Phoenix Medical Advice And Repatriation Limited

Phoenix Medical Advice And Repatriation Limited

Inspection report

Elsinore House
43 Buckingham Street
Aylesbury
Buckinghamshire
HP20 2NQ

Tel: 01296422499

Date of inspection visit:
05 September 2017
06 September 2017

Date of publication:
03 October 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

This announced inspection took place on 5 and 6 September 2017. Phoenix Medical Advice And Repatriation Limited provides care including nursing care to children and adults in their own home. At the time of the inspection the service was providing support to adults and children in their own homes, sixteen of whom were receiving personal care.

A registered manager had been in post for six weeks prior to the inspection. During this time they had identified a number of areas that required improvements. They had developed a service development plan, which had documented these areas. We saw that some changes had been initiated.

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.

People had been left without staff to cover their visits due to a shortage of staff. Staff rotas had not been completed accurately and staff were sometime expected to work long hours to cover for staff absence or gaps in the rota. The provider was planning to introduce a rapid response team to address these issues.

Medicine records were not filled in accurately. Information related to the prescribed medicine was not comprehensive, and unexplained gaps were found on a number of Medicine Administration Record (MAR) charts. Checks carried out by the lead nurse did not identify the concerns we found.

Recruitment practices did not evidence that gaps in employment history had been followed up with candidates. We have made a recommendation to the provider regarding safe recruitment systems.

Mental capacity assessments had not always been completed, and the best interest process had not always been followed. This meant people were not supported to have maximum choice and control of their lives. For one person it did not appear that staff supported them in the least restrictive way possible as restrictions were placed on the number of visitors without a stated good reason.

Staff received training and support to carry out their role. However, we found competency checks and observations were not always carried out, which meant the provider could not assure themselves, staff were carrying out care in a safe and appropriate way.

The registered manager had put plans in place to ensure staff supervision and appraisals were to be carried out regularly.

People had support with their food and fluid intake. Where people required medical support this was arranged to help them maintain good health.

People's relatives told us staff were positive and caring. We were given examples of where staff had gone over and above their required duties to assist people. Staff showed concern for people in a caring and meaningful manner. Staff showed respect for people and understood the importance of enabling people to be as independent as possible.

Records did not consistently demonstrate the service had identified and assessed monitored and mitigated risks to people's health, safety and welfare. Care plans and risk assessments were not detailed and did not cover all areas of risk to people or staff.

People and their relatives had struggled to maintain effective communication with office staff. Relatives told us concerns they shared with the office were not responded to. The provider was not fulfilling their role of listening to people and addressing problems or concerns in a timely manner. A lack of leadership and oversight of the service had led to staff feeling stressed and upset. With the introduction of the new registered manager some relatives told us they had seen a slight improvement in communication.

The provider had failed to put in place effective audit tools, to monitor and improve the service delivery. The registered manager had developed a service improvement plan and was working towards covering most of the areas we had identified to enhance the service to people.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were placed a risk of harm because we found errors in the recording of medicines. Checks of records did not accurately reflect our findings.

Recruitment checks were not comprehensive, and did not protect people from the risk of being cared for by unsuitable staff.

Staff levels did not ensure people could receive the support and care they needed at the time they needed it.

Is the service effective?

Requires Improvement

The service was not always effective

Records showed people had access to health care appointments when needed. This ensured people's health needs were maintained.

People were placed at risk as records related to care were not always detailed and risks were not always identified or mitigated.

Records did not reflect a clear understanding and implementation of the requirements of the Mental Capacity Act 2005. Best interest processes were not always followed or documented.

Is the service caring?

Good

The service was caring.

Staff demonstrated a genuine fondness for the people they were caring for, this was appreciated by people and their relatives.

Staff demonstrated how they protected people's privacy and dignity. They were able to give examples of how they showed respect to people.

Some staff went over and above the call of duty by providing

support and contact with people which was meaningful and well received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were placed at risk of receiving unsafe care, as risk assessments and care records were not all accurate or up to date.

The service did not have a complaints log. Without a complaints log, it would be difficult for the registered manager to oversee the management of complaints.

Is the service well-led?

Requires Improvement

The service was not well led

The lack of effective and consistent management in the service had resulted in a reduced standard of care in some areas. A new registered manager is now in post.

Records and care practices had not been monitored. There had been a lack of oversight of the service. This meant that improvements had not been identified or implemented.

The provider was not fulfilling their role of listening to people and addressing problems or concerns in a timely manner. A lack of leadership and oversight of the service had led to staff feeling stressed and upset. This was not conducive to good quality care.

Phoenix Medical Advice And Repatriation 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 5 and 6 September 2017 and was announced. The provider was given notice because the location provides a domiciliary care service; we needed to be sure that someone would be available to assist with the inspection.

The inspection was carried out by two experts by experience and an inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. For example dementia care.

Prior to and after the inspection, we reviewed information we held about the service including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

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. We reviewed the completed PIR and used this to inform our inspection.

We spoke with six relatives of people who used the service, and ten staff including the registered manager, a company director, staff trainer, the medical service divisional manager, the lead nurses for adults and children and four care staff. We also spoke with the company owner. We contacted health care professionals involved with the commissioning of services to obtain their views about the care provided. We received two responses.

We reviewed a range of records about people's care and how the service was managed. These included care records for four people, medicine administration record (MAR) charts and other records relating to the management of the service. We examined staff training records and support and employment records for four staff. Other documents we viewed included a service development plan and minutes of meetings with staff amongst others.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us the service was safe, comments included "It's a very safe service. [Named person's] safety has always been first and foremost. I have never been concerned about her safety." "I have no hesitation leaving our daughter alone with the nurses."

Prior to the inspection we were made aware from a service commissioner there were concerns about a lack of staff working at the service. People's relatives stated there had been occasions when staff had not turned up for visits. They told us "They [staff] missed out on a couple of Saturdays and they relied on me to cover." "Sometimes there is no cover for shifts." Staff explained to us the impact of not having available staff. They told us this meant they had to work long and extensive hours. For example, one staff member described how on occasions they had to work over 24 hours. They told us "It puts us under a lot of stress." Another staff member told us how the lack of available staff placed strain on to the family members, some of whom were already feeling pressurised.

We spoke with the registered manager about this concern. They told us they had plans in place to introduce a rapid response team. This would be made up of contracted staff that would cover in the absence of regular staff. In this way they would be able to minimise the risk of staff not being available to support people and thereby placing them at risk. People's relatives and staff also complained about the inaccuracy and gaps in the staff rotas. They told us they could not always be confident which staff member was visiting as rotas were inaccurate. There had recently been a change to the staff member responsible for completing the staff rotas. One person's relatives told us they had seen an improvement.

Some aspects of people's safety and well-being had been considered by the service and steps had been taken to ensure that the risk of harm had been assessed. Environmental risk assessments were in place alongside risk assessments related to the care provided for people. However, we found some care plans referred to protocols set out by health professionals, for example, one person who experienced epilepsy had a protocol for seizure management. This was not available in the office and we were told it was held in the person's home. Another care plan referred to a protocol to be used when administering medicines to a person. Neither of these records were available in the office.

Without access to such records the registered manager would not be able to assess if the information in care plans and risk assessments was up to date and accurate. We spoke to the registered manager about this; they told us they were planning to check all the protocols and to keep copies in the office. We found the care plans and risk assessments lacked detail, and did not cover all areas related to the care being provided. For example medicines and the use of specialised equipment.

Risks had been assessed, although not all were identified. For example, some people used particular equipment such as specialised wheelchair. In one person's care plan it stated that a risk assessment was required for all the equipment the person used, however this was not evident in the information we saw. Another person's care plan stated "Ensure [named person] is always positioned in a safe place." There was no guidance to describe how or what this would be. Another person's care plan stated they were at risk of

"gagging" or choking on food. There was no risk assessment in place for this. We were told when assessed by the speech and language therapist they found no risk of choking. This was contradictory to what was in the care plan. We were told by a staff member that they performed an invasive procedure to assist the person's bowel function. This was not recorded in the person's care plan and the risks associated with this procedure were not identified or recorded. Without clear guidance for staff on how to provide person centred care and manage risks associated with care people were placed at risk of harm.

We looked at records related to the administration of medicines. We found Medicine Administration Records (MAR) charts were not designed or completed in line with good practice guidelines. For example, one MAR chart didn't have the person's name on it. Another MAR chart had a repeated record of the same medicines information half way down the page. This placed staff at risk of doubling the amount of medicines being administered. We found gaps on some people's records which suggested the person had not been given their medicines, but found no space on the chart to explain why this was. We spoke with the lead nurse about this, they told us where there were gaps on the MAR chart an explanation would have been documented in the daily evaluation sheets. We cross referenced some of the gaps with the evaluation sheets and found no explanation was documented.

For another person staff signed to state the relative had administered medicines, without observing this had been done. Where hand written amendments had been made to a MAR chart, there was no double signature to evidence the information had been checked and was correct. For some medicines there was no description of the form of the medicine whether tablets, or liquid. On one MAR chart for Paracetamol there was no information regarding the maximum amount the person could take safely. The MAR charts had been checked by the Lead nurse, however we found no evidence the errors we found had been identified or any improvement action taken. Without clear and accurate records the provider could not demonstrate people were receiving their medicines in a safe way. This placed people at risk of harm.

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

The provider had systems in place to recruit staff. This included obtaining an application form, following up references and interviewing staff, along with a basic English and mathematics test. The records showed each successful candidate was checked through the disclosure and barring service. This is a service which specifies if employees have any previous history that is known to place them at risk to working with adults or children. We found the employment records did not evidence the provider had checked on gaps in employment histories. For example, one person had recorded in their application they had had two career breaks. There were no records to show this had been investigated further with the candidate. Another candidate's reference indicated they had been subject to disciplinary action in their previous job. There were no records to show this had been followed up or checked by the provider. Without robust systems in place to check the history of candidates, the provider was placing people at risk.

We recommend that the service consider current guidance on safe recruitment systems and take action to update their practice accordingly.

Staff had received training in how to protect children and adults from abuse. They were aware of the indicators of abuse and what action to take if they had concerns. We spoke with the registered manager about how their knowledge of how to safeguard people. The registered manager had updated the safeguarding policy to include areas such as honour based violence and female genital mutilation. The registered manager planned to set up systems to monitor and record all safeguarding concerns. This would

ensure they were able to identify any trends, and learn lessons from reported safeguarding concerns. At the time of the inspection this was not available.

Staff understood the whistleblowing policy. They knew how to report concerns both within the organisation and externally. They told us they would have no hesitation on raising any concerns.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The care plans did not include mental capacity assessments for adults whose capacity to make decisions was questionable. There was no evidence staff had followed best interest decision making on behalf of people who lacked the capacity to make decisions for themselves. Staff told us about a person who was vulnerable as they were easily influenced by others. Their care plan stated "Carers must limit the amount of visitors [person] has." There were no reasons given for this statement. Without a mental capacity assessment or process to establish the best interest of the person, this could be deemed to be an infringement of their human rights. Article 8 of the European Convention on Human Right states everyone has a right to respect for their family and private life without interference. Because we did not see any evidence as to why this was recorded in the care plan we could not be certain the person was being restricted. Following the inspection we spoke with the registered manager who agreed this needed further investigation. If a restriction was found to be happening they knew how to obtain authorisation from the court of protection.

There were no records that demonstrated people had consented to the care they were receiving. We spoke with the registered manager about this. They told us they were aware of the situation, and were planning on obtaining and recording consent from people or their legal representatives. This would then be recorded in each person's care plan. They had also identified the lack of records in relation to mental capacity assessments and best interest processes being followed. This was in conflict with the MCA requirements and associated codes of practice. All staff received training in MCA however when we spoke with them one staff member told us "I am not sure I fully understand it." Other staff were able to tell us about some aspects of the Act, but were not fully clear how it related to the person they were caring for. This placed people at risk of experiencing infringements to their human rights.

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

The provider information return (PIR) told us that three monthly observations were carried out on staff, to ensure any concerns with their practice could be identified and addressed. However, when we spoke with people's relatives and staff we found this was not always the case. One relative told us "They have started doing spot checks. In May/June they called to say they needed to do an observation to make sure things are safe." They told us there had been no spot checks in the first year of receiving care from the provider. Another person told us they felt spot checks on staff "Could be done better to check up on what is provided."

One staff member told us they had been observed carrying out catheter care by the lead nurse. Three staff told us they had not had any observations carried out on their practice by senior staff. We spoke with the lead nurse for adults; they told us they sometimes carried out telephone questions with staff to test their knowledge and skills.

We spoke with a staff member who told us they carried out a procedure to assist someone with bowel movements. We asked if they had been trained and if their competency had been assessed. They told us they had received training many years previously in another employment and their competency had not been assessed since working at Phoenix Medical Advice And Repatriation Limited. The National Institute for Excellence (NICE) guidelines state that staff should have received appropriate training, provided by a qualified healthcare practitioner competent in this area of care, and be deemed capable to meet the individual's bowel care needs. Following the inspection we received information the other staff working with the person also had out of date training. The provider was taking action to address this. Other areas staff told us they had not been assessed as competent were in areas such as medicines administration. This meant people were placed at risk as the skills and competency of staff had not always been assessed and some training was not up to date.

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

There was a mixed response from people's relatives when asked if they felt the staff were suitably trained. Comments included "We had a young girl [staff], very good care, but not so good with sensory care and educational play". Another told us "Epileptic seizures they need specialist training for. Yes they can deal with his seizures". Records showed all staff received training deemed to be mandatory by the provider. For example, fire safety and safeguarding adults and children amongst others. Specialist training was also provided to staff who worked with people who had specific health needs for example, catheter care and tracheostomy care. This enabled staff to meet the needs of the people they were supporting. The provider had employed an internal trainer. Staff spoke highly of their skills. One staff member told us if they were unsure about any aspect of care the trainer would design specific training for them. Another staff member told us "If I asked for a refresher course it would be responded to well. [Named trainer] is absolutely brilliant."

The registered manager told us they were aware that supervision and appraisals had not been carried out in line with the provider's policy. They stated each member of staff would receive supervision every three months. The registered manager had started to address the deficit by carrying out supervision with staff. For those staff who had not yet received supervision, dates had been planned to carry this out. Staff told us they felt supported by their line manager. Comments included "She [lead nurse] is wonderful. She is very positive, nothing is too much trouble for her, and she is very knowledgeable, very caring and good with detail." Staff were also invited to attend staff meetings. Although these had not been held regularly due to managerial changes, this was something the registered manager hoped to address in the future.

Where people required support with eating and drinking this was provided by staff. Where people required their food or fluids were to be given through via a Percutaneous Endoscopic Gastrostomy (PEG) rather than orally, staff had received training in this and had been assessed as competent. Staff demonstrated to us they knew people's dietary preferences well and knew how to support people with food and fluids.

People had access to health care professionals and were supported to maintain good health. Reports showed people had received physical and psychological support from specialist healthcare workers such as speech and language therapists and occupational therapists. Staff were clear of the action to take if there

was a health emergency and were confident to call for an ambulance or the GP if appropriate.

Good

Is the service caring?

Our findings

People's relatives told us they had been involved in the planning of care. There were mixed feelings about whether care plans had been kept up to date and accurate. Comments from relatives indicated care plans were not reviewed frequently, others told us this had happened when it was needed. Records we reviewed had been reviewed by staff, but we saw no documents related to care being appraised with people or their relatives.

People's relatives had mixed views about the staff. Comments included "Generally very good, but quite a bit of variability. Some are passive, some more self-driven. It would be nice if Phoenix instilled self-motivation in the carers." "I have never had anyone grumpy or been made to feel uncomfortable. It takes her [child] a while to get on with new people, but she gets on well with them. She loves [named carer] who does a lot of play with her. She [child] smiles for her." Other relatives described the attitude of staff as "Positive."

People's relatives described to us the impact the staff had on the people they cared for. One staff member was described as having "A lovely rapport" with the person. Their relative gave an example of the staff member "Knowing the Harry Potter characters and [daughter's] favourite film." "They make her feel understood. I trust my carers once I know them better and they know me and they show they care." Another relative told us "Just the way that they [staff] talk to her. Her face lights up when [staff] come into the room. She [staff] takes time and patience. It means I know she gets love as well as care."

Relatives told us how staff go over and above the call of duty, for example "The amount of compassion I have seen is phenomenal." "Frequently they [staff] will stay on a bit longer. Helping out at her birthday party." Staff showed concern for a person's wellbeing in a caring and meaningful way. A relative told us when their child was unwell "Some nurses will message me to check to see if she's better." Another relative said "They will drop everything on a shift when [daughter] has to go to hospital. They are an extra pair of hands you can trust."

A relative told us "At Christmas they [staff member] bring a present, and on her birthday. They brought Easter stickers for her, all of their own accord." People's relatives valued the caring attitude of staff.

Staff knew how to protect people's privacy and dignity. They gave us examples of ensuring the environment was private when carrying out personal care. One staff told us how they respected people's privacy by treating information as confidential. Another told us they would stand outside the bathroom rather than entering to ensure the person was safe. Staff knew how to show respect to people, they told us they asked permission before getting themselves a drink. Another told us they showed the person respect by "Making sure they are encouraged to be as independent as possible, giving her the opportunity to make choices. I treat her as an individual who has feelings and ideas." Staff understood the importance of supporting people's independence. One staff reported "I stand by and let her dress herself. I let her do what she can; she doesn't like to be mollycoddled." This meant the care people received acknowledged people's individuality and provided care when needed.

Requires Improvement

Is the service responsive?

Our findings

Prior to people receiving a service from Phoenix Medical Advice And Repatriation Limited, an assessment of their needs was undertaken. From this a care plan and risk assessment had been completed. People's relatives told us a copy of this was kept in people's homes. We found care plans were medical and task orientated, for example there were details relating to people's health and physical welfare. There was little information about the person's like, dislikes and how they wished to be cared for. We found it difficult to find information about them as a person or their chosen lifestyles. Records showed activities the person enjoyed. Care plans were not person centred. One care plan stated the doctor recommended that no alcohol was kept in the house. There were no explanations as to why these safeguards needed to be in place. There was no mental capacity assessment to establish if the person had the capacity to agree with this decision.

Staff told us they knew how to deal with complaints. The provider had a complaints policy and procedure; however, there was no complaint log at the service. This meant we were unable to view what complaints had been made and what resolution had been found. People's relatives told us they had made complaints one person told us they had made a complaint in June 2017. "When [child] fell out of bed it was not recorded that day. I also complained about an out of hour's phone call which was quite discourteous. They just left a message on my mobile. I did complain about that. They did apologise." Other relatives told us they would speak with the lead nurse or contact the manager. Another relative told us of a complaint they had made recently. "There was one time when there was a misunderstanding with one of the carers…I am satisfied with the outcome, and I am waiting for a new carer to be introduced."

Without a complaints log, it would be difficult for the registered manager to oversee the management of complaints. Without this in place they would not be able to drive forward improvement to the service and promote learning from grievances. The registered manager told us they were aware of the lack of information related to complaints. As part of their service development plan we could see they were planning to take action to rectify this.

People's relatives told us they had the opportunity to feedback on the quality of the service through questionnaires sent to them by the provider. Comments included "We had a survey, very long and not filled in yet. A very generic survey. A lot of questions, but not based on paediatric care, not about the actual essence of what they are doing." "Yes questionnaires but I do it verbally. I keep saying it they are under staffed but nothing has been done." Other people felt more positive about the questionnaires, comments included "My main gripe was communication (with the office) and this has been attended to. I think the new management is on the ball. We've definitely been listened to." "They sent a questionnaire fairly recently. I think it's better than it has been." The person mentioned the new registered manager and said "It seems to be improved". We spoke with the registered manager about the use of the questionnaires. Their view was that it needed amending so that it was more specific to the care being provided to individuals. This was part of their plan moving forward.

Requires Improvement

Is the service well-led?

Our findings

A new registered manager had been in place for 6 weeks at the time of this inspection. It was evident from talking to the registered manager, staff and people's relatives there had been a period of instability and poor governance of the service prior to the registered manager coming into post. The impact of this had been felt by some who were providing, receiving and commissioning care.

Prior to the inspection we received information from one health care commissioner informing us that they were dissatisfied with the poor level of communication received from the provider. They described the communication as "Very intermittent as both parents and continuing care had difficulty in getting replies to queries." They specifically referred to gaps in the rotas. As a result they had removed the care package from the provider. People's relatives also commented on poor communication. "I think they need to work on communication, externally and internally, staff retention and training, work flow management. It needs major improvement." "They have not always communicated well and you have to go back a couple of times to get it right. They use email and I'm not entirely sure that things have been passed on." "With the office there is not that much communication. They have only a generic email address and they don't always respond. It goes into thin air. A lot of staff changes in the office. A lot of talk and not a lot of action." One relative told us concerns "Disappear into the ether".

One staff member told us communication with the office staff was a "Bone of contention." They explained "Different departments don't communicate with each other. It is very difficult and annoying." They told us they had been asked to do extra shifts and when they had arrived at the person's home the original staff member was present. Another staff member told us how the poor communication with the office staff had been "Really distressing." Two staff told us they had good communication with the office staff. The issues that arose from poor communication from the main office had impacted on the provider's reputation. People were dissatisfied with the poor response from the provider or registered manager. The provider was not fulfilling their role of listening to people and addressing problems or concerns in a timely manner. A lack of leadership and oversight of the service had led to staff feeling stressed and upset.

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

We spoke with the registered manager about this concern. They were already aware of the concern and were looking at improving communication with people and professionals. They had started to contact people to discuss any concerns they may have had. This was reflected in some of the feedback from people's relatives. One relative told us "I have only spoken to him [registered manager] twice. [Senior staff] has been incredible in communication, and others have been in communication in the past few weeks." "[Registered manager] is very prompt with his communication." "Also, the office has improved considerably in the past month or so."

The service did not have robust quality assurance tools in place. For example, where incidents or accidents had occurred we were told these were recorded in the person's records. There were no accident or incident

logs, so the registered manager or senior staff could not have an overview of incidents that had happened in the service.

The registered manager had started to review aspects of the care being provided and had drawn up a service development plan. As part of the plan they had reviewed some of the care plans and had drawn up an action plan to improve the contents of the care plans and risk assessments. They had examined how communication could be improved with people and staff. Also included in the service development plan was how improvements could be made to areas such as people's access to the complaints procedure, improving the frequency of supervision and appraisals and ensuring service continuity improved. The introduction of regular detailed audits to check on documentation and the quality of care being provided would improve the management oversight of the service. It would also assist with driving forward necessary enhancements.

During the inspection we met with the owner of the service. We highlighted some of the areas we had found that required improvements. We were verbally assured by the owner the registered manager would receive all the support they required in order to improve the service to people and staff. The registered manager demonstrated a clear understanding of the areas needed to be improved and the reasons why they needed to be improved.

We spoke with the registered manager of the requirement to notify the Commission regarding incidents or changes to the service. Historically this had not always been carried out. This is a legal requirement. The registered manager had notified us of some changes, and was aware of the need to ensure notifications were sent promptly to the commission.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to obtain consent from people in relation to care and treatment of service users. Some people's mental capacity had not been assessed. Regulation 11(1) (2) (3) (4).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to maintain the proper and safe management of medicines. People who use services and others were not protected against the risks associated with unsafe or unsuitable care as the provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment. They had not done all that is reasonably practicable to mitigate any such risks. They failed to ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely Regulation 12 (1) (2) (a) (b) (c) (f) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the services

	provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); Regulation 17 (1) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to supply appropriate support and training to staff to enable them to carry out their role effectively and safely. Regulation 18 (1) (2) (a) (b)