Diamond Resourcing Plc

Better Healthcare Services (Cambridge)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Better Healthcare (Cambridge) is registered to provide personal care to people in their own homes. At the time of our inspection they were providing a service to 17 people living in the Cambridge area. They are also registered to provide nursing care and treatment of disease, disorder or injury. However a representative of the provider stated that they did not carry this out and would be applying to cancel these two regulated activities.

This announced inspection took place on 19, 20, 21 and 28 October 2016.

At the time of the inspection there was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. A new manager had commenced working in the role in September 2016 and was in the process of applying to the commission to be registered.

The system to monitor the quality of the care being provided and to drive improvement was not effective and this impacted on all areas of the service.

Risks had not always been managed to keep people as safe as possible. Risk assessments had not always been completed. This meant that staff did not have the information they required to ensure that people received safe care.

Incidents had not been recorded or managed effectively to identify any action that needed to be taken. Systems and training were not in place to ensure that staff dealt with behaviour that challenged others appropriately.

We could not be confident that people were receiving their medication as the prescriber had intended. Medication administration records (MAR's) had not been completed accurately which meant that it was not clear if people had received the medication that they were prescribed. The audits of the MAR's were not effective as they did not always identify areas of concern that required investigation. There were not enough staff employed to ensure that people received their care at the agreed time, and on some occasions staff did not arrive at the persons home to provide care at all. Due mainly to an insufficient number of care staff, people had experienced a high number of missed calls.

The recruitment procedure had not always been followed to ensure that only the right people had been employed.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, and to report on what we find. The provider was not acting in accordance with the requirements of the MCA.

They could not demonstrate how they supported people to make decisions about their care and where people were unable to make decisions, there were no records showing that decisions were being taken in their best interests. This also meant that people were potentially being deprived of their liberty without the protection of the law.

Care plans did not contain all of the relevant information that staff required so that they knew how to meet people's current needs. We could not be confident that people always received the care and support that they needed. People had not always received food and drink as their care plan stated.

Not all complaints had been recorded appropriately. This meant that we could not be confident that complaints were being dealt with effectively.

The provider is required by law to notify the Commission of certain events so that we can monitor the service. These notifications had not been submitted to the Commission.

Staff were aware of the procedure to follow if they thought someone had been harmed in any way.

New care staff completed induction training and shadow shifts to ensure they were competent for their role. The care staff treated people with dignity and respect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people had not been consistently assessed and action had not been taken to reduce risks to people.

There was an insufficient number of staff to meet people's needs.

Medicines were not managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not acting in accordance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. This meant that people's rights were not always being promoted or protected.

Systems were not in place to ensure people where only restrained in accordance with current best practice.

People did not always receive the support they required with food and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

Care staff promoted peoples dignity and respect. However people or their relatives didn't always feel they were treated with respect when contacting the office.

People were included in making some decisions about their care and support.

Is the service responsive?

Inadequate

The service was not responsive.

People were not always provided with care that was person centred and met their needs.

The complaints system was not effective and complaints had not been dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

There was no effective quality assurance system in place to identify improvements needed and ensure that they were carried out in a timely manner.

The provider had not notified the Commission of certain events as required by law.

Better Healthcare Services (Cambridge)

Detailed findings

Background to this inspection

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

This inspection took place on 19, 20, 21 and 28 October 2016 and was announced. This was because it is a small domiciliary care service and we needed someone to be in the office. The inspection visit to the office was carried out by one inspector. A second inspector carried out phone calls to care staff.

We undertook this inspection earlier that we had planned to because of concerns that we received from Cambridgeshire County Council and the local safeguarding team. Before our inspection we reviewed the information we held about the service. We reviewed notifications the provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about.

We spoke with the manager, the quality and training manager, the area manager, and three members of care staff. We spoke with four people who use the service and three relatives of people who use the service. We looked at the care records for three people. We also looked at records that related to health and safety including audits and medication administration records (MARs).

Inadequate

Is the service safe?

Our findings

Concerns had been shared with us by Cambridgeshire County Council regarding the safety of the service being provided to people. We found the provider had not always taken steps to reduce the risks to people who used the service.

Risk assessments were not in place for all risks that had been identified. Risk assessments that were in place did not always identify the risk or provide information about how the risk could be reduced. For example, one person's needs assessment stated, "[Name] has frail, very dry skin." However there was no risk assessment in place about their skin integrity or what action staff should take to prevent any damage or how staff should monitor the condition of the skin. On the second day of the inspection the person was found to have developed a pressure sore. The same person's care plan stated that staff should dispense their evening medication and leave it on their bedside table to take when they went to bed. There was no risk assessment regarding this procedure to identify the possible risks and how they could be reduced or monitored. Risk assessments were not always updated when circumstances changed. For example, one person's "Behaviour management and support risk assessment" completed on 4 July 2016 stated that there had not been any "incident of physical aggression/ bullying/ threatening behaviour towards others." However staff and records confirmed that they person had displayed behaviour that challenged others on several occasions. This meant that the risk to the person and others had not been identified and actions had not been taken to reduce the risk.

The manager was not aware of any incident forms being completed by staff. A folder was found during the inspection that contained two incident forms. One of the incident forms showed that the appropriate action had been taken as a result of the incident. However the second incident form had not been signed by a manager and no information had been recorded about any action that was taken by the manager as a result of the incident. The manager stated that appropriate action had been taken. Incident forms had not been completed as necessary. The manager confirmed that incidents forms had not been completed when one person had displayed behaviour that challenged others which had resulted in staff sustaining injuries. This meant that the incidents had not been reviewed or any action necessary identified.

People's medication had not been managed to ensure that they received them safely and as prescribed. Some of the medication administration records (MAR's) had been audited by the management team. However the audits had not identified all of the issues with the MAR's. For example, one person's MAR's contained a hand written entry that doubled the amount of a medication that was prescribed. There was no signature of the person who had made the entry or any explanation to say who had requested the change. One person's MAR's showed that they had not received one of the medications on four consecutive days and the reason of out of stock was given. The medication had then been signed as administered for two days and then no signature was present for another four days. Although the MAR's had been audited this had not been identified as an issue. The manager was not aware of why there were omissions for signing of the medication.

There was no record of staff initials and signatures so it was not always possible to identify who had

administered medication. When staff did not visit people at the expected time this was not taken into consideration regarding the administration of their medication. For example, staff had signed the MAR's to show that one person had been administered paracetamol three times in five hours. The manager stated that when the times of calls had varied from their normal time the required gap in-between doses had not been considered.

The daily records for one person showed that staff had covertly administered their medication in October 2016. We asked if permission had been given by the person's GP for the covert administration. The quality and training manager stated that the person's GP had stated in August 2016 that medication was not to be administered covertly. The manager stated that this information had been relayed to staff so they did not know why it was still being given this way in October 2016.

One person's care plan stated that their evening medication should be left on their beside table for them to take later. However Better Healthcare's policy states, "Staff should directly observe the taking of medication and medicines should not be left to be taken later." This meant that staff were working against the agencies own policy.

The relative of one person told us how they noticed that their family members MAR's had not been signed as administered for the day. However when they looked at the record the following day someone had signed it retrospectively. To avoid mistakes MAR's should not be signed retrospectively.

The records showed that due to staff not arriving at the expected time medication had not been administered. For example, the records showed and the person's family member confirmed that they had not received their medication before leaving for their day centre because the care staff did not arrive on time. The person's relative said that this could have had a "catastrophic effect" on them as they became breathless if they did not take their medication.

Where medication had to be administered in a certain way there was no guidance on the MAR's or the persons care plan. For one person, their medication had to be administered 30 minutes before food. However the records showed that not all of the care calls where the medication was given and food was served were 30 minutes long and on at least one occasion the medication was administered after food.

The records showed and staff confirmed that medication administration sheets were not always available at the beginning of the month. This had meant that care staff had continued to use the previous sheet or had written out a new sheet themselves. This could lead to mistakes being made if the records had not been copied correctly.

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

Staff told us about their recruitment and that they were only employed after the necessary checks to ensure they were suitable to work in with vulnerable people had been completed. However two members of staff had recently commenced working with people before their written references had been received. The manager stated that it had been an oversight.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service did not always receive the care and support that had been agreed due to

missed or late calls. The manager told us that this had been due to a number of reasons but mainly due to not having enough staff to provide the care as they had found it difficult to recruit new care staff. Six of the seven people (or their relative) that we spoke told us that they had experienced missed calls within the last few months. One relative told us, "A couple of weeks ago I received a phone call to say that I would have to go look after [name] as there wouldn't be a carer coming." One person told us, "I've had two missed calls recently. They phoned and told me about the first one but not the second." One person told us, "I have one visit every day. One weekend I went from the Friday until the Monday without the carer coming." One relative told us, "I had a call to say the carer wouldn't be going to see [name] so I had to get a bus over to provide their meal. I'd only just got home and I had another call to say they couldn't go in the evening either." People (or their relative) also told us that some calls were considerably later than planned. They told us that they hadn't always been informed that they would not be receiving a call.

One member of staff told us, "At the moment we don't have enough staff. We are being asked to do more than we can do."

Staff had not always been held to account when they had missed calls to people. The manager stated that an ex member of staff had missed some calls and that the reason for the missed calls were being investigated using the company's disciplinary procedure. However the member of staff resigned before the outcome had been concluded and there was no guidance available to inform the investigator what they should do in these circumstances. This meant that people could be placed at risk if they gained employment working with people in the future.

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

People told us that having care staff from Better Healthcare (Cambridge) helped them to feel safe. One relative told us, "Without the care staff going in [name of relative] would have to live in a care home." However they also said, "They need to improve by having regular staff at regular times and not missing any calls." One person told us, "Yes the staff help me to feel safe."

Staff told us and records confirmed that staff had received training in safeguarding and protecting people from harm. A safeguarding policy was available and staff told us that they had read it. Staff were knowledgeable in recognising the signs of potential abuse and were able to tell us what they would do if they suspected anyone had suffered any kind of harm.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA aims to protect the human rights of people who may lack the mental capacity to make decisions for themselves. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the court of protection for it to be lawful. The service was not acting in accordance with the principles of the MCA.

The manager confirmed that one person they had been providing care to was not able to consent to their personal care or the administration of medication being carried out. However no capacity assessment or best interest decision had been completed for this person. This meant that decisions were being made on behalf of people without ensuring that they were being taken in the person's best interests.

Staff had completed MCA and DoLS training. However they were not all aware of what action they needed to take if they considered that a person needed to have their capacity assessed or how this would be done. This meant that staff had not identified when a person needed a capacity assessment.

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

There was a lack of understanding by the care staff regarding what constituted restraint of people. The manager stated that staff did not use any form of restraint when working with people. However staff told us and records confirmed that when one person displayed challenging behaviour towards the staff t would have to push the person's hands down or try and release their grip. Staff had not received training to ensure that any restraint or control was only used when absolutely necessary and in line with current best practice. There was no information to show how the person was at risk to themselves or others regarding challenging behaviour which would require any restraint, or any agreed protocol that would ensure their best interest.

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

People did not always receive the help they needed with meeting their nutritional needs. One relative told us that staff had not prepared a dessert for their family member so they had tried to do it themselves. However they heated up a main course by accident. They also told us that their relative was diabetic and relied on the staff to leave them food to eat at bedtime to maintain their blood sugar levels through the night. They stated that on one occasion the food hadn't been left for the person to eat. One person told us, "They [the care staff] always check what I would like to eat and that I like it." One person told us that the language barrier of care workers whose first language wasn't English sometimes caused a problem. They stated, "They don't always understand what food I'm asking for. I asked for strawberries but they bought me a jar of strawberry jam."

Staff told us that when they started employment they completed a three day induction. The induction included e learning and practical sessions. One member of staff told us, "I enjoyed the practical training more." The records showed that the induction included training on dementia awareness, medication, infection control, food hygiene, safeguarding of vulnerable people, report writing and moving and handling. The quality and training manager told us that all new staff had also been registered to complete the care certificate within the first twelve weeks of employment (this is a nationally recognised qualification). The staff stated that they had carried out, "shadow shifts" where they observed other staff working with people and got to understand what support people needed. The quality and training manager stated that they would be providing more training regarding dementia to ensure that staff had all of the skills and knowledge they required.

Staff received the support that they needed to carry out their role. Staff confirmed that they received supervisions and where appropriate appraisals. Staff told us that if they had any work issues they could ask the manager for support and guidance.

Staff told us and records confirmed that people had been referred to the GP and other health professionals as needed. For example, one person who had developed a pressure sore was referred to the district nurse for treatment. Another person who had a history of falls had been referred to a falls specialist.

Requires Improvement

Is the service caring?

Our findings

People that we talked with were positive about the care staff who had worked for Better Healthcare (Cambridge). One person said, "I now have the same regular carer. She is lovely, brilliant." Another person told us, "The best thing about the agency is that they have some really lovely carers." One member of care staff told us, "I do really enjoy helping people with their daily routines"

Although the Statement of Purpose (information booklet) for Better Healthcare stated, "We want you to be reassured that you can expect an exceptional service, with a high degree of continuity" this had not recently been achieved for people using the services of Better Healthcare (Cambridge). People and their relatives told us that they had experienced lots of different staff and they would prefer to have the same staff. They said that this would mean they could build up a relationship with them and the staff would know how people liked their care to be delivered.

Staff told us how they treated people with dignity and respect. They told us that they made sure that people's needs were met and that, they were treated as individuals. One member of staff told us, "I don't judge people. I try to encourage them to let me help them with their personal care." One person told us, "They [the care staff] keep me covered up when they are helping me with a shower." A relative told us, "As far as I'm aware they treat [name] with dignity and respect." People's care plans included the name that would like to be used. People confirmed that this was used.

People also told us that they didn't always feel that they were treated with respect when they contacted the Better Healthcare office. One relative of a person who uses the service told us that they had contacted the office on two occasions as they were worried that they could not get in contact with their family member. They stated that they wanted to know if the care staff had seen their relative that day. The relative stated that the office returned their call on the first occasion but not the second.

People told us that staff had visited them to discuss what they would like included in their care plans. The records showed that people had signed their care plans to say that they agreed with them. One relative told us, "Someone came out from the office a couple of months ago to rewrite the care plan. We haven't received it yet though." Some of the care plans included information about how staff should encourage people to be independent. It included information about asking what people would like to wear and what they would like to eat and drink. One member of care staff told us what they thought their job was about, "It's about caring for people and doing things for people that they can't do whilst still making them feel independent and safe."

People told us they were able to speak for themselves, but if they needed support to do this they all had relatives who would help them. The manager said that advocacy information had not been shared with people but that they would make it available if needed.

Inadequate

Is the service responsive?

Our findings

All three of the care plans that we looked at did not contain enough detail to ensure that staff could meet people's needs in a person centred manner. For example, although one person's needs assessment stated that they had very frail, dry skin which must be monitored on a daily basis this was not recorded in the person's care plan. The same person's mobility assessment stated that the person used a walking stick. This information was not included in the care plan. The care plan for another person stated, "Assist with personal care if needed." The care plan did not explain what personal care the person needed assistance with, how they would prefer this to be carried out and what they could do for themselves. It is important that the care plans contain the information that care staff need to care for people in the way they prefer.

The manager told us that not all of the care plans had been reviewed to ensure they were up to date and reflected people's current needs. The manager stated although this had been planned, due to the shortage of staff this had not been completed. Staff from the local authority told us that they had taken time to explain to the manager what the care plans and assessments should include, but these changes had not all been made.

People did not always receive the care and support that they needed. One person told us that the care staff visited them once a day to help maintain a health condition. They stated that there had been one weekend when no care staff had arrived to assist them. They said that this had left them in pain and feeling unwell. The relative of one person who used the service told us, "[Relative] suffers when the carers aren't on time or don't turn up. [Relative] is very anxious and starts calling me every ten minutes if they don't arrive." The relative stated that on one occasion the care worker did not attend their family member before their transport had arrived to take them to the day centre. They stated that this had resulted in them attending the day centre without their hearing aids fitted. They said without the hearing aids in it would have been very difficult for them to communicate whilst at the day centre. One relative told us that their family member was diabetic and their calls needed to be on time as they needed to eat at a certain time. The relative stated that although this had not always been achieved they had not always received a call so that they could go and prepare the food for their relative to avoid them becoming unwell. One person told us that care staff assisted them with a shower twice a week. They stated that due to the care staff not attending on two occasions they had not been able to have their shower and had to wait until their next scheduled call. Due to a missed call one person had to go to bed in their day clothes as there was no one available to help them change into their night clothes and without their evening medication. The manager was not aware and there was no record to show if the GP had been contacted about the missed medication and if this would have any effect on the person.

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

People did not always get the information they needed from the service. One person told us, "I would like to know who is coming and at what time." Other people told us that they received a rota so they knew which care staff to expect.

People were not confident that their complaints would be dealt with appropriately. There was not a clear record of all complaints that had been received. From the information available it was not always possible to see what the nature of the complaint had been about, how it had been investigated and if the complainant had been satisfied with the outcome. We were aware of some complaints that had not been included in the complaints log. One person told us that they had complained but they had not had an appropriate response and that they thought the agency was "diabolical." One relative told us they had complained about, "Lots of issues" and stated they had received, "No satisfaction from the office." They said that they had complained about calls being late and the care staff apologised but it was still happening. One person told us that they had phoned the office as the care worker had not arrived at the expected time. The person told us that a member of the office staff stated, "You'll just have to wait. There are people worse off than you."

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There had not been a registered manager working at the service since January 2012. There was a manager in place at the time of the inspection. They had commenced the manager's role in September 2016 and stated that they were in the process of applying to the Commission to become registered. However due to being short staffed the manager had to cover the care calls on a regular basis. The manager stated that this had meant that they had not had enough time to carry out managerial tasks.

The service has not demonstrated that they were regularly monitoring the quality of the service and making the required improvements in a timely manner.

Although audits of care plans and MAR's were in place these were not always being carried out effectively or in a timely manner. For example, the quality and training manager stated that two of the care plans that we had looked at during the inspection and identified that improvements were needed had already been audited. However the areas for improvement had not been identified as part of the audit. We received information at the end of October that the MAR's for September had still not been audited. Audits should be carried out in a timely manner so that any issues identified could be dealt with without delay. One audit of one person's MAR's for September stated that there were no issues that needed further discussion with the manager. However there were issues that had not been investigated as part of the audit. The manager stated that she should have been shown the audit but had not been.

There was no record of visits from a representative of the provider for Better Healthcare (Cambridge). Although there was an area manager and quality and training manager who both had an oversight of the service there was no record of monitoring visits or areas they had identified for improvement.

Despite other health and social care professionals providing support and information on how to improve the service, issues had not been addressed to make the changes in a timely manner. For example, the Cambridgeshire County Council report from their contract monitoring visit in October 2015 had identified improvements were required in relation to care plans, medication, risk assessments, audits and complaints. However on subsequent follow up visits in May and July 2016 the required improvements had still not been made. Although the service was providing weekly updates to the Council not all action points had been completed. We found during this inspection that the same areas remained an issue.

Although some missed calls had been recorded and investigated it was not clear if this was the case for all missed calls. We requested extra information about the number of missed calls since August 2016.. However due to the lack of clear recording the manager found it difficult to determine the exact number of occasions that there had been missed calls. Although the manager and provider were aware of the issue of missed calls these continued to be a problem.

Action had not always been taken in a timely manner to establish a plan for who would provide care in the event of staff being absent. For example, we asked what arrangements had been made so that in the event of a member of staff having unplanned absence over the weekend people would still receive their call. There

was uncertainty about whose responsibility it was to ensure there was a contingency plan in place. It was only identified as a result of our enquiring about the arrangements at 2pm that nobody had organised the cover for the following two days.

Incidents that occurred when staff were working with people had not always been recorded. Staff told us that although they had been injured whilst carrying out care calls they had not recorded this in an incident report. This had meant that the incidents had not been investigated or the necessary action taken to prevent reoccurrence.

There was not an effective complaints system in place. Not all complaints had been recorded. People told us that they didn't feel their complaints were dealt with appropriately.

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

The provider had not always notified the commission of events that had happened as required by the regulations. For example, the provider had not notified the commission who was managing the service.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

The provider had not notified the Commission that there was an insufficient number of suitably qualified, skilled and experienced staff to meet people's needs. The Commission had not been notified of any allegations of abuse towards people who use the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) regulations 2014.

The daily logs completed by the care staff detailing what action they had taken during their call had been audited and identified a number of issues . The issues included the full names of staff not being used, inappropriate terminology and leaving notes for the next member of staff.An email had been sent to the staff stating what the issues were and how the logs should be completed in future.

The quality and training manager stated that new systems were being implemented that would provide better governance of the service. They said that these procedures were being put into place so that any complaints, missed calls and incidents would be recorded and reported to the quality and training manager. The outcome of audits would also be shared with the quality and training manager. They would then provide an overview of the quality of the service and identify any areas for improvement.

Staff stated that they thought the manager was approachable and that they felt confident discussing any issues with them.

People had been asked their views about the quality of the service by a telephone questionnaire. The results had been collated into a report and action plan. The manager stated that they were also planning to send out a written questionnaire for people to complete.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change Failure to inform the Commission of changes to the management of the service.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to inform the Commission of an insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not protected against the risks associated with a lack of consent, application of the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Procedures had not been established and used for when restraint needed to be used.

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failure to ensure that the recruitment procedure has been operated effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure that service users' care is appropriate because their care has not been planned and delivered with a view to achieving their preferences and ensuring their needs are met.

The enforcement action we took:

NoP to impose a condition to restrict the taking on of new packages without the prior written agreement of the Commission.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to assess all of the risks and do all that is reasonably practicable to mitigate the risk. You have failed to ensure the proper and safe use of medicines.

The enforcement action we took:

NoP to impose a condition to restrict the taking of new service users without the prior written consent of the commission.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Failure to ensure that complaints are investigated and that necessary and proportionate action is taken to remedy any service failures identified.

The enforcement action we took:

Notice or Proposal to impose a condition to restrict the taking of new service users without the prior written agreement of the Commission.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Failure to ensure that you have systems and processes that ensure that you are able to meet other requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A),

The enforcement action we took:

Notice of proposal to impose a condition to restrict the taking on of new service users without the prior written consent of the Commission.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure that sufficient numbers of staff are deployed to meet the needs of service users.

The enforcement action we took:

Notice of proposal to impose a condition to restrict the taking on of new service users without the proper written consent of the Commission.