Mrs Helen Lise Cass

Safe Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

Safe Care provides domiciliary care and support services to people with individual needs in their own homes. At the time of our inspection 45 people were being supported by this service. This inspection took place on 3 May 2016. This was an announced inspection which meant the provider had prior knowledge that we would be visiting the service. This was because the location provides a domiciliary care service, and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

The service is registered as an individual provider and did not have a condition requiring a registered manager to be in place at this service, as the provider was in day to day control. The individual provider is responsible for the day to day running of the location, and has the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. People, their relatives and staff referred to the provider as the manager, but throughout this report we have used the term provider. The provider was accessible and approachable throughout our inspection.

Staff had not received the appropriate training relevant to their role. We identified gaps in the training records. Where staff had received training some of this had been completed but dated as far back as 2006.

Care plans did not provide enough information about a person and their health condition. Risks to people were not fully documented and action plans had not been put in place for staff to follow.

The provider did not have effective systems in place to monitor the quality of the service. This had been started previously but had not been consistently completed. The provider confirmed that she was more comfortable with the hands on caring side, than the paperwork part of the job.

The provider took measures to keep people safe. This included a handbook which helped people identify staff on care visits. New members of staff met with people prior to supporting them. Staff told us they would not hesitate in reporting any concerns to the provider. There were safe recruitment processes in place to ensure that only suitable staff were allowed to work with vulnerable adults.

People were supported to access healthcare services to maintain and support good health. Staff were vigilant in noticing changes in people's health conditions.

People and relatives were very complimentary about the caring nature of staff. Staff were knowledgeable about people's needs and we were told that care was provided with patience and kindness. People's privacy and dignity was always respected.

People were encouraged to give feedback on the service they received and were able to discuss their care needs on a regular basis with the provider.

The provider was a very visible and available presence for people and completed regular care visits. Staff spoke highly of the provider and her approachable nature and felt confident to discuss any concerns they had.

We found breaches of the regulations. 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?

Good

The service was safe.

People told us they felt safe. Steps had been taken to ensure people felt safe during care visits that took place in their own homes.

Staff had been recruited following safe recruitment procedures. This ensured they were safe to work with people before they began their employment.

People's medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received all the required training relevant to their role in order to effectively meet people's needs.

Staff were well supported with regular supervisions with the provider which offered the opportunity to discuss performance and progression.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and were supported by staff who had got to know them well. Relatives praised staff for the consideration shown to their loved ones.

People's dignity was upheld by staff who afforded them time and space during care visits.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked detail on the specific health conditions people had and were not always person centred.

Where risks had been identified there was not a full assessment in place or a subsequent plan of action.

People were encouraged to provide feedback on the service they received.

Is the service well-led?

Requires Improvement

The service was always well-led.

There were not effective systems in place to monitor the quality of care and support that people received.

The provider was a visible presence for people and attended regular care visits. People spoke highly about the provider and the reputation of the service.

Staff felt supported by the provider and were confident they could approach her with any concerns and these would be listened to and acted on.

Safe Care

Detailed findings

Background to this inspection

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

This inspection took place on 3 May 2016. This was an announced inspection which meant the provider had prior notice that we would be visiting. This was because the location provides a domiciliary care service to people in their own homes, and we wanted to make sure the provider would be available to support our inspection, or someone who could act on their behalf. The inspection team consisted of one inspector, and an expert-by-experience who made phone calls to people to gain their feedback on using the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was previously inspected in June 2013 which was a focused inspection to check the provider had made the necessary improvements identified from the previous inspection in March 2013. The provider was found to have made improvements and was meeting these standards. This inspection was the service's first rated inspection.

Before the inspection we checked the information we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also reviewed the provider information return (PIR) prior to this inspection. 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 used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eight people being supported by the service and eight relatives, six staff members and the registered provider. We reviewed records relating to people's care and other records relating to the management of the service. These included the care records for six people, medicine administration records (MAR), three staff files and the provider's policies.

We undertook visits to three people in their homes to chat with them about the service they received and one of these visits included observing a member of staff. We made telephone calls to people using the

service and their relatives and staff members.

Good

Is the service safe?

Our findings

People using the service told us they felt safe. One person said "I really feel safe". Another person told us "If I have a fall the carer will stay with me until the ambulance arrives". A relative commented "I have no concerns, they are very trustworthy". We saw in people's care plans they had been provided with a service handbook, which gave people information on how to identify a staff member. This ensured people could be sure they were allowing the right person into their home. The handbook identified safe care staff by their uniform colours and their identification card, including details of what should be on the card.

The provider introduced new staff to people before they attended care visits so people were familiar with who would be supporting them. Relatives commented "Never had anyone just turn up that we didn't know, or the manager will come", "They introduce all new staff". Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff all received a copy of the 'No secrets' handbook (guidance on protecting vulnerable adults) and we saw staff had signed to say it had been read. One staff member said "I would report any concerns straight away, you don't tolerate anyone not doing a job properly".

The provider was also proactive around ensuring staff safety when attending care visits. Each staff member was issued with a personal alarm and a torch, which were checked at each supervision to make sure they worked or would be replaced. Access to one person's house was across a field and in the winter months the provider had two staff attend the visits to keep each other safe despite the person only needing one staff member for support.

People and staff had 24 hour access to an on-call number, which out of office hours diverted to the provider's mobile. The provider said she was even reachable when on holiday if someone needed her, but was looking to recruit a field care supervisor to share the on call with.

We reviewed the accident and incident's folder and there was only 3 recorded, the last accident took place in 2013. This had been recorded appropriately with information about the accident, and the action that had been taken.

The provider explained that recruitment had been hard, and for this reason some care packages that had been referred to them had been declined. The provider said they would not take on care visits unless the staff were in place first and they could ensure that the service could meet people's needs.

We looked at staff rotas for the previous weeks and saw they were consistent and did not change unless someone was on holiday or off sick. The provider also had a rota of care visits she attended and covered shifts where required. Where able people sign the staff rota to say a visit was completed and these are returned to the office. Staff told us there was enough staff and they were able to give people the time they needed. One staff said "There's enough staff, no rush between visits". Relatives told us "They have never missed a visit" and "No missed calls they always ring if late. Call times were pre-agreed and they come at this time".

Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character which included sourcing two references, driver vehicle declaration's, identification checks and a Disclosure and Barring Service checks (DBS). A DBS check helps employers make safer recruitment decisions and prevents unsuitable people working with vulnerable people.

We viewed the selection and recruitment staff policy, which documented that notes from potential candidate questions should be recorded during the interview process. The provider said there was a form available to fill out but this had not been done previously. The provider also took into account the attitude and personality of potential new employees commenting "It's about feeling comfortable with them, and if I feel they could look after my mum and dad. I like to go out with them so I can observe them in the community, chat with them about why they want to do care work and be honest about care work involves".

People's medicines were managed and administered safely. People had medicine management plans in place which documented all the medicines they were taking, any allergies, and if they were independent in taking their medicines or required a level of support. This had been signed by the person. One person told us "I do my own medicines and the staff check I have taken it, they support me they don't take over". When completing visits to people's homes we checked the MAR's and saw they were completed correctly and there were no missed signatures.

The provider told us there had been one medicine error in the past and immediate action had been taken. The care coordinator of the GP surgery had been contacted and told which medicines the person was on and which medicine the error concerned. A conversation was held between the service and the GP about how this would be prevented in the future.

One person had been prescribed 'medicine as needed' (PRN) but there was no protocol in place for staff to follow when administering this type of medicine. The provider told us this person had capacity and was able to tell staff when they needed the PRN medicine. We looked at the provider's policy on medicine and saw there was no information on PRN medicines, medicine disposal or controlled drugs management. We raised this with the provider who said they would review the policy.

Requires Improvement

Is the service effective?

Our findings

Staff had not received all the required training relevant to their role in order to effectively meet people's needs. Staff comments included "I have not had recent training, I did some last year", "As far as I know I'm up to date on training" and "I need to do my first aid training". We looked at some staff files and saw each staff member had a training and development folder in place, containing certificates of training. However some of these certificates were dated from as far back as 2006.

We viewed the training log and saw staff were not up to date with relevant training. For example only three staff out of 12 had completed training in mental capacity and this was completed in 2012. Five staff had completed safe handling in medicines training, three of which did this in 2010. Only one member of staff was up to date on manual handling training. For Infection control training three staff had done this in 2013. One person had received fire awareness training in 2009, and two carers had completed training in health and safety for carers which took place in 2009.

Only two staff had completed abuse awareness training, one of which took place in 2006 and the other in 2009. One staff had completed safeguarding training in 2009. We looked at the provider's policy on protection of vulnerable adults which stated, 'Staff will receive appropriate training in detection of abuse'. This had not happened in line with the provider's policy.

The majority of staff had completed further qualifications with five having done their NVQ health and social care level two, and four staff had completed level three. The office had a room for theory training and a further room for practical training which contained a hospital bed and a stand aid for staff to apply and practice learned skills. The provider was also a professional trainer in manual handling, elder abuse and medication, as well as being a qualified NVQ assessor. The provider informed us that staff had recently attended SSKIN bundle training (model to detect and prevent pressure ulcers) at the hospital and one staff had attended end of life training. Other staff had attended first aid training the week prior to our inspection which had not yet been logged on their training records as the provider was waiting for the certificates.

We spoke with the provider about the gaps in staff training and were told it had been a struggle to get staff on training due to courses not being held very often or problems in covering the work shifts. The provider said she thought online training would be better for staff to fit around their personal lives but admitted that hadn't seemed to work either. The provider commented "Staff have knowledge and understanding of what people need despite not having had their training up to date". One person we spoke with said "The staff look after me well, they are very good and they do have the skills". After our inspection the provider informed us that Wiltshire Council have set training in safeguarding for 22 April 2016 and the provider planned to book between six and eight staff on this training.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if new employees were effectively inducted into the service but the provider explained

there had not been any new employees to the service for a while. The staff had been with the service for long periods of time. The provider had not kept information on staff's induction progress so we could not look at this. The provider told us for future new employees she wants to start them on the care certificate induction. Staff told us their induction had consisted of time to look at the care plans and policies in the office and a period of shadowing the provider for up to two weeks. In this period staff were able to meet with the people they would be supporting.

People were supported by staff who had supervisions (one to one meeting) and an annual appraisal (review) with the provider. Staff told us supervisions were carried out regularly and enabled them to discuss any concerns they may have had. One member of staff told us "We have regular supervisions; it's useful to have feedback". Another staff commented "Supervisions are good, can say what I feel". We saw staff files contained copies of letters sent to staff informing them when a supervision or appraisal was due. The letters would state if the supervision was an office based or an on-site observation supervision and which person's home this would be held at.

We viewed some of the documented supervision records and saw discussions were held around staff development, workload, overall performance and any other issues they wished to discuss. These forms had been signed by both the provider and employee.

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 legally authorised under the MCA. For people receiving care in their own home, this is as an Order from the Court of Protection. The provider confirmed this didn't apply to anyone receiving the service at the time of this inspection, but if a person's capacity deteriorated, this would be assessed and the GP would be called or the provider would liaise with the mental health team.

We saw in one person's care plan that their relative had signed the care plan, and it was documented they had Power of attorney (POA). It did not record what decisions they could legally make on behalf of the person or if the POA had been seen by the provider. We addressed this with the provider who said she had not seen the document and agreed it should not be recorded in the care plan. The provider further said the POA had been drawn up but not officially registered yet so was not actually in place. From this the provider told us she is going to send out letters to people to ask them if they have a POA in place and if so request a copy.

If a person had requested support with food and drink staff would prepare a meal of their choice. If a person was losing weight and there was a concern a food and fluid monitoring chart would be put in place. With the person's permission staff would weigh people and record this on a weight chart to help the person monitor this and feed back to the GP or dietician. We saw it was documented in care plans that staff should always ensure a person had fluids topped up and left in accessible reach to them.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. We saw in one person's daily records staff had recorded when the person felt unwell and had taken action notifying the provider to seek advice and a GP had been called for that person. One person told us "When I'm in pain they support me". During our visits to people we saw the SSKIN bundle tool was being completed consistently by staff, which checked pressure relieving equipment such as a mattress or cushion and any pressure areas a person may be susceptible too.

The provider told us the service has not always been informed when a 'Do Not Attempt Resuscitation' (DNAR) form has been put in place, and has only known by seeing one at a person's house. The provider said there is only one person currently with a DNAR and the document is incomplete. This is going to be addressed with the family and ensure when one is in place, a copy is kept in the care plan and at the office so all staff are aware.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and were supported by staff who had got to know them well. Comments from people included "Staff are caring, they are there for me, they are supportive, and know my needs well", "All the carers have got to know me very well", "The manager said we work around you", "If I need anything slightly differently then I can ask and they will listen" and "Lovely carers, had Safe Care for a while, it's the best company".

Relatives also praised the staff and service for the consideration and care shown to their loved ones saying "The carers are good girls, they are on the ball, fantastic", "It's not just a job to them, I have never seen the staff in a rush", "Staff stay for a little chat, they are friends", "Staff are competent, very reliable" and "Punctuality is excellent. I know exactly where I am". One member of staff told us "If you don't care you shouldn't be in the job".

During one of our visits to a person's home we observed the member of staff arrive exactly on time and knock before entering the person's home despite there being a key safe. This staff member immediately called out to let the person know who it was. Whilst the person was being supported with personal care we heard the staff member engage the person in a conversation and they chatted easily throughout comfortable in each other's company.

Another person told us about an occasion they had gone into hospital and the provider had asked if they wanted a member of staff with them. This person said the provider had also rung the hospital to enquire how the person was doing. One person's relative said "It's not in the plan to make breakfast but they will if I'm not there".

People were given consistency by receiving support from regular care staff. The service would provide people with a weekly schedule of which staff were attending their visits if they wished to receive one. If someone different to their regular carer needed to cover sickness or a holiday the provider would send each person a schedule to update them of this. One person confirmed this saying "I have got a care sheet, I know who is coming". The Provider told us "The continuity of carers is important especially for people with dementia, so they can build up a rapport". One staff member said "We are a smaller company, so people get the same faces". A relative also commented "We have regular girls that come in, they are very good".

People's dignity was respected by staff. People told us "I am not rushed, they are working with me", "They give you the time and space" and "The carers are very kind and respectful, I can't think of anything that could be better". One relative told us "Staff are respectful, they always ask first". A staff member commented "We protect their privacy, if they can do things; we let them do it and give them space. We are not there to take away their dignity". People told us they were encouraged to be as independent as possible with one person saying "I like to be independent and they don't take that bit away".

Requires Improvement

Is the service responsive?

Our findings

People or their relatives were involved in developing their care, support and treatment plans. When a person started using the service an initial assessment was completed. The care plan was written up and sent to person for review and they would then either agree it or request changes to be made. Once a person was happy with their care plan they would sign it and any amendments would be made and the final care plan created. Whilst the main care plan was being put in place, a one page front sheet was put in place and a pain medication sheet so information about the person was always available for staff.

At the office we saw that care plans were kept in a locked cabinet in a separate room that had a keypad entry system. People's care plans included details of what should happen at each care visit, next of kin contacts, the person's GP, information relating to the general health of the person and any religious or cultural needs that staff should be aware of.

We saw that the care plans tended to be quite disorganised and contained letters of planned reviews from 2012 which had not been archived despite the care plan having been updated. The care plans were not very person centred and where people had a specific health need there was not always clear information in place. For example one person had an addiction that they were trying to manage. There was no guidance in this person's care plan about how staff should support this person with their addiction, if further medical advice had been sought, or an action plan in place to follow. Another person was experiencing frequent urinary tract infections (UTI) but again there was no plan of action on managing and treating this or information relating to if a referral had been made to the person's GP.

One person's care plan stated their memory was poor but did not say if they were able to retain information in order to make a decision. We spoke with the provider about the appropriateness of language used in the care plan which stated that the person 'suffers from dementia'. This was going to be addressed. There was no further information relating to the type of dementia this person had or how it affected the person's daily life and what staff could do to support this person in light of this diagnosis.

There was no end of life wishes documented in people's care plans. We raised this with the provider who told us they attended a course on end of life and dementia, and is considering putting a book in place for people to complete rather than simply asking them as these conversations can be hard to have.

One person was supported with a prescribed eye cream and we saw this had not been consistently signed on the person's medicine administration record (MAR) to show it had been given. For example one week we saw the MAR had only been signed by staff once, yet it was to be administered three times a day. On a following week it had not been signed at all, and another week showed it was sometimes given once daily and other days twice and on one day the full amount was received. There were no codes on the MAR for staff to record why it may not have been given. We spoke with the provider who said there had been an issue with the printer and it had not been printing the documents correctly but there were normally codes on the MAR's. This person's eye cream had been stopped by the GP for a short period and then restarted, which may explain some gaps but the provider agreed it had not been completed consistently.

We saw that risk assessments had not been completed appropriately. One care plan stated a person had a lot of rugs in their home and this could be a trip hazard. However there was no risk assessment in place to provide information on how this affected the care visit and ways to support the person around this. A health and safety risk assessment again mentioned the rugs but did not provide actions to take, such as if they could be moved during the time of the care visit. One person had poor mobility, and a history of falls, but under the health and safety risk assessment it was recorded that there were no risks, so no further action plan had been put in place.

We saw in one person's care plan a piece of paper had been slotted in which read that staff needed to check this person's pressure areas. No risk assessment had been put in place from this and there was no date on the paper meaning it could not be ascertained if this was part of the current care plan. We saw risks had been identified for one person who would leave the stove and taps on, and had previously burnt food as experienced confusion around time. A full risk assessment of this had not been completed and there was no action plan to show if further advice and support had been accessed for this person to keep them safe. We raised all our findings with the provider and following our inspection have been informed that care plans are being looked at and risk assessments put in place.

This was a breach of Regulation 9 (3) (a) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were reviewed regularly and as required. We saw in people's care plans there were letters reminding the person when an annual review of care needs was due. At this time the provider would also review the health and safety risk assessment that was in place. We saw people were encouraged to invite someone to attend the review with them if they wished. When a review had taken place, if a person's needs had changed, their care plan was updated and it was clearly stated in the daily records for staff to read and be aware. Six monthly reviews also took place and these were done by a telephone call to check everything was ok and if any changes were required. This was documented and then sent to the person so they could check it and sign it if happy.

We looked at the records for complaints received and saw that no complaints had been made to the provider. One informal concern had been raised and addressed through a staff memo that is sent to staff updating them about events relating to the service. It had also been addressed through staff supervisions. The provider explained this had been the person's choice as they did not want it raised directly with any one person. The provider told us she is considering documenting informal concerns as well as formal complaints.

We saw that people had been provided with information on how to make a complaint internally or externally, and the numbers and addresses of different organisations were listed should they need them. People felt confident in raising any concerns saying "I can ring the manager and she will chat to me and we will work it out", "You don't have to wait long for [X] to deal with things, she will come out to you", "I raise concerns with the manager if not happy, and she will listen and get in touch" and "Never had a problem but if I did I would talk to the manager and she would sort it out very quickly". One relative told us "If I had a concern I would speak to the manager, she pops in once a week". Another relative said "Any problem they sort".

People were encouraged to provide feedback on the service they received through an annual questionnaire. We looked at the questionnaire sent in November 2015, and saw the subjects asked included how people found the carers, if they were involved in their care plan, their satisfaction levels, and if their privacy and dignity was respected. We saw from this survey people had scored the service high and were very satisfied,

with the comments all being of a positive nature. The provider said that most people take the time to complete the survey and the results are used to produce a chart. We asked if these results are then shared with people or staff and the provider said no, but did not know why she hasn't and is going to look at doing this in the future. We saw in the theory training room at the office cards of compliments were displayed thanking the service for the care and support provided to people and their relatives.

Requires Improvement

Is the service well-led?

Our findings

The service is registered as an individual provider, and does not have a condition in place stating a registered manager needs to be in post at the service. The provider managed the daily running of the service and was referred to as the manager by people, their relatives and staff.

The provider did not have effective systems in place to monitor the quality of care and support that people received. There had not been any accidents, incidents, falls or complaints to monitor but the provider said there was no official quality monitoring in place. The provider told us visual monitoring checks are frequently completed when out on care visits and people are always asked if everything is alright but this was not being documented. The provider told us it had been attempted on occasions and we saw a folder in place from 2013 set up to record visits, any findings, action taken and outcomes. This was again started in 2014 checking key safes, care plans, out of date food in people's fridges and medicine records.

The provider told us auditing of care plans is done annually or when a review has been completed. Daily records are looked at but the provider told us she does not have time to check all of them due to completing care visits herself. This was the same for medicine records, and the provider said some were checked when on visits. The provider told us honestly that she found the paperwork side harder to manage saying "I'm more a people person than paperwork; I am thinking of having a care manager and registering them".

The provider did not have a policy in place relating to the duty of candour (ensures providers are open and transparent with people using their services). We looked at the complaints policy but it made no reference to the duty of candour. The manager was unaware of this regulation and told us she needed to refresh on the newer regulations and notifications. We checked that events requiring notification to CQC had all been made and saw that they had. The manager was open with us about improvements needing to be made commenting "It's a learning curve, I'm not afraid to say I have got things wrong".

This was a breach of Regulation 17 (2) (a) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has a positive culture that is person-centred, open, inclusive and empowering. The provider was very hands on within the service and a visible presence for people to approach. People spoke in high regard for the service commenting "The best thing about Safe Care is how they care for people, I wouldn't move from this service", "I'm happy and lucky with the service", "The manager is on the ball, really hands on", "You couldn't wish for a better team" and "Nothing to be done to make it better". One person's relative said "The manger is approachable, it's well run, they will do extra, they are flexible". The provider told us that people come to use the service by its reputation not through advertising.

Staff also gave many positive comments about the provider including "The manager is fantastic, any problems we raise it and she helps sort it", "Manager does the same job as us, she understands, it's nice to have a manager that listens", "I chose to get a job with the agency because of its reputation" and "The manager is approachable, and very understanding". The provider told us "I tell the carers they have to enjoy

who they are looking after, and people have to feel comfortable".

Staff felt supported and were kept informed about events happening in the service through a newsletter sent to staff every three months. Staff would also drop by the office to collect more supplies and update the provider on their care visits. The provider explained that staff meetings have been a struggle to hold in getting all the staff team together and ensuring visits are covered during this time. Previously two meetings have been held so staff can all attend at least one. The provider sends memos out to staff to update them on changes such as a rota change or if she was going away.

People told us the service was good at communicating things to them. One relative told us "We had a newsletter, they let us know things". Another relative commented "They are never late but if they are they always ring and tells us".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care plans were not very person centred and where people had a specific health need there was not always clear information in place. Documents were not always completed appropriately. There was no end of life wishes documented in people's care plans. Regulation 9 (3) (a).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor the quality of care and support that people received. Some monitoring had been completed visually but there was no documented evidence to support this had taken place. Regulation 17 (2) (a).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received all the required training relevant to their role in order to effectively meet people's needs. Regulation 18 (2) (a).