Primavera Domiciliary Care Services Limited

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Inspection report

26-28 Queensway
Enfield
Middlesex
EN3 4SA

Tel: 07932796709

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 November 2018 and was announced. This inspection was the first comprehensive inspection of the service since it was registered with the Care Quality Commission (CQC) on 24 November 2017.

Primavera Domiciliary Care Services Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people and people with a range of physical and sensory disabilities as well as people living with dementia.

Not everyone using Primavera Domiciliary Care Services Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection the service was providing care and support to 22 people.

There was a registered manager in post at the time of this inspection. 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.

Although care plans identified people's risks associated with their health and social care needs, the service did not always carry out risk assessments so that care staff were provided with direction and guidance on how to minimise the identified risk to keep people safe and free from harm.

Medicine management and administration processes were not always safely adhered to. Gaps in recording, incomplete information about medicines and lack of instruction and authorisation on how to administer medicines safely, meant that people may not always have been receiving their medicines safely and as prescribed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, the service did not always complete mental capacity assessments to establish people's capacity and where people lacked capacity, decisions made in people's best interest were not clearly documented.

Care plans were not person centred and did not detail people, likes, dislikes, preferences, cultural and religious requirements and background history to enable care staff to provide care and support that was responsive to their needs.

Care plans were not always current and reflective of people's needs. Care plans had not been reviewed since the package of care had commenced. Where people's needs had changed care plans had not been updated to reflect this.

Management oversight processes did not identify the issues and concerns that we found especially around medicine administration and recording. In the absence of checks and audits of care plans, the service had no insight or awareness of the issues that we found.

People and their relatives confirmed that they felt safe with the care staff that supported them. The registered manager and care staff demonstrated a good understanding of safeguarding and were able to describe the steps they would take to protect people from abuse.

The service carried out a variety of checks to ensure that only those staff identified as safe to work with vulnerable adults were recruited. There was enough staff available to meet people's care and support needs.

Assessments of people's care and support needs were carried out before they started using the service to confirm that the service could meet their needs effectively.

Care staff received appropriate and relevant training to enable them to deliver their role effectively.

People were also supported with their nutritional and hydration requirements where this had been identified as an assessed need.

People had consented to their care and support and where people were unable to consent, relatives had been involved in the care planning process where appropriate.

People and their relatives told us that they were happy with the care and support that they received and that care staff were caring and kind with whom they had developed positive relationships with.

People and their relatives knew who to speak with if they had any concerns or complaints to raise and were confident that these would be dealt with appropriately.

People, their relatives and staff spoke positively of the leadership and management of the service.

At this inspection we found the provider to be in breach of Regulations 9, 11, 12 and 17 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 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 always safe. People's identified risks associated with their health and care needs had not been assessed in order to provide guidance and direction to staff on how to mitigate or reduce the risk to keep people safe.

Gaps in recording of medicine administration and lack of information on how people were to receive their medicines did not give sufficient assurances that people received their medicines safely and as prescribed.

People and relatives felt safe with the care and support that they received and received visits from a team of regular care staff.

Recruitment processes being followed ensured that only suitable staff were recruited.

Processes were in place to record accidents and incidents when they occurred so that the service could learn and prevent re-occurrences.

Is the service effective?

Requires Improvement

The service was not always effective. Where people lacked capacity there was no evidence to show that specific decisions had been made in the person's best interest.

People's needs were assessed prior to the service providing care and support to ensure that the service could meet appropriately meet the person's needs.

Care staff were supported regularly through training and supervision.

People received the appropriate support with their nutritional and hydration needs. However, support needs in this area were not always documented.

People were supported to access health care services where this was an identified and assessed need.

Consent to care had been obtained in line with the principles of

the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People and relatives confirmed that care staff that supported them were caring, kind and respectful.

People and their relatives confirmed that they were involved with the planning of care and were able to express their views and make decisions about how they received their care and support as far as practicably possible.

People and relatives confirmed that care staff always delivered care and support whilst being respectful of their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not always current and reflective of people's care and support needs. Care plans had not been reviewed since the care package had begun and where people's needs had changed care plans had not been updated to reflect this.

Care plans were not person centred. The lack of information about people meant that care staff may not have been able to deliver care and support that was responsive to their needs.

However, despite the lack of recorded information, people and their relatives confirmed that they received care and support that was responsive to their needs.

People and relatives knew who to speak with if they needed to complain or raise any concerns. Appropriate systems were in place to deal with and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led. Lack of robust management oversight and governance meant that the provider had failed to identify the issues we found during this inspection.

People, their relatives and care staff were complementary of the registered manager and the way in which the service was run.

People and relatives were encouraged to engage and provide feedback about the service they received.

The service worked in partnership with the local authority and

other healthcare professionals to ensure that people received appropriate care and support.

Primavera Domiciliary Care Services Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 19 and 20 November 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in to support the inspection process.

The inspection was carried out by one inspector and one 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. Their involvement was limited to phoning people using the service and their relatives to ask them their views about the service.

Inspection site visit activity started on 19 November 2018 and ended on 20 November 2018. We visited the office location on 19 November 2018 to see the registered manager and to review care records, policies and procedures. On 20 November 2018 we made telephone calls to people that used the service and their relatives and we also met with three people using the service and their relatives to gain their feedback on the service.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

During the inspection, we spoke with seven people using the service, seven relatives, four care staff, one

office staff member and the registered manager. We reviewed the care records for six people to see if they were up-to-date and reflective of the care which people received. We also looked at personnel records for five members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including complaint and safeguarding records, to see how the service was run.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe and re-assured with the care and support that they received from the care staff. One person, when asked if they felt safe with the care staff told us, "Yes I do. It's how they talk and treat me." Another person responded, "Yes I do. I love the carer that comes in the morning especially." Relatives' feedback included, "They are aware of all the risks and they keep him safe", "My husband has mobility problems and it's really bad. The girl that come in the morning who gives him a shower is very good" and "Mum suffered a stroke; she's prone to coughing if food and drink go down too fast; the carers are very conscious of her needs; they have to give her a thickened liquid to drink they do it very well." However, despite this positive feedback, there were certain aspects of the service that were not safe.

Risks associated with people's health and care needs were not always assessed. Information and guidance had not been given to care staff on how to reduce and minimise the risk so that people were kept safe and free from harm. People's identified risks associated with their health and care needs included moving and handling, suicidal thoughts, not taking prescribed medicines, falls, breathing difficulties, choking and risks associated with medical conditions such as diabetes. Care plans noted these identified risks but risk assessments had not always been completed.

Where people were at high risk of falls an assessment had been completed which determined the level of risk but did not give any further instructions to care staff on how to prevent or minimise the risk of the person falling. One person who was a diabetic had noted in their care plan that they regularly suffered with hypoglycaemic episodes. This is when the person's blood sugar levels drop to below normal levels. Symptoms of low blood sugar levels can include confusion, loss of consciousness, a feeling of hunger, sweating, shakiness, weakness, seizures or death. There was no risk assessment in place for this person or guidance for care staff on the signs of hypoglycaemia and the actions to take. For another person whose moving and handling needs had changed and who now required equipment to support their mobility, a risk assessment was not in place despite the fact that the equipment was being used by care staff since October 2018.

The management of medicines was not always safe. Although the service had policies in place which directed staff on how to ensure people received their medicines on time and as prescribed, these were not always followed. Care plans did not always detail the medicines that the person had been prescribed or the level of support the person required with the administration of their medicines. We looked at medicines administration records (MAR's) for five people and found that there were gaps in administration for four people which meant that we could not be assured that people were receiving their medicines as prescribed. We could only see MAR's for the months of August, October, November 2018. The service was unable to locate any previous MAR's even though people had been receiving support with medicine administration dating back to April and May 2018.

One person had been prescribed eye drops. The MAR chart did not detail the name of the drops or the dosage and when the drops needed to be administered. The dispense date of the eye drops from the

pharmacist stated 31 October 2018 but the signatures from care staff confirming administration of the drops began from 12 November 2018. We highlighted the gap between the date the drops were dispensed and the date from when the drops were administered. The registered manager further showed us a text message confirming that the drops had been delivered to the person on the 4 November 2018. Therefore, the person had not been receiving the eye drops as prescribed between 4 November 2018 and 11 November 2018. There were also further gaps in recording noted on 13 and 19 November 2018.

Where people had been prescribed 'as and when required' medicines (PRN) these had not been identified within the person's care plan or on the MAR. PRN protocols were not in place to give guidance and direction to care staff on how and when these particular medicines should be administered. PRN medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain.

One person was receiving their medicines covertly. This means that the person's medicines are either crushed or disguised to enable the person to take them. The care plan for this person did not document clear information or guidance on why the person required their medicines covertly and how staff should administer the covert medicines. Although there was written documentation confirming that the GP had authorised covert administration of medicines, there was no further authorisations from the pharmacist that the method for giving the medicine was safe. We brought this to the attention of the registered manager who confirmed they would address this concern in line with their medicine policy.

Care staff received training in medicines administration. The registered manager told us that she observed care staff administering medicines to assess their competency, however, these observations were not formally recorded.

The registered manager had processes in place to audit and check completed MAR's so that issues and gaps in recording could be identified and addressed with the relevant care staff to ensure people received their medicines safely. However, the audits that had been completed did not identify any of the issues that we found as part of this inspection.

All of the above was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff that we spoke with knew the people they supported and were able to describe their risks and how they were to support them with their risks. One member of care staff told us, "[Person] has certain tablets which he takes at certain times. I support him with that."

We spoke with people and their relatives about the support they received with their medicines; the feedback was positive. One person told us, "I have dossett boxes; sometimes the carers dispense the meds. Yes, they give me water with the meds." Another person said, "I know what I take, they just bring it to me with a drink." Feedback from relatives included, "Yes they do; they put the meds in her food" and "Yes they do and all is given on time and correctly."

The registered manager and care staff that we spoke with clearly understood safeguarding and were able to describe how they would recognise signs of abuse and the steps they would take to protect people from abuse. One care staff member told us, "I would ring my manager and let her know what I observed. She will tell me what to do." Another care staff member explained, "I would go straight to the management, so that they can deal with it professionally." Care staff knew the meaning of the term 'whistleblowing' and named a variety of external agencies that could be contacted if they had concerns including the CQC, local authority

and the police.

There had been two safeguarding concerns that had been raised against the service since it started operating. We saw records confirming the details of the concerns, the investigations that the service had carried out and the outcomes with detail of the actions taken and improvements made as a result.

Recruitment processes ensured that only those staff assessed as safe to work with vulnerable adults were employed by the service. Checks included verification of the person's identity, conduct in previous employment, right to work in the UK and a Disclosure and Barring Service (DBS) check. A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with vulnerable people. However, where potential care staff had completed application forms and were required to provide a full employment history, this had not always been provided and the registered manager had not always explored any gaps in employment. We highlighted this concern to the registered manager and guided them to always ensure they follow Schedule 3 of the Health and Social Care Act 2008.

People and their relatives told us that they always received care and support from a regular team of care staff who arrived on time. We were also told that if care staff were running late for their call, they always received a phone call to let them know. People's feedback included, "Staff arrive on time and they let me know if they're running late" and "They usually arrive on time, but if they're running late, they let me know." Relatives told us, "There has been no issue re lateness", "Yes they let me know; once or twice they have arrived late, but we knew in advance" and "They arrive on time and they let me know if they're running late."

The registered manager confirmed that there were enough care staff available to meet the current needs of people the service supported. There had been no recorded missed visits. Rotas seen confirmed that people received care and support from a regular team of care staff. However, rotas did not state the time and duration of each person's call and therefore we could not see whether sufficient travel time had been allocated between each call and whether people's preferred call times had been accommodated. Care staff confirmed that they managed their own rotas and set the time of the visits at the time people had requested. We highlighted this to the registered manager who said that this would be an area that would be addressed so that people always received their care and support safely.

The service had no reported accidents or incidents recorded. However, the service had systems and processes in place to record any accident or incident that care staff reported while delivering care. The registered manager explained that she would discuss with care staff any concerns or issues arising from any such accident or incident so that learning and further awareness could be explored.

The service ensured that a variety of Personal Protective Equipment (PPE) was always available and accessible to staff. Adequate supplies of PPE such as gloves, aprons and shoe covers were available for staff to collect from the office.

Requires Improvement

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team.
We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. There were no people using the service that were subject to a judicial DoLS.

Care plans contained signed documents confirming that people had consented to receive the care and support that they received from Primavera Domiciliary Care Services Limited. Where people lacked capacity to sign consent, relatives had signed on the person's behalf confirming that they been involved in the care planning process.

However, care plans did not contain mental capacity assessments and best interests' decisions for people who lacked capacity to make specific decisions. For example, one person who was receiving their medicines covertly and was being supported by care staff to do this, did not have the appropriate mental capacity assessments or best interests decision to confirm that the person lacked capacity to make this decision and that this decision had been made in the person's best interest. The only authorisation available on the care plan was a signed document from the GP confirming this. This meant that the service could not show they had the appropriate consent in place to be complicit in the giving of medicine covertly.

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

Although the service had not followed the key principles of the MCA especially in relation to documenting people's level of capacity and best interests decision, people and their relatives confirmed that care staff did ask consent and always consulted them when specific decisions needed to be made. This was especially evident where people lacked capacity. One person told us, "They know me well and everything is done automatically. They respect my wishes when providing care. They would contact my son if there is a problem." One relative explained, "Mum can't consent to care, so they would call a family member."

The registered manager told us that care staff did not receive formal training on the MCA and DoLS but that she disseminated information and guidance documents to all care staff to raise awareness. Care staff

confirmed that they had received these guidance documents. Care staff were able to describe how they obtained consent to care and the ways in which people were supported to make their own choices and decisions. Examples given by care staff included, "I ask the service user for consent. If there were any concerns I would consult the family. I always ask them what they want and give them choice" and "Usually their families are involved in making decisions. Day to day I always give them choice with things such as food and personal care."

People were only supported with their nutrition and hydration needs where this was an identified and assessed need. However, care plans did not always specify the support people required with their meals, their likes and dislikes and any cultural preferences and wishes. Where people had specialist requirements including specialist diets or support with eating their meal details and guidance around this had not been clearly documented.

Despite this people and their relatives told us that they were happy with the way they were supported and were always offered choice and support where required. Comments from people included, "They give me my breakfast, lunch and dinner. They ask me what I want to eat" and "I usually tell them what I want to eat."

People and their relatives told us that they found care staff that supported them were appropriately skilled and trained to carry out their role. One person said, "They're aware of my condition and manage it accordingly." One relative told us, "I have seen them and they all seemed well trained." Another relative said, "I think they're very sympathetic and I think they are well trained."

The service ensured that each staff member underwent an induction and training in a variety of topics to enable them to carry out their role. Care staff told us and records confirmed that they had completed training in topics which included safeguarding, basic first aid, moving and handling, dementia awareness and infection control. The registered manager told us that she had not yet implemented the induction programme which was in line with the Care Certificate but planned to do so going forward. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care.

Care staff were also supported and monitored through supervision and spot checks carried out by the registered manager. Care staff told us that they found the registered manager very supportive and always guided and instructed them in their role. Feedback from care staff included, "I go to the office to meet [registered manager]. We talk about improvements to the job and anything she can do to help" and "[Registered manager] is fantastic, very supportive. We have supervision every two months. I've had one already. We talk about where I want to go, my goals, any issues and training." Care staff were yet to receive an annual appraisal as they had not completed a year of employment with the service.

The service ensured they carried out an assessment of people's needs prior to agreeing to provide a package of care so that the service could determine whether they could meet the person's needs. The service did not use a formal assessment template but gathered information on people's health and care needs and used the information provided by the commissioning local authority to compile a care plan. The registered manager explained that people and their relatives were involved in the care planning process and this was confirmed by the people and their relatives who we spoke with.

The registered manager and care staff worked effectively with each other and other healthcare professionals where this was required. Care staff documented daily their observations and tasks that they had undertaken for each person they supported so that information could be exchanged with other care staff, professionals and relatives. For most people receiving a service, family members and relatives were involved in supporting

the person with all their health care needs.

Where required the registered manager and care staff worked in partnership with social workers, GP's and called emergency services to ensure people were supported to maintain their health and wellbeing. One person told us, "I had wounds on my legs and the carer made sure she'd check my legs to see if there was any problem. In the past, they have told my family that certain wounds did not look good." A relative explained, "They're on the ball; so far nothing major has happened, but they would deal with it promptly if something happened."

Good

Is the service caring?

Our findings

People and their relatives told us that they found care staff caring and patient and that they had developed relationships with them which promoted their well-being. One person when we asked if they thought staff were caring told us, "Yes. It's just the way they speak and care for me. They
have a chat with me." Another person stated, "Yes they are; one carer has actually come to visit me in hospital." Relatives comments when asked the same included, "They are very caring; they put up with mum's rudeness and do whatever she wants" and "Yes they are, definitely; it's how they look after her and their patience with her."

The registered manager also undertook caring duties and knew each person well. This also gave them the opportunity to observe staff practice and seek feedback from people and relatives. When visiting people at their home we observed that people and their relatives knew the registered manager and we observed positive and kind interactions between them.
Care staff also knew the people they supported and told us that they had regular people that they supported on a daily basis which was confirmed by people and relatives that we spoke with. This ensured consistency in the care and support people received.

People and their relatives confirmed that they had been involved in the care planning process and that care staff supported them in a way that was according to their wishes and preferences. People told us, "I was asked and I told them what I wanted; washing, feeding." and "Yes I was involved.
I told them what I wanted." Relatives feedback included, "I have seen the care plan and I was involved in setting up the plan" and "I have seen a copy and I was involved; I told them what I wanted and it was accommodated."

Care staff knew the importance of protecting people's privacy and dignity and ensuring that they were respected at all times. Care staff gave a number of examples of how they did this which included, "We maintain confidentiality. This is their life and we do not expose this outside" and "I
cover them with a towel and I make sure I cover them when supporting them with personal care." People and their relatives also confirmed this to be the case. One person told us, "The respect my wishes; I get a bed bath and it's all done with dignity." Relatives feedback included, "Most definitely; they shut the curtains when they're changing her and ask me to leave the room when doing any intimate personal care", "Yes they do. All the personal care is done in the bedroom and they close the door" and "Mum's got dementia, and if she lets them, they do the best they can depending on mum allowing it."

Although care plans did not include information around people's diverse needs and requirements, care staff demonstrated a good awareness of people's identified needs and protected characteristics which included recognition and acknowledgement of people's faith, culture, religion and sexuality. When we asked care staff about equality and diversity and supporting people with any of their protected characteristics one care staff told us, "For me each person is of complete value. That individual is a human being. It makes no difference to me."

Requires Improvement

Is the service responsive?

Our findings

Care plans were not person centred and did not detail people's likes, dislikes, preferences or wishes on how they wanted to be supported. There was very little information on people's background or life history which would have enabled care staff to understand people's needs and provide care that was responsive to those needs.

The registered manager told us that care plans would be reviewed on a six monthly basis or sooner where people's needs changed. However, for people that had been receiving care and support from the service since April or May 2018, they had not had a review of their care plan. For one person we were told that there had been a change in their moving and handling needs and the person now required the use of moving and handling equipment to support their care needs. However, the care plan had not been updated to reflect this.

Where people had specific health and medical conditions, there was no clear definition for care staff to understand what these were and how these conditions affected the people they supported, so that care staff could deliver care and support that was responsive to their needs. One person, whose care plan stated that they suffered with mental health problems and had several hospital admissions due to their mental health, had no further information on their mental health and how it impacted on their daily living. Therefore, care staff had no information to enable them to support this person in a way which was responsive to their needs.

For another person who had specific requirements in relation to their nutrition and hydration needs, a care plan was not available at the office for us to look at. This person required thickening agents to be added to their fluids as they had difficulties in swallowing. We asked the registered manager to send us a copy of the care plan following the inspection but did not receive a copy. We were unable to confirm that the person's care plan was reflective and responsive to their specific need. This meant that care plans did not always contain information to evidence care staff were supporting people in ways which were responsive to their needs. Lack of documented information placed people at risk of harm.

This was in breach of Regulation 9 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

The care documentation did not reflect the actions of staff. For example, people and their relatives confirmed that care staff always listened to them and supported them according to their wishes and choices. Comments from people included, "They listen and respect my wishes", "I tell them what I want and what I don't want" and "Sometimes I don't always want a shower and they respect my wishes." Relatives told us, "Yes, most definitely; they do whatever she wants" and "Yes they do; he will tell them if there's something wrong." Care staff demonstrated a good understanding of person centred care and clearly knew the needs of the people they supported. Comments from care staff included, "It's their choice, what they want. It's about everything they want and it's about their needs not mine" and "It's about the client and putting them at the centre of everything we do."

The service had systems in place to record complaints. The registered manager confirmed that since the service had begun providing care and support they had only received two complaints which had also been raised as safeguarding concerns. We saw documentation confirming the detail of the concerns and the actions taken to resolve them.

People and their relatives confirmed that they knew who to speak with if they had any complaints or concerns and were confident that these would be addressed straight away. One person told us, "I would call the manager and my comments would be listened to." A relative said, "I would call the manager. Yes, she would listen to me and we have spoken about issues; she doesn't make excuses."

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. The provider had some systems in place designed to check and monitor the quality of care that people received with a view to learning and implementing the required improvements. These included medicines administration record checks and spot checks.

However, we found that these checks were not always effective and did not identify some of the concerns that we identified as part of the inspection process. This included the concerns we noted around gaps in recording on MAR's, lack of appropriate documentation authorising covert medicines administration and lack of information on how people should be supported with their medicines. Where issues were identified by the provider's internal processes, details of the actions taken and timeframes within which actions were to be completed were not always recorded.

In other areas there were no audit checks taking place, for areas such as care plans and associated records. Therefore, the registered manager was unaware of the issues that we identified. We found evidence that care records were not up to date and reflective of the care people received. This meant that the service had not kept accurate and complete records for each person in relation to the care and support that they received and the decisions that had been made for them to receive care and support that was safe, effective and responsive to their needs.

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

There were other ways in which the service was well led. People and relatives that we spoke with knew the registered manager and were complimentary of the way in which the service was managed and care and support was delivered. Responses received from people when asked if they knew the manager and what they thought of them included, "Yes I do; she's absolutely brilliant and she's on the ball and knows what she's doing" and "Yes I do; I really like the manager; she's lovely." Relatives feedback was as follows, "Yes, I do. She's very good and keeps everything in good working order" and "Yes, I do; she's very good and listens. If I have concerns she takes action"

Care staff also told us that the registered manager was very good and that they were always available, approachable and supported them in their role at all times. Comments from care staff included, "[Registered manager] is fantastic, very supportive" and "[Registered manager] is so open. I can talk to her. She is completely approachable and she is warm. She has been really helpful and goes out of her way."

In addition to supervision, care staff were also supported through regular care staff meetings which were being held every month at the time of the inspection. Topics discussed at meetings included, CQC requirements, safeguarding, prevention of pressure sores, time management and punctuality and training. Care staff said they found the meetings useful for information exchange, sharing practices and further development and learning. One care staff told us, "They are good. A lady came in once to give us some training." Another member of care staff who was yet to attend a meeting told us, "I got an email to tell me

about the meeting and what was discussed and I also talked to [registered manager] about it."

People and relatives were encouraged to give their feedback about the services that they received. The registered manager told us that she had sent some people a satisfaction survey to complete. Out of the six surveys sent to people and their relatives, the service had received responses from three people/relatives. All three responses were positive but we were unable to see when these comments were from as the forms were undated. We highlighted this to the registered manager.

The registered manager told us that she regularly conducted home visits to people to see how things were going. The registered manager said, "I call the service users directly and I go there myself and do home visits. Records of these are in the folder of person at their home. I also call them sometimes once a week." People and relatives confirmed that the registered manager did regularly visit them.

The registered manager told us that they worked in partnership with the local authority to ensure that people received the care and support that had been commissioned. In addition to this the service also engaged with social workers, district nurses and GP's to ensure people received the appropriate care and support that they required.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and did not detail people's likes, dislikes, preference, personal background or cultural and religious preferences. Care plans were not current and reflective of people's needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity the provider did not act in accordance with the MCA 2005

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's individualised risks had not been assessed so that staff could be provided with guidance on how to mitigate risks so that people were kept safe and free from harm. Medicines were not always managed, administered and recorded safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of quality assurance audits meant that

the provider was unable to identify issues that we identified as part of this inspection. Audits that were being completed were not effective as they did not highlight concerns and issues that were also identified as part of this inspection.

The service had not kept accurate and complete records for each person in relation to the care and support that they received and the decisions that had been made for them to receive care and support that was safe, effective and responsive to their needs.