Hales Group Limited

Harrison Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 24 July 2018 and was announced. This was the first inspection since Harrison Park was registered with the Care Quality Commission (CQC) in July 2017. We gave the provider, Hales Group Limited, 17 hours' notice of our inspection. This was because the location provided a domiciliary care service and we needed to be sure the registered manager and staff would be available to support the inspection process.

Harrison Park provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

There are 65 individual flats in Harrison Park. Not everyone living there receives a regulated activity. The CQC only inspects the service being received by people provided with 'personal care', for example, help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of the inspection, 37 people were receiving the regulated activity of personal care from Hales Group Limited. Most were older people who had a range of needs, which included physical difficulties and those people who were living with dementia. Some people had communication needs and some had a learning disability.

The service had a registered manager in post. A registered manager is a person who has registered with the CQC 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 Act 2008 and associated regulations about how the service is run.

During this inspection, we identified shortfalls in relation to medicines management, gaps in recording and quality monitoring of the service. These issues were breaches of Regulation 12 (Safe handling of medicines) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found people had not always received their medicines as prescribed. There had been a number of errors with medicines management and staff received additional training and competency checks, however, the errors had persisted. This meant people remained at risk of harm as the provider could not be assured people were receiving their medicines in line with the prescribing instructions. The provider was monitoring medicines management closely and there had been a reduction in errors.

The quality monitoring system and audits had identified the medicines errors but how this was managed could be improved to ensure improvements were sustained. There were some gaps in records such as

medication administration records and food and fluid monitoring charts.

Staff received training in how to safeguard people from the risk of harm and abuse; they knew what action to take if they had concerns. People had risk assessments in place to guide staff in how to minimise risk without restricting people's choices. Some of the risk assessments were very detailed, whilst others could include more information and guidance for care staff. The registered manager told us they would address this.

Staff supported people to maintain their health and nutritional needs. They contacted health professionals and emergency services when required and let relatives know to keep them informed. Health professionals said contact with them could, on some occasions, be timelier. This was mentioned to the registered manager to discuss with staff. Some people had support from staff to prepare meals and complete food shopping.

People told us staff supported them well, respected their privacy and dignity and had a kind, caring approach. The provider had a policy and procedure for end of life care and the registered manager told us people who wished to remain in their own homes could do so with support from community health care services.

People were supported to make their own decisions as much as possible. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. However, there was one instance when a person had fluctuating capacity and documentation had not been completed or had not been obtained from the local authority to reflect a decision about the use of a restricting door. The registered manager addressed this.

There was a good staff recruitment process with full employment checks before staff started working with people who used the service. There were sufficient staff employed. The registered manager monitored call times to ensure staff stayed for the time required and attended at the right time, if this was critical to the needs of people.

There was a system in place to help develop staff skills. This included training, supervision and appraisal. Staff told us they received sufficient training.

Staff were provided with personal protective equipment such as gloves and aprons, which helped them prevent the spread of infection.

The provider had a complaints policy and procedure, which was given to people when they moved into Harrison Park and received a service from Hales staff. People told us they felt able to raise concerns.

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.

Some people had not received their medicines as prescribed.

Staff were recruited safely and there was a full complement of staff. The registered manager monitored call times to ensure these were within an appropriate timeframe.

Staff had received training in how to safeguard people from the risk of abuse and knew how to raise concerns.

Staff had access to personal protective equipment, which helped them prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a general understanding of mental capacity legislation but documentation had not been completed when one person had fluctuating capacity and a restriction had been put in place. The registered manager addressed this. Staff knew how to gain consent before carrying out care tasks.

People's health needs were met although health professionals told us staff needed to contact them in a timelier way. Staff supported people to access their GP. Staff supported people to prepare meals when required.

Staff received training, supervision and appraisal to help them feel confident when supporting people.

Is the service caring?

Good

The service was caring.

People we spoke with gave positive comments about the registered manager and the staff team. They said staff had a caring approach.

Staff respected people's privacy and dignity and assisted them to maintain their independence as much as possible. They had completed basic training in equality and diversity and were aware of people's needs in relation to communication.

Staff knew how to keep personal information confidential.

Is the service responsive?

Good

The service was responsive.

People who used the service had assessments and care plans. The care plans included good personal histories and had information to guide staff on how to meet people's needs in an individual way.

The provider had a complaints policy and procedure. Complaints were logged, investigated and the outcome was communicated to people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were some shortfalls in how the service was managed, which had impacted on medicines management and persistent errors occurring. There were also some gaps in records.

The provider had an open and supportive culture. Staff felt able to raise concerns and were encouraged to admit errors so lessons could be learned.

Harrison Park

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 site visit took place on 24 July 2018. We gave the service 17 hours' notice of the inspection site visit because the location is a domiciliary care service and we needed to ensure someone would be in the office.

The inspection team consisted of two adult social care inspectors, an assistant inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used the PIR and all the intelligence the Care Quality Commission held, to help inform us about the level of risk for this service.

We contacted the local safeguarding and contracts and commissioning teams to request their views of the service. We also liaised with three health and social care professionals involved with supporting some of the people who used the service.

During the inspection, we spoke with 10 people who used the service and seven of their relatives. We looked at care records for six people and other important documentation including medication administration records (MARS) and monitoring charts for food and fluid intake.

We spoke with the registered manager, the regional manager, two team leaders and three care staff. We also looked at recruitment files for five members of staff, staff supervision, appraisal and training records, as well as other records used in the management and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe, however, there were mixed comments about staff availability. Comments from people included, "There is always somebody around", "The building is secure" and "I get three calls a day; they are on time and I'm happy with them." One person told us they used a pendant alarm to call staff when required and said they usually responded within ten minutes. One person told us they had to wait half an hour for staff occasionally and another person mentioned a two and half hour wait; they said they complained about this and timings had improved with only an occasional late call by 15 minutes. The registered manager told us they had no record of a person making a complaint about a two and a half hour wait for care staff. Other people said staff arrived on time and supported them well.

Relatives had mixed comments about staffing levels/timeliness of calls. One relative said staff told them they were short staffed. Another relative said staff arrived on time and commented, "Some stay the full length of time even if they get jobs done and they will sit and chat with them for social company. Others will go in and if they say they are okay they will just go."

Health and social care professionals told us the service was safe and they had noted improvements, although they said medication required monitoring. They also commented that there had been an initial high turnover of staff but this had improved.

People had not always received their medicines as prescribed. Medicines were stored in people's own homes and there were care plans and medication administration records (MARs) for staff to follow. Before the inspection, we had received information from the local authority about complaints raised by relatives regarding medicines management. For five days, one person was given one dose daily of an important blood thinning medicine instead of two doses daily. This meant their medicines were not given in line with the prescribing instructions. A relative told the local authority there had been several concerns regarding staff giving incorrect doses of medicines. Their relative also had a near miss when staff gave the person their insulin pen to administer a dose of insulin when this was given by a district nurse. Fortunately, on that occasion, the person could tell staff the district nurse completed the administration of their insulin. Another relative told us the person missed four doses of a set antibiotic treatment. Another relative had concerns staff were documenting that pain relief could not be given as insufficient time had passed since the last dose.

For one person, their pain relief patch had not been repeated on the MAR. Consequently, the person was without their pain relief patch for two weeks. There was an issue with the same person when staff did not remove the old patch before putting on a new one. The registered manager had raised these concerns with the local safeguarding team and completed an investigation to prevent a reoccurrence.

There were further medicines errors identified in audits completed by the registered manager. These included a pain relief patch missing the date of application, weekly medicine missed, daily doses of medicines missed, a medicine given daily when it should have been alternate days and staff administering medicines but omitting to sign the MAR.

A community pharmacist had visited the service in June 2018 to offer advice. Staff had received training in medicines management and had competency checks, however, the errors continued although these were reducing and were mainly recording errors.

Not ensuring the safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, the registered manager told us they had recently started to try a new system of medicines administration. This consisted of two senior staff completing the administration of medicines for all those people with complex needs and multiple medicines rather than the care staff who delivered their personal care calls. They were to audit this to monitor the impact of reducing errors.

In discussions with five staff, they all stated there were enough staff on duty and they had sufficient time to support people. Comments included, "Yes, I think it works. Obviously when there is an emergency it is difficult but we always work together and help each other" and "Yes, we are fully staffed. We get people phoning in sick which can be difficult. They try to cover it or more calls would be put on us or the team leaders would have to do them [calls]." Team leaders were available to answer call bells in between the carer's visits. As there were only two team leaders on duty at any time, there could be delays if they were attending to people; emergency calls were prioritised.

Staff had completed training in how to safeguard people from the risk of abuse and poor care. There were also policies and procedures to guide staff and the registered manager in the action to take should concerns be raised with them. In discussions, all five members of staff were knowledgeable about the different types of abuse and all stated they would act if they witnessed abuse or poor practice. The staff were aware of the whistle blowing policy and procedure.

People who used the service had assessments completed to identify potential risks. Those risk assessments seen included nutrition, dehydration, infection leading to confusion, medication, falls, self-neglect and health related issues such as diabetes and alcohol dependency. A risk assessment had been carried out on people's home environment to identify issues such as fire hazards. There were also risk assessments for the use of equipment such as bed rails, hoists and the shower. However, there were some instances when people's risk assessments required more guidance for staff in how to monitor or minimise them. For example, one person was at risk of taking too much medication and although this was known by staff, documentation lacked guidance for them in how to manage this. The same person had a risk assessment for the management of diabetes, falls and declining medical assistance. Some areas were detailed for example, in the description of symptoms of high/low blood sugar levels but there was insufficient information about the actions staff were to take when these symptoms were observed. Similarly, another person had diabetes and an open wound dressed by the district nursing team but limited risk management plans for these issues. These points were mentioned to the registered manager and they told us they would update existing risk assessments.

Staff were recruited safely. Application forms were completed so gaps in employment could be explored; where there were gaps, these were discussed during interview. Two references were obtained where possible but always one from the person's last employer. A check was made with the Disclosure and Barring Service (DBS), which indicated any criminal convictions or cautions and helped employers make safer recruitment decisions.

Staff had access to personal, protective equipment such as gloves, aprons and hand sanitiser, which helped them to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

People told us staff supported them with meals and maintaining their health care needs when required. They said staff knew how to support them and enabled them to make their own decisions. All said staff contacted health professionals for them when required or they could do this themselves.

Relatives had mixed comments about how effective the service was in meeting people's needs and keeping them informed of issues. One relative described how staff had been effective in identifying health issues but had not notified them when the person was taken to hospital for treatment, which meant they had gone unescorted. Another described how staff always updated them if their relative was unwell.

There were mixed comments from health and social care professionals about staff keeping them informed about people's health care needs. Comments included, "I have had several people with deteriorating health conditions and have had positive feedback from families that Hales staff have been effective in their response" and "Patient's needs are not always met with skin hygiene and the application of creams and special hosiery." One health professional described a situation when a person had not received sufficient hydration and the hot weather had added to the impact this had on their health. The registered manager told us risk management plans were to be put in place for this person if required, although they managed their drinks independently.

In discussions, staff told us most people managed their own health care appointments but they described how they contacted people's GPs for them when required. They also told us they contacted relatives to escort them if they were to be assessed at hospital. Staff said they had information sheets to give to paramedics with important details such as the person's date of birth, GP and next of kin. They also photocopied their medication administration record to ensure hospital staff had relevant and up to date information.

People had assessments of their needs, 'My Life, My Way', completed by the local authority before they became tenants at Harrison Park. We saw senior staff used the assessments to formulate care plans to ensure staff had information about meeting people's needs. There were tasks for staff identified in the care plans. Information about call times was sent to staff on special mobile phones, which they used during their care shift. When calls had been completed these were signed off the phone. This method of communication meant staff were informed of their calls and could be sent messages to update them. There was an electronic system for staff to record the start and end of their call time. This was an effective way of monitoring the length of time staff remained for the call and whether the time of arrival matched the approximate time on the care plan.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do this for themselves. The MCA requires, as far as possible, people make their own decisions and are helped to do so when this needed. When they lack capacity to take particular decisions, any made on their behalf must be made in their best interest and as least restrictive as possible.

People's initial assessment indicated whether they had capacity to make their own decisions and there was evidence they had signed agreement to their care plan when they were able to. The registered manager told us people who used the service had capacity to make their own decisions. They said some people may have fluctuating capacity due to their specific needs but they were all able to make day to day decisions. However, one person had fluctuating capacity and some safety issues about leaving the building so the local authority arranged for sensor equipment to be added to a back door; this would alert staff if the person left. There was no evidence of a detailed mental capacity assessment and best interest decision regarding this specific restriction. This was mentioned to the registered manager who told us they would address this straight away or obtain a copy from the local authority.

Staff had received basic training in MCA during their induction and the registered manager had received the training in their previous work position. However, a health and social care professional told us staff had not always reported in a timely way when people had declined personal care because of their learning disability needs or memory impairment so these could be reassessed; they queried the depth of staff's understanding of capacity issues. The registered manager told us they would consider more in-depth MCA training for staff.

In discussions, staff described how they ensured people gave consent prior to care tasks. Staff comments included, "You ask people. If people can't talk then you look for gestures", "You build up rapport and trust; talk to people and communicate with them" and "If we are giving medicines, we ask if they want it. I always let people know what I am doing and ask them if that is okay."

Staff supported people to maintain their nutritional needs and prepared meals for them when part of the care plan. There was also a café in Harrison Park and some people chose to eat their meals there. When asked how they monitored people at risk with their nutritional intake, staff said, "We have charts if required for food and fluid. If they are not eating well, we can ring the dietician; we encourage people but it is their choice." One relative felt staff could offer more choice with meal preparation instead of cooking the quickest option, which had the potential to limit choice. They said, "They [staff] will do what they [staff] want to do for their dinner and not give them choice; it's not often but it does happen.

Staff had access to training, supervision and support. Staff described their induction, which consisted of a week's training and included a range of topics. The training record showed staff had completed the five-day induction, shadowing shifts and competency-based learning for moving and handling and medicines management. There had been some concerns with staff repeating medicines errors even following additional competency assessments; the registered manager told us they were considering how to address this with the specific members of staff. Staff spoken with felt they received sufficient training. Comments included, "I've done my mandatory training and diabetes and epilepsy training. I am doing a customer care course at the moment. There is a board with training up there if we want it; we definitely get enough" and "I have done catheter care and I am booked on specific training next month; we are offered lots of training."

The registered manager told us there had been training specific to people's needs. For example, a speech and language therapist had delivered some training and care of stomas had been arranged for August 2018.

We saw records of themed care staff supervision for areas such as nutrition, safeguarding, medicines management and moving and handling. Themed supervision consisted of a line manager testing staff knowledge of specific subjects, discussing aligned legislation, looking at scenarios and determining development needs and objectives.

Good

Is the service caring?

Our findings

There were positive comments about the staff approach from people who used the service. These included, "They [staff] are always ready to laugh and joke and if I ever have a problem I tell them", "They [staff] get things for people when they need it" and "I see some regulars; they are always pleasant." All the people spoken with told us staff treated them with dignity and respect, and maintained their independence. One person said, and "I have a feeling of being cared for."

Most visitors provided positive comments about staff approach. They said, "I do feel staff are caring" and "They listen and [Name] knows them well."

Health and social care professional's comment's included, "I have seen staff promoting independence, giving privacy and treating clients with dignity" and "The carer was present [during their visit] and seemed nice; they were getting their tea ready." One social care professional said they had on occasion observed staff 'doing' things for people rather than 'enabling' them to do things for themselves. However, they also said, "I have witnessed good conversations between team leaders and people living in extra care which promotes dignity, respect, choice and control."

Staff had a good understanding of how to promote privacy and dignity. They said, "I make sure curtains are closed and cover people with a towel [during personal care]; make sure other people can't come in", "You have to be careful about communication and don't talk about personal things" and "If people are on the phone, go out of the room so you are not listening."

People who used the service all lived in independent flats but all required some level of support or oversight to ensure their safety and wellbeing. This support ranged from emergency cover only to several calls a day from care staff. Some people were very independent and others required physical assistance to meet their needs. Staff told us they tried to involve people to ensure they remained as independent as possible. Comments included, "I try to encourage people, sometimes saying things like 'I'll wash and you dry the pots'; they'll then get involved", "We let them do what they can for themselves as much as they are able to" and "We ask people what they actually need help with and don't just do it for them." People who used the service said, "I go to the shops on my own but a carer can go with me", "Yes, [is independent] but there is help if I need it" and "I go shopping and I do my own ironing; I do what I can."

Staff had received training in equality and diversity during their induction. One staff said, "I treat people with respect and don't judge them. You have to talk in a nice manner to people and gain their trust." One member of staff described the methods in place to assist people who had communication difficulties. These included electronic equipment, and knowing how specific people communicated their needs through non-verbal means; these included facial expressions and gestures and the use symbols. The registered manager told us they would look at using the themed supervision sessions to incorporate equality and diversity to ensure staff had good knowledge of people's protected characteristics such as age, sexuality and cultural needs.

Staff were aware of the need to maintain confidentiality. People's personal care records were held in their own homes and held securely in the main office. Staff personnel files were held securely. There was an office so the registered manager or team leaders could hold telephone conversations in private. Computers were password protected to ensure only appropriate staff had access.

Good

Is the service responsive?

Our findings

Out of the 10 people we spoke with, eight said that staff had time to support them in the way they preferred, one said call times had been adjusted and they were much happier and the last person felt the visits passed too quickly although their needs were met. People told us staff had been responsive to their needs and they had been involved with their care plan. Comments included, "It [care plan] is up-to-date; they reviewed it a few days ago" and "Somebody renewed the care plan yesterday."

Relatives said that on the whole people received the right support and how they wanted it to be delivered. Comments included, "They do change things if I tell them what [Name] is worried about" and "Yes, they involve me in reviews."

A social care professional said, "I have had positive feedback from Hales staff when someone has deteriorated or there is an issue. If regular carers are attending this gets picked up quicker. Hales do ask for more support if needed but they need to be clearer on what they are asking for and why so we can request it." They also said on occasions Hales staff had left issues 'a little too long' and had asked them to contact them sooner. Another social care professional described how staff had responded to concerns they had raised during a visit to a person; at the next visit they noted improvements had been made. They said staff had been extremely supportive and responsive and escalated concerns to relatives regarding a specific person.

People who used the service had an assessment of their needs completed by the local authority prior to taking up their tenancy at Harrison Park; this was called 'My Life, My Way'. There was also information provided to a panel, which assessed whether people met the criteria for extra care support. The local authority told us the assessment, 'My Life, My Way' was sent to the service once tenancy had been agreed. The 'My Life, My Way' information was designed to enable staff to complete risk assessments, check if the person's needs had changed and to devise a care plan with them to meet their needs.

There was also an assessment completed by the registered manager or team leaders at Harrison Park. Part of the assessment included key issues such as people's personal histories. These helped staff see them as people and not just as the recipients of care tasks. The ones we saw showed us people had been involved in the assessment process, as they described family arrangements, previous employment, preferences for activities and what they could do for themselves. The information enabled staff to quickly see what support was needed.

The registered manager and team leaders were in the process of updating care plans to ensure they included full information about people's assessed needs; this helped to ensure staff had up-to-date information about how to support people in ways they preferred. We saw the support plans were written in a person-centred way and some were very detailed about the tasks staff were to complete. For example, one included detailed information about a person's health care needs in relation to diabetes; it described signs and symptoms to look out for and the action staff should take if they observed them. Others required more information to ensure they included important details. For example, one person used various means to

communicate with people but they had no plan in place for when their preferred communication method failed'. When checked with staff, they were aware of how the person communicated their needs.

The provider had a policy and procedure on end of life care. The registered manager told us people could receive end of life care whilst living in their own home and supported by community services. A social care professional told us that initially it was felt the provider could not support people with end of life care but this had now improved.

Staff recorded the daily tasks they completed for people. Some of these were noted to be informative and written concisely. People had reviews of their care so changing needs could be responded to.

The provider had a complaints policy and procedure. People were provided with information on how to make a complaint when they started to receive a service from the provider at Harrison Park. There was a specific form for staff to record complaints and log the action taken. The complaints log showed the registered manager sent acknowledgement letters to people, completed investigations and informed complainants of the outcome. People who used the service told us they felt able to raise concerns if required. Comment included, "I see seniors if I am not happy with visit times; I go and tell them." Other people mentioned the name of the registered manager and told us they would raise concerns with them. Relatives told us they felt able to raise concerns with staff.

A social care professional told there was some confusion for people about who to complain to for certain issues. Some of these would not relate to the provider but to the housing organisation, Riverside. The registered manager had been proactive and told us there were regular meetings held with Riverside staff where issues relating to their tenancy could be raised by people who lived at Harrison Park.

Requires Improvement

Is the service well-led?

Our findings

Some people knew the registered manager's name and others spoke about the team leaders as the 'managers' of the service. Comments included, "I don't know their name but I think they do a good job running the place; they are approachable", "I like them and I can have a laugh with them" and "They run the place fine for me; there are no faults." Relatives said they were kept informed and could see the registered manager when required.

One social care professional told us the registered manager had helped some people understand the type of support available in an extra care service as some had differing expectations of what care support within Harrison Park would look like. They had raised expectations about the level and frequency of support provided by the two team leaders based in the service day and night for emergency calls.

The management team had developed relationships with other professionals involved in people's care. However, there were comments from health and social care professionals that this could be improved. One social care professional felt there could be improvements regarding more timely communication with their team when people were not accepting of support. Health care professionals also felt communication could be improved between management and community teams, as well as access to the building when Riverside reception staff were not on duty. The registered manager told us they would arrange a meeting with health care professionals, Riverside staff and the Hales management team to try to resolve the issues.

There was a quality monitoring system which consisted of audits, spot checks of staff practice and competency assessments for areas such as moving and handling and medicines management. We saw the audits of people's medication administration records identified errors and gaps. Staff had been spoken with and competency assessments undertaken again with them, however, the errors continued. This meant people were at continued risk of harm as they were not receiving their medicines in line with the prescribing instructions. However, it was evidenced that the registered manager had taken a more robust approach and removed staff from the administration of medicines to people. They told us they had taken disciplinary action with one member of staff.

There were also some concerns raised with monitoring records for areas such as food and fluid intake. We saw gaps in completion of these records which was also confirmed in information provided by health and social care professionals. Although risk assessments had been completed and risk identified, some of them needed more information to guide staff. These issues had not been identified and rectified via the quality monitoring system.

Not ensuring a more robust system of governance and full and complete records was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were other audits which had led to improvements, for example in care plans; the personal histories of people were well written and informative. There were also surveys each month of a selection of people's views; these included both people who used the service and staff. After each survey, the results

were collated and a section completed to demonstrate the action taken.

The registered manager told us the organisation had an open culture and they were well-supported by the regional manager and senior management team. There was an organisational structure with tiers of support. The provider's nominated individual had visited the service and was available when required. There had recently been a visit completed by a quality manager, who reported their findings to the registered manager and provided advice on the action to take to address them. The registered manager told us these were to become regular quality visits to help improve the audit process; particular attention was to be paid to the safe management of medicines. The registered manager attended meetings monthly, specifically for managers, for support, an exchange of information and networking.

The registered manager described their management style as fair and approachable. In discussions staff confirmed this. Comments included, "[Name of registered manager] is lovely", "Yes, definitely [supported]", "You are supported and if you needed a care call covering, they would do that for you" and "We are encouraged to be honest; I always feel I can say if I have done something wrong." When asked if improvements could be made, staff mentioned areas such as consistent call rounds. Some staff confirmed they had attended meetings, others had not done so yet. They said they received positive feedback at meetings as well as areas to improve. Staff were provided with a handbook, which described expected ways of working and highlighted relevant policies and procedures.

There were incentives for staff to remain working for the provider and an 'Employee Portal' for them to access which provided information about benefits and news. There was a Hales Hero Award given for staff meeting specific criteria of reliability, providing quality care and being professional. Those nominated were entered into a monthly draw and had the opportunity of winning £1000. This was a good example of the provider valuing staff and recognising and acknowledging positive achievements. Other benefits included child care vouchers, access to store discounts and remuneration when staff 'refer a friend' which results in recruitment.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not ensured medicines were administered accurately and in accordance with the prescriber's instructions.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not always ensured there was an effective system of governance and quality monitoring in place. There were shortfalls in some recording systems. The registered persons had not consistently ensured complete and contemporaneous records were maintained.