Key Care Management Limited

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Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 21 August and was announced. We gave '48 hours' notice of the inspection, as this is our methodology for inspecting domiciliary care agencies. We visited people who used the service on 24 and 26 August.

The service was previously registered with us at a different location. The service moved to its present location in September 2014 and this is our first inspection of the service at its location in Canterbury.

Summary of findings

Key Care Management Limited provides live-in care staff for people in the Kent area. Staff provide personal care and support to older people in their own homes. At the time of the inspection the service provided live-in personal care support for five people.

The service has a registered manager who was available and supported us during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The agency had a comprehensive medicine policy to guide staff. Staff had received e-learning training in medicines management, but not all staff had had their practical skills and competency in giving medicines checked to ensure they were doing so safely and in line with the agency policy. There was a higher risk of medication errors occurring because medication administrative records had been completed by one person from the agency and had not been checked by another person to ensure their accuracy.

New staff did not receive a comprehensive induction which ensured that they had the skills they required, before they started to support people in their own homes. Staff undertook e-learning training in essential areas and face to face practical training in how to move and handle people safely. Relatives said that staff had the skills and knowledge they needed to support their relative. However, not all staff had received training in food handling or The Mental Capacity Act 2005. The MCA 2005 provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

There were not effective systems in place to assess and monitor the quality of the service. The agency had not identified shortfalls in staff induction and training. Although the medication policy had been reviewed, this review had not been effective as it contained legislation that was applicable 15 years ago. The agency had not followed its only policy on supervision, appraisal and staff meetings as these were not all taking place.

Relatives said that they had confidence in the live in care staff and felt that their relative was in safe hands at all times. Staff had received training in how to safeguard people and knew how to report any concerns so that people could be kept safe.

Comprehensive checks were carried out on all potential staff at the agency, to ensure that they were suitable for their role. This included obtaining personal and employment references and a criminal vetting and barring check.

Assessments of potential risks had been undertaken in relation to the environment that people lived and worked in and in relation to people's personal care needs. This included potential risks involved in moving and handling people, supporting people with their personal care needs and with eating and drinking. Guidance was in place for staff to follow to make sure that any risks were minimised.

The agency had sufficient numbers of staff available to provide each person with a main live in member of staff or two live in staff members as needed. There were also sufficient staff available to accommodate live in staff when they had a week's break.

People's health care and nutrition needs had been comprehensively assessed and clear, step by step guidance was in place for staff to follow, to ensure that their specific health care needs were met. Staff were knowledgeable about people's complex health care needs and liaised with health professionals and family members when appropriate.

Relatives said staff knew people extremely well as they spent their day together in the same house. They said staff were kind and caring and always treated their relative with dignity and respect. Staff demonstrated they knew people well and so could quickly respond to any change in their needs.

People's needs were assessed before they were provided with a service and people and their relatives were fully involved in this process. These assessments were developed in to a personalised plan of care. The care plans gave detailed guidance to staff about how to care for each person's individual needs and routines. As people had one or two main staff members to support them, staff were very knowledgeable about their likes, dislikes, choices and preferred routines.

Summary of findings

People were informed of their right to raise any concerns about the service. Relatives said that when they had raised concerns that the manager was quick at addressing them to their satisfaction.

Relatives said that they would recommend the service and that their views were listened to. Staff understood the aims of the service and put them into practice by providing personalised care. Staff had confidence in the management of the service which they said was supportive.

We found three breaches of the Health and Social Care Act 2008 (Regulated activities 2014). You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Staff were trained in how to support people with their medicines but their competency in giving medicines safely was not checked before they supported people in the their own homes.

Checks were carried out on staff to make sure they were suitable for their role and they were employed in enough numbers to meet people's needs.

Assessments of potential risks to people and staff were undertaken to make sure they were minimised.

Staff were trained in how to safeguard people and the agency knew how to report any concerns they raised with the appropriate authorities.

Is the service effective?

Requires improvement

The service was not always effective.

New staff had not completed an appropriate induction before supporting people in their own homes.

Not all staff had had received the training necessary for their role, including how to prepare food safely or in the principles of the Mental Capacity Act 2015.

Staff were knowledgeable about supporting people with their health and nutritional needs and knew when to contact health professionals for advice.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect at all times.

People had one or two members of staff who lived in their home. Staff knew people well and treated them in a kind and caring manner.

Staff supported people to make day to day decisions and choices and to maintain or develop their independent living skills as appropriate.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and a detailed plan of care was in place to guide staff in how to care for them in an individual way.

Staff were knowledgeable about people's daily routines, likes, dislikes and preferences.

Summary of findings

People were informed about how to raise a concern or complaint about the agency and when this had occurred, action had quickly been taken to resolve the situation.

Is the service well-led?

Requires improvement

The service was not always well-led.

Quality assurance and monitoring systems were not effective in identifying some areas in which it needed to improve.

People, their relatives and staff were asked for their views about the service but they had not been collated to ensure that they agency addressed any overall shortfalls in the service.

Staff said they received good support from the management team as they were always there to support them. Relatives said they would recommend the agency to others.

Key Care Management 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 checked 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 21, 24 and 26 August, and was announced with 48 hours' notice being given. The inspection was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR within the set time scale. Before the inspection, we looked at information about the registration of the agency and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law. We also obtained feedback from questionnaires sent to people who use services.

We visited two people who used the service and spoke to their relatives, as they were not able communicate with us during our visit. We spoke to the registered manager, nominated individual/provider, administration officer, five care staff and a representative of the commissioner of the service.

During the inspection we viewed a number of records including two care plans and daily notes; five staff recruitment records, including three of the most recent staff employed by the agency; the staff training and induction programme; supervision notes; medication and safeguarding policy; staff handbook and service user guide; compliments and complaints logs; staff spot checks and quality assurance questionnaires.

Requires improvement

Is the service safe?

Our findings

Relatives told us that they felt people were safe at all times when being cared for by their live in carer. One person told us, "I have confidence in the carers as I would not want anyone that was not able, to look after my Mum". Another relative said, "I feel she is safe at all times with the girls (care staff) living in her home". Relatives said that staff were competent in giving their relative the right medicines at the right time.

The agency had a comprehensive medicines policy which set out staff and other professionals' roles and responsibilities. Guidance was available for staff in a number of areas such as how to administer and dispose of medicines safely, what to do if a person refused their medicines, a medicine error was made or a medicine was dropped on the floor. The policy set out that medicines could be stored in the original container supplied by the pharmacist or in a multi-compartment compliance aid dispensed under the supervision of a pharmacist. People's medicines were all stored in their original container as supplied by the pharmacist. Staff looked at the medication administration record (MAR) sheet to see the name and dosage of the medicine and the time that it should be given. They then took the correct medicine out of the medicine container and recorded on the MAR sheet, the medicine that the person had taken.

The medicines policy stated that only staff who had received training in how to give medicines were able to do so. All staff had received medicines training but the level of detail in their training varied. Some staff had received face to face practical medicine training, but the majority of staff had been trained in how to give medicines by completing training on line and correctly answering a series of questions about their knowledge. Staff then supported people in the community with their medicines. Checks were carried out on MAR sheets to ensure staff had completed them correctly. Observation checks on staff had started to be carried out, but had not been completed on all staff who administered medicines to ensure that they were competent to do so safely.

Medication administrative records had been completed by the provider and were handwritten or typed. When MAR sheets are completed by people other than the pharmacist, there is a risk that they may be completed incorrectly. MAR sheets had not been checked and signed by two people to confirm that the information they contained was correct.

MAR sheets contained the name and dosage of the medicine and the time that it should be given. There were no gaps in the record, which indicated that people had received their medicines as prescribed by their GP. However, MAR sheets did not include the number of medicines that the person had received each month. Therefore, it was difficult to undertake an audit of each person's medicines and so account for all of the medicines the agency had managed for each person.

Care plans contained guidance for staff of the circumstances in which staff should give people medicines which were given 'as required' (PRN). Staff were knowledgeable about recognising changes in people's body language which indicated that they were in pain and required pain relieving medicines. Staff recorded the time and the reason when any 'as required' medicines were given to people in their care.

The lack of safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The agency had a safeguarding policy which incorporated guidance from the Kent and Medway, local authority adult protection protocols. The policy set out how to recognise abuse, staff's responsibility to report any concerns and the responsibility of the agency to contact the local authority and other professionals as appropriate. A summary of the safeguarding policy was contained in the staff handbook, with the contact details of the local authority. Staff had received training in how to safeguard people. Staff told us that if they suspected any form of abuse they would report it immediately to the manager or provider. They said if it was a concern about bruising on a person, they would also report it to the district nurse who was involved in their care. One staff member told us that they could also report their concerns directly to the police if it was appropriate and another staff member that they would contact the Commission. Staff felt confident to report any concerns to the provider or manager and that their concerns would be listened to. They also knew that they could 'blow the whistle'. This is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

Requires improvement

Is the service safe?

Risks to people's personal safety and in their home environment were thoroughly assessed before the service commenced. Each potential risk was identified together with the appropriate action that staff needed to take to minimise their occurrence. Staff were alerted to which risks had the greatest impact on people as they were rated high, medium or low. All areas of the person's daily needs were assessed according to their risk, including moving and handling, continence, personal hygiene, eating and drinking and medicine administration. Where people required assistance with moving and handling a comprehensive assessment was in place. This detailed what staff support and equipment they required in all transfers, taking into consideration their individual circumstances such as if the person was able to weight bear, had any weakness in their limbs or was unbalanced.

Staff knew to report any accidents, incidents or anything out of the ordinary to the office. The provider told us that no such events had been reported to them with the exception of one staff member cutting their finger whilst preparing food. Therefore, no trends or patterns had been established in relation to accidents or incidents which required the agency to take the appropriate action.

Potential staff were screened during a telephone call to the manager or provider, to assess their suitability as a live in member of staff. Staff then completed an application which contained information about their qualifications, skills, experience and any gaps in their employment history. An interview was held, either face to face or via the internet, as many applicants did not live in the Kent area. At the interview applicant's suitability was assessed through being asked a number of relevant questions. This included information about their understanding of live in member of staff, of giving people choice and independence and talking through a number of different situations.

Before staff supported people in their own homes references were sought from applicant's previous employer and/or a person who could vouch for their good character. Two references had been received for the majority of staff. Checks of the person's identity, right to work in the UK and a Disclosure and Barring Service (DBS) check were undertaken. A DBS identifies if prospective staff had a criminal record or were barred from working with children or vulnerable people. All these checks helped to ensure that only people who were suitable and of good character supported people in the community.

The agency provided care for a small number of people and so was aware of how many live in staff they needed to meet people's needs. Each person who used the agency was assigned one or two main members of staff, according to their needs. In addition people were assigned specific staff members to care for them when their main care staff took their week break. The agency advertised live in care jobs on their company website, to ensure that any staff vacancies were filled and in order to take on new packages of care.

The agency had an on-call system provided by the manager and provider if assistance was required outside of office hours. Staff reported they felt safe knowing that there was support available to them at any time of the day.

Requires improvement

Is the service effective?

Our findings

Relatives told us that staff had the right skills for supporting the people in their care. They said that staff knew their relative extremely well and knew how to support people living with dementia, with limited communication skills and with specialist skills such as PEG feeding. Percutaneous endoscopic gastrostomy (PEG) is a tube that feeds directly into a person's stomach.

The service user guide stated that new staff received a comprehensive, competency based induction training programme on new and refreshed common induction standards. However, in practice, new staff came to the office and the provider read them the main policies and procedures of the agency such as what to do in an emergency, adult protection, infection control, medicines management, health and safety and safeguarding people. The new staff member shadowed an existing member of staff for two days and a record was made to show that they had read the care plan, could communicate with the person, complete medication administration records and move and handle the person. The new member of staff then supported this person as the second member of staff. Therefore, the new staff member was reliant on the knowledge and skills of the existing member of staff to learn new skills, as they had received no formal training. Six new staff had not started the Skills for Care care certificate. These are the induction standards which are the standards people working in adult social care need to meet before they can safely work unsupervised and includes understanding how policies are put into practice.

The provider said that staff used to attend practical training courses in all subject areas, but that now new staff undertook e-learning based training in all subject areas that were necessary for their roles. The staff member was required to undertake a test at the end of the training to assess their understanding in each topic area. The administrator told us that new staff were allocated these courses two or three at a time. New staff confirmed that they only started this training, once they had begun to support people in the community. All staff had completed e-learning training in health and safety, infection control, safeguarding people, fire safety and medicines. Most staff had completed training in fire safety and first aid, but only 15 out of 22 staff had received training in food safety despite food preparation being an important part of staff's role in supporting people in their own homes. There was no date recorded on the training record to indicate when staff would complete this necessary training.

Seven out of 22 staff had not completed training in the Mental Capacity Act 2005. The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Staff's knowledge of the principles of the Act varied and not all staff demonstrated that they understood them. One member of staff had a good understanding and explained one principle of the Act. This is that it should be assumed people have capacity, even if they cannot verbally communicate a decision, as they can make their needs known in other ways. However, other staff were not clear about what 'capacity' meant and whether people they supported were always able to make decisions; nor had they heard about best interest meetings. A best interest meeting is convened with relevant professionals and relatives so that a decision can be taken on their behalf when they have been assessed as not having the capacity to do so themselves. The provider had an understanding of the Mental Capacity Act 2005 but was not aware of the shortfalls in knowledge in the staff team.

Staff observations to check their skills and competence once they had undertaken their formal training had not been carried out by the agency since February 2015. These unannounced spot checks had recently been reinstated and included checking that staff had completed medication administration sheets appropriately, that they understood what to do in the event of a fire, how to move and handle people safely and how to minimise the spread of any infection. However, they had not been completed on all staff at the time of the inspection.

Staff said they felt well supported by the agency and a member of staff who had received formal supervision, said they found it a useful and enjoyable experience. The service user guide stated that staff were supervised every six months, received an annual appraisal and attended staff meetings. However, only one of the five staff records that we looked at contained a supervision record. No staff had completed an annual appraisal, although a number of staff had been employed by the agency for over a year, and no staff meetings had been held. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

Requires improvement

Is the service effective?

The lack of a comprehensive induction programme, training in food handling and capacity is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service user guide stated that staff were working towards or held a Qualification and Credit Framework (QCF) level two or above in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard. Seven staff had achieved a level 2 or above in this qualification.

The agency ensured that all staff received practical moving and handling training. The manager had completed a train the trainer course in how to move and transfer people safely. She gave practical training to staff which was specific to each person's moving and handling requirements. Staff said that they felt confident to support people with transfers and to use the hoist after receiving this practical training. Staff said that if they had had any concerns, they had contacted the manager and she had quickly responded to make sure that people were moved appropriately and safely.

Specialist training had been provided for 12 staff in how to support people living with dementia. One staff member was a Dementia Friends Champion. Dementia Friends Champions are volunteers who complete further training and on-going support to talk to people about improving the quality of life for people living with dementia. This staff member had organised a talk to give people an understanding of dementia in the local community where a person that they supported lived.

People's need in relation to food and fluids were assessed and the support they required was detailed in their plan of care. For people who had difficulties with swallowing, there was specific guidance in place for staff. Staff were also reminded about paying attention to people's oral care which was at greater risk of deterioration in these circumstances. The guidance given to staff was clear and easy to understand. Training in feeding and the administration of medicines by PEG tube had been given to staff a by nutrition nurse. A Nutrition nurse is a clinical nurse specialist with knowledge and experience in nutrition support and is involved with people who are unable to eat or drink normally and require special feeding tubes to receive nutrition in liquid form. The nurse assessed staff's competence in using the PEG tube before they were able to undertake the task independently. Staff had contacted the nurse to receive additional advice and support when required.

Relatives told us that staff had a good understanding of their relative's health care needs and that staff contacted the relevant health care professionals as needed. "Any small problem and staff call the district nurse or doctor", one relative told us. Staff gave examples of when they had contacted health care professionals to seek further advice or assistance. They had the contact details of the relevant professionals so that swift and appropriate action could be taken. Each person's care plan included detailed information about people's health care needs and the support that they required. The information was set out in detailed steps for each day to ensure that people's complex health care needs were met. The guidance also included information on how to observe if the person was in pain, or whether they were prone to periods of depression and how staff should respond to effectively support the person in these situations. A commissioner of the service told us that they had a close working relationship with district nurses and that they had never contacted them with any concerns about how staff supported people.

Good

Is the service caring?

Our findings

Relatives told us there were caring relationships between staff and the people they supported. They said staff knew all about the people they supported as staff and people lived in the same house and shared their lives together. Relatives said that people had regular staff so a positive relationship could develop between them. The agency was a small, family run business and relatives felt that this gave it a caring approach. One relative told us, "It is a caring organisation. Staff brought flowers for her on her birthday. She is well looked after and cared for". Another relative told us, "The girls are very patient with her. She can be very stubborn. They are more patient than I am!"

Relatives said that people were always treated with dignity and respect. They told us that when they supported people with their personal care they explained to the person what tasks they were going to undertake before doing them. For example, staff would let the person know, 'I'm just going to wash your back" before washing the person's back. A service commissioner told us that all the families of people who used the service were happy with the care that their relatives received as staff were approachable and professional.

Some people were living with dementia. Staff said that people could become distressed and agitated. They said that when this occurred they sat with them and talked with them in a calm voice to reassure them. Staff told us that sometimes people they cared for became very agitated and frightened. They explained that in these circumstances, they gave the person a cuddle and this reassured them and made them feel safe. As staff were available at all times, people who were upset could be reassured immediately which meant that they were not distressed for a long period of time.

Relatives said staff knew people's needs, preferences and individual characteristics and staff were able to describe these in detail. This meant that staff could tell when people were upset, content or in pain by their mannerisms if they were not able to express them verbally. Staff explained how they involved people in making their own decisions such what they wanted to wear and what they wanted to do. When staff described the care they provided for people, they spoke about people in a caring manner and focused on their positive characteristics. One member of staff told us, "I love what I do. I am passionate about it". Staff spoke and acted in a calm manner and relatives confirmed that this was how they supported the people in their care

The agency had received a number of compliments about their caring approach. These included: "Thank you for all the excellent care your company gave her. All the girls were lovely and caring and we couldn't have asked for better"; and "The wider family are grateful for the care he received from Key Care. The staff member became a close friend to him. He thought highly of her: No one else came close".

Good

Is the service responsive?

Our findings

Relatives told us that the registered manager came to visit them and their relative before they received a service from the agency. During this meeting an assessment was made of their relative's needs, likes and dislikes. "The manager came and had a long chat. She found out all there was to know about her and helped sort out the right equipment", one relative told us. Another relative said, "The manager told me the name of the staff that would be involved in her care during this assessment. I was impressed by this and how organised the agency were. One relative told us that they had given the registered manager guidance about how to care for their relative in a specific set of circumstances. This guidance was included in the person's plan of care and staff knew how to put it into practice.

Assessments of people's needs were used to develop a detailed plan of care for each person. This included individual information about people such as who they lived with, people who were important to them and how they liked to spend their time. This was to make sure that staff knew about people's personal lifestyles and preferences. Care plans included personalised guidance for each aspect of care that people required, such as their mobility, nutrition, communication needs and continence. Each person's daily routine was recorded together with the support staff should offer during the day. For example, one person's plan stated that staff should "Ask how she is feeling and she will indicate with a movement of the head. Roll her on to her left side but be careful of her right arm as it can cause her pain". A service commissioner told us that the agency always delivered the package of care to people as it was intended.

Relatives said that it was important to match the staff member to the person they were supporting. They said that when there was not a good match between staff and the person receiving care that the agency was effective in responding to this situation. One relative told us, "One staff was not good and the manager sorted it out straight away". Another relative told us, "There were a few problems when the care started, but the manager sorted this out and got an alternative member of staff. She now has a very good, consistent staff team".

A relative told us, "I have had no complaints. Other people told us that if they had raised any concerns with the manager or provider, that they had been addressed to their satisfaction. People were given a copy of the complaints procedure when they first started to use the service. This contained information about how and to whom to make a complaint. Staff knew that people had the right to complain and guidance about how to respond to a complaint was contained in the staff handbook. Staff said that if a person or their relative raised a concern with them, they would try and address it with them. However, if it was something that they were not able to address, they would inform the provider or manager, as it was important that people received care that met their needs. The agency had a system for recording and responding to any complaints that were made.

Staff wrote daily reports about people's well-being and the tasks they had supported them with to provide a picture of the person's day, and if they had slept well at night. Staff lived in the person's home for a one to three week period and were therefore able to provide consistent and effective care. When there was a change in the member of staff, there was a handover between them, so that staff could communicate any particular needs or concerns about each person. Where two staff supported a person, each regular member of staff had their week break at a different time, so that a regular member of staff stayed with the person to provide continuity of care.

Requires improvement

Is the service well-led?

Our findings

The systems the agency used to assess and monitor the quality of service that it provided were not always effective. The agency had identified there were service shortfalls and had started to roll out a new system to assess, monitor and audit the service. However, this system was not fully embedded at the time of the inspection. The manager was not aware of a number of shortfalls in agency. New staff started supporting people in their own homes without having a comprehensive induction and training in the areas that they required for their roles. There were shortfalls in training in food handling, which all staff were responsible for; and staff had a lack of knowledge and training in the Mental Capacity Act 2015, so it could not be certain that where people lacked capacity to make decisions that they acted in people's best interests. The management of medicines was not robust as there were no audits in place to account for all medicines coming and leaving the home. Also, not all staff who were responsible for giving people their medicines had not been assessed on a regular basis to make sure they were competent to do so safely.

The agency's medication policy was dated July 2014 and was overdue for a review. It referred to the Care Standards Act 2000, its associated regulations and the National Minimum Standards. However, this legislation had been superseded by the Health and Social Care Act 2008 and the associated regulations in 2010 and again in 2014. This meant that when the policy was reviewed, it had not been effectively checked to ensure that it was kept up to date with changes in the associated legislation. The agency was also not following its own policies as these stated that staff received regular supervision, appraisals and staff meetings, but these were not taking place.

The agency had started to use a review questionnaire for people who used the service, their relatives and staff. This involved contacting the person who used the agency and their relative as appropriate on the first day their care package started, then after two days, seven days and then on a regular basis to ensure that people were satisfied with the care that they received. This included checking the care plan and risk assessments were up to date, that people were given choices, their privacy was respected, equipment maintained and daily logs were completed correctly. Staff were also asked for their views about how their placement was going. The feedback from these questionnaires had not been collated from everyone who used the service to identify if there were any patterns, trends or shortfalls in which the agency needed to improve.

This lack of an effective system to assess, monitor and improve the agency is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was supported by the provider and an administrator. Staff told us that the service was well led and that they felt well supported. They said the registered manager or provider were always available and they felt confident to contact them for advice and support. One staff member told us, "This company is helpful; they are there if you need to phone someone. They are there for us. I haven't found this at other places as much".

The values of the organisation were set out in the service user guide, these included promoting people's independence and dignity and delivering exceptional services. Staff clearly understood the aims of the agency to enable people to stay in their own homes and to provide care that was personalised and caring. Staff were provided with a staff handbook which contained the agencies policies and procedures, their roles and responsibilities and specific guidance on the does and don'ts of living in someone else's home as a live in member of staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment The management of medicines did not ensure that people were protected from the risks associated with medicines not being administered as prescribed. Regulation 12 (1) (2) (f) (g)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing Staff had not all received training in understanding capacity, food handling or an induction programme that prepared them for their role. Nor was there is system in place for regular staff supervision and appraisal. Regulation 18 (2) (a)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance The provider did not have effective systems and processes in place audit, assess, monitor and improve the quality of the service and ensure all information was up to date. Regulation 17 (1) (2) (a)