06 Care Limited

06 Care Ltd

Inspection report

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Date of inspection visit: 25 and 26 August 2015
Date of publication: 04/12/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
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

Overall summary

The inspection took place on 25 and 26 August 2015. We announced the inspection 24 hours prior to our arrival in order to ensure someone would be in the office. We also telephoned people who used the service and their relatives on 25, 26 August and 1 September 2015.

06 Care Ltd provides support to people living in their own homes in Bradford, Keighley, North Yorkshire and the surrounding areas. Referrals are made from continuing health care, direct payments and private customers. 06 Care Ltd support people with personal care and support to enable them to live in their own homes. At the time of this visit there were approximately 80 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We were not always able to evidence that the service had consistently ensured potential risks to people's health and wellbeing were managed, monitored and mitigated. The provider had recognised they needed to improve the way medicines were managed. However, we found the new systems they had introduced did not ensure medicines were managed in a safe and proper way.

People told us they felt safe when care staff visited them and they were treated with kindness, respect and dignity. Overall feedback about the standard of care provided was good. However, most people's experience of the standard of care they received was influenced by the variance in call times. People told us this sometimes meant they didn't get help and support at the times they really needed it. Some people also commented that they did not receive a consistently good experience because some staff were more caring than others. The provider explained they were working hard to employ the right people who were committed to delivering the high standard of care that they wanted to deliver.

Procedures were in place regarding safeguarding and whistleblowing, however these needed updating to ensure they reflected current legislation. Staff had a good awareness of safeguarding, how to report concerns about people's wellbeing and what they had to do to keep people safe.

A number of staff had unexpectedly left the service which had impacted upon the consistency of people's call times. The provider had worked hard to recruit additional staff and ensured the people recruited were of good character and fit to perform the role. We found sufficient numbers of staff were employed to ensure each call run was covered.

We found the quality of information within care records was inconsistent. The information contained within care records did not always reflect people's changing needs. Further improvements were needed to ensure all care records contained accurate and complete information to ensure staff could deliver effective care. Staff had a good understanding of how to assist people with their meals and we saw evidence they provided appropriate support to ensure people ate and drank appropriately. However, the gaps in care records risked that this support was not consistent. Daily notes were not being regularly reviewed which risked that changes and issues were not always identified and acted upon.

People told us staff were well trained and provided them with effective support. We saw evidence care staff had been provided with appropriate training and support to enable them to fulfil their role. Care staff demonstrated a competent understanding of key subjects and the people they supported which demonstrated the training was effective. However, further improvements were required to ensure the training programme reflected the provider's policy commitments and that staff received timely refresher training.

People told us they felt involved in the care planning process and we saw a formal process was in place to ensure people could express their views about the care and support they received. We saw that where possible the service responded to people's requests. Care records also reflected that people and their relatives had been consulted and involved in making decisions about their care. A positive feature of the service was that staff were clear that it was the views of the person using the service that were the most important in shaping how care was provided. However, further improvements were needed to ensure the issues people raised were consistently responded to.

Most people told us they had experienced inconsistent call times. The provider had identified this was an issue and had started to put processes in place to address it. We saw this was an improving picture, however, further improvements were required to ensure the issue was fully addressed and person centred care was consistently delivered.

We found the governance systems and processes needed further refinement to ensure they consistently ensured the delivery of high quality care.

People and staff provided positive feedback about the new management team and the changes they were making. The roles and responsibilities of the new management team needed to be more clearly defined.

Summary of findings

However, it was clear the provider had invested in a pro-active management team who were committed to making the required improvements to ensure people received good quality care.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take in relation to this at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Appropriate arrangements were not in place to ensure risks were consistently managed, monitored and mitigated. Medicines were not managed in a safe and proper way. A number of areas of potential risk to people's health and wellbeing had not been appropriately identified and acted upon.

Staff had a good awareness of safeguarding and what they should do to keep people safe.

The provider had recruited staff in a safe and proper way. Sufficient numbers of staff were employed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective. Care records were not always complete and accurate. Staff assisted people to maintain an adequate diet however the support provided was not always reflected within care records.

Staff were provided with appropriate training and support and were knowledgeable. However improvements were needed to ensure staff received timely refresher training.

Staff demonstrated understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) and had a good knowledge of the people they supported and their capacity to make decisions.

Is the service caring?

Requires Improvement

The service was not always caring. Overall feedback about the standard of care provided was good. However, people's experience of the quality of care they received was influenced by the variance in call times.

Staff were clear about the importance of helping people to maintain their independence and people told us staff treated them with dignity and respect.

Staff had a good knowledge of people however care records needed more information to help staff establish rapport with people they supported.

People were supported to express their views and told us they felt involved in the care planning process.

Is the service responsive?

Requires Improvement

The service was not always responsive. The information contained within care records did not always reflect people's changing needs. Most people told us they experienced inconsistent call times which meant person centred care was not always being delivered. Daily notes were not regularly reviewed which risked that changes and issues were not always identified and acted upon.

Summary of findings

A system for managing and responding to complaints was in place and the views and opinions of people who used the service were regularly sought. Improvements were needed to ensure the issues people raised were consistently responded to.

Is the service well-led?

The service was not always well led. The governance systems and processes in place did not consistently ensure the delivery of high quality care. There was no formal system to routinely audit the quality of information within care files. Some policies and procedures needed to be improved and updated. People and staff provided positive feedback about the new management team and the changes they were making.

Requires Improvement

06 Care 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 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.

This inspection took place on 25 and 26 August 2015. The provider was given 24 hours' notice because the location provides a domiciliary care service so we needed to be sure that someone would be available in the office.

The inspection team consisted of two inspectors, one pharmacy inspector, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert by experience had experience of dementia and older people's care services. A new pharmacy inspector also shadowed this inspection.

Prior to the inspection we spoke with the local authority commissioners and reviewed the information we held about the service. Before our inspections we usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the provider to complete a PIR. We did ask some people who used the service and their relatives to complete questionnaires about their experience of using the service. The results of these were analysed and helped us to plan our inspection.

We telephoned seven people who used the service and eight relatives of people who used the service. We also telephoned six members of care staff, the registered manager, the provider, the training and complaints manager, the quality assurance manager, the compliance manager, the operations manager and two administrators. We looked at ten people's care records, medicines administration records and other documentation relating to the management of the service such as policies and procedures.

Inadequate

Is the service safe?

Our findings

We looked at the systems and records in place for managing medicines. We looked at a sample of medication and care records for 10 people who used the service. Overall, we found appropriate arrangements for recording and monitoring medicines were not in place.

The registered manager told us they had identified shortfalls in the way medicines were documented and were in the process of putting new systems into place. We looked at eight examples where the new paperwork was in use, but found the medicines records and information for care staff to follow was incomplete and inaccurate. Some of the names of medicines were recorded incorrectly; details such as strengths and doses were not always recorded and it was not always clear from records exactly what medicines people were prescribed.

Care workers supported people to take their medicines in a variety of different ways. However it was not always clear what support care staff needed to offer. Care records did not contain enough information for care staff to follow to ensure medicines, including creams and other external products, were given correctly and consistently. Without this information, people were at risk of being given too much or too little medicine or having creams applied incorrectly. We saw examples where care staff had frequently failed to sign the medicines records meaning it was not possible to determine whether the medicines had been used correctly.

The service's policies and procedures stated that regular medication audits were to be carried out. However, the management team were unable to provide us with evidence these had been done. Medication records were not returned to the office on a regular basis and there was no effective system in place to check medicines and records within people's own homes. This meant errors, discrepancies and concerns were not always being identified and addressed.

Our review of care records showed that potential risks to people had been assessed in a range of areas including their environment and people's specific needs. We found manual handling assessments were detailed and provided clear information about how staff should safely support people in different moving and handling scenarios. However, we found some risks had not been identified, assessed and appropriately managed. For example, one person lived with a disease which affected their nervous system. When we spoke with care staff that supported this person they provided specific details about how they reduced the risk whilst assisting them with day to day tasks. However, this information was not reflected within this person's care records. For another person we saw they were at risk of pressure damage to their skin. However, their care records lacked detailed information to guide care staff and did not demonstrate this risk had been appropriately managed. Our review of daily notes showed a number of areas of potential risk which had not been appropriately identified and acted upon for some people. This meant we were unable to evidence the service had consistently taken appropriate action to ensure potential risks to people's health and wellbeing were managed, monitored and mitigated.

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

Overall people told us they felt safe when their carers visited. However, most people explained that staff often arrived late which had an impact on them not getting their meals or medication at the times they needed them. Some people also told us care staff needed to be more proactive to deal with issues and manage risks. For example, one person explained that, "The carers didn't alert anyone that mum's medication had run out." However, people told us things were gradually improving now the new management team was in place.

The provider had policies in place for safeguarding and whistleblowing. These provided guidance for staff to help them effectively identify, respond and report any concerns or allegations of abuse. Both policies had been reviewed in November 2014 but needed a further update to reflect current legislation. The whistleblowing policy also did not include the number for the Commission which staff could contact if they had any concerns. We spoke with the registered manager about this. They said they would review and update both policies.

Staff told us they had received training in safeguarding vulnerable people and felt confident they could identify and appropriately respond to any concerns about people's wellbeing. We identified one safeguarding incident from September 2014 which had been reported to the local authority and should also have been reported to the

Inadequate

Is the service safe?

Commission but had not been. We spoke with the compliance manager and registered manager about this. They said this occurred before the new management team had been set up. They explained the new team were clear about when and how to make safeguarding referrals and notifications to the Commission. The information we hold about the provider confirmed a number of safeguarding notifications had been made to the Commission in recent months. However, the provider needed to ensure the roles of the new management team were defined to ensure consistency and accountability for safeguarding.

Some people told us they thought the service was short staffed and this contributed to the problem of staff running late to calls. The provider explained that several staff had unexpectedly left at short notice in May and June 2015. The provider had promptly recruited additional staff and reorganised call runs to help improve the consistency and timing of people's calls. However, whilst additional staff were being recruited this had impacted on the timing of some people's calls. We saw robust recruitment procedures were in place to ensure the staff recruited were of suitable character. This included checking previous work history, ensuring they were subject to a DBS (disclosure and barring service) check, checking their identity and obtaining references.

We reviewed staff rotas and found sufficient staff were allocated to cover each call run. Staff were allocated set runs to help improve timings and the consistency of staff caring for people. Rotas were appropriately planned with sufficient gaps to ensure staff could attend appointments promptly. However, we found the rota system could be further improved. For example, some rotas contained a list of clients to attend rather than set visit times. This could increase the risk of inconsistent visit times. The staff we spoke with told us the new rotas had improved things for them and meant they were able to support the same people on a regular basis which helped improve the consistency of care provided. They said they felt they were given sufficient time to cover each call run and didn't feel rushed.

We found there to be sufficient staff in the office to provide appropriate support to carers. This included an operations manager, compliance manager, training and complaints manager, quality assurance manager and several administrators. The registered manager and provider also worked in the office most days so were available to provide support and guidance as required. Staff told us there was always someone to contact in the office if they needed support. There was also an out of hours 'on call' number if they had a problem outside of office hours.

Requires Improvement

Is the service effective?

Our findings

Whilst we saw evidence care records were in a process of evolving to contain more detailed and person centred information; we found the quality of information varied depending which staff member had completed the care file. Therefore overall we found further improvements to care records were required to ensure they consistently contained accurate and complete information to ensure staff could deliver effective care.

Most people were supported with meals by their family. We saw evidence within daily records to show staff ensured people were offered and left with access to drinks. We also looked at the care files of two people who were supported to eat and drink by care staff. The staff we spoke with had a good understanding of people's specific needs during mealtimes. However, in both cases this knowledge was not supported by appropriately detailed and accurate care records.

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

Training was co-ordinated and managed by a dedicated training manager. Staff told us training was good and gave them the necessary skills to undertake their role. The staff we spoke with were knowledgeable about the people and subjects we asked them about which indicated this training had been effective. The people we spoke with also confirmed they felt staff were well trained to provide them with effective care and support. Staff received comprehensive induction training which included training based on Skills for Care Common Induction standards and practical manual handling training. Plans were in place to introduce the Care Certificate for new staff over the coming months. We found improvements were needed to ensure the training programme reflected the provider's policy commitments and that staff received timely refresher training. For example, four staff had started work in 2012 and had not yet received training updates in subjects such as safeguarding, infection control and medication despite the provider's policies stating staff would receive an annual training update in these areas. We spoke with the provider and registered manager about this. They said they would review the training arrangements to ensure all staff received suitable training to ensure they remained up to date with current best practice.

The registered manager explained staff were regularly offered supervisions with their manager. However they said staff would regularly not turn up to the office to attend them when arranged. The new training manager had put systems in place to try and address this and we saw plans were in place to provide all staff with appraisal and supervisions in the coming months.

People told us staff were polite and asked their permission before providing support. We asked care staff what they did to make sure people were in agreement with any care and treatment they provided. They were able to demonstrate a basic understanding of their responsibilities under the Mental Capacity Act 2005 (MCA). Care staff described how they always asked people for their consent to carry out care on every visit. They were clear they did not rely on the fact people had provided consent in the past to imply consent and ensured they obtained people's consent on each occasion they provided support.

From our review of records and discussions with people and staff we saw that staff supported people to access healthcare services and made referrals to other healthcare professionals to help people maintain good health. This included; GP's, district nurses, consultants, dentists and mental health specialists.

Requires Improvement

Is the service caring?

Our findings

Overall the feedback people provided about care staff and the standard of care provided was good. Some of the comments people made included;

“They work very hard. They are very nice girls.”

“They are absolutely fantastic they really shine. They are very good in a crisis too.”

“I couldn’t fault them they are lovely people, kind and caring.”

“It is better now we have the same carers most of the time.”

“They are very good with my mum.”

People’s experience of the quality of care they received was influenced by the variance in call times. In addition, some people commented they did not receive a consistently good experience because some staff were more caring that others. For example, one person told us, “Some [staff] are good but some are very poor.” Another person commented that, “Some staff are not caring enough. They seem to have an attitude problem. But others are lovely.” A relative told us, “Some [staff] are very good with [my relative], but others I have had to show them how to wash them properly.” People explained they felt this was because staff were “rushed and stressed.” The provider and registered manager were clear they had experienced issues with some care staff’s attitude and they had now left the service. They said they were working hard to employ the right people who were committed to delivering the high standard of care that they wanted to deliver to people. However it was clear from people’s comments that this process was not yet complete.

The majority of people we spoke with told us care staff treated them with dignity and respect. The staff we spoke with provided examples of how they maintained people’s privacy and dignity, such as closing curtains and ensuring people were covered when supporting with personal cares.

The care staff we spoke with had a good knowledge and understanding of the people they cared for. They were able to describe in detail how people preferred their support to be provided and what specific risks to people were. We also saw information within people’s care records to prompt staff about how they could help people to retain their independence, such as information about what people could still do for themselves. However, we noted care records did not always contain detailed information about people’s social needs and life history. This information is useful to help care staff to quickly establish a meaningful rapport with the people they cared for. We raised this with the registered manager and provider who said they would look to include more detail within people’s care records.

People told us they felt involved in the care planning process and we saw a formal process was in place to ensure people could express their views about the care and support they received. This included an annual care review where people were asked for areas they felt could be improved. We saw that where possible the service responded to people’s requests. Care records also reflected that people and their relatives had been consulted and involved in making decisions about their care. A positive feature of the service was that whilst staff actively involved and encouraged people’s families to express their views, staff were clear that it was the views of the person using the service that were the most important and would ultimately shape the way care and support was provided.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt involved in the care planning process. However, we found the information within care records did not consistently reflect people's changing needs. For example, one person's care record stated staff should cut food into small pieces because they were unable to use a knife and fork. Care staff told us this person's needs had now changed and on "good days" they could support themselves to eat. One staff member said, "Sometimes we cut it into small pieces, sometimes they can do it, they are keen to increase independence." This was not reflected within this person's care records which risked they would not be provided with appropriate support at all times

Most people we spoke with told us they experienced inconsistent call times. Some people told us this had improved in recent weeks. However over half of the people we spoke with told us it was still a problem. One person said, "Their timing is still erratic" and another told us, "Their timekeeping is not good – they are late most times." People told us this meant they did not always receive care and support at the times they needed it. We saw evidence of this in the care records we reviewed. For example, records showed one person should have had their morning call at around 7.30am. We checked the daily records for the first three weeks in August 2015 and found the time of this call varied from between 6.30am to 11am and was different almost every day. For example, on the 12 August it was at 6.40am and the following day it was at 9.15am. Another person's morning call should have been at 8am and their evening call at 6:45pm. Their August daily notes reflected their morning call varied from 6.35am to 9.15am and the evening call from 4.55pm to 7.35pm. The inconsistencies in call times was not conducive to person centred care.

The provider had taken action to try and address the issue with call times by recruiting additional staff, reorganising call runs and implementing systems to identify and respond to missed and calls.

Some people told us they had noted improvements in the times of their calls in recent weeks. This was supported by the complaints register which showed this was an improving picture as the number of people who had complained about missed calls had reduced between June and August 2015. However, we found the systems and processes in place needed further improvement to ensure the problem was fully addressed. For example, the system to log and monitor missed calls did not ensure all missed calls were captured and escalated to the complaints manager.

The provider did not have an effective system in place to ensure peoples' daily notes were regularly reviewed. This meant there was not an effective system to monitor the time of calls to ensure people received consistent and appropriate care. The current system was not proactive because it relied upon people or staff contacting the office to highlight changes or to raise issues with call times. There was also a risk that issues or changes to people's needs were not promptly identified and responded to. For one person we saw four occasions between 12 July and 19 August 2015 where no entries were made in the daily records to account for four scheduled calls. The operations manager was unable to explain these gaps. As this person's daily notes had not been reviewed during this period these omissions had not been identified and investigated prior to our inspection. We were therefore unable to evidence this person had received appropriate care and support on those occasions.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people began to use the service they were provided with a welcome pack which included information about how they could make a complaint. Staff were clear about how they would support people to make a complaint and felt the service took people's complaints seriously.

Some people told us they did not always feel listened to when they made a complaint because the same issue happened again. One person told us, "I have complained and they have made promises but have not followed through – this is to do with erratic timekeeping." A relative also told us, "I repeatedly ask them to ring me if they are going to be late at Dad's so that I can go, but they don't always and it causes problems." However, some people told us they had felt listened to when they had raised issues. One relative said, "We did have problems with a carer who mum could not get on with and they changed her straight away." Where people told us they felt they had not been listened to this was usually in relation to

Requires Improvement

Is the service responsive?

inconsistent call times or missed calls. We reviewed two formal complaints which had been made in relation to other issues and saw these had been thoroughly investigated and responded to.

The complaints manager had introduced a new system for capturing and investigating complaints. People told us they had noticed an improvement and said the new management team were trying hard to resolve problems for people. One relative said, "They seem to be getting their act together recently" and another said, "Things have improved greatly recently, but could still be better." We saw evidence the complaints manager was pro-active in addressing issues and demonstrated an open and honest approach in how they managed complaints. The system they had introduced ensured a more structured approach and audit trail for complaint investigations. However, they recognised there were still improvements that could be made. Such as comprehensive analysis to ensure trends and patterns of complaints could be identified and acted on. We also saw where the complaints manager had put processes in place to resolve issues, care staff were not always consistent in following their instructions to help reduce the risk of repeat complaints.

This led us to conclude that overall the systems in place to manage, investigate and respond to complaints worked well. However the provider needed to take effective action to address their governance systems and processes to ensure the underlying issues with call times and inconsistency in staff's approach were addressed.

The provider had systems in place to seek the views and opinions of people who used the service. This included annual care reviews, quality phone calls and questionnaires. When someone started to use the service they received a phone call after two weeks and a care review after six weeks. We saw this meant people were provided with multiple opportunities to discuss their care and experience and suggest improvements. We found this system needed refinement to ensure it was clear who was responsible for following up and addressing the issues people raised. The quality assurance manager told us they were responsible for obtaining and collating people's feedback but would not always be responsible for following up on issues. They explained the management team all worked together to address these issues. However, we found that because actions were not specifically allocated there were some occasions when people's feedback had not been acted upon and addressed. However, we did see some positive examples where people's feedback and suggestions had been acted upon to improve their experience. This showed us if staff had clearly defined roles and responsibilities the system in place would help the provider to be consistently responsive to people's changing needs.

Requires Improvement

Is the service well-led?

Our findings

We found the governance systems and processes in place did not consistently ensure the delivery of high quality care. We identified concerns regarding how medicines and risk were managed, incomplete care records and an absence of a consistently person centred approach to care planning and delivery. Some of these issues had already been identified by the provider prior to our visit. However they had not been fully and appropriately addressed. For example, the new medicines process did not ensure a consistent and comprehensive approach to medicines management. As part of a robust quality assurance system the registered manager and provider should actively identify improvements on a regular basis and put plans to ensure they are effectively addressed.

We found there was not a structured system in place to ensure people's daily notes and medicines administration records (MAR) were routinely returned to the office to be reviewed. We identified some gaps in people's daily activities records and MAR which had not been identified and addressed through a robust system of audit. For example, for one person over a six week period we identified four occasions where staff had not made entries within their daily notes for scheduled calls. This meant on those occasions the service was unable to demonstrate that appropriate support had been provided. For another person, their daily notes recorded potential injuries and evidenced their needs may have changed. However these issues had not been identified or addressed because effective systems were not in place to return and review people's daily notes.

We found some care records contained detailed and person centred information. However, other care records were incomplete and did not contain sufficient detail to ensure effective care delivery. This meant not all care records were completed to the same standard and did not all contain appropriately detailed and accurate information. We spoke with the management team about care file checks. They explained care records would be reviewed each month, usually by the operations manager or care supervisors. They also explained if a manager pulled a care file to investigate a complaint or complete quality assurance they would review it to ensure it was appropriate. However, there was no formal system to ensure the management team routinely audited the quality of information within care files.

We found a number of other areas where the provider needed to improve their governance systems and processes to ensure the quality of the service provided was continually improved. This included completing more detailed analysis of complaints to ensure trends and patterns were identified, improving the systems for managing missed calls and ensuring where people raised issues these were consistently followed up and acted upon. We also found some policies and procedures needed to be improved and updated to ensure they were aligned with what happened in practice and that they reflected current legislation and best practice guidance.

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

We saw the provider did operate some quality assurance systems which were effective in helping to improve the quality of care. For example, the management team performed spot checks of care staff's practice. We saw these checks were robust and effective in identifying and addressing issues with care staff's approach and attitude.

The people we spoke with provided positive feedback about the new management team. One person told us, "The new team are very good – very kind and understanding." Whilst another person said, "The new managers are very helpful, they listen and try hard to resolve problems." Staff were also positive about the management team and told us they now felt more supported and there was always someone in the office they could go to if they had a problem. People and staff told us the communication between office staff and carers still needed to be improved to ensure messages were consistently passed on and issues were appropriately escalated. We also identified that the roles and responsibilities of the new management team needed to be clearly defined. The provider recognised this was an area for improvement and said they would ensure this was addressed as an immediate priority. It was clear that the provider had invested in an effective and pro-active

Requires Improvement

Is the service well-led?

management team who were fully committed to making the required improvements, helping to positively change the culture of the organisation and ensure people received good quality care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care was not always designed and delivered in a way that met the needs and reflected the preferences of the people who used the service. Regulation 9(1).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure the service; Assessed monitored and improved the quality and safety of the service provided. Maintained securely and accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided. Regulation 17(1)(2)(a)(c).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 Care and treatment was not always provided in a safe way for service users because; risks to people's health and safety were not always being appropriately assessed, there was not always evidence that the registered person had done everything that was reasonably practicable to mitigate these risks, medicines were not always managed in a safe and proper way. Regulation 12(1)(2)(a)(b)(g).

The enforcement action we took:
We served a warning notice on the registered manager and registered provider. The notice stated that they had to take action to ensure they met this regulation by 13 November 2015.