Housing 21

Housing 21 - Saxon Court

Inspection Report

300 Turves Green Road
Northfield
West Midlands
B31 4BY
Tel: 0370 192 4363
Website: www.housing21.co.uk

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Overall summary

Saxon Court provides personal care and support to 38 people living in their own homes and to 38 people who live in an extra care facility. The extra care facility had a number of communal areas and provided dining services, a shop and a hairdresser which were available to people using the service.

Our inspection took place over two days and was carried out by a Lead Inspector and an Expert by Experience. We needed to follow up on some areas where we asked the provider to make improvements as they had not met the regulations at their last inspection in September 2013. These were in relation to the administration of medication, monitoring and assessing the quality of the service and record keeping. We have reported on our findings in these areas as part of this report.

People who used the service said they received care from kind and compassionate staff. Some people felt staff were rushed and some people commented that the management of the service could be improved upon. The majority of people felt that they were listened to and were generally happy with their care and support.

Staff described being supported by the service and told us they had received training in delivering safe and appropriate care. However, several members of staff told us that the training they had received in relation to administering medication had been “basic”. Many staff did not feel confident in this area. Staff also commented that the service lacked a consistency of management and that this impacted on the quality of care.

We found that medication was not being administered to people safely. We found a high number of medication gaps in recording and medication errors and saw that management checks had not been carried out effectively in relation to the administration and recording of medication. This posed a risk to people using the service. We found that one person had missed their care calls and as a result had not received their required medication. Staff training in this area was not adequate and needed to be improved to ensure that staff were safe and competent in administering medication.

Although safeguarding policies and procedures were in place we found that one allegation of abuse had not been responded to appropriately. This put vulnerable people at risk.

Care plans and risk assessments were detailed and relevant to the person they were written for. Staff had enough information about the people receiving care and people’s personal preferences and histories were included. People’s health and well-being was being recorded and responded to.

The service did not have a registered manager in place at the time of our inspection and there had been no consistent leadership at the service for some time. Staff were not clear when this would be resolved.

Complaints and concerns had not always been recognised as such and so had not been dealt with appropriately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that risks associated with people's care delivery were clearly documented in their care plans. This had been an area we had asked the provider to improve on following our last inspection at the service. We found that care plans and risk assessments now contained enough information to enable staff to deliver safe and appropriate care to people.

Safeguarding policies and procedures were in place at the service and staff had received training in this area. Staff we spoke with understood how to recognise and report abuse. However, we found that a recent allegation of abuse had not been responded to appropriately and the relevant agencies had not been notified. This had put people using the service at risk. This meant there had been a breach of Regulation 11 of the Health and Social Care Act 2008.

We looked at the administration of medication at the service as this was an area in which we had asked the service to improve following our last inspection. We found that the service now had robust risk assessments and care plans in place in relation to the administration of people's medication. However, we found had been a high number of medication errors occurring at the service and management checks were ineffective. Staff reported to us that they did not feel confident in administering people's medication and we found that training in this area could be improved. This meant there had been a further breach of Regulation 13 of the Health and Social Care Act 2008.

We found there were policies and procedures in place at the service in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's best interests were considered when they lacked the capacity to make decisions about their care and treatment themselves. However, staff training and understanding was limited in this area.

Are services effective?

The majority of people we spoke with at the service were happy with the care being delivered by staff. They felt that their needs and wishes were listened to.

Care records were detailed and contained people's personal preferences and an assessment of their needs. Daily records were being kept by staff and people's health and well-being was monitored and recorded by the service. Relevant health professionals were involved in people's care when necessary.

Summary of findings

People were cared for by staff who had been trained in delivering safe care. However, we found that training in relation to the administration of medication could be improved upon. Staff did not feel confident in this area and we found a high number of medication errors and gaps in recording at the service. We also found that staff had limited understanding and training in relation to the Mental Capacity Act.

Staff were supported and received regular supervisions and appraisals. There was a programme of competency checks on staff to monitor their performance and provide them with support.

Are services caring?

People told us that they received care from staff who treated them with respect and who maintained their dignity. People felt that care workers were kind and compassionate but felt that improvements could be made in relation to how the service was being managed.

There was an equal opportunities policy in place and people's care was delivered with consideration to their personal and cultural needs.

Staff reported that they understood the needs of people they were caring for and they were able to describe how they ensured people's privacy and dignity. We did observe one staff member entering a person's property without knocking. The manager informed us that this would be addressed with all staff following our inspection.

People were able to express their views about how the service was being run through regular meetings and through being contacted for feedback.

Are services responsive to people's needs?

The majority of people felt listened to at the service and we saw evidence that the service was responsive to changes in their health and well-being. Care plans and risk assessments provided staff with up-to-date information which was regularly reviewed.

Staff felt that people received the care they required at the service but several members of staff told us that they would benefit from having more time to spend with people and being less rushed.

Care plans considered the risk of people being socially isolated and there were arrangements in place to enable people to access social activities which may interest them. We observed people enjoying time in communal areas and accessing the local services in place at the complex.

Summary of findings

Complaints and concerns, when logged, were dealt with in line with the policies and procedures in place at the service. However, we found that one relative had made complaints which had not been recorded and adequately dealt with. This meant there had been a breach of Regulation 19 of the Health and Social Care Act 2008.

We found that arrangements were in place to ensure that people's rights were upheld should they lack the capacity to make decisions about their care and treatment.

Are services well-led?

We found that there was no registered manager in place at the service at the time of our inspection. People using the service and staff told us that there had been no consistent management in place for some time and that this had impacted on the quality of care being delivered.

We found that an allegation of abuse had not been notified to CQC as required by law. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008.

There were a clear set of values in place that emphasised people being encouraged to remain independent and which focussed on people being treated with respect. Staff were able to demonstrate how these were embedded into their practice.

Staff had a schedule of training in place, however, we found gaps in relation to the administration of medication and the Mental Capacity Act.

The service lacked strong leadership and the result of this was a negative impact on the quality of care.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 15 people who used the service as part of our inspection. Our Expert by Experience spoke with seven people in their own homes and we contacted a further eight people by telephone to ask them about their experiences of using the service. We also spoke with the relatives of three people who used the service.

People were positive about the care the staff working at the service delivered to them. People described being treated with respect and many of them described having positive relationships with the people who delivered their care. We spoke with one person who was unhappy about their care and support, however, they were positive about the care staff. This person felt that their care was not being managed well at the service. One person told us, "The carers are good to me and nice." Another person said, "I've got no complaints."

The relatives we spoke with were happy with the training and competency of the care workers at the service. One relative we spoke with was unhappy about how the service was being run and felt that this had impacted on the quality of care their relative received. They told us, "There were more carers when she first came here. They don't have time now." Then went on to say, "I think the carers do their best but they're too rushed."

Both people using the service and their relatives expressed concern about how the service was managed and felt that improvements could be made in this area.

Housing 21 - Saxon Court

Detailed findings

Background to this inspection

This service was inspected as part of the first testing phase of the new inspection process we are introducing for adult social care services. 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Before our inspection we reviewed all the information we held about the home, contacted the local authority and reviewed the inspection history of the service. We needed to follow-up on some areas of care which did not meet the regulations at the last inspection. We focused on how the service managed people's medication, looked at how the service assessed the quality of care provision and reviewed the records held at the service to see if the required improvements had been made.

We visited the service on 29 and 30 April 2014. The inspection team consisted of a Lead Inspector and an Expert by Experience who had experience of working and caring for people with dementia as well as a professional background in mental health and the voluntary sector.

We spoke with 15 people who used the service as part of our inspection and the relatives of three people who used the service. We spoke with people in their homes, talked to them over the telephone and observed care being delivered to them at the service.

We spoke with the manager at the service and 11 members of staff during our inspection. We looked at a number of records including people's care records, staff records and reviewed the policies and procedures in place at the service.

Are services safe?

Our findings

During our inspection of the service we spoke with 15 people who used the service, the relatives of three people using the service and to 11 members of staff. We wanted to ensure that people felt safe with the people who provided their care and that systems were in place to ensure people received safe and appropriate care. We needed to follow-up on some areas of concern which were highlighted during our last inspection in September 2013 which found some issues with the way in which medication was handled and administered at the service.

We found that most of the people we spoke with were happy with the care they received and that they felt safe with the carers who came into their homes to deliver this care. However, one person we spoke with did not feel safe living at the service. They told us, "I get scared sometimes." We observed a carer entering this person's property during our visit without knocking and without due regard being given to this person's rights and dignity. We discussed the care being delivered to the person with their relative who told us, "She's become quite insular since she's been here." The relative believed the service to be poorly managed and told us that they felt there was, "No back-up plan." This person did not feel safe using the service and we found that there had been missed calls which had resulted in them not receiving their medication recently.

We looked at this person's care records in detail in order to establish whether they were receiving safe care at the service. We found that there had been several occasions when their care had not been delivered to them as required. This person had not received a care call on the weekend prior to our inspection and this had resulted in them missing some of their medication. When we looked back at their care records we found that additional calls had been missed and their medication had not been administered as a result. This person was not able to administer their own medication due to their condition. We found that, on one occasion, only one care worker had attended a call to this person instead of two, which had resulted in them not being taken to the toilet as required. We found that this person's care was not being delivered to ensure their safety.

There were clear safeguarding policies and procedures at the service and both staff and people using the service were given information about how to report incidents or allegations of abuse. All of the 11 members of staff we spoke with reported to have received training in safeguarding vulnerable people and were able to name different types of abuse. We saw from staff training records that training had been delivered in this area. However, from looking at people's records, and the records of incidents at the service, we found that one incident had not been reported as it should have been. This was an allegation of financial abuse and it had not been reported to the relevant agencies. Therefore appropriate action had not been taken by the service in relation to this. People were not being protected from abuse as the service had not taken steps to ensure people's safety. This was a breach of regulation 11 of the Health and Social Care Act 2008 as the service had not responded appropriately to an allegation of abuse. The action we have asked the provider to take can be found at the back of this report.

During our last inspection we found that improvements needed to be made in relation to how the service recorded the levels of support people needed with their medication. Risk assessments in relation to people's medication needs did not clearly detail the support people required and provide guidance for staff on how to ensure people received their medication safely. During this inspection we found that all care plans and risk assessments in relation to people's medication needs had been revised and updated. We found these to be detailed and comprehensive and risks were clearly identified. However, we found further areas which indicated that people were not always having their medication safely administered to them.

We looked at all incidents and accidents at the service and found a high number of medication errors by staff. We found gaps in recording and instances where people had received the wrong quantities of their medication. We asked staff about the training they received in relation to the administration of medication. Several members of staff told us that they felt that the training was too basic and that this could be improved upon. One staff member told us, "I think they could improve on the medication training." Another staff member said that the medication training, "Wasn't very adequate to be fair." We found that staff were given in-house medication training when they started working at the service and that they were then required to shadow an experienced member of staff. We were told that a number of competency checks were carried out on staff in relation to administering medication, however, many of

Are services safe?

the staff we spoke with did not feel confident in this area of care. We reviewed medication records and found that medication was not always being administered safely to people using the service.

We found a high number of medication errors recorded at the service. We looked at medication administration records (MAR) and found that these were not always adequately completed by staff. For example, we found that there were gaps in some of the records with no explanation about whether the person had received their medication or not. We found a number of instances when people had missed their medication and instances when people had received the wrong quantity of their medication. We found that, although there was a system of auditing medication records in place, these audits were not done effectively. We found that some audit sheets did not indicate the dates being audited and that they failed to explain and act upon the medication errors or gaps found. We raised this with a senior member of staff who told us that these audits had not been carried out effectively. This meant that people were not having their medication administered to them safely at the service. This constituted a breach in regulation 13 of the Health and Social Care Act 2008 as the registered person was not ensuring that people were being protected from the risks associated with the unsafe management of medicines. The action we have asked the provider to take can be found at the back of this report.

During our last inspection we found that risk assessments were written generically for people and that they lacked the detail required to ensure people received safe care. We found that some areas of potential risks had not been included and there were inconsistencies in the records we looked. We reviewed care plans and risk assessments during this inspection to ensure the required improvements had been made. We found, on this inspection, that improvements in this area had been made. The risks associated with the delivery of people's care were detailed in their care records. We found these contained information for staff on how to minimise these risks to ensure that people received care which was appropriate and safe. We found the risk assessments we looked at to be detailed and to contain enough information to ensure people's care was delivered safely. The majority of people using the service described receiving care from staff who were well trained and who treated them with respect.

We found there were policies and procedures in place at the service in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). However, we found that staff training in this area was limited and staff did not have a good understanding of this area of care. We saw that people had consented to their plans of care and that systems were in place to ensure that people were protected should they lack capacity to make decisions about their care. Consent was sought and obtained in relation to people's medication and arrangements put into place when they lacked the capacity to consent. Although staff understanding could be improved upon by further training there were procedures in place to ensure that people's best interests were considered when they lacked the capacity to make decisions about their care and treatment themselves.

Are services effective?

(for example, treatment is effective)

Our findings

The majority of people using the service who we spoke with during our inspection described being cared for by staff who understood their needs and who respected their wishes. People told us that they were comfortable approaching the management of the service if they had any issues and that they felt these would be listened to.

We looked at the care records of eight people who used the service and found these to include an assessment of people's care needs and their personal preferences in relation to their care delivery. We found care plans to be detailed and found that they contained guidance for staff on how the care should be delivered to people. We found that care plans and risk assessments were regularly reviewed and updated in order to reflect the changing needs of people using the service.

We saw that daily records were made by staff in order for people's well-being to be monitored and recorded. We saw evidence that health professionals were involved in people's care and that they were liaised with whenever necessary. People's health was being monitored by the service and relevant health professionals were detailed on their care plans and consulted with.

During our inspection we saw people using the service came to the office for advice and guidance in relation to their care. We observed that staff understood people's needs and that they listened to them and acted upon their requests.

We spoke with staff working at the service. Most of the staff believed that people received good quality care. Some staff told us that communication between management and staff could be improved upon and that they did not always feel listened to. One staff member told us, "The office is chaos. I don't know how they know what's going on in the building." Another staff member said, "The communication could be improved on." Staff did not always feel they had time to spend with people using the service and so could not fully understand their needs and preferences.

We found that people were cared for by staff who had received adequate training in delivering safe care. However, we found that the medication training delivered on staff induction could have been improved upon. Staff described this training as basic and we found that this had impacted on how medication was being administered at the service. The service had recently employed a training co-ordinator who staff working at the service spoke positively about. We spoke with the training co-ordinator who told us about a number of improvements in the service in relation to staff training. We found that staff were trained in delivering safe and appropriate care although there were training gaps in relation to the Mental Capacity Act (MCA) and in relation to the safe administration of medication.

Staff received regular supervisions and appraisals and there was a programme of competency checks carried out on staff on a regular basis. These were carried out in order to ensure that staff were delivering safe and effective care. Some staff reported to us that they did not feel as confident as they should in administering people's medication. One staff member told us, "I think they could improve on the medication training." We found that medicines were not always being administered and recorded safely and this gap in training could have contributed to this.

There was no workforce plan in place at the service to indicate how staff would be developed. However, there was a structured induction and the training co-ordinator we spoke with had made some improvements in the training and development opportunities in place for staff.

Are services caring?

Our findings

We spoke with 15 people who used the service and they all spoke positively about the care workers who came into their homes to deliver their care. They described being treated with respect and many people told us about how their dignity was maintained during their care delivery. One person told us, "They're very good. I've got a rota of who's coming and what time. I'm very pleased with them. I never thought I'd have carers like that." Another person said, "They've become friends." People were less positive about the management at the service and several people felt that this could be improved upon.

We found there to be an equal opportunities policy in place at the service and staff were able to describe treating people without discrimination. We found care plans to contain people's personal histories and cultural needs to ensure that the staff delivering their care had information to enable them to do this appropriately. Care plans were individualised and provided information to allow care workers to understand the person they were caring for.

Staff we spoke with were able to describe how they ensured people's privacy and dignity was maintained whilst delivering their care. However, during our inspection we did observe one member of staff entering someone's property without knocking. We asked the person if they were comfortable with this and they told us that they were not. We raised this with the manager at the service during our inspection who told us that this would be looked into. The majority of staff we spoke with were positive about their role at the service and told us that they delivered good quality, person-centred care, although some felt at times they were rushed due to the length of time allocated to calls. One staff member told us, "The quality of care is good here. You do get time to do the person-centred care." Another staff member said, "I like it. I like the independence of the place. They still have rights and choices." Care plans reflected that people were being encouraged to remain independent whilst being supported as they required.

We found there to be a schedule of regular meetings held for people who used the service. We looked through the notes from these meetings and saw that people were able to express their views about how the service was being run and raise any issues which they felt needed to be addressed. We found that these issues and concerns were recorded at the service and that the management attempted to address them. During our inspection we observed people using the service coming to the management office to discuss any issues or concerns they had, either with their health, or with the environment they were living in. We observed staff dealing with these concerns with compassion and saw that they were assisted where needed. We also found that people were contacted, either over the telephone or in person, to find out how they felt about the care and support they received at the service. This meant that people who may have been more vulnerable or less physically able were able to express their views about how the service was being run.

There was a dignity charter in place at the service in which the importance of independence and choice were emphasised. We also found there to be a policy in place in relation to delivering person-centred care and we saw evidence of how this was being applied in practice through the care plans we reviewed and from speaking with staff delivering people's care. We found that the induction into the service placed an emphasis on person-centred care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During our inspection people told us that they were cared for by staff who listened to their needs and who responded to any changes in their health. One person said, "They ask every morning if we're alright." People described being able to express their views to the people who were caring for them. However, two people told us that they felt the care workers were too rushed to spend the time they needed with them and they felt that this impacted on the quality of care they received. The relative of someone using the service told us, "I think the carers do their best but they're too rushed."

We found that arrangements were in place to ensure that people's rights were upheld should they lack the capacity to make decisions about their care and treatment. There were policies and procedures for staff to follow and these were in place to ensure people's best interests were represented.

We saw that care plans and risk assessments referred to people's individual needs and that these were regularly reviewed and updated by people involved in their care. People were involved in the care planning process and there was evidence that people's changing needs were responded to in the way their care was delivered.

Care plans considered people being at risk of social isolation. As people were living in their own homes within the complex, the service had given due regard and consideration to bringing people together to ensure they did not become socially isolated. There was a shop and a hairdresser on-site and we saw people regularly accessing these services. People were able to meet in communal areas and spend time with one another. We found that there was a programme in place for social activities that people may enjoy and people were kept informed about what these were. There was a social committee in place which was led by people using the service and this enabled people to decide how they spent their time.

We looked at how complaints and concerns were handled at the service to ensure that these were investigated and responded to appropriately. We found there to be a complaints policy in place and people were given information about how to make a complaint. This information was provided to people in their own homes and details were available in the communal areas of the complex.

We looked at the record of complaints held at the service and reviewed how these had been responded to. We found that those complaints which were logged, had been responded to adequately. However, we spoke with the relative of someone using the service during our inspection and found that many of their concerns had not been adequately dealt with by the service. We found that issues raised had not been recorded and found that the person using the service and their family had felt that their concerns were not being listened to or responded to. We asked the manager at the service about this during our inspection. They agreed that these concerns needed to be fully investigated and this was done following our inspection. The service needed to ensure that all concerns and complaints were recorded and responded to in line with the policy in place. Although the logged complaints had been responded to appropriately we found evidence that not all concerns and complaints raised with the service had been recorded as such. This was a breach of regulation 19 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

Are services well-led?

Our findings

As part of our inspection we looked at the management of the service and how this impacted on the care provided to people. We wanted to ensure that effective management and leadership was in place which produced good quality care for people. We spoke with 15 people using the service, the relatives of three people using the service and 11 members of staff in order to do this. We found that there had not been consistent, strong leadership at the service for some time and that this had impacted on the quality of care people received.

One person who used the service described raising concerns with the management at the service but told us that they had not felt listened to or that their issues had been responded to effectively. They told us that the result of this was that they had lost their trust in the provider of the service. A relative we spoke with told us that they felt the organisation was not being run effectively and that concerns and complaints often got lost and were not responded to. The relative commented, "I'm constantly on their back about some things." Another person who used the service told us, "They don't tell you anything."

Staff we spoke with were positive about the teams they worked within and told us that they felt supported by the senior care team at the service. We found that there was a schedule of supervisions, appraisals and competency checks on staff to support them and ensure they were able to carry out their roles effectively. However, several members of staff expressed concerns about the management of the service and told us that this had undergone a lot of change. Some of the staff we spoke with felt that this had resulted in disorganisation. One staff member said, "There's no organisation, there's no manager. The office is chaos. I don't know how they know what's going on in the building." Another staff member commented, "They haven't got the management sorted."

We found there was a lack of consistent leadership at the service. There was no registered manager in place at the time of our inspection and a temporary manager was overseeing the service. Staff were not clear about the long term management arrangements at the service and the result of this was that the service lacked a clear sense of purpose and direction. We found that staff and people using the service had experienced the impact of this and concerns about this were raised with us during our inspection.

From looking at the record of incidents, accidents and safeguardings at the service we found that the majority of incidents had been reported as necessary. Most safeguarding incidents had been reported to the relevant agencies. However, from speaking with the relative of someone using the service during our inspection, we found that an allegation of abuse had not been responded to appropriately by the management at the service. This incident had been recorded and an investigation commenced, however, the allegations made had not been acted upon by the service. We highlighted this during our inspection and the manager of the service explained that this had been the result of a lack of management at the service during this time. As this was a safeguarding issue which needed to have been reported on promptly this indicated a lack of effective management at the service. The service had not met CQC requirements to notify us of all the events they are required to by law and this had put people at the service at risk. The safeguarding notification should have been sent to the appropriate authorities. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

We found that some calls had been missed during our inspection and this was due to a shortage of staff. Many staff expressed to us that they were rushed on their calls and that often they had to cover for people who were off work. One staff member told us, "You're trying to do two people's work sometimes." Another staff member said, "There are days when you have to cut calls short because there aren't enough staff." The impact of this was that people had not received the care they required and improvements needed to be made in order for the management of the service to effectively assess and monitor staffing levels to ensure people received safe and appropriate care.

We spoke with 11 members of staff over the course of our two day inspection. Staff described delivering good quality care to people but three members of staff felt that they would benefit from having more time to spend with people to understand and respond to their needs. One staff member told us, "You are trying to do two people's work

Are services well-led?

sometimes." Three members of staff described being rushed in their work due to a lack of staffing and felt that this had an impact on the quality of care they were delivering to people. These members of staff felt that more staff would enable them to respond to people's changing care needs and provide a better quality of care. This was a breach of regulation 22 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

We found that there were a number of checks in place in relation to care planning, medication, incident and accidents and complaints. However, we found that there was no management overview in relation to some of these. For example, we found some of the medication audits we looked at failed to show the period of time being audited and many medication errors and gaps in recording medication were not adequately explained and appropriate action had not been taken. As there was not a permanent manager in place at the service these checks had not been monitored to ensure they were being carried out effectively. The systems in place were not effectively monitoring the quality of care being delivered to people. This may have resulted in people receiving unsafe care. One person using the service described a number of times their medication had been missed due to calls not being attended. There was no management data on numbers of missed calls and it was not clear during our inspection how the management were ensuring that people received the care they required. This was a breach of regulation 10 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

Although we found that staff had received training in key areas of delivering appropriate care to people we found that staff were not always confident in administering medication to people. Training was delivered to staff on their induction into the service. Staff described this training as "basic" and many felt that improvements could be made in this area. From looking at medication audits were found a high number of medication errors and unexplained gaps in recording medication at the service.

There was a clear set of values in place at the service which focussed on people's independence, choice and dignity. These values talked about respect and empowering people to remain independent for as long as possible. We found that staff were knowledgeable to these aims and they described how their work reflected these values. The majority of people we spoke with described care which reflected these aims and objectives.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: There were no systems in place to monitor and assess calls. The provider did not have systems in place to measure the quality of the service in terms of calls being missed. Regulation 10 (1) (a)

Regulated activity	Regulation
	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse How the regulation was not being met: The service had not responded appropriately to an allegation of abuse as this had not been reported to the relevant agencies and action had not been taken in relation to the member of staff concerned. Regulation 11 (1) (b).

Regulated activity	Regulation
	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of Medicines How the regulation was not being met: People were not having their medication administered to them safely as there were not systems in place to ensure this was being done safely. Staff did not feel adequately trained to administer people's medication safely. Regulation 13.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Notification of other incidents

How the regulation was not being met: The service had not notified the commission of an incident as required by law. Regulation 18 (1) (e)

Regulated activity

Regulation

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

How the regulation was not being met: The service had not recorded all complaints received in line with the policy and procedure in place. Complaints had not been dealt with appropriately as a result. Regulation 19 (1) (c).

Regulated activity

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010

Staffing

How the regulation was not being met: The provider had not ensured that there were sufficient numbers of staff to meet the needs of people using the service. Regulation 22