MiHomecare Limited

MiHomecare - Havant

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 April 2016. The inspection was announced.

MiHomecare-Havant provides personal care services to older people, adults with disabilities and adults living with dementia in their own homes. At the time of our inspection there were 300 people receiving care and support from the service. The service had recently grown to this volume of people following the acquisition of another care company. There were 60 care staff, three field care supervisors, three co-ordinators who planned people's care, two part time administration assistants, a regional manager and an interim manager who was applying to the Commission to become the registered manager for the service, as the current registered manager was not working at the service.

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 felt safe; however their care visits were sometimes provided later than planned or missed. As a result people did not always receive a safe service because certain aspects of their care were not provided when they required the support. Risk assessments were completed, however they were not always accurate and identified risks were not included in people's care plans. People were at risk of not receiving their medicines safely.

Safe recruitment practices were followed and people were protected against the risk of potential abuse.

People were not always supported to eat and drink at the times they requested and this could have an effect on their well-being.

Staff did not always receive regular supervision and appraisal in line with the provider's policy. Not all staff received an induction programme and regular on-going training.

People may be at risk of not having their views taken into consideration when care was being provided because people's care plans did not describe what people were able to do for themselves and what care staff were required to support people with.

People may be at risk of receiving care that was not reflective of their needs because their care plans were task specific and did not contain the information highlighted on their risk assessments. Care plans did not reflect people's preferences.

The service had not completed or returned their Provider Information Return to the Commission.

Staff did not always feel supported and felt communication between them and management could improve.

The registered manager and staff demonstrated a good understanding of the Mental Capacity Act 2005 but did not always put this understanding into practice. We have made a recommendation for the provider to review the Mental Capacity Act 2005 and its subsequent codes of practice and ensure staff competencies are checked following training.

Mental capacity assessments were in place for people who lacked capacity. People consented to their care. People were supported to maintain good health and access on-going healthcare support.

People were involved in their care and made decisions about their care. People's independence, privacy and dignity was respected and promoted. Compliments had been received by people and their relatives in the form of thank you cards. Complaints which had been received had been dealt with, responded to and actioned where required.

Staff were supported to question practice and notifications had been submitted to the Commission.

There were a number of audits in place which monitored the quality of the service being provided, which included surveys. An improvement action plan had been implemented to resolve the concerns with staff support and people's care plans. People said they received a good service and had seen improvements with the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's care visits were sometimes provided later than planned or missed. People felt safe; however people may not always be receiving a safe service because certain aspects of their care were not provided at specific times.

Risk assessments were completed, however they were not always accurate and identified risks were not included in people's care plans. People were at risk of not receiving their medicines safely.

Safe recruitment practices were followed and people were protected against the risk of potential abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager and staff did not demonstrate a good understanding of the Mental Capacity Act 2005. However mental capacity assessments were in place for people who lacked capacity. People consented to their care.

People were not always supported to eat and drink at the times they requested and this could have an effect on their well-being.

Staff did not always receive regular supervision and appraisal in line with the provider's policy. Not all staff received an induction programme and regular on-going training.

People were supported to maintain good health and access on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

People were positive about the care and support received from care staff and the office staff. People were involved in their care and made decisions about their care. People's independence,

privacy and dignity was respected and promoted.

However people may be at risk of not having their views taken into consideration when care is being provided because people's care plan's did not describe what people were able to do for themselves and what care staff were required to support people with.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People may be at risk of receiving care that was not reflective of their needs because their care plans were task specific and did not contain the information highlighted on their risk assessments. Care plans did not reflect people's preferences.

Complaints which had been received had been dealt with, responded to and actioned where required.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had not completed or returned their Provider Information Return to the Commission.

Staff did not always feel supported and felt communication between them and management could improve. Staff were supported to question practice.

An improvement action plan had been implemented to resolve the concerns with staff support and people's care plans. People said they received a good service and had seen improvements with the service.

There were a number of audits in place which monitored the quality of the service being provided, which included surveys.

MiHomecare - Havant

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 12 April 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of two inspectors and two experts 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 reviewed safeguarding records and other information of concern received about the service. We checked if notifications had been sent to us by the service. A notification is information about important events which the provider is required to tell us about by law. We spoke with the Local Authority safeguarding and commissioning teams. This inspection was brought forward as a result of receiving some concerning information about the service.

Before the inspection we asked the provider to complete and send 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 any improvements they plan to make. However this was not submitted at the time of the inspection.

During the inspection we spoke with 35 people who used the service. We also spoke with five care staff, two field care supervisors, two co-ordinators who planned people's care, the regional trainer, the regional recruitment officer, the regional manager and the interim manager.

We reviewed a range of records about people's care and how the service was managed. We looked at plans of care for eight people which included specific records relating to people's capacity, health, choices, medicines and risk assessments. We looked at daily reports of care, incident and safeguarding logs, compliments, complaints, service quality feedback forms, audits and minutes of meetings. We looked at the

training plan for 54 staff members, recruitment records for five staff members, training records, spot check and supervision records for six staff members.

We asked the provider to send us information after the visit. This information was received.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe when they received personal care and believed they were safe from harm from staff members. People said staff were very good and treated them well. One person said staff were "good natured."

Prior to the inspection we had received information of concern informing us of missed visits and staff not always arriving to people on time and as a result people's needs were not being met. We were told people did not have regular care staff and felt "strangers" were arriving at their home to provide personal care. One person told us they had gone without lunch on two occasions because the care worker did not turn up. This person required support with meal preparation due to an on-going health issue. At this inspection the regional manager and interim manager confirmed they had experienced staffing issues when the Havant branch merged with the Southampton branch. Both the regional manager and interim manager also confirmed they had experienced staffing difficulties since purchasing another care company in February 2016 and transferring a large number of people and staff over to this service. The interim manager and the regional manager said this had affected people's call times and had resulted in some missed visits. The regional manager said that these issues were being resolved.

At the time of the inspection some people told us staff were still arriving late to their care calls and had experienced missed visits. One person told us they did not receive a visit on Sunday 10 April 2016. They said, "The carer did not come on Sunday." This meant this person did not receive support with personal care or meal preparation. Another person said care staff either arrived too early or too late and as a result they were unable to use the toilet when they needed to. Records contained in the providers safeguarding folder evidenced missed visits continued to happen. Records showed that on 25 February 2016 a staff member had failed to visit five people and a disciplinary process had been used to address the issue.

People we spoke with said they mostly received care from regular care staff who knew them well, although they never knew who was coming to support them with their personal care until the staff member arrived. One person said, "I never know who is coming, I recognise them when they get here but it would be nice to know who to expect." Another person said, "I would like to know who is coming especially in winter because I don't open my door to strangers." The interim manager confirmed they did not send out a visit plan to people. This meant people did not know when or which staff would be visiting to complete their care or who they would be answering the door to late at night.

Staff said there were enough staff working Monday to Friday but there were not enough staff at the weekend. One said, "Never enough staff – getting calls covered is difficult, myself and two other colleagues work most weekends." Another said, "Monday to Friday we don't have enough work to go around and at weekends we don't have enough staff." Staff confirmed they were often late to people because they had to cover for staff who phoned in absent at short notice. The interim manager and regional manager confirmed they did experience high sickness levels and had an absence management procedure in place to deal with this issue.

A failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they can meet people's needs and keep them safe was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were completed for people which identified risks to their environment, risks to their skin integrity and highlighted if manual handling equipment was required. However the information highlighted on the risk assessments were not always accurate or included in people's care plans. For example, one person's personal plan completed by the local authority's adult services department on 22 April 2015 identified they were at risk of falls and had a previous history of falls. However, this person's risk assessment completed by the service on 24 February 2016 stated they had "no history of falls." This person's risk assessment dated 24 February 2016 also highlighted they were at risk of falls because they were unsteady and unsafe when walking. The risk assessment identified the person required the use of a walking aid to minimise the risk of them falling. Guidance written on the risk assessment document stated, "If the answer is yes to one or more of the above, falls mitigation must be incorporated into the service users support plan and risk summary." However this information was not provided in the person's care plan. Three people's care plan files contained a risk assessment for their skin integrity and all three risk assessments were completed with the same information and scoring risk. We spoke with the interim manager who confirmed the person who completed the risk assessment had not received any training on how to complete this documentation. This meant people were at risk of receiving unsafe care because care plans did not detail how to care for people safely.

A failure to ensure care is provided in a safe way for people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed they did not have any concerns with the support they received with their medicines. Staff knew what to do when they were supporting people with their medicines and knew how to keep them safe. However some existing staff and all of the staff who had transferred over from the previous care company had not received medicines training. Staff who had transferred from the previous care company had been trained in medicines whilst still working for the previous care company. This meant these staff had not been trained to support people with their medicines in line with this service medicines policy. The interim manager stated that there were three different coloured Medication Administration Records (MAR) for staff to complete, each colour represented a different support need. Staff who had transferred from the previous care company confirmed they had not received training on how to complete MAR's and one stated they found them confusing. However all staff knew they could contact the office and seek advice if they had any concerns.

Before the inspection we received some concerning information that MAR's were not completed, or checked regularly. Completed MAR's were not present in people's care plan files. The regional manager said they were aware of this concern and had recently delegated the responsibility of collecting and checking MAR's to a field care supervisor. The field care supervisor confirmed this.

People were protected against the risks of potential abuse. Staff knew how to keep people safe from harm and could recognise signs and symptoms of potential abuse which included recognising unexplained bruising and marks or a change in behaviour. Staff said they would report any concerns to the interim manager and were confident to inform other appropriate professionals if they felt the interim manager did not deal with the concerns appropriately. One staff member said. "I would report concerns to the office." Another said, "I would report it to the manager, CQC or adult services."

Safe recruitment practices were followed. We looked at five recruitment files for staff and saw appropriate

steps had been taken to ensure staff were suitable to work with people. All staff had received Disclosure and Barring Service checks (DBS) and references, employment history had been provided and gaps in employment had been explored. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

Most people said they received care from staff who had the skills and knowledge to carry out their role effectively. One person said staff were, "Very good." However two people felt some staff did not always support them well. One said, "All good except one who I got removed as she damaged my leg." Another said, "Some carers are useless."

Staff did not always receive a supervision or appraisal in line with the provider's policy. The regional manager confirmed they were aware of this. Staff who had transferred from the previous care company had not received a supervision or spot check of their work since joining the service in February 2016. A spot check is an observation of care given made without warning. Staff who had been working for the service prior to February 2016 confirmed supervisions and spot checks did take place but were inconsistent. One said, "I used to have regular supervisions every three months but since I have come back from [planned leave] I have not had a supervision. Records demonstrated supervisions and spot checks were either inconsistent or did not take place. Staff confirmed they did not always feel supported and those staff that transferred from the previous care company felt they were not part of the service. One said, "You go to the office but you feel like no one really cares."

Existing staff confirmed they received an induction programme when starting work for the service which included shadowing experienced staff members. Staff records contained induction certificates which detailed the training given as part of the induction programme. Staff completed the Care Certificate as part of their induction programme. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. However staff who had transferred to this service from the previous care company did not receive induction training.

Staff were not always given the skills and knowledge required to carry out their role effectively. There was a training plan in place which was managed and updated by the regional trainer and assisted the regional manager and interim manager to identify which staff required updated training. The regional manager confirmed existing staff who were in place before new staff transferred into the service from the previous care company, required refresher training. The regional manager said all staff who had transferred from the previous care company had all of their training refreshed by the previous care company prior to transferring to this service. However staff who had transferred from the previous care company had not received training in relation to MiHomecare's policies and practices. Staff from the previous care company and existing staff confirmed they were not given training or their training required updating. The training plan confirmed staff required training in safeguarding, medicines and mental capacity.

The regional trainer confirmed training was computer based learning, except manual handling which was provided as practical training. Existing staff confirmed computer based learning was not always an efficient way of refreshing their knowledge but felt they had enough experience to support people well. The differences and lack of training and standards between staff transferring into the service and those already

working at the service meant people may be experiencing inconsistent support when receiving their care which may not meet their needs or be in line with the most updated legislation or care practice.

A staff member who had transferred from the previous care company was given the role of field care supervisor. Their responsibility was to complete care assessments, care plans and risk assessments for people. However the staff member had not had any prior experience of completing care plans and had not received training in how to complete the service paperwork. This resulted in care plans and risk assessments being completed inaccurately. For example, one person's care assessment identified they were at risk of a break down in their skin integrity, however there was no information on how to minimise this risk in the person's risk assessment and no mention of the support required to minimise the risk in the person's care plan.

The regional manager had put an action plan in place regarding supervision, appraisal and training of staff. The action plan included timescales for completion.

The failure to ensure that staff received appropriate training necessary to enable them to carry out their role effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The interim manager and staff did not demonstrate a good understanding of the Mental Capacity Act 2005 (MCA). The Act provides a legal framework for acting on behalf of people who lack capacity to make decisions. The interim manager understood people's capacity could vary, but said they needed to update their training on the MCA 2005 as they were not aware of the five principles. Staff said they would help people to make a choice. Staff had received training in MCA 2005 and were provided with a leaflet at the end of the session which identified the five principles of the MCA 2005 and 10 key points of the MCA 2005. However staff and the interim manager were unable to identify the five principles of the MCA 2005. The regional manager, interim manager and regional trainer confirmed they did not test staff's understanding of the MCA 2005 following their training. We recommend the interim manager and staff review the Mental Capacity Act 2005 and its relevant codes of practice and test staff competency after training has been provided.

People who did not require any support with nutrition or hydration did not express any concerns. People did not require specialised support with food and fluids; however processes were in place if this was required. Those that required support with meals and drinks did not always receive this support due to missed visits. People's care plans highlighted the support they required with food or drink such as, "Support with meal." This meant that people who required support with their meals and drinks might be at risk of dehydration or malnutrition because they did not always receive this support at the time they requested.

A failure to have regard to the person's well-being when meeting their nutritional and hydration needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed they consented to their care. People had consented to their care plans by providing a signature. Staff confirmed they would always seek the person's permission before providing care and always gave them a choice of how they would like their care to be given.

Mental capacity assessments were in place and completed as part of the assessment process for people who were deemed to lack capacity. For one person we saw a mental capacity assessment had been completed. This person's mental capacity assessment documented that due to a health condition in which the person had a mental impairment; financial decisions were to be made by their relative who held a

lasting power of attorney. Decisions relating to the person's care for washing, feeding, dressing and medicines were made as part of a best interest meeting and a care plan was developed with the support of the relative, person and other professionals. The assessment documented that this person could give verbal consent to some decisions if information was provided in a different way.

For those people who required support to access healthcare services care staff would contact the office or family member and advise of any concerns and whether a health care professional would need to be contacted. Care staff said they monitored people's health and wellbeing when they were supporting them with their personal care.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care and support received from staff. We received comments such as, "The carers are very friendly. I trust them." "They are second to none, very supportive, kind, caring and professional." "I've got used to ladies who are very kind to me and I'm very happy with service from Micare." Office staff were polite, courteous and respectful to people when speaking with them on the phone and people confirmed this. One person said, "The office staff are polite and kind. We are a team working together. That is how it feels. They make every effort to sort out any problems."

People confirmed the support they received helped them to be as independent as possible. Care staff said they promoted people's independence by encouraging and supporting them to complete some personal care tasks they were able to do. For example, one staff member said, "I ask people if there is something they can do for themselves and I get them to do it." Another said, "I will encourage people to help themselves."

However people's care plans did not describe what people were able to do for themselves and what care staff were required to support people with. People's care plans were written in a task specific way and did not include how people would like their care to be provided. For example, one person's care plan listed the tasks required using bullet points and stated, "Make sure I get up." "Help me to wash and dress." "Give me my medication." There was no detail included in the care plan to demonstrate how the person would like support to get out of bed, whether this person required support or was able to get up out of bed by themselves. There was no description of the support required with washing and dressing and what the person required support with. One person who was living with dementia and was deemed to lack capacity to consent to most aspects of their personal care also had a task specific care plan. The tasks were also listed as bullet points and did not provide any detail on how the person would like or have liked their care to be given. This meant people may be at risk of not having their views taken into consideration when care is being provided.

A failure to design care with a view to achieving people's preferences and ensuring their needs are met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Compliments about the service had been received from people and their relatives in the form of thank you cards. A compliment had been received on 1 October 2015 thanking the service for their "kindness and support."

People's privacy and dignity was respected and promoted. Staff gave us good examples of how they respected people's privacy and dignity when supporting them with personal care. One said, "Keep curtains closed and door shut when washing." Another said, "I will give people five minutes of privacy when they are using the bathroom."

Requires Improvement

Is the service responsive?

Our findings

Before the inspection we received some information of concern informing us that people's care plans were basic, out of date and did not contain sufficient detail to support people appropriately and meet their needs. At this inspection we found care plans did not document accurately the support people required and how they wanted the support to be provided. Care plans did not provide details of risks to the person which had been highlighted in the risk assessments and care plans were not always reviewed in line with the provider's policy.

The regional manager confirmed that people who had transferred from the previous care company in February 2016 did not all have updated care plans. However the regional manager confirmed people who had transferred from the previous care company were transferred with their previous care plan documentation. This meant people's care plans may not be an accurate reflection of their needs and people may be at risk of receiving care that is not meeting their needs.

The regional manager said they had a transitional plan in place to ensure that all care plans were completed for people who had transferred from the previous care company. We looked at four people's care plans files who had transferred from the previous agency and saw all four had been updated to include MiHomecare's paperwork. People had individual care folders which contained a care plan; care needs assessment, mental capacity assessment, risk assessments and completed daily logs. Two people's care plan files also contained a written assessment from the local authority called an Adult Services Personal Plan (ASPP).

However people's care plans were task specific and did not contain the information highlighted on their risk assessments. Risk assessments were also inaccurate. One person's Mihomecare care assessment was dated 24 February 2016, highlighted the person was at risk of falls, had a history of falls, and had previously fractured their neck of femur(the femur neck is a flattened pyramidal process of bone). This person required the use of a "four wheeled walker" to help mobilise around the home. The risk assessment contradicted the care assessment and stated the person did not have a history of falls and the care plan did not contain any information about the equipment the person required to use when mobilising around their home. Another person's Adult services assessment completed on 14 April 2015 documented they were at risk of pressure area breakdown and remained in bed. There was no information in the care plan, which had been updated on 15 February 2016, to indicate the person was at risk of skin breakdown and required to be cared for in bed. The care plan stated, "Put pot on the bed." "I will put dermal in water." The third and fourth person did not have any information in their care plan files.

The regional manager confirmed existing people's care plans should be in date and an accurate reflection of their needs. We looked at four existing people's care plan files and found care plans were task specific and did not contain the information highlighted on their risk assessments. One person's risk assessment completed on 14 July 2015 identified they required the use of a hearing aid, there was no mention of this in their care plan. This person also required the water temperature to be tested prior to using the shower. There was no mention of this in the person's care plan and no documentation to evidence that the water temperature had been tested. We looked at this person's daily report of care and detailed at the top in

capital letters was written, "Carers please check [name] is wearing care line on all visits. [Name] has told family they take of careline through day." Care line is a 24 hour emergency call system, in which people are provided with a pendant to wear around their neck or on their wrist and can activate an alarm if they require help. There was no evidence that this information had been added to the care plan that was currently in the person's home.

Staff confirmed that the care plans did not reflect people's preferences and needs. However staff said they did feedback to the office any changes to people's needs. People confirmed they had a care plan and were involved in the assessment of their needs but would tell staff the care they required on a daily basis. This meant people may be at risk of receiving care that was not reflective of their needs unless staff asked them how they would like care to be given.

A failure to ensure the care of people was appropriate and met their needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection we received three complaints about the provider. At this inspection we saw six complaints had been raised to the provider since November 2015, which included the three complaints received by the Commission. The complaints had been logged on the providers electronic complaints file. All complaints had been responded to. One complaint received on the 26 November 2015 had been investigated and documented the outcome as not upheld. The other five complaints were on-going. Staff, the interim manager and regional manager were confident that people knew how to make a complaint. People felt confident to express concerns and if they had any issues they knew who to complain to and would be confident that the concern would be dealt with.

Requires Improvement

Is the service well-led?

Our findings

People felt they could talk to the interim and regional manager and felt they received a good service. One person who had transferred from the previous care company stated that things had improved for them since the service took over. Professionals confirmed the service were very supportive and professional. One said, "Good communication between myself, the manager and staff at the Havant branch." Another said, "I have been working in collaboration with MiHomecare for a period of 8 years. My professional opinion is that it is a well led service. The management team are approachable and always act on any advice or guidance given to them in regards to promoting the independence and well-being of those they support."

Prior to the inspection we asked the provider to complete and send a Provider Information Return (PIR). However this was not submitted at the time of the inspection. Our records showed an email had been sent to the provider in October 2015 requesting completion and submission. The regional manager stated that due to the changeover in management the email requesting the PIR to be completed would have been missed in error.

A failure to send to the Commission a PIR when requested to do so is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager said they liked to be approachable to staff and people, keep communication open and felt as though they worked alongside staff to support them and make effective decisions about people. However staff did not always feel the interim manager and regional manager were very supportive. Staff felt communication between them and the interim manager and regional manager required improvement. One said. "I like working here but communication could be better."

At the time of the inspection there was a manager who was registered with the Commission. However they were no longer managing the regulated activity and the interim manager was applying to the Commission to become the registered manager. The regional manager had been carrying out the day to day management of the service since the previous registered manager left the service in November 2015. The regional manager stated the service had been in a transitional period for some time since November 2015 and the transfer of staff and people from a previous care company in February 2016 had caused additional issues. These issues were being resolved.

Staff were supported to question practice, were confident that if they raised any concerns they would be dealt with by management and they demonstrated an understanding of what to do if they felt their concerns were not being listened to by management. Notifications had been sent to the Commission. The interim and regional manager demonstrated a good understanding of when the Commission needed to be notified.

The regional manager had implemented a comprehensive branch improvement action plan which identified areas of improvement required in the service. The action plan included audits of people's care records to ensure all care plans and risk assessments were up to date and accurate, medicines management, managing complaints and ensuring staff files were audited and staff were supported with

supervision, appraisals and training. The action plan included timescales for completion and who would be responsible for ensuring the actions were completed.

There were a number of audits in place which monitored the quality of the service being provided. There were systems in place to analyse, identify and learn from incidents, accidents, complaints and safeguarding referrals. These audits included the lessons which could be learnt in order to mitigate any further incidents, accidents, complaints and safeguarding concerns. Surveys had also been completed by the service to ask people's opinion of the service. People confirmed they had received surveys. At the time of the inspection these results were being collated. However staff had not been given the opportunity to express their opinion about the service. The interim manager confirmed they would ensure staff were provided with a survey.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure the care of people was appropriate and met their needs. Regulation 9 (1)(a), (b) The provider failed to design care with a view to achieving people's preferences and ensuring their needs are met. Regulation 9(3)(b) The provider failed to have regard to the person's well-being when meeting their nutritional and hydration needs. Regulation 9(3)(I)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care was provided in a safe way for service users. Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to send when requested a Provider Information Return. Regulation 17(3)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient

numbers of staff to meet people's needs. Regulation 18(1)

The provider failed to ensure staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform. Regulation 18(2)