Bloomfield Care Ltd

Bloomfield Care Limited

Inspection report

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Ratings

Overall rating for this service	

Is the service safe?	
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Summary of findings

Overall summary

About the service
Bloomfield Care Limited is a domiciliary care service providing personal care to people at home. Not everyone who uses the service receives personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. There were 17 people using the service at the time of the inspection, 13 people were receiving personal care.

People's experience of using this service and what we found
Most people we spoke with told us they felt safe and were happy with the care Bloomfield Care Limited provided. However, we found some risks to people's health and welfare had not always been assessed. Where some risks had been identified they had not been kept up to date, reviewed and some did not have clear instructions to tell staff how to mitigate risks to people. This meant people's needs were at risk of not being identified and people were at risk of avoidable harm.

Medicines were not managed safely. Medication administration records had not been transcribed correctly and they did not show medicines had been administered as prescribed. Medicines had not been audited to ensure medicines were administered by trained staff as prescribed. Not all staff had completed safe administration of medicines training. This put people at risk of harm

Staff we spoke with knew how to safeguard people from abuse, however the service had not ensured all staff had completed mandatory training. This meant staff may not be aware of best practice to safeguard people. The service had failed to notify external bodies of incidents where people were at risk of safeguarding concerns. This meant external scrutiny was not always possible to ensure people were safeguarded from abuse.

The service had sought consent from people with capacity however, we found that people who lacked capacity had not always been assessed and reviewed within the principles of the Mental Capacity Act 2005 (MCA). This meant, people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
People's choice, control and independence was not always considered or reviewed in line with the principles of the mental capacity act 2005.

Right care:
Care staff were not provided with up to date and correct information in order to provide person-centred care to people using the service.

Right culture:
The registered manager and provider wanted to do their best for people using the service and sought to improve where possible. However, they did not have the consistent systems and processes in place to ensure the safe delivery of person-centred care in the least restrictive way.

This put people at risk of not having their care needs met and at risk of harm. The service was working with health and social care professionals and were working towards improving, in order to provide good outcomes for people using the service.

Staff training was inconsistent. Four members of staff had not completed their full induction before the 12-week deadline. This meant staff were not always provided with the up to date skills and knowledge to carry out their duties. Some staff had not completed training in specialist areas including Epilepsy. Staff told us they would not know what to do if a person they were supporting had epilepsy. The service was supporting people who had epilepsy, this placed these people at risk of harm.

Bloomfield Care Limited used an electronic care planning system that was not always accessible to all staff. This meant staff were unable to read up to date care plans and unable to record their daily notes in a timely manner.

Care plans were sensitively written however, we found care plans did not always contain enough information or missed important information to meet people's needs. This meant care staff were not provided with the information they needed and put people at risk of not having their needs met.

Systems and processes to provide oversight and monitor the safe delivery and quality of care provided to people were inconsistent. Audits were not always completed and when they were, they were not always effective at highlighting areas of improvement.

People told us they liked the staff as they were very caring. Comments from people included, "The carers are probably the best I have ever had" and "They are a very nice bunch". The registered manager and provider spoke passionately about providing care to people in their own homes. They had an ethos that staff should stay for the entire call and if tasks were completed before this time then staff were to stay with the person and provide companionship time. The service had started during a pandemic and with that had to manage the additional challenges this brought. The registered manager and provider told CQC they had already started to make changes in order to improve the service, this will be reviewed when we next visit to ensure improvements have been made and are sustained.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 5 June 2020 and this is the first inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report.

Why we inspected
The inspection was prompted in part due to concerns CQC received about missing risk assessments and care plans, the safe administration of medicines and poor governance and oversight of the service. This service was also an unrated service.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe care and treatment, safeguarding people from abuse, the safe administration of medicines and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvements within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Care Quality Commission

Bloomfield Care Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors and one medicines inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 2 August 2021 and ended on 13 August 2021. We visited the office location on 2 August 2021.

What we did before the inspection
We reviewed information we had received about the service since it was registered. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with four people who used the service and six relatives about their experience of the care provided. We spoke with ten members of staff including the nominated individual, registered manager, office manager, care co-ordinator, field care supervisors and care workers. The nominated individual is

responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included five people's care records and four medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with five professionals who knew the service.

Inadequate

Is the service safe?

Our findings

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not always protected from avoidable harm. Peoples risks were not always assessed and when they had been, risk assessments were not always correct and did not always contain information to direct staff on how to mitigate risks to people. This placed people at risk of harm.
- A person with a diagnosis of epilepsy did not have specific seizure risk assessments. Their care plans did not include guidance to tell staff what triggers may lead to a seizure, what signs the person may display before having a seizure or what different types of seizure the person may have.
- Not all staff working with this person had completed epilepsy training. One staff member said, "I would need more training to know what to do if [person] had a seizure and their [relative] was not there" another said, "No, I haven't had epilepsy training, I had asked but have not received any." This meant staff were not provided with the information to provide safe care and treatment to the person and placed them at risk of avoidable harm.
- Not all staff were up to date in safety-related training including, moving and handling, infection prevention and control and fire safety. This meant the service could not be assured staff were providing up to date best practice care and placed people at risk of harm.
- The service had not always taken action to investigate and provide outcomes following incidents. This meant learning from incidents had not been identified and shared with the team to mitigate further occurrences, this put people at risk of harm.

We found no evidence that people had come to harm, however the provider had failed to assess, monitor and mitigate risks to the health and safety of all the people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people and relatives told us their risks had been assessed. One relative said, "They talked about risks and risk mitigation as part of the initial assessment and highlighted some risk issues that I hadn't thought about."
- The registered manager told us they communicated with staff all the time and planned to complete lessons learned reflective documentation to record this in the future.

Using medicines safely

- The management of people's medicines was not safe. Not all staff administering medication had completed medicines training or had records to show they had been assessed as competent. One staff member told us, "No, I have not received medicines training with this company and have not been observed."
- Staff told us they did not always have access to Medicine Administration Records (MAR) and when they did, they were not always accurate. One staff member said, "MAR charts are incorrect, we have had to send them back to ask them to be re-done." One relative told us, "MARS do not contain enough information, like

when to take medication one hour before food for example or with water."
● Two of the MAR we viewed were incorrect. Directions were different to what had been prescribed including name of medication, dose and when to take it. This meant staff did not have clear directions and the person was at risk of harm.
● Staff recorded when medicines support was provided. When staff gave medicines, they recorded this on a MAR. Three MARs we viewed were not always fully completed to show why people might have missed doses. This had not been identified by the provider as they had not completed quality monitoring.
● PRN (as required) medicine protocols were not in place. This meant staff did not have guidance on when to administer PRN medicines.

We found no evidence that people had come to harm, however medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes to safeguarding people from abuse were not established. Seven staff had not completed safeguarding training. Four of these members of staff had passed their 12-week induction period. This meant the staff had not been provided with all the information and skills to know what their roles and responsibilities were to protect people from abuse.
● The service had not made appropriate referrals to the local safeguarding team following two incidents where people had been at risk of potential abuse. This meant external scrutiny was not possible to ensure people were safeguarded from abuse.

Whilst we found no evidence that people had come to harm, the provider had failed to establish robust systems to protect people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with told us they felt safe with the care staff from Bloomfield. Comments included, "Yes, I feel safe, they know what they are doing.", "Certainly [they are safe]. They are very efficient. I haven't given them a problem yet that they can't handle." and, "I feel safe with the carers"
● Staff knew how to whistle-blow and provided us with examples of when they would raise a safeguarding concern to their manager or governing body if required.

Staffing and recruitment
● The registered manager spent an average of 96 hours delivering care to people per month. This meant quality and performance of the service was not always managed and had impacted on records not being completed or updated. The service continued to recruit staff and had new starters waiting to start.
● Staff told us the company had an ethos of not cutting calls short. One staff member said, "They don't like us cutting calls short; they tell us 'You can always sit and chat to make up time'"
● People confirmed staff stayed for the length of time of the call and were not rushed. Comments included, "[The carers are] very patient.", "I'm never rushed, they are very understanding." And, "They are not rushed, on the on whole arrive on time." One relative said, "They do not rush, they turn up and nothings too much trouble, they say if I go over time, so be it."
● Recruitment systems were robust and made sure that the right staff were recruited to support people to stay safe. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as required by the regulations.

Preventing and controlling infection

- Not all staff had received appropriate infection prevention and control training. This meant staff may not fully understand their responsibilities in relation to hygiene or cross contamination.
- Staff were observed coming into the main office to collect personal protective equipment (PPE) and stocks were in plentiful supply. Staff told us how they disposed of their clinical waste using separate bins placed in people's property.
- Staff took part in routine testing to determine if infectious from COVID-19 this included at least twice weekly lateral flow device (LFD) tests and one polymerase chain reaction (PCR) test a week.
- People and relatives told us staff wore PPE appropriately and washed their hands regularly.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● The service had not always worked to the principles of the MCA. The service had not always reviewed people's mental capacity to make particular decisions and had not considered making appropriate applications to the court of protection for people being deprived of their liberty. This meant people were at risk of restrictive practices which may be unlawful.
● Not all staff had completed MCA and deprivation of liberty safeguards (DoLS) training. This meant the service could not be sure all staff understood the requirements of obtaining consent to ensure they were working within the principles of the MCA.
● Staff sought consent from people and told us some people could make decisions. One staff member told us, "[person] can make daily decisions, what [they] want to eat, where [they] want to go, but financially [they are] not able to make those assessments." However, we were unable to find documentation to support the person had had their mental capacity assessed. This meant people were not being protected by the statutory framework that protects people from being deprived of their liberty unlawfully or inappropriately.

We found no evidence of harm however; the provider had failed to ensure care or treatment was not provided in a way that controls or restrains a person which may be unnecessary or proportionate. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us staff sought consent before commencing activities. One person said, "They never do anything without asking my permission."

Staff support: induction, training, skills and experience

● The service had not always provided training and supervision to new staff to ensure they provided safe care and treatment to people using the service.
● The registered manager told us they observed staff but did not keep records to demonstrate staff were competent to fulfil their roles. Two members of staff told us they had not been observed by senior staff and had not completed training with the service.
● Training records showed staff had not completed essential training to keep people safe. Four staff had not completed all core mandatory training before the 12-week deadline. This meant staff were not always provided with the up to date skills and knowledge to carry out their duties, this placed people at risk of harm.
● Records were not kept to demonstrate staff had been assessed as competent to fulfil their duties. This meant people were at risk of not having their care needs met.

We found no evidence of harm however; the provider had failed to ensure staff had an induction programme that prepared staff for their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed this with the registered manager who told us they had identified training as an area to be improved and had plans to introduce face to face training as soon as possible. The registered manager told us some staff had completed learning disability training, this was not recorded.
● Staff told us they completed an induction which included shadow shifts until they felt confident to start on their own. One member of staff said, "[induction] was really good, I went out with [registered manager] on shadow shifts to meet everyone. [registered manager] watched when I did a couple of visits."
● We received mixed feedback from relatives regarding staff having the right skills and training to care for their loved ones. One relative said, "No, I don't think they do because they do not allow enough shadowing and training to get to know [persons] needs, [persons] needs are complex" and a staff member said, "Staff are being sent who have had not shadowing." These concerns were brought to the attention of the registered manager.
● People we spoke with told us they felt staff had the right skills and training to meet their care needs. Comments included; "I haven't found one that's not up to the job.", "I am sure they are very skilful at what they do. I would trust them right up to the end." and, "They are good at picking the right people. New staff do a shadow to learn and to get to know me."
● Staff told us they felt supported by their management team. They told us, and records showed they had regular supervision meetings which allowed them to discuss their performance, concerns or training and development needs. One member of staff told us, "Yeah, I find the [supervisions] useful. I also have appraisals every three months with the owner and registered manager, I know I can speak to them about anything they are really supportive."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service used an electronic care planning and record system which was not always effective and required time to embed into the service. Care plans were not always accessible, and two members of staff told us they were unable to clock in and out to show the start and end time of their call or to update their care notes in a timely manner.
● People had an assessment before they started receiving a service. This included their individual circumstances, what was important to them, and religious and cultural requirements, as well as the care and support they needed.
● Most people told us they were involved in the planning of their care. One relative said, "[Staff] did the assessment and always involved [person] in the conversation."

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Staff supported people to maintain a balanced diet where required, according to their cultural and religious beliefs.

● Care plans reflected the support the person needed to eat and drink and ensured people were offered choice with their food and drinks. For example, one person's care plan stated, "[Persons] favourite drink is warm, weak tea (not too milky). [Person] is sometimes able to drink independently if drinks are put in front of [them] in a red plastic mug. Please ensure you offer [person] different parts of [their] dinner, discuss dinner with [them], or wait 5 minutes."

● Staff supported people to see the healthcare professionals they needed to maintain their health including nurses and GPs. One person said, "I have severe medical problems. I find it better if the carer or the office helps. They get through more than I can."

● The service worked with other agencies including social services to provide support to people with complex care needs.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated as Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

● People and relatives told us staff were kind and caring. Comments included; "The carers are probably the best I have ever had.", "I couldn't do without them, they are very caring" and, "They are very friendly and very caring."

● People and relatives said staff were patient with them or their loved one, working at their pace. One person said, "They're very patient. They stay to do whatever is necessary."

● People and relatives told us they would recommend Bloomfield Care Limited to others. Comments included; "I would definitely recommend them, they are honest, trustworthy, regular, they never let you down. What more do you want?", "Yes, I'd recommend them. They are always here the times they are meant to be and are always happy" and. "Absolutely 110% recommend them because of their friendly nature. Nothings too much trouble, all the staff seem happy in their work, they're dedicated to what they do, and they really love what they do."

● People's care plans included protected characteristics such as religion, where these were relevant.

● People and relatives told us they felt consulted, involved in decisions and were kept up to date about their or their family member's care. One relative said, "We are always interacting and all things we require are discussed and met."

Respecting and promoting people's privacy, dignity and independence

● Staff understood the importance of respecting people's privacy, dignity and independence. One care worker told us, "We always offer choice, ask what they like and encourage people to make their own decisions."

● People and their relatives told us staff promoted their dignity and encouraged them to be as independent as possible. Comments included; "They are good with dignity and privacy and treat me with respect.", "Everyone has been very respectful, they are so helpful" and, "I have never had a problem with backchat, they are very good."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- Care plans were well written but had not always identified people's needs. Some lacked specific detail as to how person-centred care should be provided. This included signs and symptoms staff should monitor people for in relation to diabetes. This meant care staff did not always have the information they needed to keep people safe and put people at risk of not having their care needs met.
- There were inconsistencies with care plan reviews. One care plan we looked at had not been updated with important information following the persons admission to hospital. We discussed this with the registered manager who updated the care plan before the end of the inspection. The registered manager told us they planned to reduce the hours they spent delivering hands on care to provide oversight and governance to the service including reviews of care plans.

We found no evidence of harm however the provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care staff knew people well and communicated updates and changes via an independent encrypted messaging app.
- People and relatives told us their care needs were met. One person said, "They know what tasks I want them to help me with." One relative told us, "If I mention something during one visit like, [person] had an appointment at such and such they said this, the staff who visit next time will mention it, they'll say I understand this has happened, they all seem informed and know exactly what's going on."

Improving care quality in response to complaints or concerns
- The service had not kept records of complaints to demonstrate provider response and review. We discussed this with the registered manager who told us they would ensure complaints and concerns were logged going forward.
- People and relatives told us they knew how to raise complaints and concerns. One relative said, [Registered manager] has always responded very rapidly to anything I mention."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
- People's communication needs were assessed and set out clearly in their care plans. This included any

impairments that could affect communication, how people preferred to communicate and the support they needed from staff with this.

● Documents could be provided for people in accessible formats, such as large print

● The service prepared pictorial easy read documentation to ensure people could understand the information in their care plans.

End of life care and support

● At the time of inspection, the service was not providing end of life care for any person using the service

● People were asked about their advance care wishes and this was recorded in people's care plans.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Governance and quality checks were not robust and had failed to identify areas of risk which had placed people at risk of harm.
● The registered manager and provider had not understood the principles of good quality assurance. Audits were not robust at identifying areas of concerns and did not provide oversight to demonstrate how improvements could be made. This meant people were at risk of not having their needs identified and met.
● The registered manager failed to audit safeguarding, accidents and incidents, medicines, staff training and complaints this meant the registered manager was unable to ensure learning, reflective practice and service improvement was adopted. Which meant areas for improvement had been missed. We discussed this with the registered manager who told us, "You are not telling me anything I don't already know. We know my covering visits is not ideal. my problem is I'm so busy my time is being taking up in the wrong area."
● Systems for identifying, capturing and managing organisational risks and issues had been ineffective. This had led to some legal requirements not being met.
● The service had failed to notify the local authority safeguarding team of two incidents that could have resulted in harm for the person using the service. The impact of these issues not being reported is that external scrutiny was not possible to ensure people were safeguarded from abuse.
● Staff roles and responsibilities had not yet embedded. For example, care plan reviews had not been started by field care supervisors to ensure the combined management and governance of the service.

Systems were either not in place or robust enough to demonstrate the quality and safety of services was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed these concerns during the inspection. The registered manager told us they had identified lack of governance and oversight through our inspection and planned to reduce the amount of time providing hands on care in order to improve.
● The registered manager provided us with a lessons learned record to demonstrate they had reflected and understood what their legal requirements were going forward.
● The registered manager told inspectors they had imminent plans to embed staff roles and responsibilities to provide combined oversight and governance for the safe delivery of care.
Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Due to lack of governance and quality checks not all people using the service had received good outcomes. Care plans and risk assessments had not assessed and managed risk meaning people had been placed at risk of harm, of potential abuse and of not having their care needs met.

Systems were either not in place or robust enough to ensure the quality and safety of services was effectively managed to provide good outcomes for people. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with knew who the registered manager was and spoke highly about their openness and willingness to help. Comments from people included; "Wonderful, wonderful, very accommodating." and, "[Registered manager] perfect, perfect for the job, I think. Very, very nice and understanding."
● Relatives felt included and able to feedback any concerns they may have knowing the registered manager would listen and improve where possible. Comments from relatives included; "Very caring and very kind", "[Registered manager] has always responded very rapidly to anything I mention. [Registered manager] is very efficient and caring as well as management." and, "Marvellous".
● Staff told us they felt included in the running of the service and felt able to speak to the registered manager at any time to ensure good outcomes for people. Comments from staff included; "I can go and talk to [registered manager] if there's a problem and I'm listened to.", "[Registered manager is lovely, good manager and very supportive." and, "[Managers] are very caring, I've made suggestions and have been listen to and changes made."
● The service sought feedback from people using the service, relatives, staff and other services who supported the care of people. The service received 100% positive feedback for May 2021.
● Positive feedback was received from health and social care professionals who worked with 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 18 HSCA RA Regulations 2014 Staffing Staff had not completed essential training to keep people safe and at least four staff had not completed all core mandatory training before the 12-week deadline. Not all staff had not been provided with epilepsy training to care for a person with complex health needs

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always identified risks to people. Where risk had been identified, assessments had not been kept up to date, reviewed and in some cases contained incorrect information. People had not been safeguarding from abuse due to inconsistent processes and lack of training for all staff. Safeguarding incidents had not been appropriately notified to external bodies including the local authority safeguarding team. Medicines were not always managed safely. Audits had not been completed to ensure medicines were administered, not all staff had completed training and the medication administration record directions were not always clear. Staff had not all completed safety training including manual handling, infection prevention and control and fire safety. Lessons learned process was not in place following incidents or accidents.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes to safeguarding people from abuse were not established. Not all staff were up to date with safeguarding and training practice The service had not made appropriate referrals to the local safeguarding team following Incidents where potential abuse had occurred.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and quality checks were inconsistent and not effective or reliable at highlighting areas of improvement when used. The registered manager failed to audit and ensure learning from safeguarding, accidents and incidents, medicines, staff training and complaints.

The enforcement action we took:

Warning notice