Prestige Nursing Limited

Prestige Nursing Halesworth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Prestige Nursing Halesworth provides personal care and support to people in their own homes. They were supporting 70 people when we inspected on 8 December 2016. The provider was given 24 hours' notice of our inspection because the location provides a domiciliary care service and we needed to know that someone would be available.

There was a registered manager 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.

Prior to this inspection we received information of an incident following which a person died. The Commission made further enquiries into the circumstances leading up to the person's death to consider whether it should take further action under its criminal enforcement powers. We concluded that there was insufficient evidence to warrant criminal action on this specific case but did identify some systemic issues about the management of instances when a person does not respond to a house call and/or the person is not at home to receive their care. Our enquiries around this incident also raised concerns about the provider's management of complaints and application of their Duty of Candour policy and procedure.

This inspection examined the providers systems for managing those concerns. The Duty of Candour policy had been revised and records of subsequent concerns and complaints showed how this was being applied in the way in which people and their families had been involved and kept informed whilst concerns were being investigated and responded to. However there were still lessons to be learned with regard to effective communication and keeping relevant people up to date and fully informed in the interests of open and transparent communication.

During this inspection, we found that the registered provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There were not enough staff or enough travel time scheduled between calls. Ineffective scheduling of calls together with the lack of available staff meant that people could not be assured that they would receive their support in line with their assessed needs. Changes in peoples provision of care and support were not always effectively communicated,

Although care plans were written in a person centred manner, the level of detail was not consistent across the service and some had not been updated following changes in peoples care and support needs. Despite the shortfalls in the care records, people and their families told us they received personalised care which was responsive to their needs.

People told us that they felt safe whilst receiving care in their homes. Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. Procedures were in place to ensure staff were aware of how to safeguard and/or report concerns to protect people from the potential risk of abuse. Concerns had been raised regarding the management of complaints. Although most people knew how to raise concerns and were confident that they would be listened and responded to improvements were needed to demonstrate how this was being proactively used it improve the quality of the service overall.

People were complimentary about the care and support they received and told us staff treated them with dignity and respect. Staff understood the importance of gaining people's consent to the support they were providing. Although staff were generally well trained there was some inconsistencies in how quickly they were allowed to start working on their own following induction.

People were satisfied with the support they received with their nutrition and their care plans reflected their dietary needs and preferences. They received the support they needed to take their medicines and were supported to access appropriate healthcare services.

The provider had quality assurance systems in place which were used to identify shortfalls.. However, these systems had failed to identify and respond to the problems relating to scheduling of calls, staff shortages and poor communication. They had also not identified where guidance and practice were out of date.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff to deliver people's assessed care needs.

Care records included detailed risk assessments which provided staff with guidance on how the risks to people were minimised.

Procedures were in place to safeguard people from the potential risk of abuse.

Recruitment checks were completed to make sure people were safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments in relation to specific elements of people's care were not always in place.

Staff were generally well trained but there were some inconsistencies in the quality of their induction into the service.

People received support from staff who respected people's rights to make their own decisions, where possible.

People were supported to maintain good health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although staff were intuitively caring the provider needed to take action to ensure that staff were supported to be able to do this through the organisation and resource management of the service.

People valued the relationships they had with staff and were positive about the care they received.

People felt staff always treated them with kindness and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The level of detail in people's care plans was not consistent.

Care plans were not always updated following changes in peoples care and support needs.

Despite the shortfalls in the care records, people and their families told us they received personalised care which was responsive to their needs.

Concerns had been raised regarding the management of complaints. However, in the main concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Lack of organisation in the office and ineffective scheduling of calls meant people could not be assured they would receive care and support in line with their assessed needs.

Changes in peoples provision of care and support were not always effectively communicated.

Despite these concerns people and staff felt able to approach the management team and were complimentary about them.

The provider had quality assurance systems in place. However, these systems had failed to identify and respond to problems relating to scheduling of the calls, staff shortages and areas where guidance was not in place or practices were out of date.

Prestige Nursing Halesworth

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 provider was given 24 hours' notice of our inspection because the location provides a domiciliary care service and we needed to know that someone would be available. This inspection took place on 8 December 2016 and was carried out by two inspectors.

Before the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

During our inspection we visited the offices of Prestige Nursing Halesworth where we looked at the care records of ten people, training and recruitment records of staff members, and records relating to the management of the service. We spoke with eight people receiving care and support from the service and one family member. We spoke with the registered manager and six other members of staff.

Requires Improvement

Is the service safe?

Our findings

The provider did not have adequate staffing and managerial oversight and resources to co-ordinate people's care and support in a reliable, robust and safe way. There were not enough staff to deliver people's assessed care needs. One person explained, "I think they need more staff so they can get to us all and to allow the carers more time to get to people." Another person told us, "One day recently I was supposed to have someone come in. They phoned to say they couldn't send anyone. They didn't try to get anyone else. I was going to be on my own all day in bed, I wouldn't even have been able to get a drink." This person had been able to make other arrangements with their family but they went on to say, "If they can't get anyone they need to tell you the day before. They don't give you enough notice. They tell you five or ten minutes before the person is meant to arrive. They say, sorry, I haven't got anyone for today and can't get anyone." A third person commented, "I have had the occasional missed call or the office calls you to say they haven't got anyone. You just have to make do."

Staff also felt that there were not enough of them to be able to effectively cover calls. One member of staff said, "There isn't enough staff. They try and recruit but no one wants to join." Another staff member told us, "We are short on staff, we all cover the shifts but it would take the pressure off if they could get more staff in. It's not their fault though because they are always trying. They even had a table out on the late night Christmas opening to try and recruit new staff. It's hard in a small town." A third member of staff said, "There aren't really enough staff, we all have to pitch in to cover everyone's call but if people get ill it really makes it hard."

Calls were not scheduled effectively by the office to take into account the geographical locations of where staff were coming from and the order in which they did their calls. A person told us, "They send them from a distance. Some have got to travel 30 miles. I'm being rushed because they've got to get to the next one." A member of staff explained, "I think the main issue for me is not having much time to get from one call to the next. Sometimes the office don't plan them well either so you are going 20 miles to come back 20 for the next call and then go back the same 20 for another." Another member of staff said, "I think the travel schedule is a problem. Sometimes they don't plan in enough time or the calls are really far from each other. It can be stressful."

People told us how this impacted on their care. One person told us, "The carers don't have long enough to get from A to B sometimes and I think that's why they get behind. Sometimes they seem a bit stressed and flustered when they arrive and I think it's because they're running late." Another person commented, "There is very little allowance for travel time. The [staff] are trying to squeeze things in. The only way they can meet their schedules is to leave one place five minutes early and arrive at the next place five minutes late." This meant that people could not be assured that they would receive their full quota of support in line with their assessed needs

People were particularly concerned that they were not kept informed when there was change to the member of staff they were expecting to arrive to provide their care. One person told us, "I like to have people [staff] I know…Sometime people are off sick but it would be nice if they rang to tell you." Another person

explained why it was important to them to know who was walking into their home, "I can't see the door from where I sit. I say, 'Who is here tonight?' They say, 'Have they not rung you to let you know.' I say, 'You must be joking' The [staff] show me their piece of paper and say, 'They [office] know there is someone different coming why have they not let you know.' A third person said, "If someone is off sick. I understand if it's an emergency but occasionally it would be nice to inform me whose coming. Even the carers get frustrated." This demonstrated that despite the communication failure within the service following the incident where a person could not be found by a member of staff, lessons still needed to be learnt with regard to effective communication.

We discussed the shortage of staff and how calls were organised with the registered manager. They confirmed that recruitment for new staff was on-going and agreed to look at how the calls were scheduled to ensure travel time was taken into consideration.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection we made enquiries into an incident where a person living alone had fallen in their home and was not found by the carer at their next visit. At the time of the incident there had been no procedure for staff to follow in circumstances such as these. Following the incident the service introduced a 'no response checklist' to all their staff to ensure they knew the correct procedures to follow. This included alerting the office, communication with the rest of the staff team and the person's family, as well as contact with any relevant healthcare professionals. These procedures had also been discussed at staff meetings to emphasise their importance and to ensure people were kept safe. At this inspection no similar incidents had occurred for us to check the system was working, however staff were aware and able to tell us what they would do. Although implemented and understood we remained concerned about the potential risks given the shortfalls in staffing.

Care records included detailed risk assessments which provided staff with guidance on how the risks to people were minimised. This included risks specific to each individual according to their daily activities and support needs. For example, risks associated with pressure ulcers, falls, moving and handling and environmental risks.

People told us that they received the support they needed to take their medicines. There were medication assessments for staff to refer to which gave details of the medicines being taken and the level of support required. Improvements were needed because there were no protocols in place for medicines which were to be taken 'when required' to guide staff as to how and when these should be administered. Without this guidance there was a risk that people may not receive their medicines safely.

Medicines administration records (MAR) identified staff had signed to show that people had been given their medicines at the right time. We did not see that anyone had missed or late support with their medication where needed but given the shortfalls identified on staffing this was an area which needed to be monitored to limit risks as far as possible.

Staff responsible for the administration of medicines had been trained to administer them safely. Regular audits on medicines and competency checks on staff were carried out. A member of staff told us, "I had classroom training and we have observational supervisions where they watch you do the meds. If you fill in the MAR (medication administration record) wrong they [management team] pick you up too." Another member of staff said, "I have picked up a gap on a MAR before but I just phoned it into the office. If I had any query I would just call, it is better to be safe than sorry." These measures helped to ensure any potential

discrepancies were identified quickly and could be acted on.

People told us they felt safe whilst receiving care in their homes. One person told us, "Certainly, I always feel safe. More so when they're here." Another person said, "I feel safe. I wouldn't have them in if they didn't make me feel comfortable." A third person explained, "I have no reason to feel unsafe, they're helpful and help me get along with my day."

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received up to date safeguarding training and understood the provider's safeguarding adults procedures. They were aware of their responsibilities to ensure that people were protected from abuse. Staff members we spoke with demonstrated that they knew about the procedures they should follow if they were concerned that people may be at risk. A member of staff told us, "If I thought someone was at risk of abuse or had been abused I would contact the manager straight away. Or the police if I thought I needed to."

People were protected by robust procedures for the recruitment of staff. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. DBS checks help employers make safer recruitment decisions and help prevent unsuitable care workers from working with people.

Requires Improvement

Is the service effective?

Our findings

There were mixed views and experiences around staff training and competency to meet people's needs. Some told us they were confident in the ability of the staff. One person told us "I'm confident they know what they are doing." Another person said, "I've no concerns that they aren't trained. They seem to know what they need to. They do pick up on it if I'm not feeling myself." However others felt that the newer members of staff did not always have the full knowledge they needed to deliver their assessed needs effectively. One person explained, "I have a new [member of staff] come. They are constantly asking me what I need them to do, which is nice but takes longer. Then suddenly [they] have to go and I'm left with things that need doing." Another person explained to us how they had needed to show a new member of staff how to use a piece of equipment they required to help them mobilise as they had not received the appropriate training. A relative commented, "To get [person] dressed requires a certain procedure. You can write it down but it's not the same as being shown. I feel that [staff] should have at least one shadow session. It ends up with me having to show them what to do and I'm not physically fit."

Peoples comments demonstrated that there was some inconsistencies in how quickly staff were allowed to start working on their own following induction. However, staff were positive about the training they had completed when they first started working with the service. One member of staff said, "I had a full induction. They tried to put as much training in as possible. It is very very thorough. The training here is the best I've had in any company. Everything is done. They won't let you go anywhere or touch anyone until you are done and completed." Another staff member told us, "I had a good induction. I already had a lot of training In my old job but they made me redo it all here. It was pretty good and the shadow shifts after were good too."

Staff told us that they felt supported in their role and received one to one supervision where they could talk through any issues, seek advice and receive feedback about their work practice. Some staff felt that it would be useful to have more regular supervisions, one told us that they had, "Supervision usually a couple of times a year. I think it should be more often but [managers] don't have the time. I do feel supported though, the managers are very open with us and we can phone or come in and chat any time."

The competency of staff was also assessed through observational supervisions. One member of staff told us, "They [managers] do spot checks. They just turn up. They come in and have a chat. Ask the person if it's alright first. They sit in the background then go through it with you before they leave. Records confirmed that these observations took place and demonstrated that checks were being made to ensure care was being delivered in a safe, caring and compassionate way.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. We found that people had mostly been involved in determining how they wished to be supported and had signed their care plans to demonstrate their agreement. However, mental capacity assessments in relation to specific elements of people's care, such as the administration of their medicines, were not always in place.

The medicines for some people supported by the service were kept within their homes but in a locked box so they did not have access themselves. Records showed that the decision to lock away people's medicines had been taken following consultation with family members and healthcare professionals. However, there was no documentation to show that these people were in agreement with the decision to lock away their medicines or formal assessments to establish people's mental capacity in relation to the administration of their medicines. This demonstrated that the service was not following the principles of the mental capacity act in relation to the administration of medicines.

Staff demonstrated an understanding of the principles of the mental capacity act. One member of staff told us, "I had MCA training in my induction. I think I have a decent understanding and know it's about making sure people make as many choices as possible and that we always get their say so before we do things." This demonstrated that staff understood the importance of not assuming that a person does not have capacity and gave people every opportunity to be able to make decisions for themselves.

Staff were provided with detailed guidance in people's care plan's regarding the support people required with their nutrition. This included people's preferences, for example, "I like Latte [coffee] so care worker to ask me if I would like one" and "I love to drink tea with my toast in the morning and I like to drink lemon squash." Staff were also aware of people's dietary needs, one member of staff told us, "I cook meals for people and make sandwiches, that sort of thing. It says in their care plan if they have any allergies or need their food cutting up or softer foods." This demonstrated that people were being supported with their specific dietary needs and were given the opportunity to express their preferences in relation to what they would like to eat and drink.

Care plans showed that where appropriate the service had made referrals to health care professionals such as the community nursing team and GP's. A person told us, "They will phone the doctor for us if we need it." Care staff demonstrated a knowledge of the additional support being provided to people by the community nursing care team and understood how this related to the care they were providing to people.

Requires Improvement

Is the service caring?

Our findings

Although staff were intuitively caring the provider needed to take action to ensure that staff were supported to be able to do this through the organisation and resource management of the service. Late, missed or visits cut short of assessed needs was not caring overall.

People were positive and complimentary about the care they received. One person told us, "I would describe them [staff] as friendly characters with hearts of gold." Another person said, "The carers are very good indeed. I would find it difficult to say any are below average. In the main they are average or above average." A third person commented, "The [staff] are really friendly, nice, take time to get to know you and I feel as if I know them well. They listen well and know how I like things doing."

Staff had a good knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. A relative told us, "Overall I'm satisfied, the carers are friendly and generally it's the same ones every time so they know [person] really well and have a good rapport going. Every time they visit they look at the care plan and then ask us or [person] what needs doing. They make uncomfortable situations like bathing feel comfortable for [person]." A member of staff commented, "Everyone likes things done their own way but we try and stick to looking after the same people so we know them better. Like some people like their house cleaned a certain way so you get to learn it." Another staff member said, "I know the people I visit now very well so I know them individually and what they like. That information is usually in the care plan too though. Most people can tell you too."

People had regular carers who they had built a relationship with. One person told us, "I do have regular carers. They know me well and a pleasure to be with." Another person said, "I don't get the impression [staff] are rushing us. They are patient and we do get to have a chat. Our carers are really good, we always have the same ones which is nice because you get to be friendly with them."

People were encouraged to be independent where possible and to be in control of the support they received. One person explained, "[Staff] do know what we need help with but they still always ask when they come in. Sometimes I'm ok doing some bits but sometimes I want them to do it." Another person told us, "I feel in control of what they [staff] are doing when they come. They are very easy to talk with and easy going. I've a lot of trust in them." A member of staff commented, "With independence you keep in mind that they might be able to do something one day and not the next so you play it by ear and try and encourage them to do what they can so they don't lose that ability."

People's privacy and dignity was promoted and respected. A person commented, "Dignity and privacy, there are no problems there." Another person said. "The carers are respectful of me, my family and my home." A member of staff told us, "You have to be respectful of people because they're in their own home so it is their environment and you do what they want. When you're doing personal care you cover people over while you are doing each bit so they don't feel too exposed." This demonstrated that staff recognised the importance of privacy and dignity as core values and worked together with people to promote them.

People and their families had been involved in discussing their care needs and were involved in reviews of their care plans. A person told us, "Before I started with them we made an agreement on what they would do and every now and then they come over to see if I'm still ok with it." People, wherever possible were encouraged by staff to make decisions about their care, support and daily routines. A person told us, "I can be a bit fussy but they ask what I want help with and how I want it done. They don't get annoyed if I say my piece." A member of staff told us, "I ask people if they want me to do things for them or if they want help. Some people do some or all of their personal care but might need some help sometimes so you just have to be flexible." This demonstrated that staff were guided by the wishes of the people they were supporting and encouraged people to have independence and control.

Requires Improvement

Is the service responsive?

Our findings

The level of detail in people's care plans was not consistent across the service and some parts had not been updated following changes in peoples care and support needs. The relative of one person told us, "We've had it [care plan] updated very recently. One evening we had a [member of staff] who had never been in before. Prestige will say they should be able to provide care because they can follow what's written in the care plan. [Member of staff] was following precisely what was in the care plan but the care plan wasn't right. They [office and management team] should have picked it up sooner that it was not right." A member of staff told us, "Some [care plans] are brilliant. Some are not that great, some are quite bare. I tend to look at notes from previous carers."

A member of staff told us, "One person had an epileptic fit on one visit. I knew what to do but I called for guidance. [Person] has seizures, its known by [staff]." When asked about guidance in the care plan they told us, "It's not in the care plan…There should really been something in there [care plan.]" We checked this person care plan and found no reference to seizures. However, computer records showed that they were known to have had seizures previously. This important information was not included in their care plan, nor had it been added since the latest seizure over two weeks prior to our inspection. This put the person at risk as there was no information to guide staff how to support them should it happen again. We discussed this with the manager who agreed that this should be added to the care plan immediately and arranged for this to take place.

People and their families told us they received personalised care which was responsive to their needs. A person expressed how they were happy with the support they received and commented, "I think it's personalised." Another person told us, "They'll ask what I want help with every time they come." One person commented, "If you're wanting to know about the quality, I am mostly happy with it. At times you get a different carer from usual and they don't do things the way you like and that's frustrating, but my normal carers I'm happy with and have a good friendship with."

Where care plans were fully complete we found them person centred manner and included details throughout which reflected people's personal preferences and what was important to them. For example an entry in one care plan read, "I love my hair being brushed in the morning and throughout the day. I feel a lot better in myself once my hair is brushed.

People told us that their views were listened to and acted on by the care staff and that they had opportunity to express how they felt about their care and support during reviews of their care plan. We received mixed views from people about whether they felt the need for changes to their care package were acted on by the office or management team. One person told us, "The assessor came up the other week and asked if there were any problems." They went on to tell us how the times of their calls were impacting on their daily life and had requested that these were amended. However they commented, "They [office and management team] take no notice." There had been no changes made to their call visits. However, a person told us, "We are involved in reviewing things and not too long ago our time increased because [person] deteriorated a bit. They are flexible." Another person told us, "I've been reassessed because my needs have changed

dramatically. My [relative] was here while [assessor] was here."

There was a complaints procedure in place which explained how people could raise concerns One person felt that the provider had failed to be open and transparent in their approach when responding to an incident. Despite this there was no further information about how the provider would take this forward. There were lessons learned in this particular case but staff could not tell us if this had been shared with the person or not. They were therefore unable to demonstrate that the opportunity had been taken to assure the person their concerns had resulted in improved practice and reduce the risk of reoccurrence.

No other concerns were identified around the provider's response to complaints. A person told us, "I would call the office if I was worried. They are really nice in the office and I could tell them anything if I wasn't happy." A relative commented, ". I haven't ever complained but sometimes there's a minor niggle that I'll just raise with the carers when they come in, it normally doesn't happen again once I've said it."

Requires Improvement

Is the service well-led?

Our findings

Although people were complimentary about the care and support they received from the care staff, many of the people we spoke with told us they felt frustrated by the lack of organisation in the office. One person commented, "I find the carers themselves are very good. It's when you get beyond the carers I'm not as enamoured." Another person said, "I like the manager, I can always speak to them if I need to. I do think the office isn't organised well though."

The registered provider was failing to ensure people were safeguarded from the risk of harm or omissions from their care because ineffective scheduling of calls together with the lack of available staff meant that people could not be assured that they would receive their full quota of support in line with their assessed needs.

One person said, The [staff] are often rushing all over and I don't think they have time to get to everyone. I don't know if there are enough staff because once or twice they've said they didn't have anyone to send to me." Another person told us, "They've always covered," but went on to say, "More often than not it's because of the flexibility of the carers not the efficiency of the office."

Quality assurance systems were in place but had failed to address the issues around adequate staffing and breakdowns in communication. Quality assurance systems had also failed to identify where guidance and practice were out of date, for example in relation to medicines management and the Mental Capacity Act. The Care plans had not always been updated to reflect current needs, putting people at risk of receiving incorrect or inappropriate care .

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

We were made aware of an incident where the provider had not fully met the requirements of Duty of Candour, which should include a step by step account of relevant facts, the outcome of any further investigation, reasonable support, lessons learned, and a meaningful apology in person. Following this the provider revised its process and we saw records of subsequent concerns showed how this was now being implemented. Further work was needed to ensure that this new way of responding to incidents was being embedded and sustained at all levels in the service.

Despite the shortfalls we identified staff felt that they were encouraged and supported by the local management team. One member of staff told us, "They [management team] look after us as well as the clients. It is drummed into us if we feel unsafe or unsure to call. They'll guide us and say please give us a call and let us know how you've got on." Another staff member said, "I do see the managers at meetings and in the office. I can see them whenever I want and speak on the telephone regularly." Staff also told us how they were encouraged to report any issues of concern and explained that they understood the provider's whistleblowing procedures and how they would be supported with these. This demonstrated that staff were confident that they could raise any concerns and that these would be dealt with appropriately.

People and their relatives told us they were regularly asked for feedback through regular telephone calls, visits and surveys. One person told us, "The management do ask for my feedback quite regularly and I'm happy to give it." However from the concerns raised directly with us during the inspection we were not assured that a robust approach was being taken which fully demonstrated people were empowered to voice their opinions and could be confident that they would be listened to and appropriate actions would be taken to improve 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 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had failed to identify shortfalls.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet all of people's needs.