ASD UK Network LTD

SureCare Oxfordshire

Inspection report

Unit 2, Home Farm Barns
Thrupp Lane, Radley
Abingdon
Oxfordshire
OX14 3NG

Tel: 01235798867
Website: www.surecare.co.uk

Date of inspection visit:
15 November 2016
25 November 2016

Date of publication:
13 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of SureCare Oxfordshire on 15 November 2016. We also visited on 25 November 2016 to complete our inspection. SureCare Oxfordshire is a domiciliary care agency that operates in the Oxfordshire area. The agency provides support for personal care (including live-in care staff), social care and domestic services to adults in their own homes. At the time of our inspection there were 63 people being supported by the service.

We carried out an unannounced comprehensive inspection of this service as we had received concerns in relation to people's safety. One of the reasons for initiating this inspection was the Care Quality Commission (CQC) had received some information relating to concerns about people's safety in respect of how the service was being managed.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although people we spoke with told us they felt safe we found a lack of evidence to assure us that all care staff had the necessary qualifications, skill and experience to carry out care tasks. Not all staff had received the training the provider had stated was necessary before they delivered care.

Risks to people's specific needs had not been thoroughly assessed. This meant people could be at risk of unsafe care.

Staff had not received consistent supervision meetings with their managers to ensure they were supported to carry out their roles safely and effectively.

People and their relatives said most staff had a caring approach. Staff demonstrated knowledge about the people they supported and wanted to make a positive difference to people.

People were involved in assessments about their needs and in planning their care. However, care plans did not always reflect their current needs and the support they required to meet those needs.

Concerns or complaints had not always been responded to in line with the organisation's policy.

The quality assurance systems were not monitoring performance to drive continuous improvement. We had identified a number of concerns during our inspection and we found there was a lack of monitoring by the provider and the registered manager.

The provider did not always send notifications to CQC as required by the conditions of their registration.

Following the inspection, the provider contacted us with an action plan addressing all the issues we identified during feedback on the day of our visit. The action plan had clear timescales set to address the concerns promptly.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We also found one breach of the Care Quality Commission (Registration) Regulations 2009.

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?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Not all staff had received training or been assessed they were competent in this area.

Care plans did not contain details of risks associated with people's care and support needs. Where risks were present there were no plans in place to manage the risks.

Not all staff had completed safeguarding training prior to working with people.

People said they felt safe with the care staff that supported them.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not completed the training necessary to gain or maintain their skills and knowledge.

Staff had not received regular supervision to support them in their roles and ensure they were working safely and effectively.

People were supported to access health professionals when required.

Is the service caring?

Good

The service was caring.

People said they were treated with dignity and respect.

People felt cared for and were positive about staff supporting them.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always reflect their current needs and the support they required to meet those needs.

Complaints were not always dealt with in line with the service's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider and registered manager had not ensured there were effective systems in place to monitor and improve the quality of care.

The provider was not always notifying CQC of notifiable events as required by condition of their registration.

The registered manager was approachable and spent time with people.

SureCare Oxfordshire

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 15 and 25 November 2016. The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

We spoke with three people who received care from SureCare Oxfordshire and 13 of their relatives. We also spent time at the SureCare Oxfordshire office. We spoke with four care staff, the provider and the registered manager.

We looked at the care records for seven people being supported, including their medication records, nine staff files and other records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from potential risks as these had not been adequately assessed and there were not always plans in place to manage risks identified. For example, one person suffered from two medical conditions. These were recorded in their full care needs assessment. There were no risk assessments in place in respect of these conditions and no guidance for staff regarding the management of these conditions. The provider's risk management policy stated 'Generic risk assessment will determine, along with the care needs assessment, what, if any further assessments are required. These may include bathing and showering, manual handling, any equipment to be used, medicines and finances'. Further assessments had not been completed for this person and we could not be sure the provider had taken all reasonable steps to minimise risks.

The provider and registered manager had not followed a risk assessment they had put in place to manage a staff situation. When this had been enquired about prior to the inspection, the provider assured the local authority safeguarding team and the CQC that they were following the risk assessment. We found this was not the case and therefore the provider was not doing all they could to ensure the risk was managed to make sure people were safe from potential harm.

The provider had not ensured that all staff had the competence and skills to safely care for people. Three members of staff did not have any record of safeguarding training taking place in line with the provider's policy. The provider's safeguarding policy stated 'All staff will undergo formal training on safeguarding which shall include how to identify the differing types of abuse and how to raise suspicions. All staff members receive training during their induction to make sure they understand the agency's policy regarding adults at risk who need specific measures to keep them fully safe'. However, we saw two new care staff had not completed most of the training, including safeguarding until after the date of the date of the first inspection visit. There was also evidence staff had been supporting people prior to receiving safeguarding training which was against provider's policy.

There was not sufficient staff to meet people's needs and people told us missed visits were a concern. We had comments such as, "Sometimes they don't turn up and no one lets me know. Today they phoned and can't come until 10.30. It is worse at weekends. Often we can't get anyone for Saturday or Sunday" and "Mostly we have the same carers but lately it has gone wrong in the evening" and "Problems mostly in the evenings". People felt that if they got earlier calls they could end up going to bed at 6.15 pm and they did not want to do this. A relative told us the person "Had a lot of banked hours because people (care staff) had not turned up". Another person said that there had been occasions where they did not receive the care call as planned. They had received a call saying "We have no one for you tonight - can you manage on your own?' The person did not feel confident about managing on their own but eventually managed to get to bed. However, this had left them feeling unwell and unsafe. We asked the registered manager how they monitored missed visits. They said they did not have a monitoring system and relied upon people or their relatives phoning them. This meant there was a chance that if people could not raise a missed call themselves, the provider would not know about this, putting people at risk.

Medicines were not always managed safely. The provider did not have a specific medicines policy for SureCare Oxfordshire but used the Oxfordshire Joint Shared Care Protocols (SCP). These protocols had been agreed between stakeholders in Oxfordshire to ensure a consistent, safe approach to the administration of medicines in the community. The policy in the service was dated January 2011. The registered manager said they had not been sent an updated SCP. The policy regarding medicines was very clear about the need to ensure staff competency and stated; 'The provider must ensure that the care worker, before assisting the client with any medication has received training, their competency assessed and 'signed off' as detailed in Section 2 of the Care Task and Training Requirement list levels 1 to 5 of this joint working protocol'. The registered manager said staff completed e-learning on medication when they first started. However, the training records for two members of staff had no records of medicines training. We also looked to see, and asked whether there was any competency assessment and 'sign off' to ensure staff were competent in managing people's medicines. We did not see any evidence of this. This meant the provider could not be certain staff working alone were competent to safely manage people's medicines. One of these staff records had supervision notes stating that the medicines training was completed in September, some months after they had been supporting a person. The registered manager said the training was recorded on another system. We looked at both training systems and neither had details of any medicines training received by the staff member. This meant the provider was not ensuring that all staff were having medicines training and their competency checked before administering medicines to people.

We looked at the way topical medicines [creams] were administered. We saw one person had a Medicines Administration Record (MAR) for their topical creams that had been completed for a two month period and was last recorded at end of May 2016. We asked the registered manager if any more recent MAR charts were available. The registered manager stated the cream was no longer being applied. The person had been reviewed in July 2016 and it stated no changes. However, the person's care plan at the time of this inspection stated the cream was still in use. We could not be sure the person was receiving their medicines as prescribed.

The provider had a policy on Lifting Operations and Lifting Equipment Regulations (LOLER) 1998. These regulations aim to reduce risks to people's health and safety from lifting equipment provided for use at work, such as hoists or slings. The service's policy stated a LOLER record sheet would be 'Completed at the initial assessment and repeated at each and every review'. One person raised concerns that a member of staff did not know how to use the hoist correctly. They were concerned the member of staff did not appear to have been trained. They also felt the care staff was not able to retain information about how to do this. We found there was no record of a re-assessment of the member of staff or evidence of further training to ensure they understood how to use the hoist safely. We asked the registered manager about this and they stated care staff were trained in this person's home and records of this would be in the home file. As there was no evidence on any records in the office of this staff member's training for supporting this person it was uncertain what action had been taken to ensure the staff member was competent or needed re-training. There was no manual handling risk assessment to guide staff how to minimise any harm during the use of the hoist.

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

We spoke with staff and asked them about their understanding and knowledge of identifying abuse and how this would be reported. Most staff said they had some training around abuse and safeguarding and understood what action to take. One member of staff said, "The registered manager went through it all a few weeks ago. I would report to my supervisor, manager then go to social services".

People we spoke with told us they were happy with the way they were supported with their medicines.

Most people and their relatives we spoke with said that they felt people were safe with the staff. One relative said 'I know people do get abused but the carers are really nice and treat [relative] with respect'. Everyone we spoke with was confident about what they would do if they were worried about abuse. For example, contacting the manager, contacting their Community Psychiatric Nurse or social worker. People were happy about how their belongings were treated.

We heard examples of people feeling safe when receiving support and they gave examples such as making sure the wheelchair was switched off before the person got out of it, making sure they took their medicines and safety in the shower. One person said 'They are pretty good on safety'.

Records relating to recruitment of new staff contained relevant checks that had been completed. Staff files evidenced identity checks, work permits (if needed) and disclosure and barring service (DBS) checks. These checks identified if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive training required for their roles. We spoke with the provider and registered manager about the induction process for new staff. They said care staff were provided with access details to complete on-line training that covered the standards set out in the Care Certificate. The Care Certificate is an identified set of 15 standards that care workers complete during their induction and adhere to in their daily working life. Manual handling training was delivered face to face. We were told that new staff then undertook 10 hours of shadowing more experienced staff before they worked alone. However, we did not find any records on one staff file about any training undertaken in their current employment with SureCare. We asked the provider and they said the staff member had only returned to work after some absence. There was no evidence of any training for this staff member. We were told by the registered manager that training had taken place directly with the live-in carer but we saw no records on the person's care plan or daily records that this had taken place.

Relative's said the provider had not been able to get the right sort of staff to ensure people's needs were responded to. One commented, "It was all very rushed to start with. We had a few problems - it was quite a nightmare". This person explained this related to live-in carers and their suitability. They stated, "They were very poor, which put us on a bad footing. However, I am really happy with them now. I have no concerns at all'. Another relative said, "I think the challenges for the agency is getting the right quality of staff". Another relative said, "At the beginning we had two or three new ones, but now I like [the care worker] very much" and a person who was currently having mixed experiences of care staff said "If you've got a good carer it makes a difference to your day".

Staff had not received regular supervision meetings to ensure they had the support needed to effectively do their jobs. Records stated that a supervision meeting should take place two weeks after a new starter's spot check and four weeks after starting work. However, one staff member did not have any supervision recorded until five months after they had started and another staff member had their first supervision six months after they started.

We asked staff about their understanding of The Mental Capacity Act 2005 (MCA). This Act provides a legal framework to assess people's capacity to make certain decisions, at a certain time. Staff were able to tell us about the key principles of the MCA. We asked the registered manager who said staff had been trained in the MCA and she had done a course herself a few months ago. However, staff had no records of having MCA training. Most people using the service were able to understand and consent to their care. A person told us '[Care staff] always ask me what I want'. We saw people's consent to care was recorded in care files. However, we saw a record where a relative had signed a consent form on a person's behalf. We asked the registered manager who said the relative had a Lasting Power of Attorney and the person could not physically sign, but no evidence of this was available on the person's file.

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

People felt most care staff were capable and appeared to be trained and know what they were doing. We saw some specialist training had been provided to staff when needed. For example, how to deliver care needed in relation to providing nutrition via a tube into the stomach, looking after a tracheotomy (a system to assist breathing), or catheter care. Another relative told us their relative's live-in carer had definitely had training to use the hoist and was also inducted by the outgoing carer about how to support their relative to eat and drink.

Staff felt supported by management and felt they had regular opportunities to talk if they needed to. A staff member said, "Yes, I feel supported and can talk to anyone in the office at any time".

Where people required food to be prepared for them, people told us they chose what they wanted to eat and drink. Care plans contained details of people's nutrition and hydration needs and the support they required, for example, to ensure a person had a hot meal daily.

Staff kept the registered manager updated about any concerns and health professionals were contacted on behalf of the person, including GPs and district nurses. This ensured that people living in their own homes who may be isolated were able to be referred without delay to ensure their wellbeing and safety. We were told staff noticed when needs changed and took appropriate action. A relative said, "[The carer] has got to know [my relative] really well and would notice if there was anything wrong". Another relative said that the care staff would e-mail or call if they had any concerns about their relative. We heard an example of when care staff had contacted the doctor because they were concerned about the medication their relative was on. The doctor then realised that the medication was incorrect. We heard from another relative that care staff will suggest when they need to contact the GP and are also knowledgeable about other services. This person said "A level of vigilance is there".

Good

Is the service caring?

Our findings

People and their relatives were mostly positively about most staff. However, concerns were raised about how the rota's and timing of calls impacted upon choices around getting up in the morning and going to bed at night.

The majority of people and relatives we spoke with felt the care staff were very caring. Comments included, "[Name] is very friendly and very capable. She is the best", "[The carer] is kind, considerate and listens to what you say. We couldn't ask for a better carer", 'I met one and they seemed lovely and went above and beyond their duty", "They are perfect in every way. They listen to me and they do things I want doing" and "They are very cheerful and friendly. I have no complaints on that score. Two people who are regular, they are very helpful" and "The carers are absolutely fantastic". A relative commented, "The carer is good. Works out what [my relative] is talking about" and "I have all the support I need".

People told us that their privacy was respected during care tasks. A relative described when their relative needed care they were always politely asked to wait in another room. Another person described how their relative was changed in bed and that the curtains are always closed.

People's independence was promoted. People said they were offered encouragement to do as many tasks as they could. A relative said, "[Care staff] encourages [relation] to do things but dries their feet and back because they can't reach them. They are kind and considerate". Another person said, "I tell [care staff] when I want help with my back or under my arms. She does help me a lot".

People were involved in making decisions about support they received. Although not all people were offered a choice about the staff that supported them, some people had requested particular care staff and this had happened. One person described a carer by name as "Fantastic. If I had the chance I would have [name] full-time. They are the one who sorts things out". One care staff said, "I have regular clients so I get to build relationships".

Staff spoke warmly of people they supported and clearly knew them well. Staff enjoyed their job and were enthusiastic about providing good quality care. Staff understood the importance of building relationships of trust and respect to enable people to feel confident and comfortable about staff coming into their home. Comments from staff included, "Everything I do is about the person. I involve the client in every discussion. Tell them what I'm going to do and why" and "Don't treat the disease, treat the person" and "Must earn respect, make them feel safe".

Requires Improvement

Is the service responsive?

Our findings

People's said they had been involved in assessing their care needs before using the service and said they had been involved in developing their care plans. Relatives and professionals were also involved in the assessment to ensure all information was accurate.

People's care plans had notes stating they had been reviewed in order to discuss whether people's needs had changed. However, these changes had not been updated on the care plan. For example, we saw a person had their care plan reviewed in July 2016 and there were concerns about the care workers use of the hoist and some staff not being confident using it. We were also told the district nurse needed to be at the home at the same time as the care visit but there was no information about any changes to the care plan to reflect any action that had taken place about care workers using the hoist or timing of visits to coincide with the district nurse visit. We raised this with the registered manager who said that more information would be in the person's home file. We spoke with the person's relative and they stated the care plan on their home file was not accurate and they still had concerns about how their relative was being hoisted. They also said their relative's health had deteriorated markedly and the information was not up to date to show the care that was currently needed. People's care plans were therefore not reflecting their support needs to enable care workers to deliver the appropriate care and support.

People told us they felt able to make complaints and knew how to complain. However, we saw the service had not responded to complaints in line with the organisation's complaints policy. For example, the complaints policy stated that complaints would be acknowledged within three working days and updates on progress of investigations will be provided every 7 days. Investigations into complaints are held within 28 days and responded to in writing. We found not all complaints had been dealt with in line with this policy. We saw concerns had been raised about the support a relative was receiving about missed calls, late calls meaning the person's medicines were given late and quality of food. We spoke with the person's relative who said they had met with the registered manager and given them time to rectify the problems but that three weeks later the concerns had not been dealt with. The registered manager said that they felt the complaint had been adequately addressed but we did not see any evidence of how this was investigated and that it was responded to in writing as per the policy.

People told us they complained about the way they were invoiced for their care. One person said: 'We've had great difficulty with the accounting. We did put in a complaint and they did not respond at all. They could certainly tidy up their act a bit". They went on to say how stressful this had been but also added that more recently "They have tightened that [invoicing] up now. That seems to be under control". The provider explained they now had an accountant and this had helped the situation to improve more recently.

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

Care plans contained a one page profile describing what was important to the person, for example 'Travelling and watching trains'. There was also information on people's medical conditions, mobility,

communication, nutrition and personal care. Care plans showed consent to care and treatment which were signed and dated. People confirmed they had care plans in their homes and that care staff wrote notes at each visit. One staff member stated "I find the care plans are helpful".

Requires Improvement

Is the service well-led?

Our findings

Prior to the inspection, concerns had been raised about the management of the service, the lack of training for staff, missed calls and lack of checks on staff before they started working for the service.

People commented they found communicating with the service problematic. People said the service did not respond well to emergencies and they had particular difficulties to contact the staff at weekends. For example, one person said "At weekends things get into more of a muddle" and "You get through and then there are buttons. I don't always know which number to press. I should be able to get through straight away". Another person said they had called the office and left a message but no-one returned their call. We asked the registered manager how calls were logged and she stated that not all calls were logged. Therefore, there was not a consistent record of people's calls. People said the responsiveness of the agency was poor. One person said, "Depends on who you speak to in the office". People had concerns about the rotas. One person said, "They are peculiar rotas - they made it so you never knew if they were coming. We were often left without carers. I would always ring - there was never any efficiency. They were not always responsive'. They said, "The way they do the rota it isn't checked properly. There is no travel time - that means they are late and stressed. They need to be fair to carers. They are better than they used to be but they still need to check and double check'.

The service did not have adequate processes or systems in order to evaluate the effectiveness of the service and ensure that other requirements in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

We saw an audit policy stating 'SureCare will critically analyse its own performance on a regular basis by carrying out internal audits. A calendar of audits will be drawn up and displayed prominently in the company offices". The registered manager said care files were audited but we saw no evidence of these or MAR audits which we were told were audited when the care plans came into the office. We saw some evidence of staff files being audited after our first visit on the 15 November 2016.

We asked for, but did not see, any audits of risks assessments, training or medicines. This meant systems and processes were not in place to monitor the safety and effectiveness and quality of the service and to enable improvements where needed.

The service's quality assurance policy stated they would make announced/unannounced visits to homes where care was delivered, and make phone calls to ascertain people's satisfaction. People had been asked to give feedback through a questionnaire or a phone call. One person felt this was difficult as questions about care staff 'Depend on which care staff you are talking about". We saw a recent questionnaire had been returned and concerns had been raised in relation to moving and lifting, washing and bathing and helping with medication. There was no evidence any action had been taken in relation to this concern. We raised this with the registered manager and asked how questionnaires were evaluated. The registered manager stated she saw them all, although she acknowledged she had not seen this one as she had been on annual leave. There was no record of how the feedback received from people was evaluated and acted upon.

The provider's induction checklist stated that a spot check would take place two weeks after new staff started working alone to ensure they were carrying out their role competently. However, we saw one staff member's records which showed they had not been checked until two months after they started working with people. Another staff member, had no checks recorded until three months after they started. We asked the registered manager why these had not taken place. The registered manager told us this was due to senior staff shortage that impacted upon the checks being completed.

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

The provider's accidents and incidents policy stated 'All must be recorded and reported to management'. We viewed the accident /incident book and noted there were only two entries over the past 11 months and these were related to staff incidents only. We saw some incidents that had been passed to the Care Quality Commission by whistle-blowers had not been recorded or reported as needed. For example, the incident when a care worker had allegedly given a person a potentially harmful substance in error.

The service had not sent notification of incidents and events which were notifiable under current legislation. Statutory notifications help Care Quality Commission to be updated and monitor key elements of the service. For example, there had been an incident involving a hoist and this was not reported to the CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People knew who the registered manager was and felt they could contact them if they were worried about something. Office staff were described as polite and friendly "The carers were absolutely fantastic, but I wouldn't say the same for the company". Staff said they enjoyed their roles and spoke positively about the registered manager and provider. Comments included, "[Registered manager] is approachable and supportive I can talk to her and [Provider], "They are pretty good at sorting problems", "I'm in touch very frequently and report everything. I get a very good response and always follow up. Excellent personal touch".

Staff felt the provider offered a good service to people. One comment was "Good care provider, I believe they do genuinely care. Not only about the client but families and carer staff as well". "The provider is very hands on and [registered manager] caring too so that feeds into everything they do".

Staff knew how to raise concerns. There was a whistle blowing policy in place that was available to staff and had knowledge of the process of using this and who to contact.

When gaining feedback from people who use the service they did report that some of the problems were historical and that things had improved more recently. For example, one person said "There were a few problems in the early stages" and "I think people in this care company are really trying to improve but they need to do a lot more", "Historically it has been complicated, but they have been responsive to what I say about what works now" and "There has been an improvement in the agency and they are more responsive".

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 18 Registration Regulations 2009 Notifications of other incidents The service had not sent notifications of incidents and events which were notifiable.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records had not been updated to reflect people's current care needs. Complaints had not been consistently responded to in line with the complaints policy. The service did not have adequate processes or systems in place to evaluate the safety and effectiveness of the service. Regulation 17(1) and (2) (a)(b)(c)(d)(f)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive training required for their roles. Staff had not always received regular support needed to effectively do their jobs. Regulation 18(2) (a)

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Not all staff had received training or been assessed they were competent in this area. Care plans did not contain details of risks associated with people's care and support needs. Where risks were present there were no plans in place to manage the risks. Not all staff had completed safeguarding training prior to working with people. Regulation 12(1) and (2), (2) (a), (b), (c) and (g)

The enforcement action we took:

A warning notice was issued to the provider