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De Vere Care - Ealing

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

Summary of findings

Overall summary

This comprehensive inspection took place on 9 January 2018 and was announced. We gave the branch manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm the branch manager would be available when we inspected.

The last inspection took place in April 2017 and the service was rated 'requires improvement' in Safe, Effective, Responsive, Well Led and overall. Caring was rated 'good'. We found breaches of Regulations relating to person centred care, safe care and treatment, receiving and acting on complaints, good governance, fit and proper persons employed and staffing. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective, Responsive and Well Led to at least a 'good' rating. During this inspection, we found that some improvements had been made but not enough to meet all the regulations.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older people, people with learning disabilities. physical disabilities and mental health needs. At the time of the inspection, 22 people were receiving a service for a regulated activity. Not everyone using De Vere Care Ealing received a regulated activity. CQC only inspected the service being received by people provided with 'personal care'.

The service had a registered manager who also managed other locations for the provider and was based at the head office. They were not present during the inspection and we spoke with the branch manager who had made an application to the Care Quality Commission to become the registered manager. 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.

During the inspection on 9 January 2018, we saw safe medicines procedures were not always followed. The medicines training for staff and assessments of their competency to manage medicines were not up to date.

Care workers received an induction and supervision but did not have up to date appraisals, spot checks or training to ensure they had the skills and knowledge to deliver effective care and support.

Consent to care was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA)

There was not always evidence of complaints being recorded, investigated and followed up in a timely manner.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided. However records were not monitored effectively to ensure there were no gaps in the required

information.

There was a procedure in place for the management of incidents and accidents which were recorded in people's files but not logged at a single point to provide an overview of the concerns. Risk assessments were up to date and reviewed but they were not all relevant as some people were assessed to be at high risk when they were not. For example a mobile person being assessed as at high risk of pressure sores.

Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service and care workers knew how to respond to safeguarding concerns to help ensure people received care safely.

The provider had an infection control policy in place but not all staff had undertaken training in this area to help protect people against the risks of the spread of infection.

People's nutritional needs and dietary requirements were assessed and care workers knew how to support people to maintain good health.

Care plans identified people's needs and preferences and provided care workers with guidelines to effectively care for people in a way that met their needs. They were reviewed annually. People said care workers treated them kindly and with respect.

People and their families were involved in planning people's care but were not consulted about end of life care.

The manager and the care co-ordinators were available to people and care workers and listened to concerns.

We found five breaches of regulations during the inspection. These were in respect of safe care and treatment, receiving and acting on complaints, staffing, the need for consent and good governance.

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider did not always follow safe management procedures for medicines.

People had risk assessments and risk management plans to minimise the risk of harm, but not all risk assessments were relevant which meant the risk assessments were not always effective.

Care workers knew how to respond to safeguarding concerns.

Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service.

There was a procedure in place for the management of incidents and accidents which were recorded in people's files but these were not logged at a single point to provide an overview of the concerns.

The provider had an infection control policy in place but not all staff had undertaken training about this.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers received an induction and supervision but did not have up to date appraisals, spot checks, training or medicines competency testing.

Consent to care was not always sought in line with the principles of the Mental Capacity Act 2005.

People's nutritional needs and dietary requirements were assessed and care workers knew how to support people to maintain good health.

Is the service caring?

Good

The service was caring.

People said care workers treated them kindly and with respect.

People were involved with making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was not always evidence of complaints being recorded and followed up in a timely manner.

People and their families were involved in planning people's care but were not consulted about end of life care.

Care plans included people's preferences and guidance on how they would like their care delivered and these were reviewed annually.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided. However these systems and checks were not effective in improving the quality of the service people received.

People and care workers told us they could approach the manager or the care co-ordinators with any concerns or things to discuss, and they listened.

De Vere Care - Ealing

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9 January 2018 and was announced. We gave the branch manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm they would be available when we inspected. The inspection was carried out by one inspector.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding team and commissioning team to gather information about their views of the service.

During the inspection we spoke with the branch manager, the training officer, an administrator and one care worker. We viewed the care records of six people using the service and seven care workers files that included recruitment, supervision and appraisal records. We looked at training records for 31care workers. We also looked at medicines management for one person who used the service and records relating to the management of the service including service checks and audits.

After the inspection visit we spoke with three people using the service, two relatives and five care workers to get their views on the service.

Requires Improvement

Is the service safe?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to safe care and treatment. This was because the provider's medicines policy did not include guidance on PRN (as required) medicines, there was not always guidance for care workers on how to administer specific medicines safely, a Medicines Administration Record (MAR) completed by care workers was not signed every day and neither medicines refresher training nor medicines competency assessments had been carried out in 2016. Consequently, people were at risk because the service could not be sure people were receiving their medicines as prescribed and in a safe manner. Following the inspection, the provider sent us an action plan to be met by August 2017 which indicated how they would address the identified breach.

During the inspection of 9 January 2018, we saw the provider had not updated their medicines policy dated October 2016 and as at the last inspection, they did not have PRN guidelines. Not all care workers had up to date medicines training or medicines competency testing. One person received their medicines through a percutaneous endoscopic gastrostomy (PEG) tube (a tube surgically inserted into the stomach of a person to help with feeding) and we saw the provider had improved the guidance for staff on how to administer medicines safely using this method. However the guidelines for this person indicated care workers providing support to this person must be trained to administer medicines via a PEG tube and to be trained to administer medicines when the person had seizures. The manager told us the care workers working with this person had the appropriate training but could not evidence it, although they could evidence one of the care workers had had medicines competency testing regarding this person's medicines. Additionally, there was not a signature list to identify which care worker was signing the MAR charts, and when the carer worker was not present on the weekend, there was no code to indicate they had not administered the person's medicines. This meant people were at risk because we could not be sure people were receiving their medicines as prescribed in a safe manner.

Care workers told us they would respond to an incident or accident by, "If an incident happens, I report to my manager, call an ambulance and fill in a form", "I will call the office and confirm what is happening and record it. I can also contact the social worker" and "If a person [has an accident] check the area is clear, call 999 and call the office." The accident and incident policy and procedure for addressing incidents directed 'Corrective and preventative measures shall be taken to minimise the outcome of any untoward incidents in the future'. There were no incidents or accidents recorded in the incidents and accidents book and therefore no analysis had been carried out, and nor had preventative measures been put in place. However we did see the incident and accident forms kept in people's files included information about the event, the action taken and any further action required by the care co-ordinator. For example we saw a record of an incident when a hoist had broken and the provider had contacted the local authority to arrange for it to be repaired. This was not recorded in the incidents and accidents book which suggested incident and accident forms were being kept in individual files and the manager did not have an overall view of incidents and accidents, as they would have if they were logged and analysed on a single record.

The above paragraphs are a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about medicines, including self-administration, was included on people's needs assessment. Medicines audits were held by the head office and we saw one person's monthly medicines audit signed by the manager that included an action plan where this was required. One person using the service told us, "Staff sign for medicine and log it every day."

At the inspection on 5 April 2017, we identified a breach of regulation relating to fit and proper persons employed. This was because the provider did not always follow safe recruitment procedures and this meant we could not be confident people were being cared for safely by suitable staff. Following the inspection, the provider sent us an action plan to be met by August 2017 which indicated how they would address the identified breach.

During the inspection of 9 January 2018, we viewed the recruitment files of seven care workers. There were systems in place to ensure care workers were suitable to work with people using the service. The files contained checks and records including applications, interview records, two references, identification documents with proof of permission to work in the UK if required and criminal record checks. This meant the provider employed care workers who were suitable to provide safe and appropriate care to people.

People said they felt safe using the service. Comments included, "I feel safe. My husband is here" and "The older staff I can trust. I can leave them and go out."

Safeguarding training was an annual requirement of the provider for all care workers and the records we saw indicated 24 out of 31 care workers had completed the training in the last year. One of the five care workers we spoke with could not identify what might be considered an abuse, but the other care workers were able to identify the types of abuse and knew how to respond to safeguarding concerns. They told us, "I would report it to my manager or CQC", "If they are being hurt I have to call the office or call the family or social services" and "I would report it as soon as I see it. Report it to the office and record it and then call the police." We saw safeguarding adults was on team meeting agendas for discussion. The provider's safeguarding and whistleblowing policies were dated January 2017. There had been no safeguarding alerts recorded by the provider since 2014. The local authority confirmed there had been no safeguarding alerts for the service in the last year and the manager said they knew they were required to raise safeguarding alerts, record any concerns appropriately and notify the local authority and the Care Quality Commission.

The local authority's commissioners told us in the last six months, ten concerns about the service had been raised. These included two late visits, six missed visits and two concerns raised about a poor standard of care. Five of these concerns were upheld by the local authority, two were partially upheld and three were awaiting a response from the provider. The manager was working to improve care workers arriving on time through monthly audits and addressing poor time keeping with care workers each month to ensure people received care that met their needs.

Each person had a number of risk assessments that addressed general risks, people's mobility, the environment, moving and handling and people's health, for example the risk of developing pressure sores The needs assessment also included an assessment of people's home environment so that care workers were aware of possible risks and how to mitigate these. The risk management plans specified the risks and what action to take to minimise them. These were signed by the person using the service and the assessor. The risk assessments were up to date and reviewed regularly. However, we saw some people had risk assessments that were not relevant to them. For example one person had a risk assessment to indicate they were at a high risk of pressure sores even though they were mobile and another assessment said the person was at a high risk for taking medicines but they self-medicated. This meant risk assessments were not always effective.

When the service handled money for people, for example to go shopping, an 'Authorisation to deal with finance' form was signed by the person using the service and the assessor, and was reviewed annually.

The infection control policy was last reviewed in November 2016 and some care workers had undertaken infection control training in the last year. People's needs assessment included the use and management of chemicals in people's homes and care workers said, "I have to wear my gloves and apron and be safe" and "I haven't done any infection control [training] but I know you have to wear gloves and aprons and follow the care plan."

Requires Improvement

Is the service effective?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to staffing due to a lack of supervisions, appraisals, observational spot checks and competency monitoring which meant that we could not be sure care workers were being supported to develop in their roles as care workers. Following the inspection, the provider sent us an action plan to be met by August 2017 which indicated how they would address the identified breach.

During the inspection of 9 January 2018, we saw some improvements had been made but not enough to meet the regulation. The provider's training and development policy indicated care workers should have four supervisions, three spot checks and an appraisal each year. The manager told us supervision and training had been a priority since they became the manager in August 2017. Five of the seven care workers' files we viewed showed care workers had supervision in October 2017. The manager advised these were now being scheduled in to maintain one to one contact with care workers.

It had been over a year since appraisals were undertaken. As at the last inspection the spot checks we saw in care workers' files were from 2015 and 2016 and we only saw evidence of one care worker completing medicines competency testing. Although the manager told us training had been a priority, the training co-ordinator showed us that out of 31 care workers, 16 had not completed yearly medicines training, seven had not completed two yearly safeguarding, 15 had not completed three yearly Mental Capacity Act 2005 training and 19 had not completed moving and handling training. The lack of appraisals, observational spot checks, competency monitoring and up to date training meant that we could not be sure staff were being adequately supported in their roles or that they had the required skills to support the people they provided care for.

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

Newly employed care workers had a four day induction and a new care worker told us they had an introduction to the office from the manager and completed two weeks of training as part of their induction. As part of the manager's focus on training there was information on various topics printed and put on the walls with certificates for carer of the month. At the time of the inspection information on supporting people with dignity was displayed. People using the service commented, "They are well trained. They know how to encourage [person]. They know how to talk, joke and laugh" and "They're nice girls. They know what they need to do."

At the inspection on 5 April 2017, we recommended that consent was sought for care and treatment and where a person lacks mental capacity, the provider acts in accordance with the requirements of the Mental Capacity Act (MCA) 2005. During the inspection of 9 January 2018, we saw the provider had not made adequate changes to be compliant with the requirements of the 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The form used for people's needs assessments asked if they had the mental capacity to make day-to-day decisions. If they did not, the form asked the assessor to record the details of the best interests assessment and record who had Lasting Power of Attorney (LPA), as an LPA would be able to make decisions in the person's best interest. One person's needs assessment asked if they had capacity and the response was that the 'person does have capacity to make their own decisions with their parents' assistance and supervision. Their parents make all their decisions.' There was a signed assessment by the person's relative but there was no indication of best interests decisions or of lasting power of attorney. This meant the person was not appropriately supported to have their views taken in to account when decisions about their care were being made and there was no evidence that the best interests process was being followed where the person did not have the mental capacity to make decisions.

The provider's MCA policy was dated November 2015 and did not include information on consent to care or Court of protection authorisations. The training information we were shown recorded 16 care workers out of 31had completed MCA training. When we asked care workers about their understanding of MCA principles, particularly around people consenting to their care, only one care worker responded without prompting and said, "I always make sure I give people choices and that they understand. For example, what they want for breakfast or what do they want to wear." Three other care workers said they could not remember their training or were unsure about consent. However with prompting they told us, "I ask people what they want to eat or wear" and "I ask them how do you want me to do [the task] and what can I do for you."

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to being accepted by the service, a care co-ordinator visited people in their homes to complete an initial needs assessment that was used as the basis of the care plans. Some people's files included assessments and support plans completed by the local authority and we saw the provider's care plans reflected the local authority's assessments. The assessments included information on people's physical and mental health needs and the environment and had guidelines for care workers to provide the required support to people.

The service did not provide any kind of meal service except breakfast and to heat up already prepared food. Care plans contained information around people's nutritional needs, dietary preferences, health needs such as diabetes, help with meal preparation and if they required assistance with eating. One person received nutrition through a PEG tube and we saw guidance for how to undertake this. A relative of one person told us, "[Care workers] do breakfast and [person] sometimes needs help. They understand how to help her with breakfast." When we asked care workers if they gave people a choice of food, one care worker said, "They have a list of food on the file and they tell us what they like or the family is there to tell us."

Care plans provided appropriate information to meet people's day-to-day health needs. Most people had family members who were the primary contact for healthcare matters and referred people to health professionals when required. However, care workers told us if they saw any changes in a person, they would

inform the office, family or call out the emergency services if required.

Good

Is the service caring?

Our findings

People and relatives we spoke with said the care workers had developed caring relationships with people using the service. Comments included, "They talk to her very nicely and sweetly", "[Care worker] is quite nice. I am very pleased with her", "Of course they are kind" and "I'm quite satisfied with them. They are kind and respectful."

The people we spoke with indicated they were fairly independent and therefore were actively involved around decision making and their care. The care plans we viewed showed people and their relatives were involved in care planning and reviews.

Each person's care plan had a 'How I like my care to be delivered' which provided guidance to care workers for how people preferred to receive their care. These were not consistently signed by people. The needs assessment identified people's cultural needs and provided a brief life history that included people important to the person using the service. It asked if people could make choices about their individual routines or if they needed assistance. It also asked if people '…wished to express their sexuality.'

The manager told us all the people using the service could communicate verbally and they tried to match people using the service with care workers who spoke similar languages and were from similar cultures. The provider matched male care workers to male service users and one female person told us they only had a female carer as per their wishes. The manager said matching was based on what the person had requested on their needs assessment.

People using the service received a service user guide that provided information on what they should expect from the service and who to contact in the service if they needed to. The handbook indicated that people could request for it to be translated into different languages according to their preferences and communication needs.

People told us there was consistency with having the same care workers. Care workers we spoke with knew about people's needs and their likes and dislikes so they could provide care for people appropriately. People's preferences and routines were recorded in their care plans.

Comments from care workers about supporting people with personal care included, "For personal care I make sure I use the right equipment. I always ask if it is alright", "With personal care it is important to ask what they want and need for care" and "If I'm giving personal care, I need to make sure the environment is safe and I'm gentle. I tell them what I'm doing and ask if they mind." In this way they ensured they maintained people's dignity and supported them respectfully.

Requires Improvement

Is the service responsive?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to receiving and acting on complaints because we did not see evidence of how complaints were followed up. Following the inspection, the provider sent us an action plan to be met by August 2017 which indicated how they would address the identified breach.

During the inspection of 9 January 2018, we saw the provider had not made the necessary improvements to meet the regulation. The provider had a complaints procedure dated July 2017 which directed people to contact the location manager, then the operations manager and if they were not satisfied with the outcome to contact CQC. The service user's handbook said people should refer to De Vere Care's complaints procedure and provided CQC as a useful contact number. CQC is not a complaints agency and complaints in regards to social care instead should be directed to the Local Government Ombudsman. People using the service told us, "I am calling the manager and they listen to me properly", "I don't have to make a complaint. I think I have a booklet with the phone number", "I have no complaints" and "We don't really have problems, except on New Year's Day, we couldn't get a hold of anyone." Care workers appeared unaware of complaint forms. One care worker said, "I would tell the office if there was a complaint. I would write it on the daily log."

The complaints file recorded two complaints for two missed calls to the same person in May 2017. The files said the care worker was given a verbal warning and monitoring would be in place, but we saw no evidence of further monitoring. Neither complaint had an internal investigation or De Vere Care's complaint outcome form completed which included the outcome of the complaint and the action taken. No other complaints were recorded in 2017, however we saw from people's files one person's relative contacted the service to express dissatisfaction about care workers being late. We saw there was a follow up welfare check phone call. The actions from the phone call were to monitor the care workers and to ring the relative back in four weeks but we saw no evidence of monitoring or the relative being called back. Another person's monitoring form from July 2017 said they had a care worker who was argumentative and arrived late but again we could not see how their concerns were addressed and followed up.

This was a repeated breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection on 5 April 2017, we identified a breach of regulation relating to person centred care because people's calls were not always on time which meant they were not receiving a personalised service according to their care plans. Following the inspection, the provider sent us an action plan to be met by August 2017 which indicated how they would address the identified breach.

During the inspection of 9 January 2018, we saw the provider had made improvements to managing calls. The provider had an electronic monitoring system so care workers could phone in when they arrived at a person's home and again when they left. This meant the manager could monitor that care workers arrived and stayed for the agreed amount of time. Care workers had a 15 minute leeway to arrive and complete a

call. Anything outside these times was highlighted on the system. The office staff and the finance team checked this on a daily basis and this enabled them to respond to any late calls. The manager completed a monthly audit and then met with the three care workers who had the most time issues for that month, as part of improving service delivery.

When we asked people they had the same care worker and if they arrived and left on time, they told us, "[Care worker] comes on time and leaves on time. It hasn't happened that she hasn't come. There is a book I need to sign from the agency to prove she has been here", "They do come on time. Sometimes they're late with the buses. If they're going to be very late, they'll ring", "It seems it is the same carer and it is not changing" and "They need more carers if any carer is sick." Care workers comments included, "Not really enough time between calls. I normally speak to the co-ordinator. She normally sorts it out", "I have enough time between calls. I call the office if I'm running late", "The service is not bad but there is not always good communication in the office if we call in sick sometimes the client doesn't know where the carer is. There are two to three people working in the office but they don't share information so everyone knows what happens with the carer" and "They don't have enough staff but I don't want to say anything. They try their best."

We viewed six care plans for people using the service and saw there was no information around end of life care. Each file had a 'How I like my care to be delivered' record that gave details of what time to arrive and what tasks needed to be completed. Where people had capacity, most were signed by the person and the assessor. Care plans provided a brief life history and important people and things in people's lives.

Where appropriate, care plans were signed by the person to indicate they were in agreement and consented to the support identified in the care plan. Care plans had a chart with how outcomes would be achieved and was reviewed annually. However we saw one person's care plan was two months overdue. We also noted that not everyone we spoke with was aware of their care plan, but one person said, "We have a care plan. The manager said they are coming to do the review."

Care workers completed daily support and communication logs for people which were task focused and not person centred. For example one person read books with the care workers but there was no indication of what books they liked or if they enjoyed the activity.

We saw one person's file had communication logs for another person in their file, which could have compromised the second person's confidentiality and privacy. The manager said the logs should be kept separate to care plan files.

Requires Improvement

Is the service well-led?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to good governance because audits were not always being completed, supervisions and spot checks were not being carried out as per the provider's training and development policy and staff files were not being audited to ensure each care worker had the required amount of supervision and spot checks. Nor did we see any analysis of late calls so the causes could be addressed to improve service delivery and we did not see any evidence of medicine administration records (MAR) audits. Following the inspection, the provider sent us an action plan to be met by August 2017 which indicated how they would address the identified breach.

During the inspection of 9 January 2018, we saw the provider had not made enough improvements to meet the regulation. We saw the MAR charts were being audited monthly and that the manager had met with people for supervision. They were also improving the punctuality of calls by auditing and then meeting with the three care workers who had the most time issues for that month to address the issues with individual staff. However there were no appraisals in the last year and spot checks were not carried out regularly according to the frequency identified in the provider's own policies. The manager was running a monthly inspection report that looked at call times, checked three files for people using the service and three staff files to ensure there were no gaps in information and further looked at complaints, safeguarding, incidents, supervision, training and annual leave. However this was not always effective as they did not identify gaps in the information we saw in people's files. There was a comments section in the monthly report which indicated more refresher training needed to be done but there was no analysis or robust action plan to improve service delivery.

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

We did not always find a positive culture of support within the wider organisation. Care workers told us their salaries had been paid late three times but there was no information as to why. Care worker said, "Payday is a problem because they are sometimes late" and "No one knows what is happening." The manager also said they did not know what the issue was regarding salaries. This indicated a lack of communication and transparency within the service.

Care workers we spoke with said if they had a concern they would most likely raise it with the care co-coordinators. Their comments included, "I would talk to [the care co-ordinators]", and "The office and everybody in the office does the best they can. [Manager] does too, so I have nothing to say", "[The manager] doesn't have much contact with the carers like the previous manager did" and "[The manager] understands the service. If I have a problem I go to the co-ordinator."

A new manager had been in post since August 2017 and had applied to the Commission to become the registered manager. The manager told us they were aware from their previous role of their responsibility to investigate and report concerns to the local authority and Care Quality Commission. They kept up to date with current practice through emails from the operations manager and the local authority.

As a means of feedback, the provider used a monitoring form to ask people using the service if they knew what their care package was, how to complain, the care workers' capabilities, and overall how satisfied are they are with the service. Most monitoring forms we saw recorded that overall people were satisfied with the service.

The provider had team meetings once a month. However they could not show the minutes to us as an administrator was the only person with access to them and had not been available to work at the service for some time. This meant staff who did not attend the meetings did not receive information and were not kept up to date with what was discussed and any decisions that were made at the meetings. We saw a handwritten agenda for an office staff team meeting in December 2017 and two handwritten agendas for care workers' team meetings held in the last four months. Care workers told us they contributed their opinions to the meetings and one said, "Team meetings are helpful because they tell us what we need to work on."

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 The registered person did not always seek consent for care and treatment from the relevant person and did not demonstrate they always acted in accordance with the Mental Capacity Act 2005 where a person did not mental capacity to make an informed decision. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines. Regulation 12 (1)(2) (g)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system for handling and responding to complaints. Regulation 16 (1)(2)

The enforcement action we took:

Issue warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)(2) (a)

The enforcement action we took:

Issue warning notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that employees received appropriate support and training to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)

The enforcement action we took:

Issue warning notice.