ensuring people remained independent and in control of their support. People felt they had a choice over the service they received. A person told us, "I do feel that I am in charge really. I do make the choices, for example I choose and lay out my clothes the day before." We observed staff speaking to people about their service, offering options. A member of staff asked a person whether they wanted their lunch before or after going down for an activity.

Care plans were written in plain English and people told us they felt able to read what staff had written about them. Guidance in care plans prompted staff to treat people with respect, for example to ring their doorbells and wait until they were invited in before entering. We observed staff did this during visits and people told us they felt staff were respectful. A person told us, "They are very tactful and say, 'Do you want to wash those bits yourself?' When they come in they always ask if they can sit down before they do."

People were particularly positive about how staff kept information confidential. A person told us, "They do respect other people's privacy and never discuss other people. They might just pass a message from one person to another."

The management team were respectful and warm when speaking about people. The registered manager described the support staff provided, "[Person] loves to have Ed Sheeran on with their bubble bath." There was a focus on making the service better for the people who lived there. A number of people and families cited one example where a member of staff had not been caring. This poor practice was being dealt with adequately at the time of our inspection, though improvements in the overall management of the service would strengthen this process in the future. People told us they did not like being supported by agency staff. The provider was focusing on recruitment of care staff which would help develop a stable staff team who knew them well.

Good

Is the service responsive?

Our findings

People received flexible care in line with their needs. They had been involved in setting up their care when they joined the service. A person told us, "When I first started they asked me lots of questions and I do feel that I was involved in decisions about my care and I have the opportunity to make my own decisions."

Although each person had set hours, based on their needs and preferences, they told us they felt able to amend this when necessary. Although the formal process for reviewing care was not fully effective we saw care was amended as people's needs changed. A health and social care professional told us care staff responded immediately when a person they were working with needed more support. People told us, "There is never a problem if I have to change a visit for an appointment or if I miss a meal" and "I go out with the family to dinner and they are quite flexible about this." Staff confirmed they listened to people when deciding how to plan their visits. A member of staff told us, "We brought [Person's] bed call earlier as they like an early night."

People had a set number of hours provided by the on-site carers. They could choose to have additional hours with another agency. A person told us, "I think it was mandatory to have 5-6 hours of care from the home and then top up with another agency if I wanted but I was happy to have their carers." Nearly all the people had chosen to receive all their support from the on-site carers, and told us they felt their needs and preferences were being met.

A number of people told us they were disappointed there were not more activities provided. Our inspection did not cover the activities arranged at the service however we fed back to the registered manager what people had told us. We did look at how well staff supported people to access activities. For example, we observed a member of staff encouraging a person to take part in an activity to reduce their isolation. We also saw staff supporting people to go to the communal area for activities during our inspection, such as a knitting club. We received feedback from people that on some days staff were rushed and did not always have time to take them down to activities. We were assured the provider was tackling this, as part of their recruitment drive, as outlined in the safe section of this report.

No one in the service was receiving end of life care. Care plans prompted staff to discuss end of life care with people. Some people's care plans included details about their wishes for their future care. Staff had also recorded where a number of people had chosen not to talk about end of life care. We discussed with the registered manager how they intended to record any arrangements for future care for people in this situation.

People and families told us they did not always know which manager to raise concerns with, as outlined in the well-led section of this report. However, most people felt able to complain, people told us, "If I need to make a complaint I know I can. I had to go downstairs this morning and made a complaint about something and they sorted it out straight away" and "Any complaints you can go to them and they will listen."

Complaints were logged and responded to. Most of the complaints related to meals and to finance issues,

which we did not look at in this inspection. We saw a number of examples where people had complained to the registered manager about their care, and effective actions had been taken, in line with the provider's complaint processes. For instance, the manager had met with the member of staff concerned to address a complaint and had responded openly to the family member.

Requires Improvement

Is the service well-led?

Our findings

There had been a number of management changes within the first year of the service which meant systems had not been set up in a coordinated and effective manner. We found roles were not clearly defined within the management team. People, families and staff told us they did not always know when to contact the general manager or the registered manager and were concerned their information was not shared within the management team. During our inspection a member of staff told us they were aware of a concern about care, and went to speak with the general manager, rather than the registered manager. We raised an issue of concern in the office and noted this was picked up by the general manager, despite it relating to the care service.

The registered manager and general manager communicated regularly over the issues at the service but this communication was not always effective and did not result in a harmonised management team. Immediately prior to our inspection the registered manager had an unplanned period of absence. The general manager and other provider representatives had stepped in and responded to immediate risk. Some of the processes which the registered manager had implemented lapsed and necessary action did not take place in a timely manner during their absence. For example, a person did not receive one of their medicines as required, as it had run out. The checks the registered manager had put in place to minimise the risk of medicine errors were not fully acted upon by other senior staff. As a result, there was a delay in resolving the medicine error and improvements which had been implemented by the registered manager were not sustained.

The above evidence demonstrates that systems and processes were not operating effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they loved their caring role; however we found staff morale was affected by the issues within the management team and the culture at the service. People and their families were also affected by the atmosphere at the service. They told us, "Often carers don't know what is going on as management haven't told them. The carers go above and beyond the call of duty when they are short staffed and a few have left recently because of this. It's sad as they are losing a good team. If the girls aren't happy, us residents we pick up on that. You can feel the tension" and "There are about three main managers and they don't seem to communicate with each other never mind with the tenants." A relative said to us, "When I go into the office they all stand there staring at me and don't say anything, it's a bit intimidating."

People and families told us there had been a forum where they could meet with the managers but this didn't always run consistently. We saw this was being addressed by the provider and these forums were starting again. The registered manager was also sending out a survey to gather people's experience of the service.

We discussed with the Head of Senior Living our concerns that the provider had not worked more effectively with the management team to resolve concerns at the service. They recognised that until recently the management team had focused on reacting to risk and concerns. The provider was starting to address our

concerns to ensure the management responded in a more pro-active and planned way. For instance, they had arranged management training for the registered manager and access to networks outside of the service to help support them in their role.

The Head of Senior Living described how the difficulties in recruiting new staff impacted on the staffing numbers. However, we found the provider was only starting to actively address the issues around retention of existing staff. Retention to the post of care coordinator had been a particular concern. This post was vacant at the time of our inspection and we found this had an impact on the management of the service. The registered manager had been trying to cover for both posts and it was clear a number of tasks such as supervision and quality checks were not being covered fully.

Whilst there were concerns with the management arrangements at the service we found day to day management of visits was carried out efficiently. Each shift had a shift leader who oversaw the staff on duty, and people's immediate needs were met by a committed staff team who worked together well. Staff told us there was good communication between the shift leaders and the care staff on duty.

There were a number of checks on the quality of the service, for example senior staff reviewed daily records and medication records and reported any gaps to the registered manager. People told us they regularly received visits from senior care staff to check the records were up-to-date. The Head of Senior Living and the providers Quality team carried out quarterly audits of the service. These checks had highlighted some of the issues we had found during our inspection, such as gaps in training. There were action plans in place to address any areas for improvement. We did not find however, that these checks had been sufficiently robust to highlight and address some of the concerns we had around the management of the service.

The provider told us immediately prior to our inspection that there was an external audit or 'mock CQC' inspection. We did not have a copy of this report during our inspection but the provider and registered manager confirmed that the initial feedback had highlighted some of the concerns we had raised about communication and management at the service.

As the service was fairly new, relationships with local professional and stakeholders were still being developed. We spoke with four health and social care professionals and found there was mixed feedback about the service. All the professionals stated staff were pro-active, caring and keen to develop their skills. Whilst some professionals told us they had developed positive relationships with the management team at the service, we also received feedback that communication could be improved. The feedback also reflected the need to clarify management roles and responsibilities to ensure professionals could be confident the management team would respond to any queries in a timely manner.

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 Systems and processes were not operating effectively to ensure that people received a good quality and safe service.