Carevisions@Home Ltd

Care Visions at Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 11, 22 and 23 December 2014. This was an announced inspection. This means the provider was given 24 hours' notice due to it being a domiciliary care provider and we needed to ensure someone was available. We last inspected Care Visions at Home on 5 March 2014. At this inspection we found the provider was meeting all the regulations we inspected against.

Care Visions at Home are a domiciliary care company based in Newcastle upon Tyne who provided support and care for people with advanced or progressive complex needs within their own home. The service also provided support to people who were at the end of their lives. They provided support in the Northumberland, Gateshead, North Tyneside and Newcastle areas. At the time of our inspection 56 people were using the service.

The registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 the service was safe, staff had a good understanding of safeguarding adults and how to report any concerns and these were managed appropriately by the registered manager. Accident and incidents were recorded and investigated and appropriate action was taken such as further risk assessment and staff training. The provider also had a log of complaints and compliments and we found that these were responded to within specific time frames.

Staffing levels were appropriate to meet people's needs although some people told us they would appreciate a more consistent staff team supporting them. Other people said they were supported by the same staff and told us they were "More than happy, the girls are lovely."

The provider had a team of staff who dealt with recruitment processes working alongside the rota team and the training department to ensure sufficient numbers of staff were in post.

Medicines were managed safely and competencies were assessed by a registered nurse with regular observations of staff administrations of medicines.

Although staff were knowledgeable about safeguarding, mental capacity, dignity and respect we found that there were gaps in the provision of refresher training and supervision of staff. None of the staff had received an appraisal. This meant people using the service were at risk of being supported by staff whose competency and knowledge had not been appropriately assessed so the manager might not know if there were gaps in their practice. You can see what action we told the provider to take at the back of the full version of the report.

The registered manager and the staff were knowledgeable about mental capacity and understood people's rights to be involved in their care planning and review.

People were supported with their nutritional needs, social engagement and emotional well-being and care plans promoted people's independence and choice. People told us they were treated with dignity and respect and staff asked for consent before offering any support.

Regular audits and observations were completed to ensure the quality of the service was being monitored regularly. It was acknowledged that the service was going through a lot of change in order to improve processes and systems but staff were positive about this and staff morale was positive. They felt well supported by the senior team and able to seek support as needed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were enough staff to meet people's needs and to ensure cover was provided at times of holiday or sickness.

Staff were knowledgeable about safeguarding and they knew how to report any concerns.

A suitable recruitment process was in place which ensured there were enough suitably skilled and qualified staff to cover for annual leave and sickness.

There was a robust medicines policy in place and medicines were administered in a safe way.

Is the service effective?

Requires Improvement

Most aspects of the service were effective. Staff were knowledgeable about mental capacity and working to ensure people were involved in decision making and care planning.

Staff were positive and told us they felt well supported. However, staff had not received regular supervision and no staff had received an appraisal.

Specialist training was offered to staff if they were supporting people with complex health needs. The majority of staff had up to date core training or were booked on courses but some staff training was out of date or not completed. This meant people were at risk of being supported by staff whose knowledge gaps and competence had not been assessed.

Is the service caring?

Good

The service was caring. People told us that staff were kind and respectful. That staff would ask if there was anything else they could do to help and took time to understand people.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive. Care plans focused on individual needs and acknowledged people's independence as well as their support needs.

Preferences for how people liked to be supported were detailed as were their likes and dislikes.

People knew how to complain and were there had been concerns we were told that things were improving.

Summary of findings

Is the service well-led?

Good

The service was well-led. People were positive about the support they received and acknowledged that there was lots of change happening but it was all good.

The registered manager and chief executive were both supportive and had an open door policy.

Quality assurance systems were in place and audits were completed regularly with any action needed being identified and reported on.

Care Visions at Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 11, 22 and 23 December 2014 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service. We needed to be sure that someone would be in the office at the time of the inspection.

The inspection team consisted of two adult social care inspectors and a specialist advisor with nursing expertise.

Before the inspection we reviewed the information we held about the service, including the notifications we had received about safeguarding concerns. We also contacted three key stakeholders and a brokerage team who commission services for the local authority and work alongside the service to get feedback on the quality of the service provided.

At the time of the inspection 56 people were using the service. We spoke with eight people who used the service and 10 relatives by telephone. We talked with the chief executive, the registered manager, a branch manager, the rota manager and the human resources manager. We had 10 responses from care staff who we contacted by email. We looked at six people's care and medicines records and 12 staff files were reviewed. Supervision and training records were reviewed as records in relation to the management of the service.

Good

Is the service safe?

Our findings

All the people we spoke with said they felt safe, one person told us "Oh yes, I feel very safe, I like her [staff member] very much, she is excellent." Staff had a good understanding of safeguarding and whistleblowing procedures. One staff member told us "Safeguarding means protecting people's health, wellbeing and human rights and enabling people to live free from harm, abuse or neglect." They went on to say, "Abuses can be physical, financial, psychological, sexual or institutional." Another staff member told us "It's about protecting vulnerable people who are at risk of harm due to any disability" they added, "I would most definitely speak out if I saw something."

We saw there was a whistleblowing policy and a safeguarding policy in place and flowcharts which covered the action to be taken if abuse was suspected. The policy explained the types of abuse people might experience and gave signs and systems that staff should look for. There was a safeguarding file in place and we could see details of investigations and outcomes.

Home environments were assessed for risks to people and staff, and this included lone working and health and safety. Any specific equipment required to support people had been risk assessed, such as wheelchairs and hoists, as well as access to properties including paths, lighting and steps. Fire risk assessments were completed by staff and people were offered the chance to have a home fire safety check completed by Tyne & Wear fire brigade.

The registered manager told us "We rarely offer support with people's finances but do have a policy in place which is linked to safeguarding. People's care plans have a section related to finance's if appropriate." When asked what specific support could be provided the registered manager told us "We don't deal with PIN numbers, banking or bills, if we did offer support with money it would be with shopping or things like paying the window cleaner." They explained that all receipts would be kept and transactions recorded for auditing.

Accident and incident reporting was completed. We saw evidence of reporting to the Health and Safety Executive (HSE) where a care worker had been off work for more than seven days due to a work related injury. This shows that the provider understands its legal responsibility with regards to Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR). Investigations had been completed and action taken included risk assessing equipment; ensuring staff were following moving and handling plans and retraining where necessary. It was noted that there had been no accidents or incidents involving people being supported other than those reported as safeguarding alerts.

The majority of care staff we spoke with told us that they thought there were enough staff although one staff member did say "Not all the time, some calls get missed." The people we spoke with told us that staff turned up on time and stayed for the allocated time. Half the people we spoke with told us they have a regular team of staff and see the same people all the time. Other people told us there were inconsistencies in staffing and they, "Saw lots of different faces." Some people did say this was improving.

The rota was managed by a small team of office based staff, one staff member said "We have a responsibility for delivery of support as contracted so we maintain a bank of floating hours [spare capacity] to cover for holiday, sickness and new packages of support." They told us "We have a database which includes the area staff work in, who they support and what training they've had. This means we can match staff to people." They also told us "Each package of support has a core team; the short visits are covered by specific geographical teams. If someone rings in sick the shift is offered to the core team initially so the person knows the care worker. If they can't cover we look to see if they know any of the other staff and offer the shift to them. Beyond this we look at the training of staff and match someone's skills to the needs of the person." They also told us "At weekends there is a staff member on standby who is available to cover shifts if needed."

The provider employs a recruitment team who ensure ongoing recruitment, they work with human resources, the rota team and the training department to provide a joint approach to ensuring sufficient numbers of appropriately trained staff are employed. We were told, "We always seek two references and Disclosure and Barring Service checks before starting people." DBS checks are completed to see if people have a criminal record and look at people's suitability to work with vulnerable people .This was evidenced in the staff files.

We saw that the medicines policy and procedure was comprehensive and robust, clear responsibilities were detailed and it had been formally agreed by the provider on

Good

Is the service safe?

24 April 2014. The policy included detail on self-medicating, the supply, storage and disposal of medicines. Tasks staff were not permitted to do such as invasive, clinical or nursing procedures were also included, as were homely medicines, as and when required medicines, controlled drugs and the Mental Capacity Act 2005 in relation to covert medicines.

The registered manager told us "We have new MAR (Medication Administration Records) charts, competencies and policies that were developed on the back of concerns raised by relatives." They added "The pharmacist has provided dosette boxes and bottles so we can do practical simulated administrations as part of the care staff competency assessments." Staff competency is checked in training via the simulated medication test and within three month's an onsite competency check is completed. We saw that these had been recorded appropriately and any actions needed had been addressed. The registered manager said "We need to find the balance so we aren't being invasive in people's homes at sensitive and emotional times but do need to make sure staff are competent."

Medicines administration profiles were in place for people who were supported with medicines, this included details of any cultural preferences and gender preferences. As well as appropriate Medication Administration Records (MAR) for tablet and liquid medicines, there were also specific records for transdermal patch applications which included a body map to show where the patch had been applied, the date applied and the date removed. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin. We saw there was also an external preparation application record sheet which detailed specific information about applying creams and a body map to identify where cream should be applied. We saw that a specialist epilepsy nurse had written a procedure and protocol for the use of emergency medicine in one person's care records.

Medicines audits and observations were completed by the care coordinators. The registered manager told us "The new process will start in January and includes a full audit of the MAR, the daily recording and the medicines."

We saw medicines error forms were comprehensive and included detail of the error, action taken including medical advice being sought, whether family had been informed and action taken as a result of the error. We saw where a staff member had completed a procedure they were not yet trained in this had been reported, investigated and appropriate action taken. One person told us "No problems with medicines at all." Another person told us "There was a problem with the wrong dose but staff sorted it for me and it was fine."

Requires Improvement

Is the service effective?

Our findings

The registered manager provided us with a training report which showed that the majority of staff had either received training or were booked to attend training in core areas such as moving and handling, safeguarding, deprivation of liberty and food safety. We noted further sessions would be required to ensure all staff in need of refresher training were able to attend. The registered manager also told us that they were currently planning how training would be delivered to ensure they met the requirements of the care certificate. The care certificate is a certificate of fundamental care which sets out learning outcomes, competencies and standards of behaviour for staff working in social care. It is expected that this will be introduced in April 2015.

We reviewed the supervision matrix for all staff and noted that there were inconsistencies in the frequency and regularity of supervision. In the eight months since the last inspection of the 87 staff detailed on the supervision record only 13 staff had received two supervisions, 34 staff received no supervisions at all. We reviewed the list of current care staff and their start dates and found that 77 staff who had start dates before October 2014 were not on the supervision record dated 11 Dec 2014. Supervisions are used to check staff progress and provide one to one support.

It was noted that none of the staff files reviewed contained annual appraisal; when asked the registered manager told us "appraisals have never happened historically."

There were conflicting statements about support and supervision. All the staff we spoke with told us they felt supported by their manager and one staff member said "They are always available and easy to talk to." Senior staff provided out of hours support for staff and the registered manager told us "my phone is never off; I'm always available for support and will contact staff."

One staff member told us "In November this year it's been six months since I started work in this company and I had just one supervision meeting. The supervision meeting was about August. Since then I had no more." Another staff member told us "I've been working for three and a half year and had three supervisions." Records confirmed this staff member had received supervision in March 2012 and June 2014. An office based staff member told us "I feel well supported, not really had supervision as I work closely together so speak every day." Other staff told us they had supervision "As required."

We reviewed the supervision policy and procedure dated 20 March 2012 which stated that supervision should be held regularly and is seen as the primary source of support for employees, recognising the considerable demands inherent when working in adult and child care. The policy and procedure does not give guidance on how regular supervision should be but the employee handbook states support and supervision session are normally held between a supervisor and supervisee, scheduled on a monthly basis. When asked about supervisions the registered manager told us "We need to support staff, they do a difficult job, supervision and praise is really important" they went on to say "The new process is three supervisions a year plus an appraisal as a minimum using 'All About Me'. Staff can have an ad hoc supervision if needed. Managers and coordinators have been trained in 'All About Me'."

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the staff we spoke with told us that they had received an induction, which included "Moving and handling, safeguarding, medicines, hygiene and health and safety." Another staff member said "It included equality and diversity, confidentiality, end of life, palliative care, documentation, lifting and handling, medicines and personal protective equipment."

Staff confirmed that if they needed it, specialist training was provided such as when caring for people with specialist feeding techniques or those who needed stoma care for example. Staff told us "nurses do the clinical competency and sign us off, it's good."

Staff had an understanding of mental capacity and told us "It's about making sure people have the ability to make their own decisions; give people the chance to answer. Might need to get the family involved and seek support from social services." The registered manager told us "We would get other professionals involved in decision making but start from the standpoint that people have the capacity to make decisions and involve people." They also told us "new mental capacity training is being put together and the policy is being updated in line with the recent supreme

Requires Improvement

Is the service effective?

court judgement." No one the service supported currently had a Court of Protection in place, however staff knew the process to follow if they had any concerns regarding someone's capacity to make decisions."

We saw care records included information on whether people had mental capacity assessments and how to support people to make their own decisions. It was noted that care plans and pre-assessment paperwork were being updated to include more information around capacity and decision making. People or their relative or representative were encouraged to be involved in care planning and reviewing needs by attending three monthly reviews with a senior staff member and their care worker. One relative told us "they always ask before doing anything." A staff member told us "I talk through what I am doing and gain their consent before I do it. I ask the person what they prefer best during their care and give them options."

People and their relatives told us they were happy with staff and thought they understood their needs. One relative told us "They know how to look after my husband, they're nice, explain things to him. Ask consent. No complaints about them at all." Another said "[relation] likes a lot of banter and carry on and they all join in. I don't have any worries about care in our home."

Initial assessments and care records included information on people's nutritional needs and preferences. This included detail of what support was needed, how the person needed it and when it was needed, for example one care plan detailed that the person only ate kosher food but that it was mainly provided by family members. Records detailed people's preferences and choices for example 'I would like staff to ask me what I would like to eat; normally I have sandwiches, salad or baked potato.'

We saw that an occupational therapist had assessed someone's sleeping position and had provided detailed information about how the person needed to be positioned and how often the position should be changed. These instructions were included in the person's care plan. We also saw that an occupational therapist had written a handling plan for supporting someone with standing and walking. This included pictorial information for staff to follow. The occupational therapist had also delivered specific training for staff where specialist procedures were required.

The registered manager told us they work very closely with consultants, hospitals and specialists; they said "They are the professionals so we follow their lead." Some care staff felt confident and comfortable to liaise with GPs or nursing staff but where they didn't it was reported and the senior staff took a lead role.

Good

Is the service caring?

Our findings

People and their relatives told us they were happy with the staff. One person told us "Yes, I am happy, I am lucky because I have a very good carer, she'll do anything." Another person told us "They are very kind, it was my birthday last week and they gave me a card." One relative told us "The level of care is really good, they take time to understand her [relative], standard of carers is fabulous, [relative] is happy." A staff member told us "I love my job. It's about what you can do to help people; I want the best for people." Another told us "Aim to treat people how we would want to be treated."

One commissioner told us "We continue to use Care Visions for our packages as they are now very responsive, caring and understanding of the urgency of our work, the team always keep us up to date with any concerns so that we can get these back to the clinician involved with the patient. They do go the extra mile for our patients where they can without compromising quality of care. We work together which is very important in supporting the carers and families of palliative patients."

An initial meet and greet was completed with staff and this was an opportunity to get to know people's preferences such as times of visits, gender of staff, any religious or spiritual needs people may have. The person and their family were encouraged to be involved in this so staff could get to know the person and their history. The registered manager told us "We try to find the 'best fit' during meet and greets with clients and family members. Some staff files contained one page profiles which detailed their hobbies and interests and what was important to them. A senior staff member explained that these had been used so people could be involved in choosing who supported them and their interests could be matched with people. When asked why there were only a few in place the senior staff member told us "we are working on it with all staff, not everyone sees the point of them but we'll get there."

The registered manager told us "We don't offer 15 minute calls as we don't think it's enough time to deliver appropriate care and support." The rota manager said "We will offer different times if we can't meet people's needs at the time they've asked for but we review this; if they specifically need support at a certain time for medicines or something similar, if we can't meet the need we explain why. A rota is put in place and is sent out for the person's approval before we start to support them."

Care staff were able to explain how they treated people with dignity and respect and training was included in staff induction. They told us "Do personal support in a private room and don't talk to anyone else other than the staff involved about the person you are working with." Another staff member told us "Give value to good communication with individuals in ways that are meaningful to them. Showing them that you value their needs in respect of how they want to be cared for." Staff went on to tell us "I support independence by asking open questions about their needs and giving them choice to decide." People told us that they were treated with respect and their privacy was maintained. One person said "They speak very politely; have a joke and a talk."

Staff had received training in end of life and care plans were in place which detailed who to contact and what people's spiritual preferences were. The registered manager told us "the health professional details the actual care that we provide but we need to know what the person wants us to do and who they want us to contact. It's really important that we support people well and if needed we will support families after their loved one has passed."

Good

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to their needs, that they were never rushed and generally there was always enough time to meet their needs. One person told us "If more time's needed staff stay." Another person told us "They always ask if there's anything else we need before they go."

One relative, when asked if there was enough time to carry out care said "Definitely because there's plenty of time." Another told us "Yes, book them for an hour and most of the time they're here for the hour." One person said "Have had two carers four times a day and it's been reduced according to my needs."

We were told people had been asked whether they preferred to have a male or female staff member. A relative told us "Always been female. Was called one day and told a male staff could cover but my husband refused which was fine."

Initial assessments were completed with the person and their family members. Reviews were completed every three months to seek feedback on how the support was going and if anything needed to change. One person told us "They came out a couple of weeks ago to do a review." We could see reviews included people and their relatives and they were often signed by people. The registered manager told us "The main copy is kept in people's homes and they are all signed by people and family members."

Care plans were individual and included peoples preferred name and any preferences in terms of gender of staff, and any spiritual or religious needs. Assessments included information on how many staff needed to attend each visit and there was a list of contact details of other people involved in people's care, for example a carer, physiotherapist and GP.

Information on allergies, communication, social and emotional wellbeing, culture and spiritual beliefs as well as medicines, nutrition, moving and handling and personal care were all included in care plans and risk assessments. They acknowledged what people could do for themselves in order to maintain their independence. For example, one person did not need support with upper body personal care and dressing.

Details on how people liked to be supported were included. For example, one medicines care plan stated where medicines were stored, to make sure the person was in a sitting position so it was easier for them to swallow, to use the tall blue beaker for a drink and that the person liked to have a small cup of tea after their tablets. This care plan was signed by the person to say they had been involved.

Some pictorial information was included in files such as a plan for using an ambiturn that was completed by the physiotherapist. An ambiturn is a specific piece of equipment that supports people to transfer from seat to seat.

Communication care plans contained detail such as speaking to people on their level and in their line of vision, 'don't bombard me with questions' and 'give me time to answer'. Specific detail on understanding people's behaviour was included such as 'when I put one arm in the air it means move me up'.

People and their relatives told us they knew how to make a complaint and one person told us "One of the carers was more interested in watching the telly. I rang the manager and they never came out again." One relative told us "I complained when [relative] didn't have continuity of care and they took their time to respond," they went on to say "It's all resolved now." Another relative also told us about concerns with not having consistency in staff but they said "We've been told that it will be resolved in the New Year." The service had a complaints file and log which included a copy of the policy and a risk assessment tool. In June 2014 a new recording system had been introduced in order to ensure a robust record was kept of the date of the event, the initials of those involved, the number of concerns raised and the name of other professionals involved. It also gave space to record the incident or complaint, the action taken and the outcome. A colour coding system was also being used to track the status of the complaint, for example red, amber and green, so it was easy to identify progress made in investigating any concerns or complaints.

Since the last inspection there had been seven complaints received. It was seen that complaints were recorded, investigated and responded to in an appropriate and timely manner. For example one complaint was dealt with within 16 days.

Good

Is the service responsive?

One commissioner told us there had been historical concerns but Care Visions were being more pro-active in addressing concerns and there were signs of greater team working. Another commissioner of services told us "there were a few teething problems in the beginning" they added "concerns were addressed immediately to everyone's satisfaction. The team who work with us have a clear understanding of the nature of our work and ensure packages are in place quickly and as requested."

Good

Is the service well-led?

Our findings

At the time of the inspection the service had an established registered manager who understood her responsibility in relation to the submission of statutory notifications to the Care Quality Commission. They were supported by a clear staff structure which included three care coordinators, a large team of care staff and a chief executive. The service also had support from a rota management team, training department, HR function and recruitment team.

The atmosphere in the office was relaxed and open and people had positive working relationships with each other. The chief executive was seen walking around chatting with people at their desks and was keeping up to date with day to day activities. They told us "We have a transparent culture, my door is always open, I get involved in care workers recruitment and will provide care and support if needed."

An office worker told us "The manager is good, I can go with worries or concerns, we work things out if we don't see eye to eye. I can go to the chief exec if I wanted to, I know who she is, her doors always open." The registered manager told us "There's a culture of if it's wrong let's fix it." A care worker told us "The manager reacts to suggestions and listens to staff". A senior staff member told us "there's local decision making, a focus on growth and catching up with systems and processes" they went on to say "I have a direct line to the chief exec who is the change agent so things get done."

We saw evidence of regular employee forum meetings and the minutes showed inclusion from care staff representatives. Items discussed included health and safety, appraisal processes and working conditions. We saw that it had been agreed that if calls were cancelled with an hour or less notice staff would still be paid.

Staff and commissioners had raised that responsive communication was an issue, a commissioner told us "senior staff were often slow at getting back to people and open communication was lacking at times." When asked the registered manager told us "We are going to introduce a lead into each team so they can act as the main point of contact for communication and liaison." When asked about team meetings staff gave mixed feedback, half of the staff spoken to said they had team meetings and they were useful the other half of the staff said they did not have team meetings. Staff told us that information was relayed via telephone, text or email at the minute. Written handovers were recorded in daily records books and the registered manager told us they were looking at putting a more formal, detailed written handover in place for all packages of support.

The registered manager also told us that "We have recognised that the care co-ordinators need a higher skill level and so have reviewed expectations and salary," she added "we are working with people to support their development".

Governance meetings were being introduced and dates had been set for 2015 so the meetings could follow senior management team meetings. The agenda included clinical risk in the branch and the review of policy and procedures. The meetings would include analysing trends in complaints, accidents and incidents and safeguarding. The registered manager explained that this meant "Operating as a multi-branch organisation and learning from each other." They added "There's a more coordinated approach to risk now and we look at response times and action taken. There's lots of learning and discussion but it's improving things."

The chief executive told us how Care Visions were working with a Doctor in Singapore and Beijing to share good practice and learning. There were also established links with Yale and Harvard.

The service currently had a quality assurance policy and continuous improvement framework which focuses on service reviews, serious incident reviews, fact finding investigation, inspection reports, improvement plans, complaints and the review of findings from disciplinary and capability investigations and hearings. The registered manager also told us "We are assessing quality assurance and planning to develop peer reviews, self-appraisal and cross validation."

We also saw that spot checks were completed where a senior staff member would visit the person at home whilst their care staff were present to observe the quality of support provided and gain feedback from the person. The registered manager told us we are looking at a "common sense approach for working in people's own homes, looking at developing top tips."

People's files and daily notes were audited and included comments and outstanding tasks to be completed with a timeframe. We saw that the registered manager used a

Good

Is the service well-led?

traffic light system when auditing files to indicate whether urgent action was needed (red), action was needed (amber) or files were of good quality and no action needed (green).

We saw that feedback was sought from people and their relatives on an individual basis. When asked about improvements made to service provision in response to feedback the registered manager told us "Because the support we provide is often short term it's difficult to do a full annual survey but we are starting to look for trends and improvements through the governance meetings. Changes are made to individual packages in response to feedback."

We asked people what they thought of the service they received and they told us they thought it was good. The only improvement mentioned by the people we spoke with was the need for more consistency in staff. One person mentioned that the cooking skills of some staff could be improved upon. Others said there were no improvements that they could think of.

People and their relatives told us staff morale was generally good, staff seemed happy in their work and one person told us "They are always cheerful, I like them a lot."

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
Nursing care Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **People were cared for by staff who were not always supported or trained to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1)(a).**