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Princess Homecare

Inspection report

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03 December 2015
07 December 2015

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Princess Homecare is a domiciliary care agency which is registered to provide personal care to adults in their own home. The inspection was unannounced and took place on the 20 and 26 November 2015, 3 and 7 December 2015.

The service had a registered manager who was responsible for the day to day running of the agency. 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.

The registered manager is also the registered provider of Princess Homecare.

Before the inspection we received concerns about the support people received from the provider with their finances including how they were charged for services. At the inspection we found that the financial systems in place were not transparent and it was unclear what services people were paying for. The provider did not have a pricing list in place as stated on people's contracts.

The service did not follow the requirements set out in the Mental Capacity Act 2005 (MCA) when people lacked the capacity to give consent to receiving care. The provider had failed to ensure that where decisions were made on behalf of people, this was lawfully authorised.

Staff had not received sufficient training in relation to the MCA and Deprivation of Liberty Safeguards (DoLS). Not all staff had received training in administering medicines and staff did not undertake training which was specific to their role. Staff had meetings with the registered provider to discuss their performance and training needs. However, not all meetings were carried out within a suitable timescale.

Medicine Administration Charts (MARs) did not state how or how often the medicine should be taken. This could increase the risk of people not receiving the right medicines at the right time. Protocols were not in place for medicines prescribed to be administered as and when required. Body application charts were not in place for topical creams.

Records relating to the care and support people received were not person centred and lacked sufficient information. Risk assessments in relation to people's care and treatment were not fit for purpose. The organisation and standard of record keeping was poor which could impact on the care and support people received.

There were no systems of audits in place and therefore the registered provider could not be assured that people were receiving safe and effective care and support. The registered provider did not demonstrate sufficient understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as

required by their registration.

People and relatives told us the staff were very kind and caring and we observed that staff treated people with respect and dignity. However, entries in one person's daily records evidenced that this was not always the case.

There was a complaints procedure in place and people told us they would talk with the registered provider if they had a complaint.

We found breaches of the Care Quality Commission (Registration) Regulations 2009 and 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 overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The financial systems in place were not transparent and it was unclear what services people were paying for.

Risk assessments were not fit for purpose, as they did not identify potential risks or relate adequately to the person.

Staff were administering medicines to people without the required training. The provider did not follow safe recruitment practices.

People told us they felt safe in the presence of staff.

Is the service effective?

Inadequate

The service was not effective. Decisions were being made on people's behalf without the lawful authority being in place.

Staff had not received some of the necessary training required of their role.

The registered provider had failed to ensure that the training given to staff was effective.

During our inspection we observed that staff respected people's choices and gained verbal consent before carrying out care and support.

Is the service caring?

Inadequate

The service was not always caring. When staff wrote the daily record of care people had received, the terminology and phrases used were subjective and not respectful.

Staff did not always listen to people and made decisions for people without informing them.

People told us that staff were kind and caring.

Staff told us they enjoyed their work.

Is the service responsive?

Inadequate

The service was not responsive. Care records had not been adequately developed to meet people's needs.

People's needs were not being adequately assessed and risk assessments put into place.

Care records were not person centred.

There was positive feedback from healthcare professionals about the service offered.

Is the service well-led?

Inadequate

The service was not well led. There was a lack of systems and processes in place to ensure the effective running of the service.

The registered provider had not received the appropriate training required of their role as the registered manager.

The registered provider did not demonstrate sufficient understanding of the Health and Social Care Act 2008 which is a requirement of their registration.

A satisfaction survey showed that people were happy with the care they received.

Princess Homecare

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 over four days, 20 and 26 November 2015 and 3 and 7 December 2015 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR) which the provider returned. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enables us to ensure we are addressing potential areas of concern.

At the time of our inspection there were six people using the service. During our inspection we spoke with the registered provider who is also the registered manager, the deputy manager, two members of care staff, two people who used the service, a relative and a family friend.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with people, observing staff practices when we visited people in their homes, looking at documents that related to people's care and support and documents relating to the management of the service.

Inadequate

Is the service safe?

Our findings

The registered provider failed to protect people from potential abuse and improper treatment and failed to take action, when aware of potential abuse. Before the inspection we received concerns about the support people received from the provider with their finances including how they were charged for services.

An individual with involvement with the service had applied for and was granted a Lasting Power of Attorney (LPA) to manage the financial affairs of a person using the service. The registered provider was in agreement with the role being undertaken. In addition, a member of staff had applied for an LPA for the health and welfare of the same person.

There was a lack of consistency and transparency regarding the provider's financial systems. The 'service user contract' referred to a price list. However, the registered provider told us there was no price list and that a standard format for calculating charges was not used. We found that people were being charged different amounts for their personal care and any additional services. There was no rationale or criteria for these different charges being made. There were several copies of people's contracts in their file but it was difficult to ascertain which was the most current. Care plans, contracts and invoices were not cross-referenced to demonstrate clear administrative systems. There was no evidence that contracts and the fees charged were reviewed, based upon people's changing needs through a care plan review.

Invoices were not itemised so they did not show people what they were paying for. This did not enable people to effectively check the invoices to ensure they were correct. We reviewed some of the invoices and found that one person had been overcharged by £125.00. The provider was not aware there had been an error. The person was later reimbursed with an apology from the registered provider.

Daily records showed one person was sometimes resistive to personal care and could display behaviours which challenged. Some staff had delivered personal care against the person's wishes and there was a level of restraint placed upon the person by staff. There were no risk assessments or management plans in place to help staff support the person safely.

Staff had not received training in how to support people who may display behaviour which is challenging. One member of staff told us they always explained to people before they carried out personal care and would 'try again' if the person did not wish care at that time. During our inspection we observed that staff respected people's choices and gained verbal consent before carrying out care and support. However, the daily records evidenced that this was not always the practice as care was being delivered without the consent of the person involved.

The risk assessments in place did not highlight all of the potential risks and did not contain information to mitigate them. Risk assessments in relation to the action to take, in the event of a fire in a person's home did not explain what action the care staff should take according to the level of risk. For one risk assessment, the form only stated that staff should telephone the fire brigade without further guidance as to what further action they should take. The registered provider had not adequately assessed potential risks to safety in

relation to the equipment people use and how staff should safely use the equipment. This included the use of ceiling hoists, bed rails and hospital beds.

As part of the inspection planning, we reviewed the provider website and found that people who had recently joined the service, had their name and town where they lived promoted on the website. The care records did not contain evidence that people had consented to this practice. The provider told us they were not aware they were required to gain consent in order to display people's personal details on their website. The provider did not have any guidance in their 'Confidentiality policy' or other policies on using people's information in this way. The provider had failed to assess if this would place the person at risk. This was a breach of the Data Protection Act 1998.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had failed to ensure staff were appropriately skilled to provide care safely. Not all staff had received training in the administration of medicines yet had been administering medicines to people for some time. This posed a risk of error due to a lack of understanding and knowledge around the administration of medicines.

There was a lack of information around the management of medicines. There was no information to inform staff how they should support people with their PRN medicines and there were no protocols in place. [PRN is where people have a medicine as and when required]. Records did not contain information about the frequency of prescribed medicines and there was a lack of information of how topical creams were to be applied. The registered provider had not carried out medicine audits or checked staff's competency when administering medicines. The systems to undertake these checks were not in place. This further increased the risk of inappropriate and unsafe care and treatment.

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

During our inspection, we made a referral to the safeguarding team concerning the inappropriate use of surveillance, in a person's home. Whilst this was not instigated by the registered provider, they were aware of the surveillance and had failed to identify it as an issue as they had not made a safeguarding alert to protect the person. There was no rationale for the surveillance and the person involved had capacity to make decisions; however they had not been consulted and had not consented to it. The third party making the decision to install the cameras did not have the lawful authority to do so. The practice infringed on the human rights of the person and staff who supported them.

This was a breach of Regulation 10 and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff had received safeguarding training when they started working for Princess Homecare. To ensure new staff are able to recognise abuse and know how to safeguard people the provider's 'Recruitment' policy stated that, 'this training (Abuse and protection) must be completed prior to commencing work through the Agency'. At the time of our inspection on 20 November 2015, a new employee had not received this training five months after starting their role. Their induction paperwork had not been signed off for safeguarding. We looked at the first supervision record for this member of staff. The staff member's training needs were shown as nutrition and hydration, yet safeguarding people, the provider's policy and the need for safeguarding training had not been discussed. This would leave people at risk of abuse or of improper treatment and

care.

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

Records showed the registered provider did not consistently undertake safe recruitment practices. When the suitability of new staff was in question, the registered provider had not assessed the risks associated with the appointment. There was no rationale, as to why certain staff had been employed. The registered provider had not put systems into place to ensure people's safety such as additional monitoring and supervision of staff.

This was a breach of Regulation 19 of the Care Quality Commission (Registration) Regulations 2009. (Schedule 3)

People and their families told us they felt safe when they were in the company of staff. People told us they usually had the same staff member who they felt comfortable with. They said staff were always on time and never missed a visit. There was sufficient staff to meet people's needs. People's medicines were kept in appropriate storage.

Inadequate

Is the service effective?

Our findings

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 MCA 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 accordance with the principles under the MCA.

Where people did not have capacity to consent to their care, the service was not following the principles of the Mental Capacity Act 2005. The provider had not undertaken mental capacity assessments to determine if people had the capacity to consent to their care and treatment and had not done everything which was practicable to help the person make a decision for themselves before concluding that they lacked the capacity to do so. Out of the six care records we looked at, only one person had signed to give their consent to the care and treatment to be provided. Other consent forms had been signed by family members without a mental capacity assessment having been completed, confirmation of consultation with the person or evidence of a legal power of attorney for health and welfare being in place.

Decisions relating to people's health and welfare were being made on people's behalf where the person making the decision did not have the legal authority to do. This was because they did not have a legal power of attorney for health and welfare. Without the documentary evidence of a legal power of attorney being in place, the provider could not be assured that they were acting in the person's best interests and in line with the principles of the Mental Capacity Act 2005.

A form called 'informed consent' was completed for each person in relation to sharing information with other agencies and for planning purposes. One form had been completed where the person had not given consent. The reason for this was given as 'no longer has mental capacity'. There was no capacity assessment in place to validate this reason or any best interest decision process followed. People had not signed this form and there was no reference to how the registered provider had attempted to engage and consult with people regarding information sharing.

Daily records evidenced where staff had made a decision regarding the delivery of care without the necessary MCA and best interest decision documentation being in place, such as in giving a person their medicine covertly. One care worker told us they had received the training on the MCA and the Deprivation of Liberty Safeguards (DoLS). Another care worker could not recall whether training had been undertaken. Training records confirmed this staff member had not received training on the MCA and Deprivation of Liberty Safeguards. We found staff were not confident in explaining how the MCA related to the people they cared for.

Where people required an assessment for certain types of equipment in relation to their moving and handling, occupational therapy services were involved depending upon the equipment to be used. The therapist had undertaken mental capacity assessments for some people to determine if they could consent to the equipment being installed and used. However, at the time of our inspection there were no documents

in place which evidenced that people had given consent to the equipment being used, particularly as some types of equipment could act as a restraint on the person's movements. Following the inspection, the registered provider submitted a copy of a document called 'Restraint information Record/Risk Assessment' – Bed rails/Cot sides. This document stated 'Person has been given a lack of capacity assessment and is at risk of moving when unaware of risks'. The registered provider policy 'Introduction – The Mental Capacity Act 2005' states the two stage test of capacity must be met. There is no evidence provided that an MCA was carried out in relation to the specific decision or that the provider tried to engage with the person or subsequently, a best interest meeting was held and this was documented with a review date planned.

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

The registered provider predominately used an e-learning package to deliver staff training. This enabled staff to have as many attempts as possible until they achieved the required score in each subject. This information had not been analysed by the registered provider and there was no action plan to address the shortfalls or evaluate how effective the learning had been. The registered provider had not prioritised which training courses needed to be completed first such as safeguarding, the MCA and infection control to ensure staff had the skills to do their job effectively and lawfully.

The deputy manager gave us an updated copy of the training forms for five members of staff. These evidenced that the majority of staff had completed the training as set by the registered provider. The training documents evidenced that only the registered manager had received training in 'Dementia – An Understanding and Dementia – Dealing with Challenging Behaviour'. (This training is specific to behaviour management and not to restraint itself). None of the staff who delivered personal care had received this training.

The document used to record the training staff had undertaken was not complete. Some courses such as medication training had been entered as being completed but without the date of completion or number of attempts to reach competence. The training document did not identify the dates when staff were required to complete refresher courses and the registered provider's 'Training Policy' did not state the timeframe in which these courses were due for renewal. The systems in place to monitor and review the progress of staff training were not effective.

Whilst staff were able to contact the registered manager on a day to day basis, not all staff had received formal one to one meetings in a timely manner. One care worker received their first supervision five months after starting their employment with the provider. This meant that the registered provider had not taken the earliest opportunity to review the progress of staff, monitor their performance and to support staff as needed.

The registered provider's supervision policy did not give a timescale for the frequency of staff supervision. For the deputy manager, there was no evidence that supervision had taken place as there were no records which evidenced the meetings.

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

The registered provider told us that some people had arrangements in place for their nutritional and hydration needs to be met as part of the provision of care and treatment. They went on to tell us that one person had received a nutritional assessment and had been put onto a high protein diet. A daily eating plan

had been devised and this was to be checked on a regular basis and altered if necessary. The person's daily records, which we looked at, did not contain or make reference to a daily eating plan and there was no evidence of how this was being monitored. Records showed the person was to have 'optimum' fluids. There was no information to inform staff what optimum meant. Staff recorded what the person drank each day but there was no analysis of the information to ensure the person had sufficient fluids. Information recorded about the person's diet was not clear. For example, one record stated the person preferred 'medium to larger sized meals' but further down on the form, it stated, 'prefers little and often'.

Staff were undertaking the care certificate [The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life] and staff told us the modules were really good. One care worker was qualified to a National Vocational Level Two in Health and Social Care. Staff told us the registered provider supported them with their learning. Records evidenced that staff had received an annual appraisal to review their performance over the year. A member of staff said "the support we get through the registered provider is brilliant, no question is too small. We feel well supported. She will telephone each day to check we are ok and everything is running well".

People received support from health professionals when required. Each person had an allocated GP. Local community healthcare professionals such as the district nurses visited people in their homes. During our inspection, the registered provider contacted the GP to arrange a home visit as they were concerned about a cough one person was developing.

Staff had worked for Princess Homecare for a long period of time. When new staff began their employment with Princess Homecare there was an induction process in place.

Inadequate

Is the service caring?

Our findings

During the inspection, the registered provider told us they would be talking with people about their wishes for the end of their life in order to put an end of life care plan into place. However, this had yet to be acted upon.

The provider 'Record Keeping Policy' was not being adhered to by staff. Section 1.3 of the policy states 'Records must be accurate and written in such a way that the meaning is clear'. Section 1.10 of the policy states 'Abbreviations, jargon, meaningless phrases or offensive statements must not be used'. The provider 'Record Keeping Policy' highlights a common problem with record keeping is 'the Absence of clarity eg the meaning of 'had a good day' and 'slept well' is not clear'.

Within the daily records, staff used subjective language which did not reflect a respectful attitude towards people. In addition, the terminology did not enable the registered person to monitor people's care and their emotional wellbeing. Within daily records, the words 'ha ha ha!', 'yaay' and smiley faces had been used after statements. Phrases such as 'X was difficult, X was nasty, X played up' were used and 'managed to get down' was used to refer to a drink being taken. X was 'giving off' a description given when the person was woken up. 'Out like a light' was used to describe when the person went to sleep quickly.

The daily records for one person indicated that staff were not fully listening to the person and understanding their views. The notes showed that the care worker was amused by the way the person became upset when they were not being shown attention. This demonstrated a lack of compassion and disregard of the person.

Other concerns, related to a member of care staff making a decision on behalf of a person. The member of staff had decided not to inform the person that their friend had passed away because it would 'upset them'. There was no information within the person's care records to denote this person could not deal with upsetting news. Due to this, it was not a decision the staff member should have made. The decision demonstrated a lack of respect and consideration of the person's right to be given the information. The daily records were not being monitored and reviewed by the registered provider and therefore these issues had not been identified. This meant poor practice by the staff continued.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we visited people in their own homes. People appeared comfortable and relaxed in the presence of staff and staff spoke with people in a respectful and caring manner. Staff supported people to make choices, for example in what drink they wanted or what they wanted to do, such as moving position in bed or getting up to sit in a chair. Staff were able to describe people's preferences for care, including likes and dislikes for food. They were able to tell us if people were in pain and how they would respond to this.

Inadequate

Is the service responsive?

Our findings

Care plans had not been adequately developed to meet people's needs. They were not person centred as they were not tailored to individual preferences and abilities. They lacked sufficient information about how the person wished their care to be delivered and what tasks people were able to do themselves or could participate in. For example, personal preferences in terms of care routines such as bathing, showering, hair and nail care, continence needs and social activity, were not stated. The information in care plans did not fully enable staff to support people to make choices. There was little information about people's likes and dislikes.

The daily records and daily care plans were task focused and not person centred. For example, instructions stated 'wash and change, underclothes into laundry bin, check/clean teeth, check pad in place, cereal/porridge/toast with c/tea, leave j/drink, medication, bathing, weekly'. The lack of information about the person's personal preferences meant that staff could carry out the tasks without considering people as individuals.

There were risk assessments in place for people regarding various elements of their care. However, the assessments did not adequately identify what the risks were and how they were to be managed. The assessments did not link or correlate to the care plan. This meant that care plans had not been devised to take account of the potential risks to the person. For example, in one person's care assessment it states they require a 'Diabetic Diet'. As part of the care package, staff supported this person with their nutrition and hydration. There was no risk assessment in place and no information in the care plan as to what a 'diabetic diet' entailed, including what foods they could or could not eat. A food chart was not in place to monitor what was being eaten. For another person, risks had been identified around supporting the person with managing their anxiety and behaviour, the management plans in place did not give sufficient guidance to staff on how to be able to consistently offer safe care and treatment and support the person appropriately.

The registered provider did not show an understanding of behaviour management. They used terminology such as 'manic' to describe a person's behaviour without having had a professional psychology or psychiatry assessment. Part of a person's care, was that the registered provider would monitor their moods. Staff had recorded the person's mood as either 'lovely' or 'nasty'. This demonstrated a clear lack of knowledge and understanding of behaviour and emotional well-being. The provider's policy on 'Challenging Behaviour' stated that staff should record behaviour and 'be specific, using descriptions rather than one word'. The reason given was that 'words can be interpreted differently by different care workers'. This policy was not being adhered to.

Appropriate monitoring charts were not in place in order that the registered provider could assess people's emotional well-being. Within the care records, people had been categorised as having a 'learning difficulty' and 'dementia' without a formal diagnosis. This could impact on how people are perceived and their abilities not being appropriately assessed and considered within the care planning process.

We found no evidence of care records being reviewed appropriately despite changes to the care and

treatment of the person. Contracts and the fees had been updated and increased without evidence of increased or changing needs.

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

The provider had a complaints policy and a duty of candour policy. People told us they did not have any complaints and stated that the registered [person] would respond immediately if they did. The registered manager told us they had not received any complaints in the last year.

Prior to our inspection, we asked health and social care professionals for their feedback on the service. One health professional wrote "I have [found] the registered provider to be well organised and a very caring individual. She is experienced and has a good understanding of the issues facing her patients". Another health professional told us "I have always found them to be helpful, caring and knowledgeable about the clients in their care. Any concerns are quickly addressed. We have built a good understanding of how we all work and trust one another to always put the care of the patient first.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post. The registered manager was also the registered provider of the service.

The registered provider was not clear when we asked about the arrangements for one person receiving a care package. Records showed this person had an agreement for a direct payment from the local authority to pay for their care dated 14/10/2015. Within their records there was a contract, a direct payment letter, two invoices and an out of date care plan. We asked the registered provider about the care plan and the invoices. There was a lack of oversight in relation to the management of the service. The registered provider said they did not know if they were providing a service to this person. When we highlighted the direct payment letter, the registered provider said they did not know it had been set up. They told us they were waiting for the person to leave hospital before the care package would come into effect. Following the inspection we obtained information from the local authority which confirmed that Princess Homecare had been providing a service to this person following their discharge from hospital on the 14 October 2015.

The registered provider's policies and procedures were out of date and inaccurate. They did not adequately relate to the processes and systems used within Princess Homecare, for example the record keeping policy. In addition, the policies in place were not being adhered to such as the recruitment policy. A system to carry out audits of the service was not in place therefore no audits apart from the satisfaction questionnaire were carried out. This meant that the registered provider could not be assured that people were receiving safe, effective and appropriate care and treatment and that the service was meeting the standards required within their registration and the Health and Social Care Act 2008.

The organisation and standard of record keeping was poor. This included people's care records and documents relating to the running of the service. Documents were not accurate, lacked sufficient detail, were not cross-referenced to other documents, were missing or not fully completed. There was no index of the care records, which meant it was difficult to ascertain if the care records were complete. Some records were paper based whilst other were computer based. However, there was no consistency between each person's records.

Each person had a safeguarding risk assessment in place; however the size of the typeface on the document was extremely small and difficult to read. As the documents were difficult to read then staff may not be able to use the document for the intended purpose of informing them of the potential risks which people faced and how to minimise those risks. We looked at the copy of the safeguarding risk assessments kept in people's homes and these documents also had a very small typeface, making them difficult to read.

The registered provider's website had not been maintained to ensure information was current. The registered provider had used the logos of government and other agencies such as Skills for Care and the Care Quality Commission on their website without express permission. This gave the perception that these organisations were endorsing this provider.

The documentation given to new people to the service states 'Princess homecare Registration No: 1-101720821 including Child care registration. The registered provider is not registered with the Care Quality Commission to provide any type of service relating to children. The document also states that 'all staff attending to child care will be CRB enhanced'. [the CRB is now the Disclosure and Barring Service]. This information is misleading to the reader.

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

The registered provider was not adhering to the expected terms of a 24 hour live in care package. The registered provider had stated to the person's legal power of attorney that staff would be appropriately trained. However this was not the case. At the time of our inspection, one member of the live-in care team had not completed training in medication, safeguarding, infection control, the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, understanding dementia and dealing with behaviours which may challenge. We asked the registered provider if the care worker had undertaken any safeguarding training, they told us "No, if it's not done on there [the computer printout of courses undertaken]. They [the care worker] may have done it before in a previous job. Not sure, I haven't looked.

The registered provider did not meet the standard required of their job description. They undertook the same training as the staff and had not undertaken training relevant or specific to their role. This included topics such as leadership and risk management. The registered provider had taken numerous attempts to meet the grade required for the online training. The registered provider was also carrying out the staffs' assessments for the new care certificate.

When asked about medicine training, the registered provider told us there were "certificates for staff but these were probably out of date". They told us they gave staff the medicine policy but the registered provider had not undertaken specific training. They told us this was because they had been concentrating on the care certificate. The registered provider stated that staff did not administer medicines but only prompted the person. They failed to recognise that prompting is a form of administration and staff are still required to have the necessary training to ensure people are supported by staff who are competent. We spoke with a pharmacy inspector of the CQC who confirmed that medicine training was required by staff when they prompted medicines. We advised the register provider of this. When we asked the registered provider, if anyone was taking their medicine covertly (hidden in food or drink), they did not understand what we were asking.

The satisfaction questionnaires completed by the provider showed that people were happy with the care they received. There were positive comments about the staff, their kindness and the willingness of the registered provider to go out of their way to ensure people 'had what they needed'. Likewise when we visited people in their home they were very complimentary about the service and stated they could always 'get someone on the telephone if they needed'.

The registered provider told us the service had faced no challenges in the previous year and there were no issues with staffing. They felt the staff were dedicated to their work and they encouraged staff by awarding them performance certificates. All staff received a Christmas bonus and a small gift. Small gifts were given to people who used the service. The registered provider told us in the last year the service had celebrated them [the registered provider] being awarded a 'services to care award' by Wiltshire Council which they were very proud of.