Mrs Maxine Maher

Diamond Care

Inspection report

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Date of inspection visit:
17 January 2017

Date of publication:
01 March 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 17 January 2017 and was announced.

Diamond Care is a domiciliary care service providing support to 33 people living in their own homes who are in receipt of the regulated activity of personal care. The service supports older people and people who are living with dementia or other conditions, to enable them to continue living in their own homes. Some people privately funded their care whilst others had their care funded by the local authority. The service is based in Polegate, East Sussex. .

The service was the only service owned by the provider, who was also the manager. A registered provider is a person who has registered with the Care Quality Commission to manage the service. 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 asked their consent and were involved in day-to-day decisions. However, practice and the lack of records confirmed that there was a lack of understanding in relation to the practical application of the Mental Capacity Act 2005 (MCA). There was a lack of mental capacity assessments and best interests decisions, in relation to specific decisions for people who lacked capacity. Decisions regarding one person's care had been made by people who did not have the legal authority to do so.

Staff told us that they were supported within their roles and were able to approach the provider if they needed any assistance. Some staff had diplomas in health and social care. However, there were concerns with regard to staffs' access to on-going, formal training. The provider had not ensured that staff received appropriate training to enable them to have the relevant knowledge and skills to support people effectively.

There was a lack of quality assurance systems to enable the provider to have sufficient oversight and awareness of all of the systems and processes within the service. There was a lack of notifications sent to CQC. This is part of the provider's responsibilities. By not being informed of these incidents CQC were potentially unable to ensure that the appropriate actions had been taken to ensure that people were safe. Organisational policies had not been updated to reflect current good practice guidance or legislation.

People were protected from harm and abuse as they were supported by staff who knew what to do if they had concerns about peoples' safety. Risks had been assessed and managed to ensure peoples' safety. People told us that they felt safe, one person told us, "Safety? No concerns whatsoever". There were sufficient staff to meet peoples' needs and people told us that they received their calls on time and that they were always informed if staff were going to be late. People had received their medicines on time and told us they were happy with the support that they received. However, staff did not have access to training in relation to the administration of medicines.

People were cared for by staff that showed compassion and kindness. Comments from people included,

"They are wonderful", "They do everything you could ask for, I don't need anything else" and "Good as gold". Peoples' care was personalised to them and they were involved in the development of their care plans. Peoples' health needs were assessed and met and they had access to medicines and healthcare professionals when required.

Staff worked in accordance with peoples' wishes and people were treated with respect and dignity. It was apparent that staff knew peoples' needs and preferences well. Positive relationships had developed amongst people and staff. One person told us, "Very good, they have been coming such a long time we are like old friends". People, when required, received appropriate support with their nutrition and told us that they were able to choose what food they had to eat.

The provider welcomed feedback and people and relatives were aware of the procedures they needed to follow to make a comment or complaint. People, relatives and staff were complimentary about the leadership and management of the service. One member of staff told us, "She is a really good manager, if there are any problems you can go and speak to her and she does help". Another member of staff told us, "They make it inviting to come into the office, if I've got a problem I know who to come to".

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked 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?

Requires Improvement

The service was not consistently safe.

People received their medicines from staff who did not have access to appropriate training. However, medicines were administered on time and people were encouraged to be independent in the management of their own medicines.

There were effective systems in place to ensure that people were cared for by staff that were suitable to work in the sector. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Risks were assessed and appropriate action taken to ensure peoples' safety.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were involved in day to day decisions that affected their care. However, there was a lack of understanding and practical implementation of legislative requirements in relation to gaining consent for people who lacked capacity.

The provider had not ensured that staff had access to training to support them to effectively meet peoples' needs.

People had access to health care services to maintain their health and well-being. People were able to choose what they had to eat and drink and were provided with support according to their needs.

Is the service caring?

Good

The service was caring.

People and relatives consistently commented on the kindness and caring nature of staff.

People were actively involved in the care that was provided to

them. Staff had an awareness of peoples' individual needs and independence was encouraged.

Peoples' privacy and dignity was promoted and maintained. There was consistent feedback regarding the respectful nature of staff.

Is the service responsive?

Good

The service was responsive.

People received a personalised service that was centred on them.

Changes in peoples' needs were recognised and appropriate actions taken.

Feedback from people and their relatives was welcomed and encouraged. People felt that their views and opinions were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of quality assurance processes to ensure the delivery of high quality care and to drive improvement.

Staff were not always provided with up-to-date policies to inform their practice. The provider had not notified CQC of situations and incidents that had occurred to people who used the service.

People and staff were positive about the management and culture of the service.

Diamond Care

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.

The inspection took place on the 17 January 2017 and was announced. This meant that the provider and staff knew that we were coming. We did this, as the service is a domiciliary care agency and we wanted to ensure that appropriate office staff were available to talk with us, and that people using the service were made aware that we may contact them to obtain their views. The inspection team consisted of one 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.

Before the inspection we asked 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 planned to make. Before the inspection we checked the information that we held about the service and the service provider. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with ten people, three relatives, three members of staff and the provider. We reviewed a range of records about peoples' care and how the service was managed. These included the care records for five people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

This service was last inspected in 2013 and no areas of concern were found.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that people received a good service that made them feel safe. Comments from people and relatives included, "Honestly I trust them all, we know them well, and I would be able to tell if my relative was worried about anything", "Safety? No concerns whatsoever" and "I'm very comfortable when they are in my home, very trustworthy, no concerns about being safe". However, despite these positive comments we found an area of practice that required improvement.

People received support with their medicines according to their needs and preferences. People, who were able, were encouraged to dispense and administer their own medicines and medicine management risk assessments had been devised to ensure their safety. These considered the storage and type of medicines. Medicine Administration Records (MAR) showed that staff were provided with appropriate information on the administration of medicines, they detailed the type of medicine, dose, route and frequency. The management team monitored the administration of medicines during observations of staffs' practice when working alongside them. Medicine Administration Record (MAR) sheets were also regularly collected and analysed to identify any errors or areas of concern. Records of staff meetings showed that when concerns had been identified by the provider, these had been brought to the attention of staff who were reminded of the importance of signing the MAR to state that medication had been given or topical creams applied. A risk assessment stated, 'Staff to follow all correct procedures when assisting with medication as per staff training. Staff to receive training on medication'. However, not all staff had received training and the provider had not assured themselves that staff had the appropriate knowledge and skills to administer medicines safely. Records showed that people had been supported with their medicines by staff that had not received administration of medicines training. Gaps in MARs raised concerns about peoples' access to prescribed medicines, it was unclear if people had not been provided with their medicines or if staff had failed to complete the necessary records. The provider had not ensured that staff responsible for the management and administration of medicines were suitably trained and competent. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff that had undertaken the relevant checks to ensure they were safe to work within the health and social care sector. Prior to their employment commencing, staffs' employment history and references from previous employers were gained. Appropriate checks with the Disclosure and Barring Service (DBS) were also undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. This ensured that people were protected against the risk of unsuitable staff being recruited.

The National Institute for Health and Care Excellence (NICE) Guidance for home care: delivering personal care and practical support to older people living in their own homes, state that visit times should allow home care workers enough time to talk to the person and their carer. That there should be sufficient travel time between appointments and ensure that the worker has enough time to do their job without being rushed or compromising the dignity or wellbeing of the person who uses the service. The provider had worked in accordance with this guidance. Records showed that the provider had liaised with people and the local authority, who in some cases funded peoples' care, to ensure people received appropriate length of

calls to meet their needs. Travel time was taken into consideration as well as the geographical area that people lived in when allocating work to staff. People told us that staff spent the required time with them, were patient and that they never felt rushed. One person told us, "They have other jobs to go to but are not in a rush or looking at their watches while they are here". Another person told us, "If there is anything extra that needs doing they will do it". There were sufficient staff to meet peoples' needs. People and staff confirmed that they were allocated sufficient time to spend with people and that they were allocated the same people to care for to ensure the consistency of care. One person told us, "It's the same person all the time unless she is off".

People were supported by staff that were aware of the signs and symptoms to look for that might indicate abuse and knew what action to take if they had concerns about peoples' safety. Staff told us that the provider operated an 'open door' policy and that they felt able to share any concerns they had in confidence. Staff were provided with whistleblowing and safeguarding adults at risk policies and procedures within the handbook given to them when they first started employment. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace. People were aware of their right to receive safe care and knew who to contact if they had any concerns. One person told us, "If there was something wrong I would tell them".

Peoples' safety was maintained through the completion of risk assessments and the knowledge of staff. Records showed that risk assessments had been completed when people first joined the service and their care plan was reviewed if there were any changes in their needs. Risk assessments recognised risks in peoples' home environment to both people and staff. Risks with regard to peoples' individual needs were also in place. For example, risks were managed for one person who had been assessed as being at high risk of falls. The person's risk assessment advised staff to ensure that items such as rugs were removed, flooring secure and that the person was wearing appropriate footwear to ensure that the risk of a trip hazard was minimised. Staff were provided with clear guidance as to how to support people safely when assisting them with moving and positioning. People had been fully involved in the assessment of their needs and in the guidance that was provided to staff. There were minimal accidents and incidents. Those that had occurred had been dealt with effectively and were used to change practice. For example, risk assessments had been revised in response.

Requires Improvement

Is the service effective?

Our findings

People told us that they had access to healthcare services when required and that staff assisted them when they were unwell. One person told us, "I felt a 'bit iffy' and the carer noticed this and stayed a bit longer. Other times when I've had been ill they have rung my daughter". However, despite this positive comment, we found areas of practice that required improvement.

People told us that they had confidence in staffs' abilities and that they received effective care. New staff had been supported to understand their role and responsibilities by working alongside other members of staff and by completing induction workbooks. Regular supervision meetings were conducted to review staffs' performance and identify further areas of development. Staff told us that they felt supported within their roles. Records showed that some staff had completed diplomas in health and social care. One member of staff, who supported a person to move and position using a hoist, told us that they had met with an occupational therapist that had provided guidance as to how to use the equipment safety.

However, there were concerns with regard to staffs' access to on-going, formal learning and development opportunities to ensure their competence, and to ensure that they had the relevant knowledge and skills to care for people effectively. We asked staff about their responsibilities. Their responses were inconsistent and raised concerns about their knowledge and competence. Some staff told us that they had received support and guidance from other staff and the provider, whereas others told us that they had not received any training and records confirmed this. For example, records for one member of staff, who had been employed at the service for over two years, showed that they had not completed any formal training. When asked about the learning and development they had undertaken, one member of staff told us, "I didn't really do much training, I've learnt as I've gone along". The provider employed 11 members of staff, records showed that six staff had not undertaken any training since being employed and only two members of staff had completed all of the training which the provider considered essential.

A moving and positioning risk assessment stated, 'Staff trained in use of hoist'. However, records showed that staff, who had not undertaken manual handling training, had supported people with this task. This created a potential risk to the safety of both people and staff. The provider had taken some measures to ensure that staff were provided with some guidance within their roles. Care plans contained detailed guidance with regard to peoples' support requirements and memos had been sent to staff advising them of certain conditions. However when the lack of training was raised with the provider they told us, "I have to be honest the training is not up-to-date. I have awful trouble getting training and getting them to attend. Some of them have had training at other places before they came here". However, staffs' records showed that certificates of previous training had not been collected for all staff and therefore the provider had not assured themselves that staff had the relevant skills to meet peoples' needs. The provider had not ensured that staff had received appropriate training or professional development as was necessary for them to carry out the duties that they were employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were asked for their consent and were involved in day-to-day decisions that

affected their care. However, there were concerns regarding the lack of understanding and practical application of relevant legislation. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA. There was a lack of understanding with regard to the MCA and its implementation and impact on people who lacked capacity to make certain decisions. Records for one person showed that they were living with dementia. When asked if the person had capacity to be involved in certain decisions the provider explained that the person did not. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where peoples' movement is restricted, this could be seen as restraint. Bed rails are implemented for peoples' safety but do restrict movement. The provider explained that a healthcare professional had advised that the person used bed rails to ensure their safety. However, there were no bed rail risk assessments which considered the risk, how to eliminate the risk or identify that the least restrictive options such as the use of low profile beds or crash mats, had been considered. Therefore it was not evident how this was decided to be in the person's best interests or was the least restrictive method to use.

There were no mental capacity assessments to show that the person's capacity had been considered in relation to them giving consent to the use of bed rails. When a person lacks capacity to be involved in a particular decision and there is no lasting power of attorney for a person's health and welfare, a best interests decision meeting should take place, enabling relevant parties to discuss and agree that any decisions made are in the person's best interests. There were no mental capacity assessments in place to determine the person's ability to be involved in certain decisions and therefore staff had assumed that the person was unable to give their consent because they were living with dementia. Decisions which affected the person were made by people who were legally unable to make those decisions and therefore measures, such as the use of restrictive practices, were made unlawfully. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they had access to relevant healthcare professionals to ensure their health and wellbeing. Records showed that people had been supported to attend healthcare appointments and staff had contacted peoples' GP when they were concerned about peoples' well-being. Records showed that people who required support to maintain their nutrition and hydration received appropriate support according to their needs. People told us that they were happy with the support they received and had a choice of food.

People, who required assistance with their communication, were provided with appropriate support. Records showed that one person had experienced a stroke that had affected their communication. In order to ensure that the person was able to communicate their needs to staff, staff had been advised, 'X has had a stroke and communication can be difficult though X can understand and use key words and written signs'. Effective communication was evident amongst the staff team. The provider ensured that staff were kept up to date and provided with information about peoples' changing needs, as well as the running of the service. Regular phone calls or texts were sent to staff as well as information sheets and memos. Team meetings were also held on a regular basis. Staff told us that they were able to raise and discuss issues of importance in an open way.

Good

Is the service caring?

Our findings

People and relatives told us that the staff that supported them were kind and caring. Comments included, "They are wonderful", "They do everything you could ask for, I don't need anything else" and "Good as gold".

The service is family run and has a small team of care staff. It was evident that a caring attitude was at the core of the service provided. When staff spoke about people they did so in a respectful way and observations of the provider engaging in telephone conversations with people further demonstrated a caring and compassionate approach. The aims and objectives of the service stated, 'We recognise that your care worker is somebody with whom you can form a special bond, and for this reason we take great care in selecting a staff member with whom you feel completely comfortable'. People were supported by staff that were known to them to ensure a consistent approach and to promote effective relationships. People told us that new members of staff or staff that had not supported them before were formally introduced to them by familiar members of staff, before being allocated to support them. This demonstrated respect for people, enabling them to meet staff before they provided assistance to them.

People told us that members of staff were sometimes late for their visits, however, when this did occur they received a telephone call advising them of the reasons for this and of the time to expect the staff to arrive. This demonstrated respect for peoples' time and acknowledged the anxieties and disruption that a late call might create for people. Comments included, "If they're going to be really late, 15 or 20 minutes, they always ring me", "Normally they come on time but if they're extra late I give them a call or they call me", "I appreciate Diamond Care because they keep to a routine, when you're old you need that" and They're dependable, honestly they always cover us, they never let us down". People and relatives told us that they found the support they received a great comfort. A relative told us, "A great circle of care around us, so good, so kind, I can't praise them all enough. My relative is very trying and complains a lot but the carers cope very well and always come out of the room smiling". One person, who had experienced bereavement, told us, "I miss having someone to talk to. They have been very good with me, they will stay and have a chat and if I'm in trouble they will always help me".

People and relatives were able to express their needs and wishes and were fully involved in peoples' care. Quality assurance surveys had been sent to people and relatives in the past to gain their feedback on the service they received. Comments included, 'We want you to have positive feedback as we are so pleased with the way it is all working out. X makes my relative laugh and it is so good for them to have male company', 'It is a very good service and I am very happy with it' and 'The carers are absolutely wonderful. It really makes a difference having someone you feel relaxed and comfortable with coming into your home, it's fun." For people who were unable to express their wishes, referrals to advocacy services could be made to enable them to access additional support to express their needs and wishes. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Peoples' differences were respected and support was adapted to meet their needs. People used the service

for various reasons, some requiring minimal support, receiving a visit twice per week whereas others had several calls each day. The provider ensured that the support provided to people was person-centred and enabled them to receive the type of support they chose. Staff had a good understanding and awareness of the importance of maintaining peoples' privacy and dignity and people consistently told us that staff respected this. Peoples' right to privacy with regard to information that was held about them was respected. Records were stored in locked cabinets within the office and records of a staff meeting showed that staff had been reminded about the importance of not discussing peoples' needs with other people who used the service.

People were encouraged to be as independent as possible. Care plans showed that people were asked what they needed support with and that they were able to continue to be as independent as possible, to enable them to retain their skills and abilities. They provided staff with guidance as to what people could do themselves and what they would need support with. Staff were mindful of the importance of promoting independence. One member of staff told us, "If we are assisting them with their personal care we always encourage them to do what they can manage themselves. We get them to help rather than do it for them".

Good

Is the service responsive?

Our findings

People told us that they received a service that was responsive to their needs. One person told us, "I can ring them up anytime and they will do whatever they can to sort the problem out".

Records confirmed that an initial assessment of peoples' needs was conducted and this was used to devise the person's individual plan of care. The assessment was enabling and person-centred, encouraging the person to discuss their preferences and identify areas that were important to them. It recognised the skills and abilities that people had, whilst also identifying aspects of peoples' lives that they required further support with.

Peoples' needs were assessed holistically. Peoples' emotional, social and physical needs were taken into consideration. Care plans contained information on peoples' health and physical needs and risk assessments had been completed to ensure that people were supported in a safe manner. Care records provided comprehensive, pertinent information that provided staff with guidance as to how the person liked to be supported and what was important to them. For example, care records for one person stated, 'X likes a pot of tea, cup and saucer, teaspoon and milk jug'.

The provider had plans to develop the care plans even further and was in the process of implementing a life history document that would, if people were in agreement, detail their likes, dislikes, hobbies and interests as well their previous occupation, to enable staff to have a better understanding of peoples' needs before they had started using the service.

People were able to choose, as much as possible, what times they had their visits and if they received support from a male or female member of staff. People told us that the service was responsive to their needs and that they were able to alter their requirements at any time. Observations of telephone conversations showed staffs' flexibility with regard to adapting the care and the call times to meet peoples' changing needs. This demonstrated that staff respected peoples' rights to make decisions and change their minds.

Peoples' needs were reviewed on an ongoing, day-to-day basis. For example, in response to a person experiencing a fall the person's care plan had been updated to reflect the change in support and in the person's confidence. It stated, 'X will need assistance from one carer when walking with frame as is quite unsteady and this is causing a lack of confidence with mobility'.

Observations and records showed that staff communicated with one another about changes in peoples' needs and the support that people were provided with was adapted accordingly. Regular telephone calls, texts and memos were sent to carers if they needed to be alerted to any changes in peoples' condition before they met at the next team meeting or were next in the office.

People's social needs were taken into consideration and the provider and staff ensured that, even when this type of support was not included in their care package, time was given to talk to people. One person told us about their carer, they told us "X is jolly and caring; they like to talk and always sit and have a chat".

The provider had a complaints policy which was provided to people when they first joined the service. People were aware of how to make a complaint but told us that they had never felt the need to. One person told us, "I can always get someone on the phone in the office or on the mobile if I need to, they are extremely helpful and understanding". Another person told us, "No improvements. They do everything you want them to".

Requires Improvement

Is the service well-led?

Our findings

People, staff and relatives were complimentary about the leadership and management of the service. One member of staff told us, "She is a really good manager, if there are any problems you can go and speak to her and she does help". Another member of staff told us, "They make it inviting to come into the office, if I've got a problem I know who to come to". However, despite these positive comments, we found areas of practice that required improvement.

The service had organisational policies that informed staff of the requirements of their roles. However, these had not been reviewed since 2012. Policies should provide up-to-date information for staff to inform them of current legislation and good practice guidance. The policies had not been reviewed and therefore staff were not provided with current guidance to inform their practice. For example, the provider's safeguarding policy did not ensure that staff were aware of the changes in relation to adult safeguarding since the Care Act 2014. Reviewing and updating organisational policies is an area of practice that is in need of improvement.

Part of providers' responsibilities under their registration with the Care Quality Commission is to have regard, read and consider guidance that is provided in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the providers' responsibility to notify us of certain events or information. Records showed that there had been two safeguarding investigations conducted by the local authority. The provider had failed to inform us of these events. Providers are required to inform CQC of these incidents to enable us to have oversight to help ensure that appropriate actions are being taken and to ensure peoples' safety. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The regulations state that providers must have systems and processes such as regular audits of the service to enable them to assess, monitor and improve the quality and safety of the service. The provider had mechanisms in place to ensure that people were receiving their medication and appropriate care, they also monitored late or missed calls. An audit was conducted periodically to monitor the daily care records that care staff were completing as well as the MARs. Records showed that some audits had identified that some records had missed signatures and dates and records showed that this had been raised with staff at staff meetings. However, the lack of robust audits meant that shortfalls in some of the systems in place had not been recognised. This related to information in some peoples' care plans not being updated to reflect their current needs or situation. For example, records for one person stated that the person's relative supported the person with their medicines. However, MARs showed that care staff had been dispensing and administering the medicines on some occasions. The lack of audits also meant that the provider had not recognised that one person did not have a mental capacity assessment or appropriate decision making records in place. The provider had failed to recognise that they had not assured themselves that staffs' knowledge and access to training needed improvement or that their policies did not reflect current legislation or good practice guidance. There was also a lack of notifications to CQC. Although the provider had audits in place to monitor the daily records and MAR, there were no other quality assurance systems and processes used within the service. The lack of quality assurance processes did not enable the provider to assess, monitor and improve the quality and safety of the services provided. This was a breach of

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

The service was family run and was owned by a provider who was also the manager of the service. The service had a warm and welcoming atmosphere. The aims and objectives of the service stated, 'We aim to provide our clients with a comprehensive service of care of the highest quality within their own home environment. We strive to offer a flexible, efficient and professional service which is tailored to meet each person's independent needs. We will treat each client with respect and remain sensitive to their individual needs and abilities and aim to promote independence and to maintain the personal dignity of all of our clients'. It was evident that this was at the core of the service provided and that both the provider and staff strove to implement it. The provider worked in partnership with people and their relatives, if appropriate, as well as healthcare professional to ensure that peoples' needs were met. People were aware of the provider and spoke fondly of them. Explaining that they could approach them at any time to discuss their care requirements. Comment from people included, "They do everything you could ask for, I couldn't ask for anything else".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Care Quality Commission (Registration) Regulations 2009 Notification of other incidents. Regulation 18 (2) (e) of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. The registered persons had not notified the commission of any abuse or allegation of abuse in relation to a service user.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014. Need for consent Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The registered person had not ensured that care and treatment of service users was provided with the consent of the relevant person.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities)

Regulations 2014. Safe care and treatment.

Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The registered person had not ensured that staff responsible for the management and administration of medication were suitably qualified and competent and that this was kept under review.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good Governance. Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. The registered person had not assessed, monitored and improved the quality and safety of the service provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing. Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that staff received appropriate support, training or professional development to enable them to carry out the duties they are employed to perform.