Practical Care Ltd

Practical Care

Inspection report

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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 at the Practical Care office on 12 and 13 March 2018. Following the inspection on the 14 March 2018 we made telephone calls to people and relatives who used the service. On the 26 March 2018 we made further calls to staff members to gain their feedback on the service.

At the time of the inspection Practical Care provided domiciliary care and support for 89 people in their own home. The service worked primarily with older people living with dementia and people with physical and mental health needs. People received varying levels of support depending upon their care needs from 24-hour care to one visit per day.

The Care Quality Commission (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.

At our last inspection on 29 September 2015 we completed a focused inspection that looked at the key question of 'effective' only. This was to ensure that a breach of regulation found at the previous comprehensive inspection on 22 December 2014 regarding documenting people's ability to consent to their care had been addressed. We found that the service had addressed the breach of regulation and the key question of effective was rated as 'good'. This meant that the service was rated 'good' in all key questions and therefore 'good' overall.

At this inspection we found a breach in regulation around adequate risk assessments. The service is now rated 'requires improvement'. This is the first time the service has been rated as 'requires improvement'.

There was a registered manager in post. A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was present throughout the inspection.

Risk assessments were inconsistent and did not always detail known risks. There was insufficient guidance for staff on how to minimise known risks to people receiving care.

Medicines were overall well managed but we have made a recommendation about medicines management.

People's care plans detailed tasks to be completed at each care visit. However, care plans were not always person centred. The provider was in the process of updating the care plan format.

Staff understood what safeguarding was and were aware of how to report any concerns if they had them. Staff understood what whistleblowing was and who to contact if necessary.

People are supported to have maximum choice and control of their lives and staff support them in the least

restrictive way possible; the policies and systems in the service support this practice.

Staff had received training in infection control and were aware of how to control and prevent infection.

Staff received regular, effective supervision, appraisal and training.

People and relatives were positive about staff and felt that they were kind and caring. People received a continuity of care and often had the same staff.

The service worked well with people at the end of their lives and provided end of life care. Staff were compassionate regarding caring for people at the end of their lives.

Audits were carried out across the service on a regular basis that assessed areas such as medicines management, health and safety and the quality of care. Telephone surveys were completed with people who use the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

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. Risk assessments were not always in place for identified risks. Where risk assessments were in place these did not provide adequate guidance for staff on how to minimise the known risk.

People were receiving their medicines. However, there were no 'as needed' medicines protocols in place. We have made a recommendation regarding medicines.

The provider followed safe staff recruitment practices.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

People received a continuity of care and usually had the same staff visiting them. Staff were on time and stayed for the full duration of the scheduled care visit.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and how this impacted on people that they worked with.

Staff received regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

People were supported to have enough to eat and drink so that their dietary needs were met.

People were promptly referred to healthcare professionals in a timely manner.

Is the service caring?

Good

The service was caring. People were supported and staff knew people well and understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care and were involved in planning their care.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive. People's care plan detailed tasks to be completed. However, people's personal histories, likes and dislikes had not always been noted. The service was updating care plans.

Staff were knowledgeable about individual support needs, their interests and preferences.

People were encouraged to be independent, be part of the community and maintain relationships.

People knew how to make a complaint. There was an appropriate complaints procedure in place.

End of life care was well managed.

Is the service well-led?

Requires Improvement

The service was not always well led. Whilst risk assessments had been completed the registered manager had not audited them to ensure that they provided staff with enough information to mitigate known risks.

Medicines audits had failed to pick up issues identified during the inspection.

There were regular staff meetings that allowed the sharing of information and ideas.

There was good staff morale and guidance from the registered manager and senior staff members.

The service had a positive open culture that encouraged learning. Staff felt supported by management to carry out their role effectively.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

Practical Care

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.

We gave the service 48 hours' notice of the inspection visit because it is a small domiciliary care agency and we needed to be sure that members of the management team would be available to support the inspection.

This inspection took place on 12, 13, 14 and 26 March 2018. The inspection was carried out by two adult social care inspectors and three experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. At this inspection the experts by experience made telephone calls to people that used the service and their and relatives following the on-site inspection.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to us. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service. We also gained feedback from two external stakeholders from the local authority that commissioned services with Practical Care.

We used information the provider sent us in the Provider Information Return which we received on 11 August 2017. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, the quality manager, other office staff and one staff member that provided care to people. We also spoke with the nominated individual. The nominated individual is someone who is registered with the CQC as a key point of contact and is responsible for ensuring good communication with CQC. We looked at eight staff files including recruitment, supervision and appraisal's, nine people's care plans and risk assessments and other paperwork related to the management of the service including staff training, quality assurance and rota systems.

Following the inspection we spoke with 10 people that used the service and 14 relatives. We also spoke with six staff members.

Requires Improvement

Is the service safe?

Our findings

People's healthcare conditions were detailed in their care plans. However, we found that risk assessments were either not in place or failed to provide enough information on how to minimise the risks associated with people's health conditions. For example, one person's care plan stated that they had a catheter in place. However, there was no further information on how this was managed and no risk assessment in place to ensure that staff understood how to minimise any associated risks. One person was noted to have a history of pressure ulcers but had no risk assessment in place. Another person's care plan stated that they had recurrent falls and were at risk of urinary tract infections (UTI). There was no falls risk assessment in place or explanation of why the person was at risk of falls. There was no risk assessment around the known risk of UTI's or information on how staff could recognise if the person was developing a UTI.
This may place people at risk of harm because insufficient guidance has been documented in people's risk assessments to ensure that staff are fully aware of how to minimise known risks.

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

We raised the inconsistency and lack of risk assessments with the nominated individual at the time of the inspection. The nominated individual told us that risk assessments would be reviewed. Following the inspection, the nominated individual sent us a sample risk assessment for one person. The risk assessment was much improved and detailed each risk the person had, how it may affect them and gave guidance for staff on how to minimise the risk. People had regular staff visiting and staff that we spoke with knew people and understood their risks and how to work with them. However, while we are satisfied that the provider is now reviewing the risk assessments, this will be checked at the next inspection.

People that we spoke with were positive about the support they received and said that they felt safe with the staff from Practical Care. People said, "They do make me feel safe and I've never had any concerns. They provide personal care such as bathing" and "I feel safe in their hands" and "I do feel safe with carers in the house." Relatives commented, "I have the utmost confidence in them and they are also very friendly", "He does feel safe when they come, they make sure he's breathing okay and they take things slowly and do not rush him" and "We do feel safe with the carers that are coming and safe with them in the house. My wife gets agitated, but they are very good with her."

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. Staff comments about safeguarding included, "We had training. I know there are different forms of abuse. If I needed to I would report it to the office" and "It's [safeguarding] to keep the client safe and protect them from abuse." Staff had received training in safeguarding which was refreshed each year.

Staff understood what whistle blowing was and how to report concerns if they needed to. Whistle blowing is where staff are able to make any concerns known to an organisation external to their company, such as the

local authority and CQC, without fear of recrimination.

Records showed that staff received medicines training and were subject to a competency assessment following training before being allowed to administer medicines alone. Medicines, where required, were administered in people's homes and staff completed Medicine Administration Records (MARs) to show that medicines had been administered. We found some concerns regarding the services medicines auditing process which has been detailed in the 'well-led' section of this report.

People told us that they were given 'as needed' medicines (PRN) when necessary. However, the arrangements around this were not always documented and there were no PRN protocols in place. 'As needed' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain. We discussed this with the nominated individual at the time of the inspection who said that this would be reviewed.

The service was in the process of putting new medicines forms in place for each person that included all prescribed medicines and any PRN medicines and we looked at five people's new formatted medicines records. However, this had not yet been completed for all people that the service administered medicines to.

We recommend that the provider seeks guidance from a reputable source around management of medicines within a Domiciliary Care Agency (DCA) setting.

The service followed safe recruitment practices. We looked at eight staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role. The recruitment policy had been updated since the last inspection and the provider now re-applied for staff members' criminal record checks every three years in line with best practice. The registered manager also told us, "Following the first [criminal records check upon initial employment] the agency registers each [staff] with the on-line service so that we can re-check easily."

We asked people and relatives that we spoke with if staff turned up on time for care visits and if they stayed the correct amount time that they were supposed to. Feedback included, "They've been very good. They come even when we've had terrible weather, they get here trudging through the snow. I like to think of them as 'Carers Who Care'", "They've been late on occasion, but they've always turned up" and "Sometimes they may be a few minutes late. They don't let me down. They always stay for their time." Where people required two staff to visit at the same time we found that staff arrived in good time. A person said, "I have double ups who arrive separately or together. When they arrive separately they are never far apart." A staff member said, "Yes, I stay the right time. It can take you more time because people are often happy to see you and I like to have a chat."

Rotas showed, and staff told us, that they had enough travel time between care visits to ensure correct arrival times. The nominated individual completed rotas daily and told us that people had regular staff. People were asked their choice of time and the service accommodated this as far as practicable. The service understood the importance of people receiving a continuity of care to help build and maintain a caring relationship between staff and people. People and relatives told us that they received regular staff. The service had no records of any missed visits and people and relatives that we spoke with said that staff always turned up. The nominated individual told us that people and relatives would contact the office if there were any concerns or staff had not turned up, but this had not happened in the past year.

People were protected from the risk of infection and staff had received training in infection control. The office kept an adequate supply of Personal Protective Equipment (PPE) such as gloves and aprons. People and relatives said that staff always wore PPE when giving personal care. Documented spot checks on staff showed that the service checked that staff were following correct infection control procedures when delivering care.

Accidents and incidents were documented. The service had recently moved offices and had archived some of their paperwork including accidents and incidents. There was one incident documented form December 2017. This had been well documented and followed up. We also saw that the service had visited the person following the incident and completed an investigation and contacted relevant healthcare professionals. Accident and incident reporting forms were located in each person's home and included guidance for staff on how to complete them.

Good

Is the service effective?

Our findings

People were supported by staff that received regular management supervision and training. Staff received an induction when they commenced employment which included training and shadowing before being able to work alone. A staff member commented, "We shadow for a week and then a spot check is completed to see if you are ready [to work alone]. Some people need one or two spot checks and they give longer shadowing if you need it." People were aware and informed when new staff were staring and shadowing. A person told us, "They [staff] know what they are doing. They brought a young one round to show her what to do."

Staff received regular supervision every two months to support them in carrying out their role. The service alternated spot checks and supervision. One month staff received supervision and the next month a spot check. We were told that this enabled supervisors to document and follow up spot checks and helped maintain the quality of care being provided. Staff said about their supervision, "We look at training, it gives us advice and how to improve. It's quite good actually" and "They always review all my work." Records showed that staff received yearly appraisals which allowed the staff and the service to review their working practice and identify any training needs.

Staff received regular training. Mandatory training such as safeguarding, health and safety and mental capacity was refreshed yearly. The nominated individual told us that where there may be a requirement for specialist training, this was provided. For example, where people required food via a specialist feeding method such as PEG. A PEG is a way of feeding a person, that is not able to swallow, directly into their digestive system and requires specialist training. People commented that they felt that staff were well trained. One person said, "I think they [staff] are well trained and have training programs and it seems detailed. I can only say from what I have observed, how they do their work, they seem to have their part of it well organised". A staff member said about the training, "They won't let you leave the training until they are sure that you understand what has been said. It's very thorough."

The service completed regular spot checks on staff performance that was completed by a supervisor in people's homes. A staff member said, "Spot checks looks at everything from the client. How the service user is and how we look after them. It's good because if you are not doing something right we can be corrected on the spot which is good for us and the client as well. It's about learning." We saw that where an issue was identified, this was addressed with the staff member and actions taken or required were documented.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the

Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team.

There were no people using the service that were subject to a judicial DoLS. We checked whether the service was working within the principles of the MCA. People's care plans documented their capacity and whether they could make decisions. Where people had capacity, we saw that they had signed their care plan. Staff were aware of what steps to take if they noticed a change in a person's ability to make decisions. A staff member said, "If we notice that someone may not be able to make a decision and see that there could be a change in the person's mental capacity then we report it to the office, contact the GP and next of kin or someone with Lasting Power of Attorney (LPA) would need to make the decision."

Once the service received a referral they visited the person and where appropriate, the family. The pre-assessment looked at all aspects of the person's care. The nominated individual told us that the care plan was the finalised written up assessment.

The service provided light meal preparation for people where this was required. This was often heating food up for people or making a snack such as sandwiches. Staff commented, "We prepare light meals like sandwiches. I ask what they [people] like. One lady has a special diet. We communicate with the daughter and she tells us what to do." Another staff member said, "If I go in at lunchtime and they have a meal, I go to them and ask what they would prefer. So that they can make a choice of what they want."

The service did not generally attend healthcare visits with people as these tasks were completed by family members. Where the service was providing 24-hour care to people staff did attend healthcare appointments. Staff were aware of how to refer people if they thought their health needed attention. Relatives commented, "That's my responsibility [healthcare appointments] but they have prompted on a health issue on one occasion", "They inform us of any health conditions that need attending to" and "They would tell me if there was a problem with general health."

Good

Is the service caring?

Our findings

We asked people and relatives that we spoke with if they felt that staff from Practical Care were kind and caring. Feedback from people and relatives was positive and comments from people included, "I have a splendid relationship with the carers and they remind me of things that to be done sometimes" and "They are caring and show it." Relatives told us, "They do care, you can tell that it's not just a job for them, they are genuine helpers" and "I know they are caring because they will shut the curtains and ask her if she is warm enough and do you want a blanket? Generally, the flat is usually quite warm, but it shows they care enough to ask."

Staff understood how to promote and maintain people's dignity and respect. All staff that we spoke with could explain how they would ensure dignity when carrying out personal care including ensuring the doors and curtains were closed, only exposing parts of the person being washed and communicating with the person as to what they were doing and checking that this was ok. A person told us, "I can close my door and get my privacy if I don't want to be disturbed. They assist with bathing, they help with things I can't do. When bathing and dressing, they make sure I'm covered up and my modesty is intact."

A staff member spoke about how they ensured dignity and respect around people's religious beliefs and told us, "It [dignity and respect] is also around someone's religious values. For example, we live in a diverse country, it could be food or clothes that the service user prefers based on their religious values. I need to understand and respect that and give choices based on their preference."

Telephone surveys conducted by the service with people and relatives asked if they felt that staff treated them with dignity and respect. Records we saw as well as people and relatives that we spoke with were positive about the culture of the staff and felt that they were always treated with dignity and respect.

Staff understood the importance of promoting independence where possible and encouraging people to do things for themselves. People were positive about the staff promoting their independence and told us, "They let me do what I can do myself", "Oh yes they do [promote independence]. They think I am too independent. I like to do everything myself" and "Yes definitely, I can now manage to get showered and dressed myself and soon I won't need the carers at all." Relatives said, "Yes they help him. He now washes and does his teeth in the bathroom before he was doing it in bed, with a bowl of water" and "They will encourage mum if they feel it's needed; if she doesn't want anything done, they will respect her wishes."

Staff were aware of the importance of talking to people and communicating effectively whist delivering care. Relatives said, "Sometimes I am not in the same room, but I can hear them having a conversation with my husband. It's like a friendship and they are saying what they are going to do. When they are leaving I hear them say "I'm going now, and that tells me they are caring people", "What I have noticed is that they speak to him while they are caring for him, so he has a rapport with them" and "I do feel they care, they speak to him while taking care of him". Rotas ensured that staff had enough time to provide care in a compassionate and personal way.

Staff were positive about working with people who identified as gay, lesbian, bisexual or transgendered (LGBT). Staff told us that this would not make any difference to how the person was treated. Staff understood that homophobia was a form of abuse. One staff member said, "There's no effect. It's basic we are all human beings."

Good

Is the service responsive?

Our findings

People had regular staff and staff that we spoke with knew people well and were able to talk about individuals likes and dislikes. A relative said, "I would actually say they are very good and I do feel he gets the care he needs. I have not discussed likes or dislikes or any preferences with service, but they are very good". Staff that we spoke with confirmed that they had access to up-to-date care plans in people's homes. A staff member said, "They're [care plans] are in people's homes. They have information that helps us understand the client."

Care plans contained detailed guidance for staff on tasks that needed to be completed at each visit. However, there was no information in care plans around people's life histories. People's likes and dislikes documented were inconsistent in the care plans we looked at. For example, one person's care plan gave staff detailed guidance on how to provide personal care, whether the person wanted soap or shower gel, what the person was able to do for themselves and what they required help with. Other care plans did not contain this type of detail, for example; one person's care plan noted that the person 'requires help with food'. However, the care plan failed to state what type of help the person required or what their preferences may have been. Another person received three care visits a day and was noted as having a history of panic attacks and depression. The person's care plan did not state how the panic attacks and depression affected the individual and what staff should be aware of if the person's mental health was declining. For another person, their care plan stated that the person had 'confusion'. However, there was no further information on what this meant or how it may impact on care provided.

Following the inspection, the provider sent an updated care plan that had greater detail around the person, their history and preferences. Whilst we were satisfied that care plans were being reviewed and people told us that staff knew them well, this will be checked at the next inspection.

People and relatives told us that they were involved in planning care and had input into the care plans. A person said, "I have copy of the plan in my file. I was mostly involved in its contents." Relatives commented, "My mother has one [care plan] which I've looked at. I was there when management visited and we went through it" and "[The] Care plan was arranged with my brother and there's a copy in front of the folder." Another relative said, "They also discuss his condition with me, we are able to discuss and make decisions about [relative's] care. The line manager comes about every three months and we have a chat about how things are going and he is very helpful."

The service kept records of complaints it had received. We saw that for any complaints an internal investigation was carried out and any actions taken were noted. People were given information on how to complain when they began using the service. Feedback through telephone surveys and reviews showed that the service encouraged people to complain if they were not happy with any aspect of the service being provided. People told us that they knew how to raise concerns or complaints if they needed to and had been given information by the service on how to do so. Feedback included, "Oh yes, I have the office's number. The office staff are very friendly", "I have a telephone for the blind. I press nine and I am through to the office" and "The Practical Care number. I have phoned them when the carer was a bit late. They resolved the

issue and came back to me."

People and relatives told us that they felt the service listened to them and took their views into account. One person said, "Yes, I think they do listen." Where possible, people were given the choice of a male or female staff member. Relatives told us, "I was given the choice of male or female carer to live in and I chose female as I could not have a man living in the next room" and "They are respond to our needs, my husband is not able to speak, but I know when something is not right, and I can speak to carers and the manager if I need to but have not had to do so. They listen to what I have to say. He did not get on with one carer and I told the supervisor and we got another one with no problem".

The service worked with a high number of people requiring end of life care. Care plans we looked at for people receiving end of life care were person centred with regards to information on care visits and what care workers needed to do during each visit. The service was often commissioned to work with people in the last days or weeks of their life and care provided was primarily around personal care.

The registered manager told us that the service did not provide specific end of life training to staff. However, all training provided contained elements of end of life care and the registered manager said, "End of life runs through all training as it relates to each area, such as infection control. A lot of our carers are experienced in providing end of life care."

Compliments received by the service regarding end of life care included, 'A note to say a big thank you to you and the girls. Your care was second to none and mum's dignity remained throughout', 'Our personal thanks and appreciation to [staff] for their care, patience and attention, which made it possible for mum to remain in her own home. We particularly appreciated how she was treated as a person, with her own wishes and preferences, not just a job to be done' and 'The help, support and compassion shown was greatly appreciated through a very difficult time for mum and our family. An exceptional team who were all professional in their approach and who showed such empathy from beginning to end'.

Requires Improvement

Is the service well-led?

Our findings

When looking at 'well-led' we look at how the provider ensures good governance and oversight of the service. At this inspection we found that the systems for checking and auditing the care provided by the service were not always effective. This related to medicines and risk assessments.

We looked at seven people's MAR charts that had been returned to the office for auditing. Auditing had picked up gaps in signing for medicines. Where this was identified the service had investigated and provided the reason for the staff member not signing. For example, person in hospital or medicines given and recorded in daily notes but not signed on the MAR. However, for five of the MAR charts we looked at we found that there were gaps that had not been picked up by the auditing process. One person's audit stated that the person continuously refused their medicines. However, the audit failed to say what had been done about this and what staff needed to do.

Risk assessments failed to provide sufficient guidance for staff on how to mitigate known risks as documented in the 'safe' section of this report. There were monthly client audits that looked at care plans. However, issues identified at the time of inspection regarding risk assessments and care plans had not been identified by the service.

Staff were positive about the nominated individual and felt that they received timely and appropriate support from him. Comments included, "He's [the nominated individual] hands on. Every detail of everything, he is involved. We can call him anytime. He's always there" and "I think he's very professional. He's friendly and knowledgeable and will help you when you need it. Very approachable."

People and relatives that we spoke with were also positive about the nominated individual and communication with the office. People said, "Their attitude is good and I sense that they care" and "I think by and large they employ good people; my only contact with management was very favourable." Relatives told us, "They're very good and I'm very pleased with them; no problems at all" and "I think it's a good enough service. When I called up initially, the management seem to know what they were doing and were business like."

We received positive feedback from two staff within local authority who commissioned services from Practical Care. We were told that they had not received any complaints about the service and said that the service maintained good communication with the local authority. The nominated individual told us, "We work closely with the local authority. If we need something we can phone them. We update them and they update us. You can't be on your own, we have to work together for the clients."

There was a system in place for the service to gain feedback from people and relatives. People's care files documented that regular telephone surveys were conducted with people that used the service and their relatives. People commented, "They rang me on Monday to see how things were. They come round every few weeks."

There were various audits conducted by the service to check the quality of the service. Staff files were audited monthly and monthly client audits looked at communication logs, spot checks and telephone surveys. There were systems in place to ensure that staff training was up to date and training records were updated monthly. Training audits looked at each staff member and what training they had completed and identified training still required. Supervision records showed that staff were able to identify and request training. Where specialist training needs were identified, this was provided by the service. The service audited supervision to ensure that staff were receiving regular supervision. Where any issues were identified, we saw that actions had been noted and followed up.

There were records of regular staff meetings that allowed staff to discuss care needs and development of the service. Staff told us that they could talk to the registered manager at any time.

We reviewed accident and incident logs. It showed that the manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read. Staff told us that they knew how to report and record accidents and incidents.

We were told, and we saw records, that the office staff started each day with a meeting. A member of the office staff prepared a handover for the day which provided an overview of issues that needed to be addressed that day. This included following up any care provision, staffing matters and general tasks. Staff said that they felt that this meeting meant that the nominated individual and the registered manager had a good oversight of service management.

All policies and procedures held by the service were up to date and included date for review. The provider updated policies as and when necessary according to legislation changes and reviewing care practices within the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments failed to provide adequate guidance for staff on how to minimise people's known risks.