Moorlands Home Link

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection visit took place on 18 August 2016 and was announced. The provider was given notice of our inspection visit to ensure the executive manager and care staff were available when we visited the agency's office.

The service was last inspected in July 2013 when we found the provider was compliant with the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Moorlands Home Link is a domiciliary care agency with charitable status providing care for people in their own homes. Around half of the people who used the service received weekly support with bathing, other people received support with personal care through several visits each day. On the day of our inspection visit the agency was providing support to 45 people and employed 13 members of care staff.

The charity also provided a number of other services in the community. These included a friendship and support service to people who were elderly or needed support to go out. A day centre run in a local community centre, meals on wheels, transport arrangements via minibuses and trained volunteers.

The service did not have a registered manager at the time of our inspection visit. 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. As there was no registered manager in post at the time of our visit we spoke to the executive manager and the acting manager, who were managing the service in the absence of a registered manager.

The provider had recently changed their company status which came into effect in 2015. However, the provider had not re-registered their service with CQC when their legal status changed. This meant the provider was operating under an out of date registration with us. We have asked the provider to register their service under their new legal status without delay.

Processes to manage the risks to people's safety required improvement. Care records did not provide staff with enough information to consistently identify and manage risks associated with people's care. Medicine procedures required improvement to ensure care staff recorded the administration of all prescribed medicines.

Care records were not sufficiently up to date to provide staff with the information they needed to ensure people received consistent care. The executive manager had conducted a recent audit on care records and identified a need to update all care records, using a new format which gave staff more information on the needs of people they cared for. New care records were being introduced over the next four months.

There were systems to monitor and review the quality of service people received and to understand the

experiences of people who used the service. This was through regular communication with people and staff, surveys, spot checks on care staff and a programme of other checks and audits. Where issues had been identified, the executive and acting manager were implementing improvements. However, auditing procedures were not always sufficiently detailed to ensure issues for improvement were identified. For example, auditing procedures had not highlighted the need to record all the medicines administered to people.

People told us they felt safe using the service. Care staff understood how to protect people from abuse and keep people safe. The character and suitability of care staff was checked during recruitment procedures to make sure, as far as possible, they were safe to work with people who used the service.

There were enough care staff to deliver the care and support people required. People told us care staff usually arrived around the time expected and stayed long enough to complete the care people required. People told us care staff were caring, kind and knew how people liked to receive their care.

Care staff received an induction when they started working for the agency to give them the skills they needed to care for people effectively. The provider ensured staff continued to have the right skills and attitudes for their role, by offering staff regular updates to their training, observing their practice and monitoring their performance.

Staff were supported by managers through regular meetings. There was an out of hours' on call system in operation which ensured management support and advice was always available for care staff during their working hours.

The executive and acting manager understood the principles of the Mental Capacity Act (MCA), and care staff respected people's decisions and gained people's consent before they supported people with personal care.

Staff, people and their relatives felt the acting manager was approachable. People knew how to complain and information about making a complaint was available for people in the service user guide each person had in their home. Care staff said they could raise any concerns or issues with the executive or acting manager, knowing they would be listened to and action would be taken.

We found there was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 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

The service was not consistently safe.

Risk management plans were not always in place to manage identified risks to people. Medicine procedures required improvement to ensure people received all their prescribed medicines. People felt safe with care staff. Care staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough care staff to provide the support people required and there was a thorough staff recruitment process.

Is the service effective?

Good

The service was effective.

Care staff completed training and were supervised to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act 2005 and care staff respected decisions people made about their care. People who required assistance with their nutritional needs received support to prepare food and drink, and people were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

People were supported by care staff who they considered kind and who respected people's privacy and promoted their independence. People received care and support from regular care staff that understood their individual needs.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in decisions about their care and how they wanted to be supported. People's care needs were assessed and people received a service that was based on their personal preferences. People knew how to make a complaint. The management team responded to feedback and

acted to improve the service.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

There was no registered manager at the service to ensure people were supported in accordance with the Health and Social Care Act 2008 and associated Regulations. The provider had failed to notify us of specific events at the service, according to their regulatory responsibility. The provider's registration status required updating to ensure they were registered appropriately. People told us management procedures could be improved, to ensure they always received their scheduled calls. People told us they knew who to contact in the office if they needed to speak with a manager. The management team supported staff to do their work, as they were available when needed.

Moorlands Home Link

Detailed findings

Background to this inspection

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

The inspection visit took place on 18 August 2016 and was announced. This service was inspected by one inspector. The provider was given notice of our inspection because the agency provides care to people in their own homes. The notice period gave the executive manager time to arrange for us to speak with them and staff who worked for the agency.

We reviewed information received about the service, for example the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR reflected the service provided at the time it was submitted to us.

During our inspection visit we spoke with the executive manager, the office manager, and one member of care staff. We later contacted the acting manager, as they were unavailable on the day we visited. We also contacted seven care staff via email to gather their feedback about the service, we received two responses.

We contacted people who used the service and their relatives to obtain their views of the care they received. We spoke with four people and three relatives via telephone. We reviewed three people's care records to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the service's quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with care staff who visited them in their homes. One person said, "They are very good, there are no problems with care staff."

There was a procedure to identify and manage risks associated with people's care. People had an assessment of their care needs completed at the start of their care package that identified any potential risks to providing their support. Risk assessments however were not always detailed enough to provide staff with clear information on how they could mitigate risks to people safely. For example, one person required staff to monitor their skin to identify areas that might develop skin damage. This was because the person had limited mobility and was at high risk of developing pressure sores. The person was being visited by the district nursing team to care for their skin, although it was unclear from their records whether the person had a pressure sore. The risk assessments stated staff should monitor the person's skin, but did not provide staff with information on how or when the monitoring should be performed, or how their skin would look if it was deteriorating. Creams that needed to be applied to the person's skin to prevent their skin from deteriorating were not shown on the medicine administration record (MAR), records did not state how and when cream should be applied. In addition, care staff had not received specific training in recognising and managing pressure sores.

Another person required assistance from staff to move them using a bath lift, there were no instructions or risk assessments for staff to refer to with regard to the use of the equipment. The lack of adequate risk assessment and risk management plans meant people were at risk of harm, as care staff may not consistently understand the risks posed to the person or how these should be managed.

We spoke with the executive manager regarding the lack of risk management plans. They explained the provider had already audited people's care records and had identified they needed updating to ensure risk assessments were accurate. They had already developed a new format for care records and some people already had these in place. The new care records were more detailed and provided staff with the information they need to ensure people's safety was maintained.

We looked at how medicines were managed by the agency. Some people we spoke with administered their own medicines or their relatives helped them with this. Only care staff who were trained in the safe administration of medicines assisted people with taking their medicine. Care staff told us they administered medicines to people as prescribed. In some cases this involved dispensing medicines from a 'blister pack' which was pre-prepared for each dose of medicine by the pharmacy. Some people however were prescribed creams and tablets that were not pre-prepared in 'blister packs'.

Care staff were instructed to record in people's records that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this. In cases where medicines were not given staff used a code to record why. We reviewed the MARs for three people and found that there were gaps in each of the MAR records. We brought this to the attention of the executive manager during our inspection visit. They explained staff didn't complete the MAR if people administered their own medicines, or their family

assisted them with this, which explained some gaps. However, in one person's MAR where we found gaps, the person lacked the capacity to administer their own medicines. They could not gain access to their medicines as these were locked in a secure cabinet to prevent them from taking too much medicine. In addition, the daily records for the person did not explain whether the person had received their medicines from family members, or from staff. This meant we could not be sure the person had received their prescribed medicines as they should.

The daily records showed that people were being given cream by care staff which was applied to their skin. These creams were prescribed by a health professional. We found that creams were not shown on the MAR records, and staff were not always completing daily records to show when cream had been applied. This meant we could not be sure people received their prescribed creams. Completed MARs were returned to the office every month for auditing. It was not clear why the medicines audit had not identified gaps in the MAR that needed to be investigated.

People were supported by staff who knew how to protect them from the risk of abuse. Staff attended regular safeguarding training which included information on how staff could raise issues with the provider and other agencies if they were concerned about the risk of abuse. Staff told us the training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone's safety. The executive manager told us there had been no safeguarding concerns to report. However, we confirmed with them they understood their responsibilities and they had a procedure in place to refer information to the local safeguarding team and the local authority where required.

The provider's recruitment procedures checked staff were of a suitable character to work with people in their own homes. Staff told us and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

Most people told us there were enough care staff to meet their needs. However, two people told us they didn't feel the agency employed enough care staff to deal with emergencies, such as when care staff were off sick. The two people explained they had not received an expected call due to a problem with staff sickness. Other people told us care staff usually arrived on time and stayed for the right amount of time. One person said, "They always come, they call morning and night each day."

The executive manager and care staff confirmed there were enough care staff to cover all the calls people required. The executive manager explained they recently had some problems with scheduling, staff sickness and staff rotas, which had been resolved by the implementation of a new rota system and the recruitment of more care staff. They told us they monitored care staff arrival times to ensure people received their call. They did this using a range of quality assurance techniques, by speaking to people who used the service, and by checking daily records and time sheets submitted by staff and signed by people who used the service.

The executive manager explained staff were now also given paid travelling time between each scheduled call to reduce the risk of care staff arriving late. We saw rotas gave care staff the correct time allocated on each care package. These measures helped to ensure people received their scheduled calls at the right time. The executive manager told us, "If staff are going to be late to visit someone, they would liaise directly with the person and let them know. If they couldn't make a call they would contact the office, we would then arrange someone else to go. The 'on call' number is available 24 hours a day, 7 days a week if the main office is closed."

Good

Is the service effective?

Our findings

People told us care staff had the skills they needed to support them effectively. One relative told us, "Yes the staff are very good."

The provider had a recruitment process in place to recruit care staff who had the right skills and values to support people. Care staff told us they received an induction to the job when they started work. This included working alongside an experienced member of care staff, and training courses tailored to meet the needs of people they supported. One member of care staff told us, "The induction was really good, I shadowed an experienced member of care staff for around three months to ensure I had the skills I needed." The executive manager told us in addition to completing the induction programme; all staff had a probationary period and were regularly assessed to check they had the right skills and attitudes required to support people.

The induction training for new staff was based on the 'Skills for Care' standards and provided care staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care is an organisation that sets standards for the training of care staff in the UK. This demonstrated the provider was following the latest guidance on the standard of induction new care staff should receive. In addition, the provider expected existing staff to take the 'Care Certificate' to ensure all staff had been trained to the set standard.

The acting manager kept a record of staff training and when training was due to be refreshed, to ensure staff kept their knowledge and skills up to date. However, the executive manager told us refresher training had fallen behind their internal schedule due to the previous manager leaving in July 2016. This was because the previous manager had been a qualified trainer. Some refresher training was due to be organised as soon as a permanent manager was in post. We asked the executive manager what type of refresher training was due for care staff, they stated some care staff needed their yearly refresher in manual handing and health and safely. However, all care staff had been initially trained in these areas and supported people safely. One member of care staff confirmed this saying, "Staff training on refreshers is a bit behind, due to the manager situation. I'm sure these will be caught up as soon as we have a new permanent manager in place. I would like to do a national vocational qualification then too."

Care staff told us they were supported by managers who they met with regularly. Managers held regular individual and team meetings with staff to make sure they understood their role and received up to date information on the people they supported. In addition to their regular meetings, staff told us the manager operated an 'open door' policy where they could request a meeting with a manager at any time. The executive manager told us, "We hold open supervision meetings every Monday, when any staff member can come into the office to see a manager."

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The executive and acting manager understood their responsibilities under the MCA and confirmed no one was being deprived of their liberty. They confirmed the agency supported people who could not make all of their own decisions. We reviewed the care records of two people who could not make all of their own decisions. The records did not describe which decisions people could make on their own, and which decisions needed to be made in their 'best interests'. However, the executive manager explained the agency was currently updating care records and planned to review the paperwork in this area. We saw where 'best interests' decisions had been made, family members, people's representative, and health and social care professionals had been consulted regarding the decision.

Care staff understood the principles of the MCA. They explained they should always assume people had the capacity to make their own decisions, unless it was established they could not. They described supporting people to make decisions in their daily lives, for example, obtaining their consent before proceeding with personal care tasks. One care staff member described how they put their knowledge into practice saying, "We support one person who has dementia, they can still be supported to make decisions, we help and assist rather than taking over, they just require prompting to do most things themselves."

Care staff confidently described how they would request support from a manager and other health and social care professionals to make 'best interests' decisions, where people were unable to make their own decisions. One member of care staff said, "If people have lost the capacity to make their own decisions, then there will be a multi agencies/person approach to decisions that involve them. There can be family involved who may have power of attorney, social workers, partners, doctors etc. The process will be carried out in such a way that the person receives whatever support is necessary, with the least amount of intervention whilst keeping the person safe and well. The aim will be to keep any person as independent as possible and the process is always carried out with the person's interests at the centre of everyone's input."

Most people told us, they, or their relative provided their meals and drinks. Some people received support from the charity through their 'meals on wheels' service. However, those people who were reliant on care staff to assist them with meal preparation were satisfied with how this was provided.

Care staff and people told us Moorlands Home Link worked well with other health and social care professionals to support people. Most of the people we spoke with managed their own health care appointments and organised care and support from health professionals when it was needed. However, they described staff helping them to contact health professionals or other organisations where this was required. One care staff member said, "We support one person who has some mental health issues, but we have good communication with their social worker. They communicate with us if we need to be informed of any changes to their medicines or appointments." Another member of care staff said, "One person had a medical problem that needed to be referred to the district nursing team. The acting manager made a number of referrals to health professionals, we worked alongside the district nursing team to resolve things. The manager has been really supportive."

Good

Is the service caring?

Our findings

All of the people and their relatives told us care staff treated them with kindness, and staff had a caring attitude. Comments included; "The care staff are very prompt, caring and helpful", "The care staff are lovely people, I'm very satisfied."

Care staff had a good understanding of people's care and support needs. People told us this was because they were usually supported by the same care staff. One person said, "I always have the same person." Another person commented, "Yes, the staff know me well." Care staff told us they supported the same people regularly so they knew people's likes and preferences. One care staff member said, "I feel as Home link is only small, we have close contact and trust with people." Another member of care staff commented, "People rely on us, it feels like you are part of the family, people chat and relax, it's quite social."

People told us the charity helped them to remain independent and continue to live in their own homes, because of the services on offer. One person said, "I couldn't live without them." Care staff told us they supported people to maintain their independence by providing them with a range of services, but also by encouraging people to do as much for themselves as possible. Care staff told us, "To maintain people's independence we encourage them to do as much as they can for themselves and involve them in making choices for example, regarding food they like to eat, clothes they prefer to wear."

People who used the agency were supported with personal care, to take their medicines and prepare food. Other services offered to people included transport to and from the day centre and to attend appointments or do their shopping. One staff member commented, "I have a lot of respect for the elderly and I enjoy being able to help them to remain independent in their own homes." Another staff member said, "I enjoy my role, very much so, especially providing support to people so they can stay independent in their own home, it is very rewarding."

Staff told us they enjoyed their role, and often performed tasks for people they supported in their own time. This was because the service was run by a charity, and some staff gave their time as volunteers in addition to their paid hours of work. One care staff member said, "I must admit I go above and beyond and collect prescriptions for people, we also provide support with shopping, sometimes I assist one person with their weekly shop, they like to pick their own food and pay as this gives them self-confidence."

People and their relatives were fully involved in the care planning process so that care could be tailored to suit each person. We found the care people received differed from person to person, with each person having an opportunity to express their wishes over how their care was delivered, for example, if people wanted to receive care from care staff of a specific gender. People told us care staff treated them with respect and dignity and asked them how they wanted to be supported. One person commented, "They treat us with respect. A relative joked, "I'd like them to come and support me too."

People told us their privacy and dignity was respected by care staff, as personal care routines often involved bathing. People described care staff covering them, and shutting doors and curtains during personal care.

Comments included, "They are very discrete." "Yes, they respect my privacy and dignity."

Good

Is the service responsive?

Our findings

People told us care staff did the tasks they asked them to do. One person said, "Nothing is too much trouble."

People told us their support needs had been discussed and agreed with them when the agency began supporting them. Their care package was based on their individual needs, choices and preferences. For example, information was included on which food people enjoyed, their home life and relationships, their interests and hobbies.

People were able to go out in their local community with the support of care staff from Moorlands Home Link. These arrangements were made with people according to their needs and wishes, and were agreed as part of their care package.

Care records were reviewed each year with the person and their representatives or family members. However, we found the care records we reviewed were not up to date and did not include sufficient information to instruct care staff on how people's care should be delivered. In some instances care records were contradictory, for example, in one person's record it stated they administered their own medicines, however staff were administering the person's medicines. In another person's record we saw staff should monitor their mental health, but did not give staff instructions on what they should be aware of, and who to alert if the person's health deteriorated. Care staff told us how they would respond, one member of staff saying, "Any concerns we have are communicated straight to the office, and to our manager. I sometimes speak with family members and social workers so we can also keep them informed."

Care staff told us they had an opportunity to read the care records and daily records people had in their homes, but they also got to know people by speaking with them and their families when they began supporting them. The care records included 'handover' (daily records) information from the previous member of staff which updated the following member of staff with any changes since they were last in the person's home. Care staff explained the daily records supported them to provide responsive care for people because the information kept them up to date with any changes to people's health or care needs.

People told us they knew how to make a complaint if they needed to. We saw there were procedures in place to monitor and track compliments and complaints to look for any trends or patterns. The complaints policy was contained in the service user guide each person had in their home. The executive manager confirmed during our inspection visit the service had only received three complaints in the last year. These were regarding late or missed calls due to staff sickness or mistakes in scheduling. We saw the complaints had been investigated and responded to in a timely way. The trustees of the charity had reviewed the outcome of the investigation and responded to the complainants directly. The provider reviewed how they could make improvements to scheduling in the future to learn from the complaints.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager at the time of our inspection visit. 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.

The previous registered manager had left the service in July 2015. Since that time a new manager had been recruited, who worked at the service for a number of months. However, before they became registered with us they left the service in July 2016. This meant the service had been operating without a registered manager for more than a year. The service was being managed by an executive manager and an acting manager at the time of our inspection visit, whilst a new registered manager was recruited in September 2016. One person we spoke with told us they did not feel the service was well led, due to the lack of a qualified and registered manager. They explained the lack of a registered manager had impacted on the recruitment of staff and the scheduling of calls, resulting in them having a missed call.

We reviewed information received about the service before our inspection visit, for example the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We found the provider had not notified us of all the important events that occurred at the service. For example, the provider had not notified us of the absence of a registered manager at the service. The provider had not notified us of a change to their nominated individual.

The provider had recently changed their company status which came into effect in 2015. However, the provider had not re-registered their service with CQC when their legal status changed. This meant the provider was operating under an out of date registration with us. We have asked the provider to register their service under their new legal status without delay.

There was a system of internal audits and checks completed to ensure the safety and quality of service was maintained. The provider directed the acting manager to conduct regular checks on the quality of the service in a number of areas. For example, the acting manager conducted checks in staff timekeeping, medicines administration and care records.

Some auditing procedures needed improvement to ensure people were receiving the care they needed. For example, auditing procedures for medicines administration had not identified gaps in the MAR that needed to be investigated, or that prescribed creams were not recorded on the MAR. Gaps in the MAR, and a lack of recording of prescribed creams, meant we could not be sure people were consistently receiving their prescribed medicines.

Care records and risk assessments were not kept up to date. A lack of up to date care records and risk assessments meant staff were not always provided with all the information they needed, to ensure people

received effective and responsive care. We spoke with both the acting and executive managers regarding the lack of up to date care records and risk management plans. They explained they had already identified through audits that some care records require updating. A new format for care records had been developed. The new care records were more detailed to provide staff with the information they needed. A full review of people's care records had begun. The acting manager explained they were reviewing two people's care records each week, some people already had their new care records in place.

We found there was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance

The service was part of a local charity. The executive manager told us, "The charity is managed by a board of trustees who meet regularly to discuss the accounts and monitor the service people receive." The executive manager oversaw the day to day operations of Moorlands Home Link agency. The acting manager managed the daily running of the agency and worked alongside other managers called service managers, each of whom managed a specific part of the charity's service to people in the local community.

The values and vision of the provider were to help people go out in their local community and to support, engage and involve older people in their local community. The charity provided a friendship and support service, a day centre run in a local community centre, meals on wheels, transport arrangements via minibuses and trained volunteers. Any money generated by the charity was re-invested into the services people received.

Staff we spoke with understood the values and vision of the charity, they told us they enjoyed working for Moorlands Home Link. One staff member said, "It's a very good place to work. A real caring approach for each person is very important, and I feel this is met."

Care staff told us they received regular support and advice from managers via the telephone and face to face meetings. Care staff were able to provide feedback to the manager on the quality of the service and put forward ideas for improvements or changes. We reviewed the minutes of staff meetings where a range of items were discussed. Staff and managers used these meetings to update each other and exchange information. We saw in a recent meeting staff had suggested they exchange phone numbers with each other to improve communication, and had asked for rotas to be improved and shared to reduce the possible re-occurrence of missed calls. These actions had been implemented.

Staff told us the manager also operated an 'open door' policy which meant they could visit the office or have a meeting with the manager whenever they requested. Care staff were able to access support and information from a manager at any time as the agency operated an out of office hours' advice and support telephone line, which supported staff in delivering consistent and safe care to people.

People and their relatives were asked to give feedback about the quality of the service they received through a range of different routes. People were visited in their home by managers who conducted 'spot checks' on the work of care staff. The manager also contacted people regularly by telephone to ask them about the service they received, and people had yearly reviews of their care where they could provide feedback. In addition a regular yearly customer satisfaction survey was undertaken. We were able to review the comments in the latest customer satisfaction survey, people expressed a high level of satisfaction on the support they received from care staff. Comments included; "I have no complaints", "Fabulous service from [Name]", "Service superb, could not be better."

As a charitable organisation the board of trustees invited everyone involved in the service to attend an

annual general meeting to discuss the charity's goals and objectives. This included people who used the service and their relatives. People were sent a copy of the annual report, giving them information about the charity each year. The trustees, or a sub group of the trustees, met each month to discuss the work of the charity and its services with service managers. The acting manager prepared monthly reports for the provider so they could be assured care was delivered and monitored consistently. Service managers shared these monthly statistics across the management team and with the board of trustees, which allowed managers to learn from each other. The sharing of information enabled managers to identify any trends and patterns in statistics which could indicate where improvements needed to be made. For example, the causes of accidents and falls, and how complaints were handled.

The acting manager's role included checking staff monitored and reported on people's care and any incidents that occurred, to make sure appropriate action was taken when necessary. Records showed, for example, accidents and incidents were recorded by the individual affected, the time and location of the incident, the possible causes and the actions taken. Actions taken as a result of analysis included referring individuals to other health professionals where needed.

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 There were insufficient processes in place to assess, monitor and improve the quality of the service. There were insufficient processes in place to ensure risks were assessed, monitored and mitigated. Records were not always accurate, complete and contemporaneous in respect of each service user.