Voyage 1 Limited

Voyage (DCA) Wiltshire

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 1, 2 and 7 August 2018. The inspection was announced and the service was given 48 hours' notice to ensure a member of staff would be present.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger adults who have learning disabilities, autism and/or physical disabilities.

People using this service live in single houses of multi-occupation across Trowbridge and Salisbury. Houses of multiple occupation are properties where at least three people in more than one household share a toilet, bathroom, or kitchen facilities. Staff support people with personal care, medicines, cooking, shopping, activities and other day to day tasks.

At the previous comprehensive inspection, on 12 and 18 July 2017, the agency was rated as requires improvement. We found the service had not complied with Regulations 9 and 11 of the Health and Social Care Act Regulations 2014. We found care plans were not always person centred and did not give staff guidance on how to meet people's changing needs. We also found the staff were not following the principles of the Mental Capacity Act (MCA). The provider wrote to us, explaining the actions they would take to meet the requirements of the legislation. At this inspection we found some improvements had been made. We made a recommendation about staff attending training in the principles of the MCA.

This is the second consecutive time the service has been rated Requires Improvement.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy.

The current manager was undergoing the process to be registered with CQC. 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.

Medicine systems were not always well managed. Staff that administered medicines had attended appropriate training. We saw records of administration were mostly signed to show medicines administered. For one service, the records of administration were not consistent with the directions noted on the medicines in stock. Also, staff were not always signing records when topical prescriptions, such as creams and lotions were applied. The manager took prompt action to ensure people were having their medicines as prescribed.

The staff were not given clear guidance on when to administer medicines prescribed to be taken. as "when required" (PRN). Where protocols were in place we observed that staff did not follow the guidance or updated the protocols to reflect current practice.

Care plans and risk assessments were combined. Where risks were identified action plans on how to minimise the risk were devised. Care plans had aspects of person centred approach.

Guidance from healthcare professionals to support people's behaviours, was not always followed. We found that at one service, people did not receive support in accordance with what was recorded in their care plan.

There was an online system of reporting incidents and accidents. However, copies of the incidents were not always completed and a review of the care plan was not triggered for re-occurrences of the same incident. This meant people's needs were not reviewed to develop action plans that prevent or reduce the potential of the same incident from reoccurring.

Staff knew the day to day decisions people were able to make. One person told us the day to day decisions they made. We observed staff giving people choices about their meals and activities.

Mental capacity assessments were not always in place where people lacked capacity to make complex decisions. For example, decisions regarding the use of lap belts, administration of medicines and clothing used to alter behaviours. Members of staff accepted decisions made by relatives on behalf of their family members, without first ensuring they had the legal power to make them.

Quality assurance systems were in place to assess and monitor service delivery. An action plan on improvements was developed from a recent assessment of the service. The manager's awareness of current risks were not always from process used to monitor and assess system delivery. Some documents had not been analysed and had not been the means used to prioritise or identify where improvements were needed. For example, analysing incidents and accidents. During the inspection we also identified that medicine systems needed improvement in one service. A new format template for weekly meetings with field supervisors was to be introduced to ensure the office staff were aware of people at greatest risk.

The people we spoke with told us they felt safe with the staff. Relatives also felt their family members received safe care. We observed people responded well while in the company of staff and during interactions. Staff told us they had attended safeguarding training. They knew the signs of abuse and the expectations on them to report allegations of abuse

The people we spoke with said the staff were "good". During our visits we observed the staff addressed people by name and with people participated in activities. Staff knew how to respect people's rights and relatives said staff were respectful.

One person told us there were staff shortages, but the staff that supported them were regular. Some relatives and staff said there were staff shortages and we noted in one service staff worked long hours.

New staff received an induction to the service, this process ensured they were confident in their role. Staff were positive about the training they received. There were mandatory training sessions for staff to attend as part of their role. The staff we spoke with told us they had regular one to one supervision meetings with their line manager.

Healthcare visits were arranged by relatives, or by field supervisors where necessary. Staff said they were

kept informed about visits from healthcare professionals. Copies of healthcare professional's visits were kept in care files. Health action plans and hospital passports were in place.

When complaints were received, the manager had investigated them according to the policy and procedure. People knew who to contact if they had concerns.

Staff told us they worked well together as a team. The staff were positive about the manager and the improvements that were taking place. However, they told us there had been many management changes and this had impacted on the morale of the staff.

There were links with social and healthcare professionals. These professionals told us their input was sought in a timely manner. We were told of instances when their advice was not followed. However, one social worker told us the staff on other occasions "communicated effectively and completed assessments before an admission to a service. The assessment was thorough and the approach that was used was on the correct level for the person."

We found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicine management systems needed improvement. Guidance on the purpose of medicines was not provided to staff. Protocols for 'when required' medicines and topical creams lacked guidance on when to administer them. .

Where risks were identified combined care plans and risk assessments were developed. However, staff were not following guidance given by healthcare professionals when people presented with behaviours requiring additional support.

People said they felt safe with the staff. Staff knew the procedures for the safeguarding of vulnerable adults from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The staff were not always following the principles of the Mental Capacity Act 2005. People's capacity to make complex decisions was not always assessed. Staff acted on decisions taken by relatives without first establishing they had legal powers to make these decisions.

Staff had access to a range of training to ensure they had the correct knowledge and skills to provide people with the appropriate care and support.

There were opportunities for staff to discuss their personal development with their line manager.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring. We saw positive interactions between staff and people using the service

People told us the staff respected their rights. Members of staff

were knowledgeable about building relationships with people and why this was important.

Is the service responsive?

Requires Improvement

The service was responsive.

Care plans were mostly person centred and action plans gave staff guidance on how to meet people's needs. However, guidance was not always followed by staff.

People told us they knew the complaints procedure and who to approach with their concerns.

Is the service well-led?

Requires Improvement

The service was not well led

The quality assurance systems in place were not fully effective. Copies of records returned to the office were not always analysed for patterns and trends. This meant the manager may not become aware of risks in a timely manner.

Members of staff worked well together to provide a person centred approach to meeting people's needs

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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.'

This inspection took place on 1 and 2 August 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 1 and 2 August 2018 and ended on 7 August 2018. It included visits to three services and during these visits we spoke with people and staff, there were phone interviews with people, relatives and healthcare professionals. We also used questionnaires to gain feedback from staff and social health care professional. We visited the office location on 1 and 2 August 2018 to see the manager and office staff; and to review care records and policies and procedures.

This inspection was carried out by one 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.

Before the inspection, we reviewed all the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

We spoke with two people and observed four people during our visits to the services. We also spoke with one person and seven families by phone. We spoke with the manager, area manager and two senior managers.

We sent questionnaires to 20 staff to gain their feedback and received three responses. We spoke with two field supervisors and two support workers.

We looked at documents that related to people's care and support and the management of the service. We

reviewed a range of records which included four care and support plans. We reviewed the staff matrix provided, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises we visited and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

Medicine systems were not always managed safely. We checked medicine systems in two houses. We found the medicines in stock were not consistent with the records of administration. This meant people may not be receiving their medicines as prescribed.

We found staff were not signing medication records to show topical creams and lotions were applied as prescribed. Where PRN protocols were in place they lacked detailed guidance on when staff were to administer these medicines. For example, the pain relief PRN protocol for one person stated the medicine was for "pain relief" and to be administered "if there are signs of pain". For another person the topical cream protocol instructed staff to apply "as frequently as needed." Good practice guideline recommend that PRN protocols should detail the purpose of the medicines, the symptoms to look out for and when to offer the medicine. The person's ability to ask for the medicine should also form part of the protocol. For example, if they need prompting or observing for signs of need for pain relief such as non-verbal cues.

PRN protocols were not updated to reflect the current practice. During our inspection we observed the staff response to one person when they verbally expressed pain and pointed to where the pain was. Staff told this person to drink water and disregarded their expressions of pain. The PRN protocol for when to administer pain relief stated "when xx expresses pain or his behaviour indicates he is in pain, may point to the parts of his body that is painful. XX may cry and point to the area when asked if he is in pain." The communication care plan also stated how the person expressed pain "generally do this by tapping his head as an indication he is in pain. Staff will try to decipher where the pain is by using yes and no." Members of staff told us "managers and relatives" had told staff that the behaviours were "attention seeking and staff were to offer water." However, this information was not detailed in the protocol. We made the manager aware of our findings.

There were people who at times presented with behaviours that staff found difficult to support. The staff had sought input from healthcare professional for one person on developing strategies to manage these situations. The daily notes showed the staff were not following strategies in place when these behaviours were presented. For example, staff were to offer personal time, give clear directions and provide structured activities.

Recording of inappropriate behaviours showed that "little sensory stimulation and boredom" were the cause of some behaviours. However, the risk assessment and care plan was not reviewed following these incidents. The healthcare professional involved with this person told us the staff had sought their input in a timely manner. They said that while staff were provided with suggestions on how to support the person, strategies were not implemented. For example, there was a lack of "good reporting to access trends and antecedents, structured activities and lack of outcome focus".

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

For another person there were clear strategies in place for staff to follow when the person became anxious or agitated. Strategies made it clear that the behaviours presented were a means of communication. Guidance included a description of the person's usual behaviour and their likes and dislikes. Detailed were the triggers, such as an inconsistent approach, lack of control and medical conditions. Also described were the signs that alerted staff to the person becoming anxious and how staff should respond. For example, staff were to give the person space. When behaviours escalated, the staff were to ensure other people were not in the vicinity and to give the person an opportunity to remove themselves from the situation.

Some people were receiving care and treatment from staff that were working long hours due to staff shortages. Also staffing levels in some services were maintained with external agency staff. Some relatives said there were "issues in terms of consistency." One relative told us there was "no continuity of staff" and their family member was sent home because there were insufficient staff to cover the hours needed. The manager told us there were changes in the deployment of staff which reduced the use of external agency staff. Over recruitment was to take place to ensure staff were able to cover shortfalls in staffing levels. For example, annual leave and training. This manager gave us their reassurances that external agency staff worked with permanent staff to maintain continuity.

A member of staff responsible for devising rotas told us that each person had "independent support assessments" that gave the hours that were to be commissioned by the Local Authority. Rotas in place showed that staff worked shifts of 7am to 4pm and 4pm to 10pm.

Individual risks to people were assessed and action plans were developed to supported them to stay safe. Staff told us and records confirmed they had attended moving and handling training. For people with mobility needs, combined risk assessments and care plans were in place for safe moving and handling procedures. For example, the moving and handling care plan for one person detailed the number of staff needed for each transfer. The mobility equipment used by the person and for transfers were also detailed in the assessment. People's ability to reposition themselves was detailed in their moving and handling care plans and where support was needed with repositioning the frequency was included.

A member of staff told us how people's individual risks were minimised. They told us guidelines ensured people were protected from harm. For example, soft foods were served where people had difficulties with swallowing.

People we spoke with told us they felt safe with the staff. We observed in one service people seek staff attention and smiled when staff joined them in activities. The staff we spoke with told us they had attended safeguarding of adults training and records confirmed this. Staff knew the types of abuse, how to identify the signs of abuse and to report their concerns.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection, in July 2017, we found a breach of Regulation 11 of the Health and Social Care Act Regulations 2014 Consent to Care. This was because we found that staff had not followed the principles of the Mental Capacity Act. Mental capacity assessments were not always undertaken to assess people's capacity to make specific decisions. Also, staff did not consider whether relatives had the legal power to make decisions as part of the assessment process. The provider wrote to us telling us that additional checking and reviewing of assessments would take place to ensure ongoing compliance with the principles of the Mental Capacity Act by November 2017.

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.

Although we found some improvements at this inspection people's capacity to make complex decisions was not always assessed for some people. For example, administration of medicines and the use of lap belts. Records showed that relatives made decisions on behalf of their family members but staff were not aware if they had the legal powers to make complex decisions. For example, a health screening document for one person stated "mum acts in best interest. Staff to check with mum about factors that may increase risk." For another person relatives had provided specialised underwear to prevent a specific behaviour. The use of the specialised underwear may have restricted the person's freedom. There was no evidence to show the relative had legal powers to make these decisions. This meant people's mental capacity was not assessed and best interest decisions taken for complex decisions where they lacked capacity.

Some mental capacity assessments were undertaken by social workers for complex decisions. For example, personal care and medicines. For some people their abilities to self-administer their medicines were assessed. Where people lacked capacity the best interest decision taken was for staff to administer medicines.

One person told us the daily decisions they made and who supported them with more complex decisions. Training matrix showed that except for one the staff had not attended MCA training. The "staff information" booklets in the agency office gave staff brief information on MCA principles.
We recommend that the service finds out more about training for staff, based on current best practice, in relation to the principles of the Mental Capacity Act 2005.

Where people were referred to the agency for support their physical, mental health and social needs were assessed to ensure they received consistent support. Social workers comprehensive assessments were provided to the home before an admission. For some people, initial assessments gave detailed information about the person. These assessments were used by managers to base their decisions on staff's ability to meet the needs of people referred to them for support.

The staff employed by the agency attended relevant training to ensure they had the skills needed to deliver effective care and support. Staff told us training had improved. A member of staff said their induction was for one week and they felt confident to undertake their role. They said, "training is good". There was an onsite trainer, which meant staff not meeting the required standards could be referred for refresher training." The training matrix showed staff attended courses in autism awareness, basic life support and MAPA (Management of Actual or Potential Aggression verbal de-escalation techniques and physical disengagement techniques on how to respond to strikes and holds).

Staff's performance, including their training needs, was monitored and they received support from their line manager with their personal development. Staff told us they had one to one supervision meetings with their line manager. They told us supervisions were six to eight weekly and during their one to one meetings, concerns and performance was discussed. A member of staff told us they were registered on training to gain professional qualifications, as part of their professional development.

People were supported to eat and drink enough to maintain a balanced diet. During our visits we saw staff offer snacks and refreshments and offering people choices of meals. We saw staff prepare the meals and assisting people to eat their meals. Staff told us they prepared individual menus.

People were supported to live healthier lives, they had access to healthcare services and received ongoing healthcare support. Staff told us for some people the relatives arranged and accompanied their family member on healthcare visits.

The Government said that people with learning disabilities sometimes have more health problems than people without a learning disability. The Government also said that some people with a learning disability find it hard to access mainstream health services and that sometimes their health needs are not met.

Health care action plans were in place however for some people their action plans were incomplete. Where people had medical needs their health action plans did not detail how their health care needs were to be met. This meant that people may not be supported to access appropriate healthcare services in all areas.

Where healthcare professionals had input into people's care we saw copies of their correspondence in care records. We saw guidance was given to staff on how to support specific medical conditions. For example, epilepsy profiles listed the types of seizures experienced along with guidance on how to support the person with each type of seizure.

Hospital passports that assist medical staff to communicate with people in the event of an hospital admission were in place. Within hospital passports was information on "what staff must know about them," such as contact details of family members and "what staff need to know" about them. For example, medical conditions and prescribed medicines. Where people's likes and dislikes were listed, medical staff were informed about the person's preferences on how their needs were to be met.

Good

Is the service caring?

Our findings

The people we spoke with said they were treated with kindness. One person said, "they've been absolutely brilliant" and most staff try their best". We visited three locations and found the staff treat people with kindness and respect. We observed staff giving people choices from options available and explaining to people the tasks they were about to undertake.

Relatives we spoke with told us the staff were caring and kind. A relative described the staff as being "encouraging, considerate, fun, engaging" and, "can't speak highly enough of them." While relatives were in agreement that the staff were kind and caring, they also were concerned about the management of the agency due to frequent changes.

We observed staff addressed people by name and when we visited one location we were welcome into the home by one person. However, we observed staff using terms of endearment such as "buddy" which people at the service may not understand.

The staff we spoke with told us it was important to understand people preferences. A member of staff said support plans provided guidance and "it was important to understand people to make sure their wishes were met which ensured information was not misinterpreted." Another member of staff said, "We read the care plan, meet friends and family if possible, attend social functions, and discuss [people] in depth. We keep diaries for historical referencing on every [person]."

The manager told us how they ensured people were cared for in a kind and compassionate manner. This manager said, "I visit services weekly. People want to give me feedback. I sit with people and have a chat. I explain to people what is happening. I observe practice and observe for a caring approach." Staff received feedback from the manager when their actions were observed not to be caring. A field supervisor told us, "We try and spend time in services, by being part of the routine. We build a good rapport with people. I have worked hard to build trust with people."

Some relatives said they were kept informed about important events or appointments. While others said they were not always told about events and appointments. A relative said the majority of the time they "find out about events and appointments accidentally", once they've already taken place.

The staff were aware of people's rights and how these rights were respected. A member of staff told us they "listened to people about their wishes" and strived to support them in their preferred manner. This member of staff said people were encouraged to be independent and "given opportunities to share their opinion and express their views in a way that can be understood". Another member of staff told us they always asked people before delivering personal care. Care plans in place gave staff direction to respect people's privacy and dignity. For example, one person's preference was for female staff to deliver personal care.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection, in July 2017, we found a breach of Regulation 9 Health and Social Care Act Regulations 2014 Person-centred care. We found that care plans were not always specific on the plan of care and action plans were not person-centred and did not give staff guidance on people's preferences. The provider wrote to us telling that by September 2017 all support plans were to be person centred. At this inspection we found some improvements were made.

One person told us their goal was to stay at home without staff support. Another person told us they were asked if they wanted a care plan, however they were unaware if a care plan had been developed. Staff told us care plans told them about people's preferences and gave them guidance on their how care was to be delivered. A member of staff said relatives were approached for information where people were unable to tell them about their preferences. Another member of staff told us that all "staff should be involved in developing care plans. People are involved [with developing care plans] to ensure they are happy with the support they receive."

Care plans had aspects of person centred care. For some people, there were one-page profiles that detailed "what people liked" about them, "What was important" to them and "how to support" them. For one person their personal care plan stated "likes to wear bright colours especially purple. XX likes to have hair brushed and to look good." For one person there was a social history that described their family and friends network and education.

Communication care plans gave staff guidance on how to present information in a way that people understood. For one person the communication care plan stated that staff "were to present information in a clear and simple way". The person used Makaton (form of symbols and words) and pictures to communicate. However, guidance was not always followed. For example, the communication care plan for one person stated that staff were to take photographs of facial expressions. The staff we asked said this was yet to be "organised". For another person, the care plan stated that communication aids were used, but staff said this was "not used". This meant people's care may not be responsive to their needs.

Daily notes were used by staff to record the care delivered, activities and any visitors the person had seen. For example, for one person the staff described the support offered and how the person responded. It was evident from the daily notes that people had limited opportunities for structured activities when there were holidays from colleges and day centres. A healthcare professional also told us that during holidays from college there was a lack of structured activities for one person. During a visit to one house staff suggested playing video games with one person. At another house one person played table football against the staff.

The manager told us people living in shared houses joined clubs, went to pubs and supported their football team. One person was successful in joining the Police force as a volunteer. There was a "good news stories" file that included photographs of people participating in activities. For example, pet assisted therapy, visits to places of interest and attending discos and BBQ's.

The responses from relatives about raising concerns were varied. Some relatives told us they were confident to raise concerns, or they have done in the past. While others told us that they didn't know who to go to with concerns, or how to make a formal complaint. A relative told us they had no complaints or suggestions, saying "the staff were great at the job they're doing".

The biggest issue raised by relatives was the consistency of staff, they suggested having staff who are "more understanding, better at communicating and more family orientated." However, another relative told us "the staff are thoughtful, family orientated, committed to their job and daughter is happy." The manager told us there were two complaints from relatives that was being investigated.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection, in July 2017, we rated Well Led as Requires Improvement. We identified that while quality assurance systems were in place, these were not always effective. At this inspection we found quality assurance systems to be more effective however more improvements were needed.

The manager told us the organisation's quality team undertook the most recent assessment of the service. A detailed and "consolidated" action plan was then developed from the assessment, based on quality, risk management and care delivery. Where shortfalls were identified, an action plan was developed. Within the action plan were the staff identified to complete the actions, the date of completion which senior managers signed to confirm the completed action.

The approach to quality did not always cover all areas of care delivery and managers were not always aware of potential risks that may compromise quality. While systems were audited we noted that not all areas identified for improvement at the inspection had been identified by the provider and was therefore not included within the consolidated action plan. For example, the provider had not identified that staff were not always following guidance from professionals when supporting people with difficult behaviours. Audits had not identified that staff were still not following the principles of the Mental Capacity Act (MCA) to ensure decisions were made in people's best interest. When we identified issues with medicines, the manager took immediate action to ensure people's safety. For example, ensuring people were receiving their medicines as prescribed. During our inspection the manager developed feedback forms to be used during weekly meeting meetings with field supervisors to ensure areas of potential risk were discussed.

There was an online system of reporting accidents and incidents as well as safeguarding of abuse concerns. The staff assigned for action depended on the impact level. For example, senior managers and the quality team were copied into accidents and incidents reports scored at high level. However, we saw that some accidents and incident reports were not fully completed. There were no further actions where there were repeated incidents and where there was evidence of staff not following guidance. For example, for one person, the incident reports stated the triggers to the behaviours were due to "little sensory stimulation". Another incident report stated that staff had delivered personal care when the person resisted. This meant patterns and trends were not identified so that action could be taken to prevent or reduce the potential of the same incident reoccurring .

We spoke with "transitional" managers whose role was to support staff to improve specific packages of care. For example, for one service a field supervisor and transitional manager were assigned to support staff to deliver complex packages of care. For a new service an action plan was developed to help with the transition which included team building for core staff and to identify local activities for people.

While some relatives said the office staff were contactable, other relatives told us improvements were needed, especially with the consistency and communication of staff. Staff told us there was good working relationships, but "sometimes the information isn't communicated between the support team and management team." Another member of staff told us they had regular contact with their field supervisor.

They said this field supervisor "will address all issues big or small with a sense of urgency. She is very supportive and ensure the procedures are followed exactingly."

A manager was in post and undergoing the process to become registered with CQC. The manager told us there was an "open door" policy and said, "I show respect and expect it to be mutual." This manager said the current challenges included operating a service in a rural area, which meant the geography had to be considered when prioritising workloads for staff. Recruitment of staff was another challenge that has been "eased with the recent appointment of new staff."

Although staff said the current manager was approachable, they said there had been many changes of managers. Some staff said many staff had left and new staff were recruited. A member of staff said there has been some friction between staff and "there are high levels of sickness. They said, "I am part of the change" as this staff member was recently recruited, and also that "it's been hard for staff". Another member of staff said the staff have a lot of confidence in the manager. They told us, "It's been stressful but we now have an [office] team that can do the staff rotas. There is loads to do but its more manageable. It's a fresh new outlook and I am glad I stayed."

Values of the organisation include, 'empowering', 'together', 'honesty', 'outstanding' and 'supportive'. The staff we spoke with knew the values of the service and how these were embedded into practice. A member of staff told us, "everyone is different and are treated equally." Another member of staff told us, "I follow the job description."

The manager told us there was reflective practice to ensure learning from events was shared to promote better outcomes. This practice was at all levels which included senior managers, peers and with field supervisors during weekly "catch ups". The manager also told us, "we are growing, we are visible and we are meeting contracted hours. We are seen as competitive" and staff benefits were good. Then stated, "People enjoy us [staff] supporting them and people want to us to support them."

There were links with community resources. The manager told us there was regular contact with social and health care professionals such as the Community Team for People with Learning Disabilities and colleges. The manager attends care forums to build networks with professional and with other managers share ideas and discuss experiences.

Social and healthcare professional told us their input was sought in a timely manner. While we were told of instances when their advice was not followed a social worker told us of other occasions when staff "communicated effectively and completed assessment before an admission to a service. The assessment was thorough and the approach that was used was on the correct level for the person."

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 Medicine systems were not always managed safely. Records of administration were not always consistent with medicines held. Medicine records were not always signed when topical creams were applied. Protocols for medicines prescribed to be taken when required lacked detail and were not updated when people's needs changed. When people presented with inappropriate behaviours staff were not following the guidance.