Comfort Call Limited

Comfort Call (Liverpool - Meadow Court)

Inspection report

Meadow Court
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 February 2016 and was announced. Comfort Call (Liverpool- Meadow Court) provides domiciliary care services to people in their own homes, within Meadow Court, which is an extra care housing scheme. There are 68 flats within the scheme and on the day of inspection, support was being provided to 38 people.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with told us they felt safe living in Meadow Court and receiving support from Comfort Call and we found that there were adequate numbers of staff available to meet people's needs. Staff we spoke with had a good understanding of safeguarding and we found that appropriate referrals had been made to the local safeguarding team as required.

Risk assessments had been completed to monitor people's health and safety, however not all completed risk assessments reflected consistent information regarding risks to people.

Medicines were not always managed safely within the service. There were a number of gaps in administration records and some hand written instructions for administering medicines were incorrect. A medicine policy was available to help guide staff.

Although a policy was in place regarding safe recruitment of staff, we found that this was not always followed. All staff had Disclosure and Barring service checks completed; however, the most relevant references were not always sought prior to a staff member commencing employment.

Staff were provided with personal protective equipment such as gloves and aprons, in line with infection control requirements.

People receiving support told us they were happy with the care they received from Comfort Call at Meadow Court and people told us staff knew them and their preferences, well. Staff we spoke with told us they were informed of any changes within the home, including changes in people's care.

We found that people were supported by the staff and external health care professionals to maintain their health and wellbeing. People receiving support told us that staff were kind and caring, treated people with respect and protected their dignity.

Staff told us they always asked for people's consent before providing support and care files contained completed consent forms in relation to care planning and medicines. Families were involved when people

were unable to provide consent.

Staff were supported in their job role through induction, supervision and appraisal, as well as regular training to ensure they had the knowledge to meet people's needs.

People we spoke with were happy with the support they received with their meals; however support provided was not always recorded.

Most care files we viewed were very detailed and specific to the person, reflecting their wishes, choices and preferences and people, or their relatives, had signed to confirm their involvement with the plan of care. We found however, that not all care plans contained sufficient detail regarding people's needs.

People receiving care and staff, told us that the support was flexible due to the care service being based in Meadow Court. For instance, one person told us if the carers called in the morning and they were not ready to get out of bed, the staff would arrange to come back later in the morning.

Processes were in place to gather feedback from people and listen to their views. People had access to a complaints procedure within the service user guide provided to people when their support was arranged.

A range of activities were offered to people and a reminiscence room was also available.

Feedback regarding the management of the service was positive. Staff felt supported and had access to advice from managers at all times.

Staff were aware of the company's whistle blowing policy and told us they would not hesitate to raise any issue they had.

Processes were in place to monitor the quality and safety of the service. However, issues identified during the inspection were not all picked up through the providers audit processes.

We looked at processes in place to gather feedback from people and listen to their views. Resident and staff meetings were also held regularly and people told us they were encouraged to share their views and felt they were listened to.

The manager had not notified the Care Quality Commission (CQC) of all reportable events and incidents that occurred in the service in accordance with our statutory notifications, such as safeguarding referrals.

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.

People felt safe and there were adequate numbers of staff available to meet people's needs.

Staff had a good understanding of safeguarding and appropriate referrals had been made to the local safeguarding team as required.

Not all risks had been assessed accurately to ensure people's safety. Safe recruitment practices were not always followed.

Medicines were not always managed safely within the service.

Staff were provided with personal protective equipment such as gloves and aprons, in line with infection control requirements.

Is the service effective?

Good

The service was effective.

Staff were informed of any changes within the home, including changes in people's care.

People were supported by the staff and external health care professionals to maintain their health and wellbeing.

Staff mostly sought people's consent regarding provision of care.

Staff were supported in their job role through induction, supervision and appraisal and regular training and felt well supported.

People were happy with the support they received with their meals; however support provided was not always recorded.

Is the service caring?

Good

The service was caring.

People receiving support told us that staff were kind and caring, treated people with respect and protected their dignity. People's independence was promoted.

Staff knew the people they were caring for well, including their needs and preferences.

People's care files were stored securely.

Information regarding advocacy services were available to people.

Is the service responsive?

Good

The service was responsive.

Plans were specific to the person and people were involved in the development of their support plans. However, not all identified needs were reflected within the care plans.

People told us support was flexible.

Processes were in place to gather feedback from people and listen to their views and people had access to a complaints procedure.

A range of activities were offered to people and a reminiscence room was also available.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Feedback regarding the management of the service was positive. Staff felt supported and had access to advice from managers at all times.

Staff were aware of the company's whistle blowing policy and told us they would not hesitate to raise any issue they had.

Processes were in place to monitor the quality and safety of the service. However, issues identified during the inspection were not all picked up through the providers audit processes.

The manager had not notified the Care Quality Commission (CQC) of all reportable events and incidents that occurred in the service.

Comfort Call (Liverpool - Meadow Court)

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 24 February 2016 and was announced. We gave the provider 48 hours' notice because the registered manager is not always based in the office and we needed to ensure that relevant people would be available to answer any questions we had or provide information that we needed.

The inspection was undertaken by an adult social care inspector. Before our inspection we reviewed the information we held about the home. We looked at the notifications the Care Quality Commission (CQC) had received about the service and contacted the commissioners of the service.

During the inspection we spoke with the registered manager, regional manager and scheme manager. After the inspection, we spoke with three people receiving support, the relatives of two people who were unable to speak with us due to memory difficulties and two staff members.

We looked at the care files for four people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living in Meadow Court and receiving support from Comfort Call. We were told, "There is always someone on hand" and, "Staff come quickly if I press my buzzer."

We looked at the systems in place for managing medicines in the service. People told us they received their medicines from staff when they needed them. Medicines were stored safely in people's homes. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection. Staff told us and records we viewed confirmed, that staff had completed training in relation to safe medicine administration and had their competency assessed each year.

We looked at people's MAR charts and found that there were a number of gaps evident for medicines that should have been administered. The scheme manager was aware that there had been gaps in the signing for medicines and had raised this at a recent staff meeting and had commenced supervisions with staff to address this further. The manager advised that disciplinary action would commence if MAR charts continued to contain gaps in the recording of medicines administered.

MAR charts were hand written and directions for medicine administration were not recorded as checked by a second member of staff which is recommended best practice for safe administration of medicines. We found a number of inconsistencies between the directions recorded on the MAR chart and the medicines signed as administered. For instance, one chart recorded that a medicine should be given three times per day, but was only signed as given each day in the morning and evening. The manager looked into this on the day of inspection and confirmed that the written instruction was incorrect and should have read two times per day. Another medicine record contained the instruction, "Take two daily" but was recorded by staff as administered twice per day. The manager agreed to investigate this further to establish whether an error had occurred and take appropriate action.

The MAR charts we viewed contained a number of medicines that had been crossed out without explanation as to who instructed the discontinuation of the medicine.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how staff were recruited within the service. We looked at four personnel files and found that Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. The scheme manager told us that they renewed all DBS checks every three years to ensure they were aware of any changes. For staff that had previous convictions, there was no system in place to assess any potential risk and ensure the person was suitable to work with vulnerable people. The records showed that the most

relevant references were not always sought prior to the person commencing in post. For instance, one person's file contained a reference from their previous employer, dated after the person was employed. Another file did not contain any evidence of references. The manager told us that the head office would have copies of those references and they would ensure copies were available for the personnel file. All files contained the required photographic identification of staff.

This was a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas, such as falls, nutrition, mobility and skin integrity. Care files showed that people had a completed risk assessment regarding medicine administration. These risk assessments however, did not always provide accurate information. For instance, one assessment indicated that a person was unable to understand their medicines, yet their medication administration record (MAR) showed that they were administering a number of medicines themselves. This meant that staff may not have access to accurate information regarding the levels of risk to the people they support. The scheme manager advised that this person was able to understand their medicines and would ensure that the risk assessments were reviewed.

We spoke with staff about adult safeguarding. Records showed that staff had completed safeguarding training and staff we spoke with confirmed this. Staff had a good understanding of what constituted abuse and how to report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the staff room. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made by staff and staff told us they would not hesitate to raise any concerns with the manager.

We looked at staffing levels within the service. People receiving support told us there were always sufficient staff to meet their needs. The people we spoke with told us that carers always arrived and were "more or less" always on time. People told us they liked the flexibility of having the care staff based on site. Staff we spoke with told us that staffing levels had improved recently following recruitment and there were now adequate numbers of staff available. The regional manager told us staffing levels were based on the number of block hours they were commissioned to provide by the local authority. This had recently been increased due to the dependency needs of people residing in Meadow Court. On the first day of inspection there were five care staff on duty, providing differing levels of care to 38 people. The manager told us there were always two staff on duty overnight and the scheme manager provided telephone support out of hours. The manager told us one staff member had phoned in sick and the support they were due to provide had been reallocated to the five carers on duty. We were told agency staff were not used in the service as existing staff covered any required hours.

We looked at accident and incident reporting within the service and found that accidents were recorded electronically by staff. This enabled managers to review the records and identify any themes or trends and take action to prevent recurrence.

The landlord was responsible for maintaining the building and equipment such as bath hoists and staff had access to relevant contact numbers to report any concerns or required repairs in relation to the building. People who lived in Meadow Court had a PEEP (personal emergency evacuation plan) to help ensure their safe evacuation in the event of a fire. Not all of these had been fully completed and the manager agreed they would ensure each person receiving support had a completed PEEP in place.

Staff were provided with personal protective equipment such as gloves and aprons, in line with infection control requirements.

Good

Is the service effective?

Our findings

People receiving support told us they were very happy with the care they received from Comfort Call at Meadow Court, and relatives we spoke with agreed. One relative told us they were, "Really happy" with the care their relative received and that the staff were, "Like family to [relative]."

People told us carers knew their needs well and staff told us they had got to know people as individuals as well as the support they required and preferred. Staff told us they were kept updated of any changes in people's support needs through handover processes and reading people's care plans.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

During discussions with staff they told us they always asked for people's consent before providing support, such as when entering a person's flat or providing personal care. Care files we viewed showed that when able, people had been consulted regarding their support and consent was given in areas such as care planning and administration of medicines. People we spoke with told us care staff regularly spoke with them about their care and relatives we spoke with agreed.

When people were unable to provide consent to their care, records showed that people's families had been consulted and relatives we spoke with confirmed they had been involved in the development of their relatives care plan. The manager told us that if they believed a person lacked capacity to make a specific decision, they would involve a social worker to undertake a mental capacity assessment and include family and a community psychiatric nurse in best interest decision making. The manager told us staff would then provide care agreed in the best interest of the person. One staff member we spoke with confirmed this; they told us that if a person lacked capacity to consent to their care, they would follow the care plan that social services would provide and liaise with people's family members.

There were no Deprivation of Liberty Safeguard (DoLS) authorisations in place and the scheme manager told us they would liaise with the allocated social worker if they felt this was required for any of the people supported at Meadow Court.

People were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the G.P, social worker, speech and language therapist, community matron and district nurse. People we spoke with and their relatives told us staff responded appropriately if they were unwell. For instance, one relative told us their family member had experienced a

medical emergency and staff remained calm and reassuring and called for an ambulance to ensure the person received the necessary medical attention. The scheme manager told us if required, the care staff supported people to attend medical appointments and this was arranged and funded privately.

We looked at staff personnel files to establish how staff were inducted into their job role. Staff told us that induction included completion of all mandatory training courses prior to supporting people. Staff also shadowed a more experienced member of staff for at least 16 hours, in order to get to know the needs of people receiving support. Staff files contained a set of scenario questions completed as part of recruitment and induction, providing the manager with an understanding of how staff would respond in certain circumstances. All staff we spoke with told us the induction was sufficient and prepared them for their role. The regional manager told us the induction programme had been refreshed to ensure it met the requirements of the care certificate. The care certificate is an identified set of standards that health and social care workers should adhere to in their daily working life.

One family member we spoke with told us that their relative received support from carers that knew their needs and if new staff were employed, they worked with other staff to get to know people before they supported their relative.

We looked at on going staff training and support. Staff we spoke with told us they completed regular training in areas such as mental capacity, dementia, health and safety, infection control, food safety, medicine management, record keeping and privacy, dignity and choice. Records showed that staff also completed training specific to people's health needs, such as diabetes, Parkinson's disease and end of life care. One staff member told us they supported a person with Parkinson's disease and had requested more in depth training to help their knowledge and understanding of the condition. The company arranged this training, which helped to ensure staff can provide safe and effective care to the person.

Training dates were recorded electronically and a system was in place to alert the scheme manager when staff were due to refresh their training. This system also allowed the registered manager and regional manager to review compliance in completion of training courses. We viewed an electronic overview of completed training and found that most staff had completed courses the provider considered compulsory.

Staff we spoke with told us they felt well supported and were able to raise any issues with managers at any time if required. Staff told us and records confirmed, that they received regular supervisions and an annual appraisal to support them in their role.

Staff supported some people with their diet and nutrition, through meal preparation and overview of dietary intake. People we spoke with were happy with the support they received with their meals. One person told us, "The staff make me whatever I ask for." One family member told us their relative required a pureed diet and that staff adhered to this and were knowledgeable about their relative's needs.

We viewed a care file that indicated staff were required to add thickener to a person's drink to reduce risks associated with a swallowing needs. The manager told us this was always added and a relative of the person confirmed this, however this was not evidenced. The managers agreed to review systems of recording all care provided to people.

A café was also available within Meadow Court which was open to the public and care staff assist people to access the café for meals should they choose to.

Good

Is the service caring?

Our findings

People receiving support told us that staff were kind and caring and treated people with respect. People told us staff were, "Very obliging", "Very nice", "I can't fault them" and "Very kind." One person told us, "I am very lucky, I get good care from the staff" and another person told us, "They do their best; they are very polite and have always got a smile for you." Relatives agreed that staff were caring and told us they were, "Really happy with the care," that staff, "Are very respectful," "Are like family to [relative]" and that their relative, "Has a really good relationship with the staff."

Staff described ways they respected people's privacy and maintained their dignity. Examples included, knocking on people's door before entering their flats, even though they were using a key from the key safe; referring to people by their preferred name; ensuring privacy during personal care, such as closed doors and curtains and not discussing people's care needs in front of other people receiving support. During discussions, staff spoke about people in a warm and caring manner.

We found through discussion, that staff knew the people they were caring for well, including their needs and preferences.

Most care files we viewed were very detailed and specific to the person, reflecting their wishes, choices and preferences. Files provided information on people's life events, what people were able to do for themselves and what they required support with. Preferences regarding daily routines, where and how they liked to spend their day, what activities they enjoyed and dietary likes and dislikes were all reflected. This enabled staff to provide support based on people's preferences, wishes and choices.

Care plans were written in such a way as to promote people's independence. For example, one care plan described the support staff were required to provide, but stated that staff were to encourage the person to do as much for themselves as possible and that staff were not to take over. One of the person's care plan goals was to retain independence. This helped to ensure that staff provided support to people in a way that promoted their independence.

Although people had care files within their flats, the office copies were stored securely in the scheme manager's office.

For people who had no family or friends to represent them, contact details for a local advocacy service were available within the service user guide for people to access, which was given to people when they began receiving support. One person had appointed an advocate to support them and the person's advocate regularly met with the scheme manager to discuss any concerns or issues the person had and records of these meetings were viewed during the inspection. Actions were recorded based on the outcomes of the meetings.

Good

Is the service responsive?

Our findings

We looked at how people were involved in their care planning. Most people we spoke with told us they had been involved in the development of their care plans and were happy with the support in place. One person receiving support told us, "Staff talk to me about my care plan." Records we viewed, showed that people or their relatives had signed to confirm their involvement with the plan of care.

The care files we viewed had been reviewed and rewritten each year and updated through the year as and when changes occurred. For instance, one person's care plan had been updated regarding their dietary requirements, following advice from the speech and language therapist. This meant that staff had access to up to date information to help ensure they could effectively meet the person's needs.

Relatives told us they were regularly asked about the support in place for their family member and whether they were happy with it. One relative told us the care plans were always updated if there was any change in their relative's condition, and staff always knew about the changes and families were kept well informed.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers between staff, reading the communication book and through viewing people's care files. The scheme manager also showed us a newly created document which was due to be implemented, to record brief details regarding people's care each day to form part of the handover process.

We observed planned care records in areas such as personal care, mobility, medicines and skin integrity. Care plans were specific to the individual person and most were detailed and informative and reflected people's preferences and choices regarding their care. Care files contained life histories for people which enabled staff to get to know people, understand their experiences and backgrounds and provide support based on their preferences

We found however, that not all care plans contained sufficient detail regarding people's needs. For instance, one care file contained information that reflected the person required support to maintain their safety as they had left home on one occasion and got lost due to memory impairment. The care plan however, did not reflect this risk, or provide information to staff on how to support the person to remain safe. Risk reduction measures had been implemented following liaison with social services, such as a door sensor on the person's flat to alert staff when the person was leaving. This, or actions staff should take if the person left the building, was not reflected within the plan of care. This meant that staff may not have access to appropriate information regarding people's needs and how to support them appropriately. The scheme manager told us this had been an isolated incident and they had worked closely with the social worker to implement measures to reduce potential future risks. The scheme manager agreed to ensure a care plan was implemented to reflect the support in place for the person.

People receiving care and staff, told us that the support was flexible due to the care service being based in Meadow Court. For instance, one person told us if the carers called in the morning and they were not ready

to get out of bed, the staff would arrange to come back later in the morning.

We looked at processes in place to gather feedback from people and listen to their views. Most people we spoke with who received support told us that they were regularly asked if they were happy with the service and relatives we spoke with agreed. Care files contained completed quality assurance documents, gathering people's views in areas such as punctuality of calls, whether their privacy was respected by carers, whether they were treated with respect and whether people were happy with the service. If people were unable to take part in the quality assurance review, relatives were contacted by phone to gather their views. Feedback recorded was positive and any actions required based on the feedback were documented. For instance, one relative asked that their thanks be passed to care staff and this was actioned.

People had access to assistive technology with in their flats to enable them to call for staff support when required.

Although the care service mainly provides personal care, some activities were provided to people who lived in Meadow Court, such as bingo, raffles, meals, quizzes and sing a longs. These were held in communal lounge areas and people were made aware of the activities available through staff or posters delivered to people's flats. The scheme manager told us they hoped to increase the activities available to people as staffing levels have recently been increased. One person told us the staff support them to access bingo twice each week which they enjoyed.

A newly developed reminiscence room was also available, which was decorated to resemble a living room from years gone by and contained books, old furniture and a music player. The scheme manager told us they planned to develop more activities based around reminiscence therapy.

People had access to a complaints procedure within the service user guide provided to people when their support is arranged. Care files we viewed showed that people had signed to confirm they had received a copy of the service user guide and that they had been advised how to make a complaint should they wish to. People we spoke with told us they would raise any concerns with the seniors or scheme manager and felt they would be listened to, but had not had to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we looked at how the manager and provider ensured the quality and safety of the service provided. Quality checks were completed soon after care provision commenced to ensure the support provided was effective and met the person's needs and these were observed within people's care files. Logs were in place to monitor the incidence of complaints, accidents and incidents and safeguarding referrals.

An audit was completed by the provider's internal quality assurance team which looked at all areas of the service. This audit had recently been increased to six monthly and we viewed the findings from the last audit in February 2016. Although many of the actions had been completed, the new registered manager would be responsible for recording the completion of all actions.

Care files also included monthly log books which recorded daily care provided and a record of medicines administered to people. An audit was included within the log book which was to be completed at the end of the month to monitor the quality of medicine administration recording. We found that the audit had been completed for the care files we viewed, however they had not been signed or dated and they did not identify the issues we found during the inspection. For instance, the completed audits had been ticked to show that there were no gaps in recording on the MAR charts, however there were numerous gaps in all of the charts we reviewed. The manager was however aware of this issue and had recently held a team meeting to raise this issue with staff and advise disciplinary action would be taken if it continued. The audit systems in place also did not identify the issues we highlighted regarding inaccurate risk assessments and lack of information within some care plans. This meant that the audit systems in place to monitor and improve the service were not effective.

This was a breach of Regulation 17 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post who had registered with CQC in February 2016. The registered manager was responsible for three of the provider's locations and there was a scheme manager in post who was based at Meadow Court. We asked people their views of how the service was managed and feedback was positive. People referred to the scheme manager as the manager of the service and told us they could raise any concerns with them and they were confident they would be listened to. We received positive comments regarding the scheme manager and people described him as, "Approachable", "Very polite," "Very kind" and "Always available." Relatives agreed and told us that he was, "Helpful" and that they had, "A good relationship with [manager]."

Staff felt well supported in their role an staff told us that the scheme manager was supportive. One member of staff told ud the scheme manager was, "Really understanding" and was available for them to speak to at any time, even out of hours. Staff also told us they had contact numbers for the regional manager and felt able to contact them should they have to.

Staff were aware of the company's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

Staff told us, and records confirmed that staff worked in partnership with other health care professionals, such as the community matron and district nurse. This helped to ensure that people received joined up and coordinated care.

The manager had not notified the Care Quality Commission (CQC) of all reportable events and incidents that occurred in the service in accordance with our statutory notifications, such as safeguarding referrals. This meant that CQC were not able to accurately monitor information and risks regarding the service. The manager agreed to ensure all relevant notifications were made.

The scheme manager completed three monthly quality assurance reviews with people who received a service. These included reviews of the person's care file and a discussion with the person to establish if they were satisfied with the service. We observed that the care file we observed that lacked detail regarding care requirements had been reviewed and the same issues had been identified within the quality assurance review and actions had been recorded to rewrite the care plans. This however, had not been completed by the day of the inspection.

Information regarding all areas of the service was reported in an electronic system. This enabled the scheme, registered and regional managers to review levels of compliance in areas such as staff training and supervision, care plan reviews and staffing levels. The regional manager told us no formal audits were completed from this information, but they did raise any areas of noncompliance with the registered and scheme manager.

We asked the management team about any improvement plans in place for the service. The managers told us that improvements were being made to quality assurance processes. For instance, commencing next month, the regional manager would be completing audits during their visits to the service. This would include the review of five care files and log books. The regional manager also explained that the provider was part of a quality governance group which shared real events from services and used them as an opportunity to learn and improve services. This had led to the introduction of themed supervisions in areas such as medicines, mental capacity and safeguarding.

We looked at processes in place to gather feedback from people and listen to their views. Resident and staff meetings were also held regularly and people told us they were encouraged to share their views and felt they were listened to.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with medicines because medicines were not managed safely in the service. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service. Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People use services were not protected against risks associated with recruitment of staff as systems were not followed to ensure staff were suitable to work with vulnerable people. Regulation 19(2)