Nestor Primecare Services Limited

Allied Healthcare Stafford

Inspection report

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02 July 2018

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

Summary of findings

Overall summary

We carried out an announced inspection at Allied Healthcare Stafford on the 20 June 2018, 21 June 2018, 25 June 2018 and 2 July 2018. This was the first ratings inspection since the provider had registered with us in September 2016.

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 disabled adults. At the time of the inspection there were 51 people receiving a service.

Not everyone using Allied Healthcare Stafford receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager at the service who was also a registered manager at another location under the same provider. 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.

We found that there were not effective systems in place to monitor and manage the service. This meant there was a risk that unsafe and ineffective care was not always identified and acted on. People's records did not always contain accurate and up to date information and improvements were needed to ensure there were effective communication systems in place.

People and staff told us there were not sufficient staff available to provide support in a consistent, unrushed way that met people's preferences. Improvements were needed to ensure unfamiliar staff were aware of people's risks to enable staff to lower the risk of harm.

The provider was not always following the principles of the Mental Capacity Act 2005. This meant that people were at risk of receiving care that was not in their best interests. We found that staff had received training. However, improvements were needed to ensure staff were trained to meet people's specific needs. Improvements were needed to ensure staff were aware of changes in people's needs and people's preferences were not always met as recorded in their plans of care.

The provider had systems in place to gain information about people's cultural and diverse needs to enable a holistic approach to people's care. The provider had safe recruitment procedures in place which ensured people were supported by staff of a suitable character.

People were supported to eat and drink sufficient amounts and nutritional risks were assessed and monitored. People's health was monitored and health professionals input was sought where needed to

ensure their wellbeing was maintained. Staff were aware of their responsibilities to protect people from the risk of harm and infection control measures were in place to protect people from the potential risk of cross infection.

People's choices were promoted and respected by staff in a way that promoted people's individual communication needs. People's dignity was maintained and their right to privacy was upheld. People and relatives knew how to complain and the provider had a complaints procedure in place.

Staff felt able to approach the registered manager and felt supported in their role. Staff performance was monitored and discussed to ensure people received their planned care. The registered manager was aware of their responsibilities of their registration with us.

We found there were two breaches in Regulations 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 consistently safe.

Improvements were needed to ensure topical medicines were managed safely. Improvements were needed to ensure people received support from a consistent group of staff at a time they needed it. There was not always sufficient guidance for new or unfamiliar staff to follow to ensure they understood how to support people with their risks.

Staff who visited people regularly knew people's risks and how they needed to support people safely. Staff were aware of their responsibilities to protect people from the risk of harm. Safe recruitment procedures were in place and infection control measures were in place to protect people from potential infection risks. Procedures were in place to ensure lessons were learnt when things went wrong.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure people's ability to consent to care was assessed effectively.

Improvements were needed to ensure staff had the knowledge and skills required to support people effectively.

People's diverse needs were considered in the assessment of their needs to enable effective planning of their care.

People were supported to eat and drink sufficient amounts and their nutritional risks were managed.

People's health was monitored and health professionals input was sought where needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Improvements were needed to ensure that people received unrushed and consistent support.

People were able to make choices that were respected by staff. Staff understood people's communication needs and supported people to make choices in line with their individual way of communicating.

People's dignity was maintained and their right to privacy upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some improvements were needed to ensure people's preferences were recorded and they were kept informed when changes were made to their planned care.

People knew how to complain and complaints were managed in line with the provider's complaint policy.

People's care was reviewed to ensure they received care that met their changing needs. However, improvements were needed to ensure that people's records were updated with this new information.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements were needed to ensure that effective systems were in place to monitor the quality of the service provided to ensure people received their assessed care. Records were not always accurate and up to date.

Improvements were needed to ensure changes in the service were communicated effectively.

The manager was aware of their responsibilities of their registration with us and informed us of any incidents that had happened at the service. The registered manager worked in partnership with external agencies.

Staff felt able to approach the registered manager who was supportive and their performance was monitored.

Allied Healthcare Stafford

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 was 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.

We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the registered manager would be in. We also needed to ensure that consent was gained from people who used the service to enable us to make telephone calls to them.

Inspection site visit activity started on 20 June 2018 and ended on 02 July 2018. This included telephone calls with people and/or their relatives and we called staff to assess their knowledge of people they supported and the procedures they needed to follow. We visited the office location on 20 June 2018 to see the manager and office staff; and to review care records and policies and procedures.

Before the inspection we reviewed the information included we held about the service, such as feedback from staff and people. We also checked any notifications we had received from the provider about events that had happened at the service, which the provider is required to send us by law. For example, serious injuries, safeguarding concerns and changes to the service provided.
We spoke with 11 people who use the service and five relatives. We also spoke with five staff, the registered manager, the care delivery director and the head of quality management and compliance. We viewed six records about people's care and records that showed how the home was managed. This included training and induction records for four staff employed at the service.

Requires Improvement

Is the service safe?

Our findings

People could not be assured that there were sufficient staff available to provide their commissioned care according to their individual preferences. People and relatives we spoke with gave mixed experiences of the staffing levels. Some people told us that staff arrived on time and stayed for the amount of time they needed them. One person said, "The staff are mostly on time. All the details are in the care plan and they call within a half an hour time slot. They are mostly on time and I know all of the staff who come". However, some people told us that staffing levels were an issue and they often had late calls and staff were rushed. One person said, "The morning calls seem to be okay and on time. There seems to be a problem in the evening as staff are regularly running later. They can arrive at any time between 7p.m and 9p.m so I don't know when to expect them and who is coming. The schedule doesn't always tell me either". A relative said, "The service is very haphazard and staff are not punctual. We don't always get regular carers. We have sometimes had to cancel because of the lateness of the calls". Another relative said. "Weekends seem to be a problem. We have no concerns in the week but we get different staff on a Sunday. My relative doesn't know them well so it's difficult to trust staff when you don't know them". We viewed the rotas for five people and they showed that people did not always receive care from consistent staff. For example; in a week period one person received care from eight staff from the provider's other branches. Another person received support from seven different staff in a week period of which three were staff from the provider's other branches. This meant improvements were needed to ensure people received the support by a consistent group of staff.

Staff told us that there were not enough staff available to meet people's needs. Staff had developed strategies to manage their time which meant that people did not always receive their full commissioned care calls. One staff member said, "The staffing is not good we are very short staffed and staff are exhausted. We don't get enough time to get from calls and this has a knock on effect as people then get late calls. We have been told that recruitment is underway and we get some help from other branches". Another staff member said, "There are not enough staff and staff are leaving because of the pressure they are being put under. I need to cut calls short to make sure I can fit all my planned calls in because the travel time is unrealistic". We spoke with the registered manager who told us where there were staff shortages and they were actively recruiting. They told us that the staff shortages have been covered by staff from the provider's other services to ensure people received a call although this has meant that some people had received care calls from unfamiliar staff. This meant that improvements were needed to ensure there were enough staff available and people received their support in a consistent, unrushed way at a time they needed it.

This showed that there were insufficient staff available to meet people's needs in an unrushed and consistent way. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that the staff helped them to have their oral medicines and to apply creams. One person said, "They [staff] help tackle my dry skin with creams ". Another person said, "The staff remind me to take my medicine and put my creams on after my wash to stop my skin from getting sore". A relative said, "The regular staff members always put my relative's creams on". We saw that there were Topical Medicine Administration Records in place (TMARs) for staff to record when they had supported people with

their creams. However, the care plans we viewed did not contain sufficient information about people's topical creams for staff to follow. For example; one person's care plan did not contain any information about their cream and where it needed to be applied. Another person's TMAR showed a cream was being applied. But there was no information about how often the cream was required and no body map in place to show where staff needed to apply the cream. The registered manager was not aware of this cream and why it was needed. Staff we spoke with who regularly visited people were aware of the topical creams to be applied, the frequency and where people's creams were needed. However, there was a risk that new or unfamiliar staff would not have the required information and documentation to apply and record the creams safely and we had been informed by the registered manager and staff that staff from other branches were covering calls. The TMARs we viewed contained gaps in the recording and we could not be assured that people had received their creams as prescribed. This meant that improvements were needed to ensure that there was sufficient guidance for the administering of people's topical creams and these were recorded consistently.

We recommend that the provider considers the National Institute for Health and Care Excellence (NICE) guidance for managing medicines for adults receiving social care in the community.

People and relatives told us that staff who visited them regularly knew how to help them safely. However, people told us that new staff needed direction from them as they were unsure of the support needed. One person said, "Two staff visit me as I need them to make sure I'm safe. I have had no falls whilst the staff are with me because they make sure I am safe when I move about". Another person said, "The staff I get on a regular basis are good they know what I need and they have raised issues to ensure they manage any signs of pressure damage. The new staff don't always know what to do but I tell them and they are okay then". A relative said, "The staff are mainly good. Some of the staff we don't know too well need some direction and we have to tell them what they need to do". Staff who visited people regularly explained how they supported people to reduce risks and had a good knowledge of how to reduce people's risks, which matched what people had told us. However, the care plans and risk assessments did not always contain the information that people and staff told us and the records did not always provide sufficient guidance for staff to follow. This meant although regular staff knew people's needs well, there was not always sufficient guidance available to ensure unfamiliar staff supported people in line with their needs.

People we spoke with told us that they felt safe when they were being supported by staff. One person said, "I feel safe with staff. I trust them, they are nice". Relatives told us that they trusted staff and knew that their relatives were supported safely. One relative said, "My relative is very safe with staff. I trust them and see how staff treat my relative. I have no concerns". Staff explained how they supported people to remain safe and the action they would take if they felt someone was at risk of abuse. One staff member said, "There are lots of signs to look out for which may be a sign of abuse, such as; bruising, people shying away from certain people or their mood changes. I would report any concerns immediately and I understand the procedures to report concern anonymously if needed". We spoke with the registered manager who told us the procedures they followed if they had been made aware of suspected abuse. They were aware of the professionals that they needed to inform and we saw that where there had been concerns about a person's safety they had reported this as required. This meant that staff knew how to ensure people were protected from suspected abuse.

People we spoke with told us that staff always wore aprons and gloves when they were supporting them. One person said, "The staff use gloves and aprons when they visit me". Another person said, "They were gloves and I remind them too as I know how important it is". Staff we spoke with understood the importance of the prevention of infection and told us that there were always gloves and aprons available for them to use. This meant that people were protected from the risks of infection control and cross contamination.

We saw that the provider had a recruitment policy in place. Staff had been employed using safe recruitment procedures. Staff told us and we saw that they had received checks of their character and references from previous employers which ensured they were suitable to provide support to vulnerable people. This meant people were supported by staff that were of suitable character and had been recruited safely.

We saw that incidents were logged and the registered manager reviewed these to ensure that any issues were identified and acted on. The registered manager told us this was carried out to ensure that people were safe and where errors had been made by staff these were raised in supervision. The registered manager told us that further training was provided for staff after discussion in supervision to ensure that they had learnt from the incident. This meant that the registered manager had taken action to ensure lessons were learnt where issues had been identified.

Requires Improvement

Is the service effective?

Our findings

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

People who were able to understand decisions about their care told us their consent was gained by staff before they provided support. We saw that people had an 'incapacity' plan in place, which gave staff guidance on whether people were able to make decisions. However, these plans were holistic and not specific to individual decisions about care such as decisions around medicines, care and treatment and daily choices. For example; one person's incapacity plan stated that they had no capacity and staff needed to make all choices for this person. There was not an assessment in place to show how this person's capacity had been assessed. Staff we spoke with told us that this person could make some daily choices and they were able to clearly state what they wanted. This meant this person's ability to make decisions had not been assessed effectively. We also found that two people's ability to consent to their care was contradictory. The records stated that both people lacked capacity and decisions needed to be made on their behalf. However, we saw that both these people had consented to their care plan and to medicines administered, which meant that this gave unclear guidance for staff to follow. Staff we spoke with had a good understanding of people's ability to consent and they supported people to have choice in their care; although this conflicted with the details in the records. We feedback our concerns to the manager, who agreed that this information needed to be updated and re-assessed to ensure staff had clear guidance. The Head of Quality Management & Compliance stated that the provider was in the process of reviewing mental capacity and changes will be made where required. We will assess the progress of the review and effectiveness of the actions taken at our next inspection. This meant improvements were needed to ensure people's capacity was assessed effectively.

Staff told us that they received an induction and shadowed experienced staff members before providing support to people. Staff told us they had received training which included manual handling, safeguarding vulnerable adults and medicines. The records we confirmed what staff told us and we saw that competency checks were carried out on medicine administration to ensure staff were competent. However, we found that staff were not always recording medicines as required, which meant we could not be assured people were receiving all of their medicines as prescribed or that the training staff received had been effective in this area. The training matrix we viewed showed that staff had not received training in other areas that were specific to people's needs, such as; challenging behaviour and diabetes management. One person told us that they felt staff were not trained to support them with their diabetes. Staff confirmed that they had not received training in these areas. This meant that some improvements were needed to ensure staff had sufficient knowledge and skills to support people effectively.

We found that before a person used the service an assessment of their needs was to ensure that the person's needs could be met at the service. We saw that information was gathered from the person themselves,

family members and any other representatives that were involved in the person's life. This information included details such as; the person's past medical history, physical and emotional needs and people's likes and dislikes. We found that the assessment form contained information about people's diverse needs such as cultural background, religion or their sexuality. This meant there was an effective assessment system in place to ensure people's needs in all aspects of their life were considered.

People and relatives we spoke with were happy with the support they received from staff in relation to their food and drink. One person said, "The staff do my food and drink. They are very good and make sure they ask what I want. I normally have pre-made food in but they will do something else if I fancy something different". Another person said, "The staff all make sure I have a drink available and leave one for me when they go". Staff we spoke with were aware of people's dietary needs and how they needed to support people to eat and drink sufficient amounts. For example, one person was at risk of losing weight as they often refused food due to their dementia. The records we viewed showed that staff encouraged this person to eat at each visit to maintain their wellbeing. Staff told us that they completed charts to monitor the person's intake. The registered manager had sought a red plate to help the person eat their food and we were told that this had helped the person and their nutritional intake had improved since this had been put in place. This meant people were supported with their nutritional and hydration needs.

People were supported if they felt unwell. People and their relatives told us that staff ensured their health needs were monitored and they contacted relatives or health professionals directly when needed. One relative said, "The staff alert us if they feel that a doctor is needed for our relative". Staff told us how they looked for signs that people are unwell such as; physical and emotional wellbeing and they would contact a doctor or emergency services if needed. We saw that the registered manager had referred a person for support from a Community Psychiatric Nurse because their mental health had deteriorated to gain advice to ensure this person was supported effectively. This meant people were supported to access health professionals when needed.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff were caring when they provided support. However, people told us that staff were often rushed because staff were under pressure to get to their next call. For example; one person said, "The staff that help me are good. It's all just a bit rushed". Another person said, "I think improvements are needed as it's not very customer friendly because they don't have enough staff". A relative said, "The carers are all very nice and caring. They get on well with my relative but they need to be a little less rushed. The staff don't have enough hours in the day". Another relative said, "The staff are all very nice and treat my relative well, but can be rushed as they are very busy. I feel sorry for staff as they do care and are trying their best". Staff told us that they often felt rushed and although they met people's needs they were unable to give people time to chat as they would like to. One staff member said, "I always give a good standard of care, but I feel that we have to rush some of the care and this isn't fair on people because they like to have a chat after I have supported them and I can't do this". Another staff member said, "Staffing is a problem and it means that we can't give people the time they deserve as I leave as soon as I can after I've supported people to try and keep on track with my calls". This meant that people were not always supported in a caring way because staff did not always have enough time to support people in an unrushed manner.

People and relatives told us that they were treated with dignity and respect when staff were supporting them or their relative. One person said, "The staff are polite and respectful and always make sure they carry out any of my support in privacy. They make me feel comfortable". Another person said, "A relative said, "The staff help my relative with dignity. My relative is relaxed with the staff and they are always polite and respectful". Staff told us that they always made sure that people's dignity and privacy was protected when they were providing care and support. This meant that people's dignity was maintained and their right to privacy upheld.

People told us staff always asked them what they needed and acted on their wishes. One person said, "The staff ask me what I need and I am given choices in what I want to eat or drink. Sometimes I don't need as much help and they listen and let me do things for myself". A relative said, "Before my relative had support from the agency they were asked what they wanted. The staff follow this and they also ask how my relative would like to be supported". Staff told us they always asked people before they provided support and took account of their wishes. One staff member said, "I always ask people what they need each time as things may change. If people have difficulties communicating I make sure I keep questions short and show them so they can make a choice". The records we viewed contained guidance for staff to follow to ensure they understood how people communicated their needs. This meant that people were supported to make choices about their care in a way that met their individual communication needs.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us and care records showed that they were involved in the assessment and planning of their care. One person said, "I did have a lot to say in what was provided as they [the registered manager] came out to see me before they provided the calls". Another person said, "I was involved in the planning of my care as the manager came out to see me and to talk about what I wanted". People told us that they preferred their 'regular' staff because they understood their needs well. Staff we spoke with knew people's preferences and were able to describe how people liked to be supported to maintain their independence, such as food choices and how people liked their care providing. The care records we viewed detailed how support needed to be provided and were personalised to people's preferred times for their care to be delivered. However, people told us that their preferred times were not always met and it was dependent on whether staff were available at their preferred times. People also stated that they often received calls from staff they did not know and they had not always been introduced to before the visit. One person told us that they used to receive rotas so that they knew who would be visiting them. However, they told us that this did not always happen and if they had received a rota there were often changes that they had not been informed about. Another person told us that particularly in the evenings staff arrived anytime between 7pm and 9pm and they were not provided with a schedule so they were unaware of who was visiting and at what time This meant that improvements were needed to ensure that people's preferences were met and people were kept informed when changes were made to the staff providing their care.

People and relatives told us they had been involved in the reviews of their care and changes had been made to their care when people's needs had changed. One person said, "I have had reviews and we discuss what I need and if I need any changes to be made". A relative said, "We are involved in reviews and are kept informed of any changes". We saw records of reviews that had been undertaken and although staff we spoke with were aware of changes in people's needs these had not always been reflected in the care plans. For example, one person's care had been reviewed because they were at risk of malnutrition and equipment had been put in place to help this person to eat. Staff we spoke with knew about this equipment. However, this person's records did not contain this information for staff to follow. This meant improvements were needed to ensure information about changes in people's needs were available to all staff.

People and their relatives told us that they knew how to complain and they would approach the staff if they had any concerns. People and relatives that had complained told us that they felt listened to when they complained. The provider had a complaints procedure in place to provide guidance to people and staff of how complaints were to be handled. We viewed complaints records which showed that complaints had been investigated and the response was forwarded to the complainant to show the action taken to make improvements. This meant that complaints were managed in line with the provider's policy.

At the time of the inspection the service was not providing end of life care. We saw that where people had a Do Not Attempt Resuscitation (DNAR) in place this was detailed in the records to ensure staff were aware of people's advance decisions. The registered manager told us that when people reached the later stages of their life the care plans are then reviewed and people's end of life wishes would be discussed. This meant that there were systems in place to record people's wishes at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

The providers governance and quality assurance systems required strengthening. There were some systems in place to monitor people's care. however, these were not always effective in mitigating potential risks to people's health and welfare. For example; we found concerns with the way topical medicines were recorded and the registered manager was unaware of these issues. The registered manager told us that they reviewed people's MAR sheets every six months to ensure that people were receiving their medicines as prescribed. The audit system in place had not picked up the issues we identified because they had not been carried out regularly. The length of time between audits was too long and meant that any errors or omissions in medicines management would not be identified or addressed in an appropriately timely manner.

We also identified concerns with people's individual care records that had not been identified by the provider's quality assurance systems. For example; mental capacity assessments had been completed, but these were not decision specific and the records were contradictory. One person's records stated that they had no capacity and all decisions needed to be made for them. However, we saw that they had consented to their care plan. Another person had been assessed as requiring food and fluid charts to ensure they were eating and drinking enough. The system to monitor the food and fluid charts was ineffective because these records were not available at the service to enable the registered manager to monitor whether this person was eating enough. The registered manager told us these should be monitored monthly to ensure this person's risks were being mitigated. We spoke with the head of quality management and compliance who told us that the provider policy stated that monitoring needed to be completed monthly for food and fluid charts and every six months for daily records and MAR charts. They said, "We have been following the policy but I understand what you are saying. This has highlighted some issues and I will look into these". This meant that there were not effective systems in place to monitor and mitigate the service.

People's care records were not always updated to provide guidance to staff in how to meet people's care needs in a consistent or personalised way. For example; staff and the registered manager told us that one person had recently experienced behaviour that may challenge. However, the records we viewed did not contain information of how staff needed to support this person and what the possible triggers to their behaviours were to enable staff to lower the risk of incidents. Another person's care record stated that they had diabetes. However, there was no information or guidance in the records to show how staff needed to support this person to remain healthy. We found that staff who visited these people regularly were aware of their needs and the support required to lower their risks. However, staff from the provider's other services were regularly providing support to people due to the difficulties they were experiencing with the recruitment of staff. People were at risk of receiving inconsistent support from unfamiliar staff because care records were not always up to date and they did not always contain sufficient guidance for staff to follow. This meant that improvements were needed to ensure records were accurate and up to date.

The registered manager told us that there was a system in place to ensure that people received their care calls and any calls that were running late were flagged. The office staff or out of ours staff contact the care staff member to ensure people receive their calls. People we spoke with told us that staff had no missed calls. However, people and relatives experience of communication from the office varied. For example;

people told us that they did not know which staff would be visiting and when staff were running late they were not always informed. One person said, "They let me know if they can". Another person said, "The office needs to be better organised". Another person said, "Their need to be better communication". On a Sunday the carers are often late. Staff tells us they have passed it to the office but we never get told". This meant that the system in place to ensure people are informed when there are changes to their care times was not always effective and that this had impacted upon people's experience of receiving care.

The above evidence shows that systems were not always in place to effectively monitor and improve the quality of care that people received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that the provider and the registered manager was supportive and approachable. One member of staff said, "The registered manager is very approachable and supportive if I need anything". Another member of staff said, "I can get in touch with the registered manager if I need to and find them approachable". Staff and the registered manager told us that spot checks were carried out whilst staff were providing support to ensure performance was monitored. On staff member told us these were useful as they received feedback to enable them to improve in certain areas to ensure they were providing a good standard of care. We saw records which confirmed what staff had told us. Staff received supervision sessions with a member of staff from the management team. A supervision is an opportunity for staff and management to discuss work related issues and areas of staff development. We saw that where any concerns had been raised regarding a specific staff member's performance a supervision meeting had been held to discuss and monitor their performance. Staff told us that these were helpful to discuss any concerns they had and their development needs. The registered manager told us that the provider had a rewards scheme in place to recognise staff achievement and an employee engagement forum, which meant that staff were able to provide feedback to inform service delivery. This meant staff felt supported in their role, had opportunities to provide feedback and staff performance was monitored and rewarded.

We saw that the registered manager and provider had contact with other agencies on a daily basis. This included health professionals such as G.P's, district nurses, hospital staff and consultants. Relatives told us that the service contacted health professionals when their relatives were unwell or needed further intervention from health professionals. Health professionals we spoke with were happy with the communication and referrals made by the management to ensure people received a good quality of care. This meant that the registered manager and provider worked in partnership with agencies to make improvements to people's care.

The registered manager understood their responsibilities in relation to their registration with us (CQC). We had received notifications of incidents that had occurred at the service as required by law. These may include incidents such as alleged abuse and serious injuries. The provider had also ensured that there was a registered manager at the service which was a condition of their registration.

The provider told us that they had plans to focus on recruitment to increase the number of staff employed to improve the consistency in the staff that provided people's care. However, we could not yet see that these plans had been effective. We will assess the effectiveness of this at the next inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place were not always effective in monitoring and managing the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff available to meet people's needs in an unrushed and consistent way.