Community Care Worker Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We completed an unannounced inspection at Community Care Worker Limited on 19 January 2016 and 20 January 2016. This was the first inspection since the service was registered with us (CQC) on 28 September 2015, we looked to see if the service was meeting the required standards.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration Requirements) Regulations 2009. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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 .

Community Care Worker Limited are registered to provide personal care. People are supported with their personal care needs to enable them to live in their own homes and promote their independence. At the time of the inspection the service supported 14 people in their own homes.

There was a registered manager at the service who was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from the risk of harm because staff did not understand their responsibilities and actions required to safeguard people from the risk of abuse.

People's risks had not been assessed or monitored effectively to keep people safe. Staff did not give consistent accounts of people's risks and how these needed to be managed to keep them safe.

The provider did not have a system in place to monitor incidents and accidents to lower risks and ensure that people were protected from the risk of further occurrences.

There were not enough staff available to meet people's assessed needs. The provider did not have an effective system in place to monitor the staffing levels against the needs of people who used the service.

The provider had unsafe recruitment procedures and we found that the required checks had not been carried out on all staff to ensure that staff were suitable and of good character to provide care to people who used the service.

Systems were not in place to ensure that medicines were managed safely and in a way that they had been prescribed.

Staff had received some training before they provided care but we found that they had not received training in important areas such as; The Mental Capacity Act 2005 and staff had limited knowledge about safeguarding people from harm and how to support people who displayed behaviour that challenged.

We found that people had not consented to their care and where they were unable to consent there had been no mental capacity assessments carried out to ensure that decisions were made in their best interests. Staff and the provider did not understand their responsibilities under the Mental Capacity Act 2005.

We found that there was no evidence that other health and social care professionals were contacted when people's health and wellbeing had deteriorated.

People and their relatives had not been involved in the planning of their care. We found that people's preferences in care had not been considered or acted upon to ensure people received the care they wanted at a time they wanted it.

The provider did not have an effective system in place to handle and respond to complaints that had been made by people who used the service and their relatives.

People had not been asked to provide feedback about the quality of service they received. Where people had given feedback this had not been recorded or acted upon by the registered manager and the provider.

The provider had no systems in place to assess and monitor the quality of the service and the concerns we raised at the inspection had not been identified. Risks had not been mitigated to ensure people were receiving safe, effective and responsive care.

Some people told us that staff treated them in a caring way and showed dignity and respect when they provided support. However, some people told us that their dignity had not been respected and people's choices were not always listened to or acted upon to ensure that they had control over the care they received or at a time that they needed it.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration Requirements) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

People's risks had not been assessed or monitored effectively to keep people safe. The provider did not have a system in place to monitor incidents and accidents to lower risks and ensure that people were protected from the risk of further occurrences.

People were not protected from the risk of harm because staff did not understand their responsibilities and actions required to safeguard people from the risk of abuse.

There were not enough staff available to meet people's assessed needs and the provider had unsafe recruitment procedures.

Systems were not in place to ensure that medicines were managed safely and in a way that they had been prescribed.

Is the service effective?

Inadequate

The service was not effective.

Staff had received some training before they provided care but we found that they had not received training in important areas such as; Mental Capacity Act 2005 and staff had limited knowledge about safeguarding people from harm.

We found that people had not consented to their care and where they were unable to consent there had been no mental capacity assessments carried out to ensure that decisions were made in their best interests.

People were not supported to eat sufficient amounts and people's risks of malnutrition had not been considered.

We found that there was no evidence that showed that other health and social care professionals were contacted when people's health and wellbeing had deteriorated.

Is the service caring?

Inadequate

The service was not caring.

Some people told us that staff treated them in a caring way and showed dignity and respect when they provided support. However, some people told us that their dignity had not been respected and people's choices were not always listened to or acted upon to ensure that they had control over the care they received at a time that they needed it.

Is the service responsive?

Inadequate

The service was not responsive.

People and their relatives had not been involved in the planning of their care and we found that people's preferences in care had not been considered or acted upon to ensure people received the care they wanted at a time they wanted it.

The provider did not have an effective system in place to handle and respond to complaints that had been made by people who used the service and their relatives.

Is the service well-led?

Inadequate

The service was not well led.

People had not been asked to provide feedback about the quality of service they received. Where people had given feedback this had not been recorded or acted upon by the registered manager and the provider.

The provider had no systems in place to assess and monitor the quality of the service and the concerns we raised at the inspection had not been identified and risks had not been mitigated to ensure people were receiving safe, effective and responsive care.

Community Care Worker Limited

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, 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 19 January 2016 and 20 January 2016. We carried out the inspection unannounced because we had been made aware of concerns about the way the provider carried out the service.

The inspection team consisted of two inspectors at the office location on the 19 January 2016 and an inspector carried out telephone interviews with people who used the service or their relatives and staff members on the 20 January 2016.

We reviewed other information that we held about the service. This included notifications we received about incidents and events such as; safeguarding and deaths that had occurred at the service, which the provider is required to send to us by law. We contacted local authority commissioners to obtain a view of their experiences with the service and provider.

We spoke with four people who used the service, five relatives, five care staff and the provider. We viewed six records about people's care. We also viewed records that showed how the service was managed, which included 11 staff recruitment records.

Inadequate

Is the service safe?

Our findings

People and relatives told us that staff did not always know how to support them safely. For example, one person's relative told us that staff were often late for calls which meant that the person was in bed for longer than they should be, which placed them at a higher risk of developing a pressure area. The relative told us that their relative used a specialist pillow to ensure they were safe in bed and on one occasion after staff had been the person had fallen on the floor, because the pillow had not been left in the correct place. The staff we spoke with were unaware of the requirement to ensure that the pillow was placed correctly to protect this person from harm. There was no record of this incident or a care plan in place to give staff guidance on how they needed to ensure that the pillow is placed correctly to keep the person safe. This meant that this person was at risk of receiving unsafe care because their risks had not been assessed or managed.

People's risks had not been assessed or monitored effectively to keep people safe. For example; one person's moving and handling assessment stated that the person suffered from dementia, which could affect how they were moved. The person had communication difficulties and at times became aggressive when being supported to move. We found that their risk assessment did not contain any guidance for staff to follow on how to manage this person's risks. Staff told us that this person regularly became aggressive when providing support, but staff gave different accounts of what they needed to do to reassure the person and provide support in a way that met their needs. This meant that this person was at risk of unsafe care because staff did not have guidance to follow to protect this person from the risk of harm.

We also found that the risk assessments we viewed for one person did not contain details of their risk of developing pressure areas, which was detailed on their local authority care plan. There was no detail of how this should be managed by staff to ensure this person's skin was kept intact. After the inspection we were informed by the local authority that this person had developed a pressure area, which meant the provider had not assessed or monitored this person's risks to keep them safe from harm.

We saw that incidents that had occurred whilst people were using the service were not recorded appropriately. For example; the communication records for one person showed that they had become aggressive and had shouted and grabbed staff when they were providing this person's care. There had been no updates in the risk assessments or care plans to guide staff on how to manage the behaviour that challenged in a way that kept them safe. The registered manager was not aware of this incident and we found that changes had not been made to this person's risk assessments to lower the risk of further harm. There were no systems in place to enable the registered manager to analyse accidents for any trends or that ensured the appropriate action had been taken to lower the risk of a further occurrence. This meant that this person was at risk of receiving inconsistent and inappropriate care that did not meet his needs because their risks had not been assessed and mitigated.

People and relatives told us they did not always receive their medicines as required. For example, a relative of a person who used the service told us that staff were not giving their relative medication at the right times. We were told that on numerous occasions staff administered medication to this person within two hours and not the four hours as stated. This meant that there was a risk of harm to this person because they were

not receiving their medicines as prescribed. Another person's relative told us that staff had forgotten to administer medicines on four or five occasions. This had been recorded by the relative in the communication records and we were told the relative reported this to the registered manager, but there had been no action taken to prevent a further occurrence. We found that people's topical creams were not recorded within the records and there was no guidance for staff to follow. For example; the records we viewed did not state how often the creams needed to be applied and where they needed to be applied. The communication records showed that people's creams were not consistently applied to protect them from developing pressure areas. We were unable to view medication administration records (MARs) for people who were supported with their medicines and topical creams, because we were told these were not at the office at the time of the inspection. We asked the registered manager how they assured that people were receiving their medicines as required and we were told that they were unable to check the MARs because staff had not taken them into the office. This meant that improvements were needed to the way people's medicines were managed.

The above evidence shows that people's risks were not assessed and managed safely to protect people from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there was not enough staff available to support them and staff were often late and they did not always stay for the required amount of time. One person told us they had to get down stairs alone because staff regularly did not arrive to provide the support, which put them at risk of harm because they had been assessed by the local authority as being a high risk of falls. This person told us they were also at risk of harm because they needed support to prepare their breakfast and they had been assessed by the local authority as requiring support from staff to lower the risk of further harm. Staff told us that they had provided support to people alone when people had been assessed as needing two staff members to be in attendance to ensure that people were supported safely. Staff told us this was because there was not enough staff available to meet the requirement of two. This put people at risk of serious harm because they did not receive their assessed care carried out in a way that kept them safe. Some staff told us there was not enough time provided between care calls, which meant people regularly received late calls or missed calls. This meant there were not enough staff available to support people safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at 11 staff recruitment files and found that the registered manager had not undertaken the required recruitment checks for four staff members to ensure that people were supported by suitable staff who were of good character. The required checks include references from previous employers and checks to ensure that staff did not have a criminal record that could impact on their suitability to provide safe care to people who used the service. The registered manager told us that staff had provided the checks carried out by their previous employers, but we did not see evidence of this. Staff we spoke with told us that they had not taken in their previous DBS to be checked to ensure they were suitable to provide support to people. Staff also told us that they had provided support to people alone before their DBS check had been returned and checked by the registered manager. This meant that staff were working without the proper checks in place and people were at serious risk of harm because the provider did not have safe recruitment practices in place. We could not be assured that staff were of good character and were safe to provide care to people who use the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from inappropriate or unsafe care because the registered manager and staff did not have a clear understanding of their responsibilities to protect people from harm. Staff we spoke with had varying understanding of how they needed to protect people if they felt that they were at risk of abuse.

Some staff were unable to clearly state the various signs and scenarios that may constitute abuse. Staff told us that they would report any concerns they had to the registered manager. We asked the registered manager if there was any investigations being carried out to safeguard people from alleged abuse and we were told that there were no current investigations. During the inspection we found that one person was subject to a safeguarding investigation because of an allegation that unsafe care had been carried out. The registered manager had not recognised that this was an investigation to safeguard this person from alleged abuse. This meant that people were at risk of harm because there were no systems in place to ensure staff and the registered manager were aware of their responsibilities to manage and report abuse.

Inadequate

Is the service effective?

Our findings

People told us they felt that staff did not always know how to support them effectively. A relative said, "I don't think they [staff] are trained properly as they don't know what to do". Another relative said, "I had to show staff how to use the hoist because they didn't know how to use it properly". One person told us that staff did not know how to support them with the bathing and application of creams to maintain their physical wellbeing, which had resulted in some reddening to their legs and the risk of deterioration in their condition. Staff who we spoke with had varying knowledge of safeguarding and no knowledge of the Mental Capacity Act 2005. We viewed training records that showed staff had received some in house training from the provider, but staff had not been trained sufficiently and we found there were large gaps in staff knowledge due to the lack of training. This meant that people were at risk of inappropriate care because staff had not received sufficient training to carry out their role.

The above evidence shows that staff had not received appropriate training to enable them to support people who use the service effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not following the guidance of the Mental Capacity Act 2005 (MCA). The 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 and their relatives told us that they had not consented to their care where they were able to. One person said, "I don't know from one day to the next when staff are coming and I wasn't asked to consent to anything". A relative said, "We haven't been asked to consent to the care and neither has my relative". Staff we spoke with had no understanding of their responsibilities under the MCA 2005 or what it meant for people. Staff were not aware of the actions they needed to take when a person lacked capacity to make decisions. One staff member said, "I don't really know much about that at all. We haven't had any training. I'd just use my own judgement really". Another member of staff said, "I don't know what it means".

We saw that the registered manager had not considered or undertaken mental capacity assessments where people were unable to make informed decisions in certain areas of their care. For example, we saw manual handling risk assessments which stated 'can be confused' and 'has dementia'. There were no capacity assessments in place to give staff guidance on how to support people with decisions if they lacked capacity to do so for themselves. Staff did not know if people had the capacity to make decisions about their care and treatment and how to support people if they were unable to make certain decisions for themselves. We asked the registered manager how they undertook their responsibilities under the MCA 2005 and we were told that these had not been considered or taken account of. This meant that people were at risk of inappropriate and ineffective care that was not in their best interests because the provider was not acting in accordance with the MCA 2005.This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to receive sufficient amounts to eat. A relative we spoke with told us that they often found that the staff had stated that their relative refused food. The relative told us that the food that was being prepared was not of a good standard and not always what their relative liked or wanted. We viewed the communication records for this person, which showed that staff had reported concerns that this person was refusing food. We saw no evidence of actions taken to lower the risk of malnutrition for this person. There were no risk assessments or care plans to give guidance for staff on how to ensure this person received sufficient amounts to eat and their actions to take if food was refused. We asked the registered manager what had been put in place to lower the risk of harm and they told us they had not put anything in place. This meant that this person was at risk of harm because the provider had not put plans in place to ensure that this person received sufficient amounts to eat.

Relative's told us that when their relative had not been well or required any input from other health professionals, such as the doctor, they had raised these themselves with professionals as they did not feel this would be acted on by the registered manager. Staff told us and we saw in the communication records that they had raised any issues with people's health and wellbeing to the registered manager. The registered manager told us that they had rang professionals when staff had raised concerns, but they were unable to provide any evidence such as updates to care plans or risk assessments to show what actions had been taken when people's health and wellbeing had deteriorated. This meant that we could not be assured that action had been taken by the registered manager when concerns were reported to maintain people's health and wellbeing.

Inadequate

Is the service caring?

Our findings

Some people told us that staff maintained their dignity when they provided support by ensuring they felt comfortable when providing personal care. However, some people did not feel that their dignity was protected. For example; a relative told us that their relative needed to be supported to use the toilet before going to bed and the staff had not supported them with this on numerous occasions. The person had then been found by the relative and had been incontinent because they had not used the toilet as required. The relative told us that this upset their relative as they did not like to be incontinent but were unable to get to the toilet by themselves. This meant that the person's dignity had not been maintained by staff.

Another person (who was female) told us that they were provided with a male carer without prior consent. They told us they were upset and refused the care offered and they felt that the registered manager had not considered that they would feel uncomfortable having personal care provided by a male member of staff. The records we viewed did not state if this person had been asked whether they had any preferences of who provided their care. This meant that people's dignity had not been considered by the provider in the planning of their care.

People gave varied experiences of the staff and whether they were caring. One person said, "They are nice when they do come, but I never know when" and "They are quite rushed, but they are polite enough". However, some people and their relatives told us that staff did not arrive to provide the care and they were often late which had an impact on the care. For example; a relative told us that the staff often missed calls or arrived late, which meant that their relative was left in bed for long periods of time, which had an effect on their emotional wellbeing as they liked to sit downstairs. This meant that people did not always feel cared for because the provider did not have systems in place to ensure that people received their care when they needed it.

People and their relatives told us that staff offered them some choices in care, but these were not always listened to. For example; one person told us that they told staff how they wanted their care to be carried out but only one or two staff listened. They said, "I need my care providing in a certain way, especially my skin or it gets sore. Some staff listen to me, but it feels like other staff are scared to undertake the care I want". People and their relatives told us that they felt that their needs were not listened to when they were not happy about the care and because of this they were considering cancelling the service. People told us that they felt the service did not have enough staff that were trained appropriately to be able to carry out the care in a way and at a time that reflected their choices.

Inadequate

Is the service responsive?

Our findings

People told us that they had not been involved in the assessment or review of their care. One person said, "There was no assessment completed before the service started. I didn't meet them [the staff] before we had the care. I've not been involved and there hasn't been a review as far as I know". Another relative told us, "No one came to meet my relative or me before they provided care. We didn't have a meeting before to discuss what my relative needed, other agencies we have used have always met with us before to discuss the care needed". Staff gave different accounts of the care and support they provided to people and were not aware of people's preferences in care. For example; one person told us how they liked their care providing in a certain way, but staff told us different to what we had been told. We saw that assessments of people's care needs had not been carried out by the provider before care was provided. We were told by the registered manager that they used the local authority care plans. This meant that people had not been involved in the planning and assessment of their care before they received care.

People told us that they did not always receive care in a way that they wanted it and met their preferences. One person said, "Staff don't know how I like my care to be provided and I have to keep telling them how I like it to be done, some staff do it the way I want it, some staff don't". One relative told us, "Nobody has ever asked my relative what they preferred or anything". Another relative said, "We've not been asked what we wanted or preferred". The registered manager had not sought people's preferences as to and whether they preferred a male or female carer to provide personal care. Two people told us that they had been provided with a male carer without prior notice, which had upset them. They said, "I wasn't asked if I preferred a male or female carer and they sent a male, which I didn't want and it upset and frightened me" and, "My relative was never asked if they wanted a male or female carer and a male just turned up. It wasn't what they really wanted but we just put up with it". This meant that people did not receive care in a way that they wanted it that met their preferences.

People and their relatives told us that care was not being provided at a time that they wanted or the amount of time they needed. For example, one person's relative told us they were not receiving the care they needed for the time they needed it. We saw the local authority care plan for this person, which stated that they needed three care calls a day to meet their needs. The communication records we viewed did not match the amount of visits this person had been assessed as requiring to be provided. We found that there were regular occasions when they did not receive the care required, for example this person had received 15 minutes at lunch instead of 45 minutes and they had received 35 minutes in the evening instead of the 60 minutes they had been assessed for, to meet their needs. The communication records also showed that this person's calls had also significantly been reduced to one call a day when they had been assessed as needing three calls. The relative we spoke with told us that they had been asked to have less calls over this period by the registered manager and they agreed, but it was not their choice or preference as less calls impacted on the person and their relative.

People told us that they did not receive consistent staff at consistent times. One person told us that staff did not always turn up on the days that their care was needed and staff have arrived on a day that was not

scheduled for, which had startled and frightened them because they don't know they are going to provide care. The relative of this person said "My relative is scared and upset because it frightens them when different people turn up at various times of the day without knowledge of who or when the staff are providing care". Another person told us that they did not have regular staff and most of the staff did not know what to do for them, which meant they had to keep telling each member of staff that provided their care what they needed to do for them. They told us that some staff listened to their preferences but some staff did not take these into account. The records we viewed did not contain information on how staff needed to carry out care in line with people's preferences.

The above evidence shows that people were not involved in the assessment and review of their care, which meant that people did not receive care that met their needs and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew how to complain and who to complain to. We spoke with nine people and their relatives and seven people were unhappy about the care they received. We were told that people had complained to the registered manager about their concerns on numerous occasions but no action had been taken to make improvements to the care they were receiving. Four people we spoke with were considering cancelling the service as they felt that they were not listened to and they were not receiving the care they needed. One relative said, "I've been unhappy with the way the care has been carried out and when staff don't turn up, but nothing has changed it still happens. We are in the process of changing to another agency". Another relative said, "I've complained to the registered manager because my relative is not receiving the care they should and sometimes staff don't turn up at all. Nothing has changed since I complained". We asked the registered manager if there had been any complaints received at the service. We were told that there had not been any complaints from people and we did not see any evidence of a complaints log or complaint policy available to people or their relatives. This meant that complaints raised were not being investigated and there were no effective systems in place to manage and act on complaints from people and their representatives.

The above evidence shows that there were not effective systems in place to manage and act on complaints received about the service. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We found that there no systems in place to monitor and assess the quality of care. The registered manager was unaware of the concerns that we had raised at the inspection. There were no checks in place to ensure that staff were supporting people correctly with their medicines and topical creams. The registered manager told us the Medicine Administration Records (MARs) were in people's homes and had not been brought into the office so there had not been any checks carried out. There was no evidence of spot checks of staff and we were told that this had not been put in place. This meant that the registered manager could not be assured that staff were effective in their role. We asked the registered manager how they ensured that people were receiving the care that they were assessed for and we were told that there was not a system in place to do this. This meant the provider did not have systems in place to assess, monitor and improve the service to ensure that risks to the health and wellbeing of service users were mitigated.

The registered manager told us that there had not been any safeguarding investigations relating to people who used the service. We found that there was an investigation being carried out by the local authority because a person had been put at risk by staff using water that was very hot and inappropriate unsafe transfer of a person by staff using the hoist inappropriately. This was verified by the relative we spoke with, but not considered as a safeguarding by the registered manager. This meant that the provider was unaware of the risks to people and unaware of their responsibilities to enable people's risks to be addressed, monitored and mitigated to protect people from harm.

We saw that there were no systems in place to manage missed or late calls. The registered manager told us there had been no missed or late care calls at the service. However, people we spoke with told us that they had missed and very late calls and had complained to the registered manager about this. We saw no evidence that the concerns raised by people had been acted on to make improvements. This meant there were no systems in place to ensure people were receiving the care they had been assessed for at a time that they needed it.

We found there were no systems in place to monitor incidents and accidents that had occurred whilst care was being carried out. The registered manager told us there had been no incidents at the service, however, we saw that one person had become aggressive with staff and this had not been recorded as an incident. There had been no changes made to their care plan or risk assessments to show how this needed to be managed.

We found that the registered manager had not gained feedback from people about their experiences of the care provided. People told us they had not been asked for feedback and when they had raised any concerns they had not been listened to or acted on by the registered manager. The registered manager told us that they had asked for feedback from people verbally, but there was no evidence to show this has been carried out or evidence of any actions that had been put in place to make improvements to the quality of the care provided.

During our inspection on the 19 January 2016 at the location's offices we requested information from the

registered manager on numerous occasions. For example, we requested staffing tools to ensure that the registered manager had assessed the amount of staff required to provide safe care, staff rotas from November 2015 to 19 January 2016 and the actual hours that staff had supported to people. This was not provided when we requested it at the time of the inspection which meant we were unable to be assured that people were receiving their care when they wanted it and for the assessed amount of time.

The above evidence shows that there were not effective systems in place to assess and monitor the quality of the service provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.