Community Care Team Ltd

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This comprehensive inspection was announced, which meant that we gave the provider 48 hours' notice of our inspection, in line with CQC guidance for inspection of domiciliary care services. This is so we can arrange for someone to be at the agency office to assist with access to information we need to see. We visited the agency office on 01 June 2017.

The service is registered to provide personal care for people who live in the community and who have a physical disability, a sensory impairment, older people, younger adults and those with mental health issues.

The well-equipped office is located on an industrial business park in Leyland. It is within easy reach of the City of Preston, Leyland and Chorley town centre. Public transport links are nearby and ample car parking spaces are available.

This location is a new acquisition for Community Care Team Limited and this is the first inspection since their registration. The registered manager was on duty at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are registered persons. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated regulations about how the service is run.

When asked to describe the care they received in general terms, people who used the service and their relatives did not express any significant concerns. While some described the service as overall 'very good', others said, 'It could be better' and 'It's quite good'. The main issue raised was in relation to the time keeping of staff.

A business continuity plan had been developed, which outlined action to be taken in the event of any environmental emergency, which could affect the operation of the agency.

People's needs had been assessed prior to a package of care being arranged and the planning of individual support was person centred, in order to accurately reflect specific needs. We found that people were treated in a kind and caring manner, with their privacy, dignity and independence being promoted.

We found that mental capacity assessments had not always been completed for those who were living with dementia, in order to establish if they were able to make specific decisions in relation to the care and support they needed. Therefore, people were not always supported to have maximum choice and control of their lives. However, staff supported them in the least restrictive way possible and the policies and systems in the service supported this practice.

Some care files we saw showed that individuals had signed consent forms for areas, such as support with medications. However, one care file we saw showed that consent for care workers to apply topical creams and to instil eye drops was signed by a relative of a service user who did not lack capacity to make decisions,

but was unable to sign the consent form herself because of physical disabilities. We made a recommendation about this.

At this inspection we found that people were satisfied with the support they received around meal preparation.

A structured system for assessing, monitoring and improving the quality of service provided had not been fully developed at the time of this inspection. However, the provider recognised this was needed and therefore had plans to implement a formally recorded system, which would help to mitigate any potential risks and therefore promoted people's safety. We made a recommendation about this. A wide range of risk assessments had been introduced in relation to people's health care needs and the safety of the environments in which people lived.

Records showed that people's views about the quality of service provided were sought in the form of surveys. We made a recommendation about introducing surveys for the staff team. Complaints were being managed well and systems were in place for reporting safeguarding incidents.

People we spoke with told us they felt safe using the services of Community Care Team and that care workers were kind and caring. We found that recruitment practices were satisfactory, which helped to protect people from harm. Risk assessments were in place, which outlined actions that staff needed to take.

The staff team were well supported by the management of the home, through the provision of information, induction programmes and a wide range of training modules. The staff members we spoke with had a good understanding of people in their care and were able to discuss their needs well. Staff personnel records showed that regular supervision sessions were provided for staff. However, annual appraisals were not always evident.

It was evident that care staff sought advice from community care professionals, should the need arise. This helped to ensure that people's health and social care needs were being appropriately met. Medicines were being managed well. However we made a recommendation about hand written entries on the Medication Administration Records (MAR) and protocols for 'as and when required' medicines.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for need for consent.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not consistently safe.

People felt safe using the services of Community Care Team and we found recruitment practices to be satisfactory.

Medicines were, in the main being well managed, but hand written entries had not been witnessed and PRN protocols had not been implemented.

Safeguarding incidents were documented and risk assessments were in place.

Emergency plans had been developed and safety policies and procedures were in place.

Is the service effective?

Requires Improvement

This service was not consistently effective.

People expressed their satisfaction with the support they received around meal preparation and staff members were well trained.

Mental Capacity Assessments had not always been conducted for those who were living with dementia.

Consent had not always been obtained from those who had legal authority to make decisions on behalf of people.

Is the service caring?

Good

This service was caring.

Feedback from those who used the services of Community Care Team was mostly positive. People told us that, in the main staff were kind and caring.

People's privacy and dignity was consistently respected and their independence was promoted as far as possible.

Is the service responsive?

Good

This service was responsive.

Health and social care profiles were in place and needs assessments had been conducted. We found the plans of care to be person centred, reflecting people's support needs well.

The plans of care had been agreed by individuals and their needs had been regularly reviewed.

Complaints were being well managed.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

Records showed that people's views about the quality of service provided were sought in the form of surveys. We sis not see any recent staff surveys having been conducted.

There were some audits in place, but many of the systems to assess and monitor the quality of service provided were informal and were not recorded.

We found shortfalls in implementing the principals of the Mental Capacity Act and obtaining consent.

Community Care Team Ltd

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This announced inspection was carried out on 01 June 2017 by an Adult Social Care inspector from the Care Quality Commission (CQC). An expert by experience obtained telephone feedback on behalf of the CQC inspector, in order to establish the quality of service provided. An expert by experience is a person who has had some experience of the type of service being inspected or has been involved in caring for someone within this particular client group. Our expert had cared for family members with medical conditions or who were living with dementia and who had used regulated services.

At the time of our inspection of this location there were 77 people who used the services of Community Care Team Limited. We were able to speak with seven of them and four relatives. We also spoke with four staff members and the registered manager of the agency.

We looked at a wide range of records, including the care files of eight people who used the service. This enabled us to establish if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We also looked at the personnel records of five staff members. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

Prior to this inspection we looked at all the information we held about this service, including things the provider had told us about. We also listened to what people had to tell us and we were in regular discussion with local commissioners and community professionals about the service provided by Community Care Team.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe using the services of Community Care Team. However, some people told that new staff would not be introduced to them and would just turn up for their visit. When asked how people were sure the staff were genuine, they told us that they recognised the uniform, or that the carer had the key code, so they must be from the service provider. We subsequently discussed this with the registered manager, who confirmed that staff are not normally introduced to clients before they visit. She told us that she would review the policies of the agency in relation to first visits by care staff, to ensure a more structured approach was adopted. However, the registered manager added that any new staff shadow existing staff for a week; during shadowing staff work in different areas and are introduced to as many clients as possible. Staff are always in uniform and all have an ID badge which they are to show on the first visit to a new service user; staff also arrive at the time the service user expects them, stating their name and that they are from Community Care Team. We recommend that the provider ensures care staff are introduced to people before their first visit, in order to safeguard those who use the service and to promote reassurance.

Comments we received included, "Yes, I feel safe"; "I get different people [carers] coming"; "Different people come. They just come and say I'm a carer"; "I know who they are, they have a uniform"; "They must be a carer, as they know the code"; "I know it's them, because they use the key safe." And, "They are very good, I feel safe and I've never had any trouble with them."

Staff members had received specific medicines training and regular medicine audits had been conducted. This helped to ensure that people were protected against medicine errors. People we spoke with did not have any concerns about how their medicines were being managed.

We looked at a selection of MAR's [Medication Administration Records]. These had been signed appropriately to show when medicines had been taken by those who needed some support. However, we found that hand written entries had not always been signed, witnessed and countersigned and protocols for 'as and when required' medicines [PRN] were not in place.

We recommend that handwritten entries on MAR charts are always signed, witnessed and countersigned to ensure that all transcriptions are accurate and that PRN protocols are implemented to provide staff with clear person centred information about when PRN medicines may be required.

The care records we saw contained risk assessments around people's health care needs, such as moving and handling, visual impairment, allergies, continence, safety, nutrition, mobility and the risk of falls. Actions to minimise the potential risks had been recorded. This helped to keep people safe in relation to these areas of possible risk.

We saw that a business continuity plan was in place at the agency office, which outlined action that needed to be taken in the event of an environmental emergency, which may affect the delivery of care, such as severe weather conditions, outbreak of infectious diseases or a pandemic.

One person's records showed that they were at risk of developing tissue damage, due to prolonged pressure. Preventative measures had been implemented by the service, so that the potential risk of developing pressure wounds was minimised. Their care file stated, 'Carers to check skin daily for breakdown/pressure sores and report any concerns to the DN [District Nurse] or GP.'

We saw risk assessments had been conducted in relation to the environment in which people lived. These identified areas, which needed to be further considered as a possible hazard for those who used the service. It was evident that one family had arranged installation of a wet room and grab rails in their relative's home, in order to improve their safety and comfort.

During our inspection we saw that a wide range of safety policies and procedures were in place at the agency office. These covered areas, such as emergency health issues, infection control, lone working, Personal Protective Equipment [PPE], moving and handling, missing persons, safeguarding and whistle-blowing. These helped the staff team to follow safety guidance whenever necessary.

During our inspection we looked at how safeguarding incidents were being managed by the agency. We found that relevant records were retained on the premises and that incidents were documented well. A clear account of events was evident and details of any investigation were recorded. Relevant authorities had been informed of any safeguarding incidents and clear multi-agency safeguarding policies were in place at the agency office. This helped to ensure that staff were fully aware of action they needed to take in the event of an allegation of abuse or neglect being reported. Records showed that regular training in relation to safeguarding was provided for the team and staff members we spoke with confirmed this to be accurate. They told us that they were confident in reporting any actual or potential allegations of abuse to the relevant authorities, should the need arise by following the whistle-blowing policies of the agency. This helped to protect those who used the service from abuse.

Accident and incident records had been completed with personal information, a full description of the incident, action taken and any recommendations made. There was evidence available to show that emergency services had been contacted, as was required. We saw three good examples of when urgent medical advice had been sought, including that of a GP for someone who had refused to attend the Accident and Emergency department. Accident records were retained in line with data protection guidelines, to ensure that personal information was maintained in a confidential manner.

During the course of our inspection we looked at the personnel records of five people who worked for Community Care Team Limited. We found that recruitment practices adopted by the agency were satisfactory. Each potential employee had completed an application form and a health questionnaire. Acceptable forms of identification had been submitted. Those who fulfilled the recruitment criteria were then invited for interview, where any gaps in employment were discussed and recorded. Two references had been sought for each applicant and although these were sometimes obtained after employment commenced, it was confirmed by the management team and staff we spoke with that new employees were not allowed to work in the community until all checks had been received. Until such a time new staff were assisted through their initial training programmes within classroom settings. Confirmation of Disclosure and Barring Service (DBS) checks were evident. DBS checks highlight if the prospective employee has received any criminal convictions or cautions. This helps the provider to decide if the individual is deemed fit to work with the vulnerable people who use the service. Each new employee was issued with an identification badge. This helped to protect those who used the service.

Requires Improvement

Is the service effective?

Our findings

When asked about their care plans, the comments received from people we spoke with included, "I've never seen it" and "What is a care plan?" This was explained, but the individual did not know if there was one available. Two people referred to a 'care book', which carers recorded their visits in, but they were unable to confirm if this book contained a care plan or if it was just an information booklet. However, several of the care plans we saw had been signed by those receiving care and support, which indicated that they agreed with the contents.

Only one person we spoke with was able to tell us what was in their plan of care. This person said, "They [the carers] don't come at the times on my care plan. Sometimes it's 4:20pm, when it should be 5.15pm. My care plan says they should stay 50 minutes, but they just get everything done and stay about half an hour."

People reported that staff were short of time and therefore just did basic tasks. Where care workers assisted people to prepare meals, this was done to their satisfaction with carers making meals of their choice. One person told us, "They ask me what I want and then make me the sandwiches." And another said, "They make my breakfast for me. I tell them what I want and they make it."

Other comments received from people who used the service included, "They [the carers] generally come at the same time. I'm not to half an hour"; "They [the carers] just come to make sure I've eaten and taken my medicine, they stay five or ten minutes"; "I used to have three visits a day, now it's just one. They [the carers] come about 10.15am-10.30am. I don't know why it changed." And, "I'd like them to come earlier."

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.

Where people receive support in their own home, applications to deprive a person of their liberty must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the care files for people who used the services of Community Care Team and found that when mental capacity assessments were needed, they had not always been fully completed. For example, one care file we saw showed that the person was living with dementia. However, a mental capacity assessment had not been conducted to establish if they were able to make specific decisions in relation to the care and support they needed. Evidence was not available to demonstrate that decisions had been made in this person's best interests.

We found that the provider had not established if people had the capacity to make specific decisions in relation to care and treatment. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care files we saw showed that individuals had signed consent forms for areas, such as support with medications. However, one care file we saw showed that consent for care workers to apply topical creams and to instil eye drops was signed by a relative of the service user, because although the service user had the mental capacity to make decisions, they were unable to sign the relevant records, due to physical disabilities. The only representatives who are able to sign consent on behalf of people are those who have been granted legal authority to do so and this was not evident in this case. The registered manager subsequently sought advice from the DoLS team in relation to consent forms for those who had capacity to make decisions, but lacked the ability to sign the forms. It is recommended that advice receive from the DoLS team is followed, to ensure that only those with legal authority sign consent on behalf of those who use the service.

We established that new employees were issued with a wide range of information when they first started to work for the agency, including Job descriptions relevant to their role and terms and conditions of employment. An employees' handbook was issued to all new staff, which contained important policies and procedures and a wealth of information to help them do the job for which they were employed and to outline what was expected of them whilst working for Community Care Team Limited.

Records showed that a detailed induction programme was provided for all new staff. Modules covered during this initial training included, principals of care, safety at work, understanding the role of the worker, safeguarding and the policies and procedures of the service. This helped new employees to gain some knowledge around important areas of care and to support them in carrying out their duties in an effective manner.

The probationary period for new employees lasted for a period of six months, during which a shadowing programme was incorporated. This was confirmed by staff members we spoke with. The probationary period gave new starters the opportunity to decide if they wished to continue to work for the agency and allowed managers to determine the suitability of each new employee. We saw evidence of when a probationary period had been extended, so that the new recruit could obtain additional experience and training. This helped to ensure that the staff member was assessed as being competent to carry out the duties expected of them in a safe and appropriate manner.

Staff members we spoke with told us that the training they received was good and they felt supported in obtaining the learning modules they needed. Records we saw and certificates of training showed that a varied programme was provided for the staff team. This included first aid, health and safety, load management, nutrition and food hygiene, dementia care, infection control, medicine management, fire safety, equality and diversity, stoma care and record keeping. Some planned updates were also evident in relation to safeguarding adults and the Mental Capacity Act [MCA]. Each member of staff had training and development plans in place and training needs analysis set up to ensure that they kept up to date with all required learning modules.

Records showed that structured supervision sessions for staff members were routinely held and those we spoke with confirmed this as being accurate. This helped to ensure that the staff team was well trained and regularly monitored, with support systems being implemented for personal development. The supervision sessions covered specific topics, such as diet and nutrition, continence care, effective communication and record keeping. They also included, 'What went well' and 'What didn't go so well', action needed and the

value of each formal supervision session. Annual appraisals for staff were in the process of development.

One new member of staff we spoke with talked us through the recruitment process and detailed induction programme. Other staff gave us some good examples of learning modules they had accomplished, such as safeguarding adults, infection control, fire awareness, moving and handling and whistle-blowing.

The members of staff we spoke with were knowledgeable about people they provided support to. One staff member was very aware of assessed risk and gave us three examples of when she had needed to contact community health care professionals, including emergency services. This helped to ensure that people received the health care they required.

Good

Is the service caring?

Our findings

People we spoke with were, in the main happy with the care they received. They felt their privacy and dignity was respected, although many did tell us that time keeping could be an issue. Their comments varied and included, "My carers are all very kind and caring"; "They [the carers] are in five minutes and then they are gone. They never have time to do things, like post a letter. They say they haven't got time. They are alright I suppose. The one I have tonight is brilliant though and so is her daughter too. They are both fantastic carers and they always come on time"; "They [care workers] are kind and caring. Yes they are very good, but they do rush me a bit. I won't be rushed, although they do try. I am quite satisfied with the care I get though. I have no complaints. The night girls come on time, but they don't always come on time in the morning, but I don't mind, as I can have a lie in then." And, "They are short staffed. They just come when they can come. Sometimes they get held up."

Other comments we received were, "Most of them [carers] are very kind, but some of them have a short fuse"; "They have been very good today. I've not been well and they just turned up and have done everything for me." And, "The best thing about the service is there are some excellent carers, but some can't get in and out quick enough. It depends if they have been held up."

One family member told us, "We are very happy with the service. The staff are down to earth and very easy going. They have a laugh and joke with us. [Carer] is very good. They [care workers] arrive generally on time and stay for as long as is needed. They are very insistent that [name removed] is comfortable before they leave." And, "Generally speaking, the carers are very good. One is a bit brusque and a little bossy. Some will sit and chat with [named], but there are two of them on the visits and sometimes they talk over [name], or about them, as if they don't exist. It's not very professional and I know that annoys [name]." This person told us that there were 90% good carers, 10% could be better, but nobody was really bad."

The care file for one person stated, 'Service user has made an advanced decision about DNACPR [Do Not Attempt Cardio-Pulmonary Resuscitation]. The GP has it on record, 'Do not resuscitate.' There was no copy of this directive on the person's records or within the agency office. We advised that this be followed up by the registered manager, who subsequently informed us that this service user confirmed there was no DNACPR order agreed by them. The registered manager told us that she had made a note of this on the person's risk assessment, as well as contacting the GP in relation to this anomaly.

Surveys completed by those who used the service indicated that staff were kind and caring. Those we spoke with confirmed this information to be accurate. Staff members we spoke with were able to talk about the sensitive approaches needed by those in their care.

Care records we examined incorporated the need for privacy, dignity and independence, particularly during the provision of personal care. Training programmes for staff included end of life care. This helped to ensure that people were supported in a dignified manner during the last days of their life.

We established that families were encouraged and supported to be involved in the care of their relatives, if

they wished to be so. Family members we spoke with told us that they were kept informed of any changes in their relatives needs and that communication from the carers was good.

We received some feedback from community professionals about the quality of service provided by Community Care Team Limited. One response was from a group of health care professionals who wrote, 'Following discussion with the district nurses we find that the carers are very caring and any concerns about the clients they soon contact the district nurses. The clients say that they are happy with the carers.'

Good

Is the service responsive?

Our findings

We asked people we spoke with if they knew how to contact the agency office, should they need to do so. We were told that they did. One person said, "The manager's telephone number is in the care book. I just leave a message. I can't remember the last time I called or why." Another person said, "I'm sure they would be responsive if I asked for a change, but I don't need any." And a third stated, "I can change my times by ringing the office, if I need to." However, one person we spoke with said they had asked for a particular care worker not to attend any more, but that the agency still sent them.

During the course of our inspection we looked at the care records of people who used the services of Community Care Team Limited. We found that a support plan had usually been received from the funding authority, which outlined each person's needs. This information was incorporated into the care planning system, which helped appropriate care to be delivered.

Staff members we spoke with told us of how people's needs were assessed prior to a care package being delivered. This helped the staff team to be confident that they could provide the care and support needed by those who were considering using the agency.

Each care file contained a good summary of the support people needed and a description of their social history, including their likes and dislikes, as well as any known allergies. These documents were entitled, 'My support plan at a glance' and they contained important information about individuals who received support. This helped to ensure that the care people needed was delivered in an appropriate and person centred way.

The record for one person, under the heading of, 'How you can best support me' stated, 'I require the carer to ensure that I am wearing my back brace, compression stockings, hearing aids and lifeline' and 'I am blind. Everything must be put back in the same place or inform me of any changes.' The domestic duties, which needed to be completed, were also recorded, as well as the application of a variety of topical skin creams. Together this information provided care workers with a good overall summary of the needs of this person, which helped to ensure they received proper care and support.

The plans of care we looked at were person centred and had been agreed by the individuals themselves, or their representatives where appropriate. Evidence was available to show people's needs had been reviewed and updated on a regular basis and that any changes in circumstances had been recorded.

We noted that a large number of compliments had been received by the service, which had been passed to relevant staff members. A complaints procedure was in place and an appropriate system for the recording of complaints received by the agency had been implemented. We found that complaints were being well managed, outlining action taken following any investigation and providing feedback to the complainants. People we spoke with were confident in making a complaint, should they wish to do so.

Requires Improvement

Is the service well-led?

Our findings

One person who used the services of Community Care Team told us, "I speak with the office staff regularly. They do help if there are any problems. [Name] rang only yesterday. They are all very attentive and interested."

We received some comments from a family member we spoke with, in relation to a particular morning visit. The circumstances had been reported under safeguarding procedures. The report of the conclusion of the safeguarding investigation stated: Not Substantiated on the balance of probabilities.

One member of staff said, "I am very happy working for the agency. The managers are very supportive. We get loads of training." Another told us, "I love it. It's the best thing I have ever done. It is a really worthwhile job. They [the service] got two references and a DBS [police check] before I was even offered a job."

The registered manager and office staff were very co-operative and helpful throughout the inspection process. Staff we spoke with provided us with positive feedback about the management of the agency. We were told that an open door policy was in place at the office, so that people involved in the agency could speak with any member of the management team to discuss any concerns they may have or to highlight any areas of good practice. This helped to promote a management system of openness and transparency. We observed many staff members visiting the agency office during our inspection. Those we spoke with were positive and happy in their work.

We saw clear monthly audits of accident and incident records, so that any patterns of re-occurrence could be easily identified and appropriately addressed. Regular audits of staff personnel files were also seen. However, we recommend that the assessing and monitoring process be extended to include formal audits around care planning and the management of medicines. The registered manager told us that this would be addressed with immediate effect.

The registered manager did not have access to a business plan at the time of our inspection. Therefore, the provider sent us this subsequently. This covered an overview of the service, action needed to make improvements and adjustments within the following twelve months.

The business plan outlined the monitoring systems of the service and showed that the provider regularly visited the office to meet with the registered manager, in order to provide support and address any issues requiring his attention.

The provider confirmed that many of the systems in place were informal and not recorded. However, he recognised that there was a need to develop a more structured and formal system for the assessing and monitoring of the quality of service provided. Therefore, plans were in place to establish documented management meetings every four months, annual appraisals for the whole management team and spot checks by the provider.

A Statement of Purpose clearly provided a good amount of information about the service, outlining the aims and objectives of the agency. These included areas, such as privacy and dignity, people's rights, independence, choice, fulfilment and diversity. This helped prospective service users to make a decision about accepting a care package from Community Care Team Limited.

A wide range of policies and procedures were in place, which had been reviewed and updated during 2016. This helped to ensure that the staff team were provided with any changes in legislation or good practice guidelines. The policies and procedures covered areas such as, access to premises, accident and incident reporting, advocacy, codes of conduct, complaints and confidentiality. The company had achieved an external quality award, which showed that a professional organisation had assessed the quality of service delivered. We saw the most recent report, which provided positive feedback.

Records showed that staff meetings had been held periodically. However, the registered manager told us that attendance had dwindled over recent months and therefore these meetings were now arranged annually. This allowed important information to be disseminated throughout the workforce, enabled employees to discuss any relevant topics and to keep up to date with any changes in the care practice industry. We were told that any new information was circulated by memos.

We established that people were able to contact the registered manager at any time for advice and that there was an open door policy, so that anyone could visit the office to raise any concerns or areas they wished to discuss. Staff we spoke with had a good understanding of their roles and responsibilities towards those who used the service.

We saw that surveys for those who used the service and their relatives had been conducted during 2016, when 28 responses were received. This helped the management team to seek people's views about the quality of service provided. The results were analysed and produced in a percentage format for easy reference. The surveys covered a broad range of areas and all responses received the minimum of 94%, with many resulting in 100%. We recommend that this process be extended to staff members. This would help the management team to assess what it was like to work for Community Care Team.

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 11 HSCA RA Regulations 2014 Need for consent We found that the provider had not established if people had the capacity to make specific decisions in relation to care and treatment.