Care Quality Commission

Serene Care Ltd

Rugby Care Centre

Inspection report

53 Clifton Road, Rugby CV21 3QE
Tel: 01788 542353
Email jay@serene.care

Date of inspection visit: 10 and 14 September 2015
Date of publication: 05/10/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected this service on 10 and 14 September 2015. The inspection was unannounced.

The provider had taken over the ownership of the home in April 2015. They had retained the registered manager and staff who were employed by the previous provider at that time.

The registered manager had been in post for a continuous period of ten years, as they had been employed by two previous providers. 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 service provides accommodation and personal care for up to 29 older people, some of whom are living with dementia. Twelve people were living at the home on the day of our inspection.

There were policies and procedures in place to minimise risks to people's safety. Staff understood their responsibilities to protect people from harm and were

Summary of findings

encouraged and supported to raise any concerns. The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks.

There were enough staff on duty to meet people's physical and social needs. The registered manager checked staff's suitability to deliver personal care during the recruitment process. The premises and equipment were regularly checked to ensure risks to people's safety were minimised. People's medicines were managed, stored and administered safely.

Staff understood people's needs and abilities because they read the care plans and shadowed experienced staff until they knew people well. Staff received training and support that ensured people's needs were met effectively. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager had obtained guidance from local and national agencies to make sure the care they provided did not deprive people of their liberty. No one was subject to a DoLS at the time of our inspection.

Risks to people's nutrition were minimised because people were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs and staff understood the importance of helping people to maintain a balanced diet.

Staff were attentive to people's moods and behaviour and understood when to implement different strategies to minimise people's anxiety. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health or when their needs changed.

People and their relatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs, abilities and preferences and care plans were regularly reviewed.

The provider's quality monitoring system included regular checks of people's care and health, medicines management, meals and suitability and management of the premises. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence.

People who lived at the home, their relatives and staff were encouraged to share their opinions about the quality of the service. The new provider had consulted with people, their relatives, staff and external specialists before making improvements to the garden, the décor and to the meals. The provider took account of people's opinions to make sure planned improvements improved people's actual experience of the service

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home. Medicines were stored, administered and managed safely.

Good

Is the service effective?
The service was effective. People were cared for and supported by staff who had relevant training and skills. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to other healthcare services when their health needs changed.

Good

Is the service caring?
The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence, by supporting them to lead their lives in the way they wanted.

Good

Is the service responsive?
The service was responsive. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes. Staff supported and encouraged people to take an interest in their surroundings and their community. People were confident any complaints would be dealt with promptly.

Good

Is the service well-led?
The service was well led. People, their relatives and staff were encouraged to share their opinions about the quality of the service which ensured planned improvements focused on people's experiences. The new provider's quality monitoring system included checking people received an effective, good quality service that met their needs.

Good

Rugby Care Centre

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 took place on 10 and 14 September 2015 and was unannounced. The inspection was undertaken by an inspector, an inspection manager 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 residential care service.

We had not asked the provider to complete a provider information return (PIR), but they were able to give us all the information we requested during the inspection. The PIR 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 also reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with four people who lived at the home and four relatives. We spoke with the providers, the registered manager, the deputy manager and five care staff. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us the service was good and they felt safe. They said, "It feels like a safe place, because there's somebody here with me. I don't feel frightened" and "I feel safe when the carers support me from the bed to my wheelchair." A relative told us, "I think [Name] feels secure, feels safe." Relatives were confident that their relations were safe at the home. We saw people were relaxed with staff and spoke confidently with them, which showed people trusted the staff.

Staff knew and understood their responsibilities to keep people safe and protect them from harm. Care staff told us they had training in safeguarding and felt encouraged by the whistleblowing policy to raise any concerns. A member of care staff told us, "If I were to see bruises without an explanation, or if a person was unkempt, I would report it to the manager." They told us the manager would escalate their concerns to the safeguarding team, or they could contact the safeguarding team themselves if action was not taken by the manager. The manager had not needed to make any referrals to the local safeguarding team.

The provider's policy for managing risks included assessments of people's individual risks. In the three care plans we looked at, we saw the manager assessed risks to people's health and wellbeing. Where risks were identified, people's care plans described how staff should minimise the identified risks. For example, the manager checked risks to people's mobility, communication and nutrition and described the equipment needed and the actions staff should take to support people safely. Staff told us the equipment they needed was always available and was maintained, repaired or replaced when necessary.

A member of care staff told us risk assessments had been completed to minimise the risks of people or staff being injured when one person displayed behaviour that challenged others. Staff followed the guidance in the person's care plan. For example, the person became agitated when staff offered support with personal care. Staff walked awayand gave the person time to consider their offer. Staff went back a few minutes later and spoke quietly and reassuringly to the person. They explained what they were doing and the person accepted their support.

Staff recorded incidents, accidents and falls in people's daily records and kept an on-going log for analysis. Records showed the manager analysed each person's falls, the location, time, and outcome to identify patterns or trends. No patterns were identified in the previous six months, but actions had been taken to minimise the risks of a re-occurrence for each individual. For example, three different people had fallen during the night, and each person had an appropriate change in their care and support. One person had asked for bed rails to keep them safe while they slept, one person had moved to a ground floor bedroom so staff could check their safety more frequently, and a third person had a sensor mat (a mat which alerts staff that the person is moving) placed by their bed. A relative told us, "[Name] has a mat by her bed so staff know if she gets out on her own."

Records showed that the provider's policy for managing risk included regular risk assessments of the premises and emergency plans for untoward incidents. The fire alarm, water and electrical systems were regularly checked and serviced. All staff received health and safety, first aid and fire training to ensure they knew what actions to take in an emergency. Emergency contact details for the pharmacist, nurse, electrician, lift and call bells were prominently displayed in the registered manager's office and a floor plan and emergency procedure were displayed in the front hall, where staff could access them in an emergency.

There were enough staff on duty to meet people's needs. One member of staff told us, "We have three in the morning and three in the afternoon, and everyone gets the right amount of attention." They told us problems could occur when staff were off sick, or at weekends when the registered manager was not around as a back-up. The provider showed us their policy on staffing the home. The policy authorised the senior lead member of staff to call in other staff or agency staff to cover the rota. The provider told us they would post the policy on the board in the care office to remind staff of their authority and responsibility for decision making.

The registered manager checked that staff were of good character before they started working at the home. They showed us records of the checks they made of staff's suitability for the role. The manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

Good

Is the service safe?

People's medicines were managed and administered safely. Staff told us only trained staff administered medicines. They told us they were supervised for six weeks to check they were competent and confident in administering medicines, before they administered medicines independently. Medicines were delivered by the pharmacy with a medicines administration record, which was marked with the name of the person, the dosage, frequency and the time of day they should be administered, and were kept in a locked cabinet.

The three MARs we looked at were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. The deputy manager told us, "The medicines are more person centred now each person has their own drawer with boxed tablets. It works because we check the balance every time. There are no issues and I have no concerns with medicines."

Staff were knowledgeable about people's ability to understand why they had been prescribed medicines. The senior care staff told us, "You need to be patient with [Name], you need to explain. I say, 'here's your tablet from the doctor', she says, 'has he been to see me?' and I say 'yes and he left these for you'." The senior member of staff told us that some people were able to say when they would like pain relief medicine, but some people could not express themselves verbally. We saw a written protocol for one person, which said, "Watch facial expression", so staff understood the person was not able to describe their pain, but staff would be alert to the signs of pain and offer pain relief accordingly.

Good

Is the service effective?

Our findings

People and relatives told us the staff supported them or their relations according to their needs and abilities. One person told us, "I think that the staff are well trained to meet my needs." One relative told us they thought the service was so effective they hoped, "[Name] can stay there the rest of her days."

People received care from staff who had the skills and knowledge to meet their needs effectively. A member of care staff told us they had an induction programme which gave them confidence in their role, because they had shadowed experienced staff and had training. Care staff told us, "We have had training in dignity and respect, safeguarding, food hygiene, dementia and challenging behaviour" and "I did find out some things I didn't know before."

The provider told us they were researching additional training for staff because of people's changing needs, such as sensory impairment, as this would improve staff's understanding and people's experience of care. Care staff told us they could access the on-line training during their core hours on the rota, by additional paid hours or from home, if they preferred. On-line training included a test so the registered manager knew when staff completed it. The registered manager told us they knew training was effective because they observed staff in practice.

The provider had planned performance appraisal meetings for all staff who had been in post for over a year, to discuss their personal and career development. Staff told us they had already had a supervision meeting with the provider to talk about their practice and the provider's plans. One member of care staff told us they had accepted a promotion to senior carer and another member of care staff told us they had been encouraged to study for a nationally recognised qualification in health and social care as a result of their supervision meetings with the provider.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to make decisions for themselves. We looked at two care plans of people who did not have capacity to make their own decisions. They were signed by the person's representatives, which demonstrated that they had been involved in discussions about how the person should be cared for and supported.

Care staff we spoke with understood the requirements of the MCA. Staff asked people how they wanted to be cared for and supported before they provided care and understood that people made their own decisions. For example, a member of care staff told us, "Two people keep their legs straight in a wheelchair. You can't make them put their feet on the footplates, only encourage."

The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. The registered manager understood their responsibility to comply with the requirements of the Act. The registered manager told us they had followed the guidance about DoLS issued by the local authority and by the Social Care Institute for Excellence. The guidance re-assured the registered manager that no-one living at the home was deprived of their liberty, so they did not need to make an application under the DoLS legislation.

People and relatives told us they could have a cooked breakfast and there was a choice of meals twice a day. One person told us, "Cooked breakfast is fresh – egg, bacon, toast. It's a good breakfast and will see you through." People and relatives told us they had been invited to a tasting session, because the provider had suggested having the main meals delivered from a specialist supplier, instead of recruiting a full time chef.

The provider told us they had contracted with the specialist supplier to assure them of consistency in the quality and nutritional value of the meals. They had tested the meals on their own parents in the spirit of CQC's question, "Would I want my mum to have this food?" A written menu and information about the nutritional content of each meal was available in the hallway, so relatives knew which meals were offered and whether the food was suitable for their relations. The provider said they were keeping the new catering arrangements under review and would get feedback at the resident and relatives meetings. One person told us, "I'm not keen on bought in food. We had a tasting evening, but it's not as good as I anticipated." The person was confident their concerns about meals would be addressed.

Good

Is the service effective?

The care plans we looked at included a list of people's food preferences, needs and allergies, to ensure people were supported to maintain a diet that met their needs. People's dietary requirements were written on the noticeboard in the care office to remind staff. We saw that staff recorded which meal people ate and staff had recently been reminded to record how much people ate, so they could monitor people's appetites. Records showed that several people who were not able to say what they thought of the food, but who were also at risk of poor nutrition, had gained weight since the catering arrangements were changed.

At lunch time meals were presented to look appetising. There were enough staff to assist everyone who needed support to eat, because the registered manager worked alongside staff. The dining tables were laid with cloths, cutlery, napkins and condiments and everyone sat down together. The meal was unhurried and staff gave people time to savour and enjoy their meal. Most people ate everything on their plate and people were offered second helpings and a choice of drinks. One person told us, "If something is not to my liking they offer a choice of puddings." At tea time people had the choice of a hot meal, soup or sandwiches.

People told us they were supported to maintain their health. People told us, "The doctor is called when you need and so is the dentist, chiropodist and optician" and "The chiropodist came this week." Staff told us that some people were able to say if they did not feel well, but they had to watch for changes in moods, appetites or behaviours for those people who could not explain how they felt. One member of care staff told us, "[Name] can say if they are not well, or feel dizzy and the senior will call the GP." A relative told us, "I have no concerns. The deputy always tells me what's happening."

Records showed people were referred to other health professionals, such as the speech and language team and mental health nurses, appropriately. Staff kept a record of other health professionals' visits and their advice, and shared information at handovers at the end of each shift. Care staff knew who was currently under the care of the doctor, district nurse or dietician and the advice they had given, which meant they understood people's healthcare needs.

Staff told us the district nurse visited one person at the home twice a day, so they were able to get advice straight away if they had any concerns about people's health. The district nurse told us although they occasionally had to remind staff about using the right pressure relieving cushions, they had no concerns about the care people received. They told us one person who was at risk of broken skin, was being supported effectively by staff to move every two hours, which maintained the skin condition and ensured they did not acquire pressure sores.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at the home. They told us the staff were kind and thoughtful. People told us, "The staff are caring and kind. They treat me with respect" and "All the staff are lovely. They have the right attitude." One relative told us, "As soon as you open the door, it's a lovely atmosphere, warm, friendly, smells nice."

People were involved in discussing and agreeing how they were cared for and supported. A relative told us they had been involved in care plan discussions, which enabled them to share information about their relation's life. Records showed that one person, who did not have close family to discuss their care plan, was supported by an external advocate to express their wishes.

The care plans we looked at included a section entitled, 'choices and preferences', which included the person's religion, culture, personality traits, family and significant events. Care staff told us this helped them to understand the person and to get to know them as an individual. One member of care staff said, "The care plans tell us about people's religion. If people believe something you get to understand a little more about them. Most people say they have a religion, but they don't all want to go to church. [Name] goes to church on Sunday and we have communion here."

A relative told us, "The staff are so kind to her, really affectionate. They put their arms around her." Care staff told us their knowledge helped them understand people's anxieties and behaviours. They told us, "I read the care plans and take opportunities to talk with people and their relatives" and "We talk with people, get to learn about them." We saw staff understood people who were not able to communicate verbally and supported them with kindness and compassion. We heard staff say to one person who was agitated, "You look beautiful, have you had your hair done?" The person smiled in response and their body language changed to a more relaxed posture, which showed how staff responded to the person's emotional needs.

The manager showed us their plan for a 'buddy' system, which matched people and staff by their shared interests and friendships. They told us named staff would be responsible for practical aspects of people's lives, such as clothes and toiletries, and their well-being, through supporting them to live the lives they wanted and weekly contact with their family or representative. One person told us, "They are introducing a key worker system soon. I think this is a good idea and can't wait for it to be implemented."

Records showed there were regular meetings for people and their relatives to talk about things that were important to them, such as meals and the current refurbishment of the home. The provider showed us the 'mood boards' they had created, including samples of wallpaper and fabrics, for people to choose the décor for their own rooms, to promote their independence. One person told us, "I would like to come back to my own room (after the refurbishment). I have told the owners." They were confident they would move back after the redecoration was completed.

We saw staff respected people's privacy and promoted their dignity, for example, by speaking discretely when offering personal care. Staff kept people's personal information and records in a locked cabinet so only staff could access them. Relatives told us they felt welcome to visit at any time and staff treated them and their relations with dignity and respect. Relatives told us, "I feel really welcome, really at ease when I visit" and "I feel welcome to visit. I come whenever I feel like, it's never a problem."

Good

Is the service responsive?

Our findings

People told us they were cared for and supported in the way they wanted. They told us that care staff understood them and knew what they liked and disliked. One person told us, “The manager’s wonderful. Doesn’t matter what you want, she always makes time for you.” Relatives told us, “She is treated like a person” and “It is a great relief for me to know if there is a problem they will deal with it and call us.”

We saw people chose when to get up, when to go to bed and where to eat. People’s care plans recorded their likes, dislikes, preferences, hobbies and interests. For example, one person’s plan said, “[Name] likes to eat alone in the lounge.” We saw care staff supported this person’s preference. A member of care staff told us, “I can sit and chat with [Name] because he goes to bed late.”

Care staff told us they got to know and understand people well because they read the care plans, talked with people and their relatives and watched how people responded to their care and support. People told us they were supported to do the things that interested them. One person told us, “The staff take me to the [Named] local supermarket.” A member of care staff told us, “I can take people to the shop if they want to go. It’s not far, or I can get things for them if they don’t want to go out.”

We saw people spent their days in their preferred way. For example, one person enjoyed being out in the communal garden, sharing their photos and reminiscing about when they had enjoyed tending their own garden. Another person preferred to spend time watching the television. They told us they always chose which programmes they watched. A member of care staff told us, "[Name] does his own thing. He never rings the buzzer, he wheels himself around, but it’s promoting his independence. People seem happy here.”

Relatives told us they were invited to events held at the home, such as birthday parties and musical evenings. In the hallway we saw information about local groups and community events that people were encouraged to attend, such as the library exchange and a timetable of events offered by a local Age UK service. One person told us, “We have requested activities (at home) and this is in hand.” The provider had responded by recruiting an activities coordinator. We saw their proposed programme of events and activities would encourage people to develop their creative talents in card making, painting, poetry and creating life story books, scrap books and memory boxes.

Care staff told us the information they shared at the shift handover was detailed enough to let them know how people were and whether there were any changes in their needs and abilities. People’s daily records included information about their moods, appetites, whether anything was ‘unusual’ and if visits from other health professionals were booked or had taken place. A relative told us, “If there are any falls or concerns with mum they will call us straight away.”

There was a copy of the provider’s complaints policy and procedure in the hallway for anyone to read. People and relatives told us they had no complaints. People knew which staff they would speak with if they ever needed to complain. People told us, “I would go to the [Named] manager. I like her and she has a tough job. I will go to the [Named] deputy manager if the manager is not here.

A member of care staff told us, “If I heard any complaints I would tell it straight to the manager on their (the person’s) behalf.” The registered manager told us they had received four compliments about the food and care provided, and only one complaint. The complaint had been dealt with and resolved to the complainant’s satisfaction within 28 days. The compliments re-assured the manager which aspects of care people were happy with, so they were able to apply the same principles across the whole service delivery.

Good

Is the service well-led?

Our findings

The people we spoke with were happy with the quality of the service. People told us, "It's a lovely home. All the staff are lovely" and "I am more than happy with the care, the staff, the room." Relatives told us, "[Name] loves it there. She loves the girls. I am so pleased we chose this home" and "They did the garden up. It made a big difference."

The provider had taken over the home in April 2015. They had retained the registered manager and staff who were employed by the previous provider at that time. People told us the new provider had already 'made a difference'. One person said, "The place is looking better bit by bit. It has been a long time since it has been decorated." The provider explained their plans to redecorate and refurbish the entire home, in consultation with people, relatives and specialist suppliers and advice.

The provider had consulted with The Alzheimer's Society and University of Stirling Dementia Services Development Centre to understand how people living with dementia were affected by their environment. They had obtained a range of paints, fabrics and furnishings from suppliers who specialised in creating dementia friendly environments. The provider had shared their learning and plans with the local commissioners and at meetings with people who lived at the home, their relatives and staff.

Relatives told us they felt well informed. Relatives told us, "The manager is very good and is friendly and approachable" and "The owners said if I wanted to know anything, just ring them. I was very impressed with their openness." A member of care staff told us, "I like the new owner. You can tell her things."

The provider told us they planned to put a suggestion box in the front hallway and had already asked staff for their suggestions for improvements. Care staff told us they had had a one-to one meeting with the new provider and were asked for their opinions and suggestions. One member of care staff told us, "I had a one-to-one with the providers, so I could get to know them. So far they have done what they said they would do." Another member of care staff told us, "I suggested they reset the toilet light sensor to stay on for half an hour, not just a few minutes. People were getting anxious and feeling unsafe. Now the light stays for half an hour." Care staff were confident the provider would listen to any concerns and suggestions for improvements in how people were cared for and supported.

The registered manager had worked at the home for ten years and had been employed by two previous providers. The registered manager told us they were not always office based, but worked on the floor with staff. They told us this was invaluable as they could observe staff and observe how people responded to the care they received. Records of staff supervision and staff team meeting minutes included reminders to staff of their responsibilities and guidance about delivering safe and effective care. The registered manager told us they were able to take a lead role in care, because the new administrator had taken over some of the quality monitoring administrative tasks they had been responsible for under the previous provider.

The registered manager told us the quality monitoring system included electronically scanned daily records being sent to the providers, which they could access remotely. We saw copies of the daily work and monitoring schedules for care, for the kitchen and housekeeping and daily handover records. The provider told us the work schedules had been based on the existing audit framework, updated by staff who were experienced in how the home operated at a practical level, so they could be confident it was a realistic, achievable programme of work.

Records showed that all staff had responsibilities for recording and sharing information with the provider to keep them up to date with any changes in people's needs and the actions staff had taken. A member of care staff told us, "The provider monitors records all the time. He asks, 'what are you going to do about it?' Records showed the provider took action to improve when issues were identified. For example, the provider planned to conduct a survey of people and relatives to measure their satisfaction with the new catering arrangements.

The registered manager explained that accidents and incidents were reported in real time, on an on-line form, which had to be completed in full before it could be submitted and sent to the provider. The system analysed information and reminded staff to seek medical assistance and prompted them to notify CQC in accordance with the regulations. The registered manager had sent us statutory notifications about important events at the home, in accordance with their legal obligations.

Good

Is the service well-led?

Care staff told us all the staff shared the same values, because they focused their efforts on meeting people's needs. We saw this matched the organisational values, that were described on a poster in the front hall, of dignity, respect, integrity, trust, empathy and kindness. Care staff told us the whole staff team had worked extra hours to cover a recent period of staff changes and staff sickness. Care staff told us, "The deputy manager covers sickness on her day off. She never says no" and "The deputy is always on the floor. She is a diamond."

Care staff told us the provider recognised and appreciated their efforts to maintain a quality service. Care staff told us, "The provider has noticed and thanked me for the amount of hours I have worked" and "I was thanked for starting early and finishing late. They tell you they appreciate you." Records showed the provider had begun recruiting additional staff to promote an appropriate work-life balance for staff and to increase the size of the staff pool to cover unanticipated staff absences.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.