The Brandon Trust

Brandon Trust Supported Living - Earlsfield

Inspection report

Earlsfield Business Centre
Unit 10, 9 Lydden Road
London
SW18 4LT

Tel: 02038567050

Date of inspection visit:
26 April 2016
27 April 2016
28 April 2016

Date of publication:
15 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 26, 27 and 28 April 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. This service was previously registered under a different name. This was the first inspection of this service under its new registration.

Brandon Trust Supported Living – Earlsfield provides support to people with learning disabilities with a wide range of support needs. Support ranges from a couple of hours to 24 hours cover across services ranging from people's individual homes to shared group homes in the Southwark, Wandsworth and Croydon boroughs of London.

At the time of the inspection, the provider was supporting approximately 100 people living in 20 different supported living schemes. The landlords in most cases were housing associations. There were seven registered managers for the provider. They each managed a number of schemes between them, with each being responsible for approximately four schemes.

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.

People using the service told us they were happy with the care and support they received from staff. They said they led independent lives and were supported by staff to do so. We spoke with and observed them in their homes and saw that where they were able to, they were free to come and go and had the freedom to live their life how they wanted.

People's nutrition and hydration needs were met by the provider. People who were more independent told us they helped staff when preparing and cooking food. Staff involved people when planning menus and used picture cards to offer a choice to those people who were not able to communicate verbally. Care records included risk assessments and support plans in relation to nutrition and referrals were made to dietitians to provide specialist input where needed.

The provider supported people with regard to their health needs by corresponding with professionals such as their GP, psychologists and other community teams.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Capacity assessments for specific decisions such as finances and self-administration of medicines took place. If people lacked the capacity to make decisions, best interests meetings took place to ensure their rights were protected. If any restrictions took place to protect people, referrals were made to ensure these were lawful.

There were thorough recruitment checks in place which helped to ensure care workers were safe to work with people. New staff submitted written references and underwent Disclosure and Barring Service (DBS) checks before starting work. All staff completed a comprehensive induction based on the Care Certificate and this training was refreshed regularly.

We found that care records were not always fully completed in the schemes that we visited. For example, some risks were not fully assessed, care and support plans were not always in place and key worker reports were not always documented.

We also found that some people may have been at risk of not receiving their medicines appropriately or in a safe manner. Some Medicine Administration records (MAR) were not accurately completed.

There was an open culture at the service. There was evidence that concerns and incidents were documented and investigated, sometimes involving external agencies where appropriate. Senior managers had a good oversight of the services and an action plan was in place to drive improvement.

We found two breaches of regulation in relation to safe care and treatment and person centred care. You can see what action we have told the provider to take at the back of the full version of this 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.

We found that care workers were not always correctly recording medicines administration correctly.

Although risk assessments were in place for each person, they were not always accurately completed.

Thorough recruitment procedures were in place which helped to ensure that care workers were safe to work with people.

People told us they felt safe living at the home and learning from safeguarding concerns took place.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction programme based on the Care Certificate. Thereafter, they received regular training to maintain their competencies.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Best interest meetings were held for people with limited capacity to understand decisions related to their care.

People had their nutrition and ongoing health needs met by the provider. Where required, appropriate referrals were made to provide specialist support.

Is the service caring?

Good

The service was caring.

People told us that staff were friendly towards them and supported them when needed.

People's privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

We found that although care records were comprehensive in scope, they were not always complete. Some support plans were non-existent or not up to date.

The provider had procedures in place for dealing with complaints and investigations took place to explore concerns.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt well supported. There was a culture of learning from any untoward incidents.

Quality monitoring in the form of audits and feedback took place. Plans were put in place to address any shortfalls identified.

Brandon Trust Supported Living - Earlsfield

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 inspection took place over three days, on the 26, 27 and 28 April 2016 and was announced.

This inspection was undertaken by one inspector. We visited the head office on the first day, and six supported living schemes on the second and third days.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We also contacted 30 health professionals after the inspection to gather their views and received responses from three of them.

We spoke with 10 people using the service, nine care workers, three registered managers, the operational development manager, the area director, HR assistant and the recruitment specialist during the inspection. We also attended a 'driving up quality' forum where we met a number of people from different schemes who told us about the care and support they received.

We looked at records including eight care records, staff records, and other records related to the management of the service including Medicine Administration Records (MAR), complaints, and incidents/accident records.

Requires Improvement

Is the service safe?

Our findings

People using the service told us staff supported them with their medicines. One person said, "They call me or come down with my tablets", another said "I get help with medicines, my medicine comes from the pharmacy."

Guidelines for supporting people with medicines and medicine profiles were in place, although these were not consistent across all the schemes we visited. Medicines profiles gave information about people's current medicines, their uses and other related information.

We checked MAR charts for five people using the service, we found that these were not always accurate. We found that in some cases the medicines we counted did not always correlate to what had been recorded. One person's 'Pro Re Nata' (PRN) medicines, which means medicines that are given as required did not add up according to the service's medicines count. In another instance, the Medicine Administration Record (MAR) chart for a medicine was not being correctly administered from a Dosset box. Staff had signed to indicate this person had received this medicine for 10 consecutive days between 18/04/2016 and 27/4/2016, however there were still two medicines in the dosset box. Also, for another medicine staff signatures for administration did not correlate to what we found in the dosset box. We found that not all staff were following the same procedure, some care workers had written 'D' for declined when people had refused medicines whereas others had not. Some staff had also signed where medicines were still in their dosset box.

We found that one person's insulin was kept in a fridge but the fridge temperature was not monitored or recorded. Another person had a nasal spray which was not marked with the date it had been opened and it stated on the package that it needed to be discarded three months after opening.

Although quality assurance visits were undertaken by registered managers from other schemes, there were no internal medicines audits undertaken by staff from each scheme which could potentially have picked up on the errors that we found.

Although there were individual risk assessments in place for people, we found there was inconsistency across some of the schemes and in some cases risk assessments had not been completed.

We also came across some identified risks that had not been documented. For example, one person had clearly been identified as vulnerable while out in the community, with a lack of road safety awareness and was unsteady and prone to lose their balance. However, these risks had not been assessed and there were not management plans in place to help protect the person from harm. We spoke with the care worker about this person who acknowledged that the care records were not up to date.

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

Where they had been completed, the risk assessments were proportionate and centred around the needs of people whilst enabling them to lead more independent lives, with appropriate staff support. The risk assessments we saw documented the potential risk for each assessed activity and the people that could be harmed as a result. The potential risk and control measures which were implemented were also recorded. Some examples of areas that were risk assessed included self-administration of medicines. We also saw evidence that where people displayed behaviour that challenged, referrals were made to psychology and challenging behaviour support teams in the community. One care worker said, "We have behavioural guidelines in place and we work with psychologists to support people."

People's feedback about the safety of the service was good and they told us they felt safe. Some of the comments included, "I like it here", "They treat me well. I feel safe", "I'm happy" and "I've been here a long time, the staff are alright."

Safeguarding posters were on display in some of the supported living schemes we visited along with guidelines for staff to refer to if they had any concerns about people's safety. Staff we spoke with were able to identify different types of abuse and told us they would not hesitate to raise any concerns either with their team leaders or more senior managers within the organisation.

There was a culture of learning from mistakes and an open approach. We reviewed some of the current safeguarding concerns with the registered managers. They told us about the actions they had taken in response to these to keep people safe from harm in the future. These included providing extra training for staff where needed and working with the local authority and other professionals to come to an agreement to keep people safe. We saw evidence that action had been taken as described. All safeguarding matters were reviewed by the operations development manager and an area office co-ordinator to identify any common themes.

The provider had set up an internal Protecting Adults at Risk' (PAR) board which included registered managers and senior managers. They met every month and reviewed all the safeguarding cases that were being investigated. One staff member said, "It's about being aware but also learning from it. We come up with themes and case studies that managers can then go away and discuss in their teams."

We spoke with registered managers about staffing levels within their service and looked at staff rotas in some of the schemes we visited. We found that there were adequate numbers of care workers employed to meet the needs of people using the service. Some people needed additional one to one support either in the home or to access the community, where this was the case this was provided for them outside the normal staffing levels.

Recruitment systems were thorough and ensured that the right staff were recruited to keep people safe. We spoke with the recruitment specialist who told us that every member of staff had a recruitment file and there was a system in place for verifying references and Disclosure Barring Service (DBS) checks. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. We saw evidence of staff DBS numbers on file. Two references were required from a previous employer and any gaps in employment were accounted for.

Good

Is the service effective?

Our findings

The provider ensured people's needs were met by staff who had the appropriate competencies and training. New care workers received a thorough induction that gave them the skills to carry out their roles effectively so that people had their needs met.

Staff told us they were satisfied with the training they received. Some of the comments included, "I am always encouraging staff to take up the training that is on offer here", "The training is good, I recently went to the plan for life and first aid refresher", "I'm self-motivated. I'm interested in training so I sometimes deliver safeguarding and medicines training" and "We have had training in intensive interaction and how to support people with eating and drinking."

We spoke with the learning and development coordinator. They told us they had reviewed their induction programme for new staff and amended it to reflect The Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

There were 15 topics in total, covering the mandatory and organisational training requirements. The 15 topics were medicines administration, data protection act, diet and nutrition, emergency life support, fire and evacuation, health and safety, lone working, moving and handling, person centred thinking, safeguarding adults and children, equality and diversity, food safety, mental capacity act and infection control. All team leaders and registered managers were trained to carry out the observations and assessments relevant to each topic. One registered manager told us, "I'm doing the Care Certificate training for new staff. I meet them monthly, go through their workbook, observe them and sign off if they are competent."

Each new care worker was put onto one of three training pathways. The first pathway was for people completely new to care, they covered all 15 standards and observations. The second pathway was for people that were not new to care but did not have any formal qualifications or previous training. The provider tried to recognise their level of experience and they completed a test, workbook and underwent an observation to ascertain their level of understanding and if gaps were identified they would complete specific modules. The third pathway was for those with experience and qualifications. These people completed a self-assessment against each of the 15 topics and they completed any topics in which they were found lacking.

Senior staff at each scheme completed a training needs analysis, which was used to identify any gaps in training. The provider also had access to the local authority training portal. This allowed them to book onto any courses provided by the local authority. The provider had a programme in place called 'step up – step in' to enable existing staff to take on more responsibility either on their same pay scale or a level above through internal vacancies.

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 application procedures for this are called the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with were familiar with the Mental Capacity Act 2005, and the need to obtain consent from those who used the service. One care worker said, "[Person] cannot communicate verbally, but they can tell you what they want through body language or expressing in some other way" and "The MCA is used to check if people are able to understand decisions about their care." Another said, "MCA is basically about listening to people and the law around how we support people with no capacity."

Specific assessments of capacity forms were completed, for example to manage finances for people. These included a decision making tool, in which people had agreed for the provider to manage their finances and indicated that they understood and had the capacity to make that decision. However in one example although the form was completed fully, the person had not signed it to indicate that they agreed with its content.

We were given examples of best interests meetings that had been held when supporting people in relation to their health and other matters such as finances and going on holiday. Decision making records were in place advising staff how decisions were made on behalf of people that lacked capacity. In the cases we saw major decisions were supported by capacity assessments and best interests meetings. We saw one example where a decision around finances needed to be taken for a person without the capacity to understand decision making around finances. The provider followed accepted guidelines and held a best interests meeting with the social worker, family member and team leader so that a decision could be made on behalf of the person that protected their rights.

People were not restricted from leaving schemes unless it was unsafe to do so. One person said, "I go out by myself, I've got my mobile and I call them if I'm not coming back." A care worker told us, "This is their home. They are not forced to do anything." Some people living at some schemes were restricted from doing certain things, such as leaving home on their own and accessing the kitchen by themselves. Others needed continuous support and supervision. Where restrictions had been placed, the provider had submitted DoLS applications for them to ensure that these restrictions were lawful.

People using the service told us, "The food is fine", "The carers help me with dinner, they ask me what I would like to eat", "They cook shepherd's pie for me, I like it" and "I do my own cooking, I prefer it. I cut the veg and peel potatoes." Care workers said, "[Person] loves Guinness. We take them to the pub, they love it" and "[Person] loves Caribbean food."

The kitchens were clean and staff followed recommended infection control guidelines such as using colour coded preparation boards to separate raw meat from other food items. We saw that food was stored in fridges and in date. We saw there was a plentiful supply of fresh and frozen, good quality food, including fruit, vegetables and dry stores in each of the schemes.

Some schemes had individual menus for each person, whereas others had set menus for the home. There

was evidence that people were involved in menu planning. We saw that people's cultural and other health related dietary requirements were being met by the provider. Where required, food diaries were kept and picture menus were available to offer people a choice where they were not able to communicate verbally.

There was evidence of assessments of choking and dietary risks. Where people required extra support with their meals, guidelines were in place providing staff with information on how best to support them. These had been developed by specialists such as Speech and Language Therapists (SALT) or dietitians. Dietary instructions were on display that had been reviewed recently by the dietitian which included the type of food that was recommended for people. There was evidence that these recommendations were being adhered to.

Care workers supported people with medical conditions that affected their health. People's needs were regularly monitored and reviewed with relevant professionals and people using the service were consulted.

People told us they were supported to see their GP or other health practitioners if the need arose. Care workers told us, "We support people to attend any appointments."

Some schemes had separate health action plans in place documenting current medicines that people were taking, records of health correspondence, and appointments and care plans relating to health. Health profiles were also seen containing important personal health information such as allergies, pain management, important health professionals involved and their medical history. They also contained a document called 'About my health' which included information on current health issues, health screening, vaccinations and health checks. These health action plans were not seen in all of the schemes we visited.

People had hospital passports in place in the event of a hospital admission. There was evidence of correspondence with healthcare practitioners and we saw that appropriate referrals were made, for example to their GP or other community teams to support people. There was evidence that people had regular reviews for their ongoing health needs, for example diabetes reviews.

Good

Is the service caring?

Our findings

People using the service told us, "They treat me with respect", "I enjoy it here, very nice people" and "Staff look after me but I can look after myself as well."

There was evidence that people were supported to maintain family relationships where appropriate, this was demonstrated through family member involvement in best interests meetings, through visiting schemes and also people going to stay with them. People told us, "I can go out by myself, I go to Balham see my friends", "My sister comes to visit me" and "On Sunday I'm going to my sister's daughter's christening."

People's homes and bedrooms were personalised to their liking. One scheme had converted a second living room into a sensory room in order to meet the needs of people living there. All the schemes had pictures from day trips and holidays on display in people's bedrooms and homes. Some rooms had en-suite bathrooms and all had been furnished with personal memorabilia.

We observed interactions between staff and people in their homes and we saw that they were comfortable in each other's company. There was a lively atmosphere in the homes we visited. We saw people being supported to have breakfast whilst in others we saw people coming back from the day centre or from days out.

Staff were aware that they were supporting people in their own homes and were careful in respecting their privacy and dignity. They knocked and asked people's permission before entering their rooms.

Some care plans included records related to people's likes/dislikes, and documents entitled 'important things I need help with', 'things I am worried about' and 'goals and dreams'. These were written in single sentences and simple English. Communication records were in place recording how people communicated, how they indicated yes or no, and how they could be involved in decision making.

Care workers demonstrated how they communicated with people who were not able to communicate verbally. Picture cards were used to offer people who were not able to communicate verbally a choice of activities and meals. Some people had communication guidelines in place, giving information to staff on the best way of communicating with people. One care worker told us, "[Person] will indicate they are hungry or want to go out by certain gestures which we recognise", another said, "If you offer [person] something and they don't like it, they will push it away or refuse to eat."

People's independence was promoted by staff. They told us, "I have supervision every six weeks", "Staff do the cooking, I help with the washing up" and "I go out shopping by myself." Staff told us that each person was different and some required more support than others and others were more independent. One care worker said, "[Person] will go out, [they] have their mobile phone and will call if there are any problems."

Some of the schemes we visited were set up for people who were more independent and who wished to move into their own accommodation with minimal support. We spoke with people who had done this

recently and they praised staff who supported them in their supported living schemes and spoke about how they liked to go back and visit them.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of not receiving care and support that met their individual needs as their care records were not always fully completed or up to date. We found variances across the schemes we visited. Some support plans were complete and others were not. For example, there was a lack of clear goal monitoring, key worker reports, support plans in place and some records were not dated. Some care records contained duplicated information and a mixture of old care and support plans.

Some people had a 'my life in a month' record completed by their keyworker which included their views on how things had gone in the past month in relation to general issues, housing, health, things that had gone well and not so well and activities they had done. These were signed by people and their key worker. Other key worker meetings were not held as regularly. For example one record indicated that the last key worker meeting had been held in February 2015. Another person who had moved into the service in May 2015 had monthly key worker review forms completed for January, February and March 2016 but these did not contain any assigned actions to be followed up. There were also no care or support plans in place for this person, the care worker told us "I haven't had time to do one yet."

Other care records were not complete. A new 'plan for life' had been introduced but these had not been implemented and many sections were incomplete. The 'plan for life' was split into important personal information, assessment of needs, my plans, support plans, and reviews. Care plans were in relation to communication, daily living, eating and drinking, personal care, health, medicines, relationships and finances. Some care plans had been signed by staff and dated even though they did not contain any information, there were no documented actions for staff to take to support people, no outcomes/goals, and no clear risk assessments.

In one person's daily living support plan, it stated that specific support plans that were to be documented included keeping the house clean, laundry, cooking however these were not seen in the person's records. An annual care plan review was seen but not in all services and not for all people.

Staff that we spoke with told us that people's care plans were in the process of being re-written and transferred into the plan for life but this process had not been completed.

The above identified issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One care worker said team meetings were supposed to be held monthly but could not provide evidence of this. When we checked the relevant folder, the last documented meeting seen was dated 13/5/2014. In other services there were team meetings held on average every three months and items discussed included activities, holidays, menus and shopping.

Where completed, care plans were appropriate and documented what was important for people, actions for staff to support people, and if there are any related risk assessments. An example of some completed care

plans included an eating and drinking plan which advised staff that the person needed a soft, moist diet and small pieces to avoid the risk of choking.

Some people had a daily schedule, advising staff of their daily routine for example what time people liked to wake up, activities they liked to do and medicines they needed to take. They also had support plans in place for example, in communication, daily living, eating and drinking, personal care, health, medicines, relationships and finances. Each assessed care plan had short and long term goals along with who was involved in achieving the goals and the timescales for completion of these.

Where people had one to one support for certain hours, some schemes completed a one to one activity support record to evidence the activities they were supported to attend. Daily care records were also completed. There were guidelines in place for staff working with people, some of these were written in consultation with specialists such as psychologists. These steps included how staff were to communicate with people, things to avoid and ways in which they could work together to provide appropriate support. Other guidelines were in place in relation to personal care and, use of hoists, going out in the community, using a wheelchair in community and breakfast/mealtimes.

People were protected against the risks of social isolation and loneliness and were supported to carry out activities within the service or in the community. People told us, "I've just been to the market, I brought a handbag", "I go to Streatham on the bus", "I'm going to the gym", "I'm going on holiday in September to Budapest."

There was evidence that some people had been supported to study for and obtain qualifications. One person had obtained a certificate for developing ICT skills and personal digital photograph processing. People were supported to go on holiday and attended various day centres. The provider had an allotment that they procured for people to go and contribute and take an active interest in. A manager spoke about the great impact that this had had on people's wellbeing and mental health and said that people had taken ownership of it and cared for it with pride.

People using the service told us, "If I'm not happy I would let [staff] know", "I'm very happy, if I was unhappy I would speak to staff."

People's concerns and complaints were listened to during keyworker and residents meetings where these took place. Formal complaints were resolved within each scheme where appropriate and investigated by the relevant registered manager. These were documented and reviewed by senior managers. If complaints were not dealt with satisfactorily, they were assigned to more senior managers to investigate.

Good

Is the service well-led?

Our findings

Support workers and registered managers told us they felt well supported by both their peers and managers and enjoyed working for the provider. Some of the comments included, "The team leader is very good, she is fair. I can't complain", "We have a good team, we get on" and "I can email anyone and ask for help, I don't have any problems."

One care worker told us, "There are opportunities here to progress." Each scheme was managed by a team of care workers and there were team leaders in place for each scheme to manage services. Registered mangers had overall responsibility for a number of schemes. Registered managers were a visible presence in their services; this was evident from our observations of their interactions with people when we visited the schemes.

We spoke with the operations development manager who oversaw compliance and quality within the service. There had been some changes in management recently with the area director not in post. The operations development manager had been acting up in this role since November 2015. The operational development manager told us they carried out service visits to schemes, carrying out spot checks. They said, "It gives me an opportunity to speak to staff."

Registered managers told us, "You get good peer support here", "We meet up once a month with other managers and we do support each other."

A number of management level meetings took place, some of which had been introduced recently. Monthly meetings between registered managers and the area manager took place. We reviewed some minutes from these meetings, some of the topics that were discussed included good news, workload, team development, team leader development, values and behaviours and social events. Other meetings that took place included those between area managers and meetings between HR and registered managers.

There was good management oversight with regard to any incidents or concerns within the service. The provider had an appropriate system for recording these events. One staff member said, "There is a culture here where people do report concerns." All incidents were required to be recorded and notified within 24 hours. We saw copies of incident/accident reports at each scheme which were completed fully, recorded on a database and overseen by senior managers. These were shared with other professionals such as social workers where appropriate.

Regular audits took place which were used to monitor the service against CQC methodology for inspection. These were undertaken by registered managers from other services. We found that there was a lack of consistency, especially in relation to the quality of the care plans across services which the area director acknowledged was an area of improvement. One staff member said, "We have good values but sometimes there is a lack of consistency amongst registered managers."

Surveys were sent to people. These were provided in an accessible format to ensure that the views of a wide

range of people could be captured. For example, one survey was observational for those people that were not able to communicate verbally.

The area director showed us an action plan which was in place to ensure services were providing good care, they said "So we know where there is a shortfall which I can discuss with locality managers." The quality action plan looked at infection control, DoLS, customer satisfaction, quality audits, sample visits, compliance checklist, staff engagement, quality meetings and appraisals.

A staff conference had been held in March 2016 with over 100 attendees. The theme for this conference was 'communication'; this theme was then discussed at lower level meetings.

On the second day of our inspection, we attended a 'driving up quality' day which was being held in the main offices of the provider. It outlined a shared set of expectations of what quality means in the 21st century, and established a framework for providers to evaluate their performance. Importantly, it required providers to publicly declare their findings and set out their commitments for improving what they did and how they would do it. This was an inclusive event which people from all the services were invited to in order to give their views on how quality could be measured and improved within the service. People were supported by care workers to attend this and give their views. This demonstrated the open culture of the service in ensuring the voices of the people it supported were being heard.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always appropriate and did not always meet service users' needs. Regulation 9 (1) (a) (b).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess or effectively mitigate the risks to the health and safety of service users in relation to care or treatment. Medicines were not managed safely. Regulation 12 (1) (2) (a) (b) (g).