Mears Care Limited

Mears Care Limited - Maidstone

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 9 and 10 October 2018. The inspection was announced.

Mears Care Limited (Maidstone) is a domiciliary care agency which provides care and support for people in their own homes. Care is provided for a range of people including older people and people with dementia. The service operates in areas including Margate, Ashford and Medway. Not everyone using Mears Care receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection there were 173 people using the service.

The service had a registered manager. 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.

There were not enough staff to meet the needs of those using the service. This meant people received support which was later than their preferred time, or sometimes did not receive support at all. People were not being respected because they were not being informed of changes to their support, and they told us the uncertainty made them feel anxious. Improvements were not always made effectively as a result of complaints, for examples the service continued to take on additional clients even though people were complaining that there were not enough staff to meet the needs of those already using the service.

People did not always receive their medicines in a safe way. Audits on people's medicine records were not being fully completed, and where errors were identified, these were not always followed up or sufficient steps taken to learn from mistakes. Overarching quality assurance audits of the service were not taking place, so the registered provider was not aware of all the concerns we identified during our inspection.

People were not always receiving care according to their personal preferences. Records showed people's personal preferences were not always considered when providing care. Information was not always being presented to people in a way they could understand.

People were protected from abuse by staff who were trained in how to identify and report abuse. They told us they thought any concerns they had would be treated seriously by their managers. Risks to people were assessed and steps were taken to reduce the risks. Checks were made to ensure newly recruited staff were recruited in line with nationally recognised guidance and best practice.

People's needs were assessed before they started to receive support from staff, but care was not always delivered according to these assessments. Assessments took into account peoples protected characteristics such as their ethnicity and sexuality. Staff were trained to have the skills and knowledge to deliver effective care and support. Newly recruited staff completed a week long induction. Where

responsible, staff supported people to eat and drink enough to maintain a balanced diet.

Staff made referrals to health professionals when required, and worked together to ensure that people received consistent and person-centred support when they moved between different services. The registered manager was working with professionals such as district nurses and occupational therapists to ensure people received joined-up care. When people lacked the capacity to consent to care, staff sought consent from people in line with best practice legislation.

People told us care staff treated them in a compassionate manner, and were mindful of their dignity. Staff supported people to be involved in making decisions about their care. People's personal and confidential information was kept secure. There were procedures in place if people needed support at the end of their life.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about the Care Quality Commission's regulatory response will be added to the report after any representations and appeals have been concluded.

We found an additional shortfall in the service in relation to which we have made a recommendation. This was because the registered provider was not always providing information to people in a way they could understand.

This is the first time the service has been rated Requires Improvement.

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.

There were not enough staff to meet people's needs.

People did not always receive their medicines in a safe way.

Lessons were not always being learned when things went wrong.

People were protected from abuse.

Risks to people were assessed and staff took action to reduce the risks and keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed but care was not always delivered in line with current legislation.

Staff received the training so they could carry out their roles effectively.

Staff worked together across organisations to help deliver effective care when people moved between services.

People were supported to live healthier lives and have access to healthcare services.

Staff were knowledgeable about the Mental Capacity Act and knew how to seek consent for care

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect.

Staff supported people to express their views and be actively involved in making decisions about their care.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that was personalised to their needs and preferences.

People knew how to complain, but improvements were not always made following complaints made.

People were supported at the end of their life to have a comfortable, dignified and pain free death.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance processed did not identify shortfalls in the service.

People's feedback was not used to shape the service or make improvements.

Staff were working with health and social care professionals to help people receive joined up care.

Mears Care Limited - Maidstone

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 registered persons continued to meet 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 comprehensive inspection took place on the 9 and 10 October 2018, was announced. It was the first inspection of the service since it changed its legal entity in October 2017. We gave the service 48 hours' notice of the inspection visit because staff may be out of the office supporting other staff or providing care. We needed to be sure they would be in. The inspection team consisted of two inspectors, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us. These are events that happened in the service that the registered persons are required to tell us about by law. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

During the inspection we spoke with twelve people who used the service. We also spoke with three members of a care staff, one administrator, two care coordinators, one recruitment coordinator, the training coordinator, the quality manager, the registered manager and the regional director. We visited people in their homes and observed interactions between care staff and people being supported. We looked at the care records for fourteen people receiving a service. We also looked at records that related to how the

service was managed including training, staffing and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "They get me up in the morning and make sure I am washed and dressed, they leave me feeling safe. They give me my lifeline and fall safe, and leave me safe at home." Another told us, "They are all very good, very kind. It's nice to know they are coming to check on me." A third person commented, "I am not bogged down worrying about things because they are here to help me now." However, people did not always receive their support in a safe way.

People and staff said there were not always enough staff to meet their needs. This meant people were being affected by poor time keeping and carers not carrying out visits as planned. During the inspection we spoke to the registered manager about staffing levels. They said it had been a difficult year in terms of recruitment, for both carers and office based staff. They said the early part of the year had been particularly challenging, with a number of care staff leaving meaning senior staff, including themselves, needing to provide personal care to people. This had taken them away from their substantive post and had caused backlogs in administrative tasks such as reviews and audits. Recruitment problems were demonstrated at the inspection. The registered manager had arranged for a week-long pre-employment training programme for 7 new members of staff, all of which had been successful in their interview. However, the training programme began on the first day of the inspection with only one person in attendance. The registered manager told us, "This is the problem. It's been like this for some time." They also said they had started to seek guidance from external resources to help improve recruitment and retention. This included from well-known experts in the care recruitment industry.

Following the inspection, we received a significant amount of feedback from people concerned about staffing levels, and the impact the levels had on them. One person said, "The carers are so stretched, they seem to have more clients now and are being stretched to do more and work longer hours." Another person added, "There probably aren't enough staff as they seem to be under pressure and very often late." Further feedback included, "I know the recruiter (recruitment coordinator) needs to answer the phones to cover calls as there aren't enough people in the office. Maybe that's why they can't recruit new carers." The registered manager confirmed that part of the role for office-based staff was to carry out care visits if needed, and this had needed to happen at various points during 2018.

One person we spoke with was concerned about carers not arriving for their visits at all. They said, "I have to ring the office to find out what is going on. The weekends are a worry as they sometimes don't come at all." Another person reported anonymously via our website on the day of the inspection, "Missed calls - sometimes no calls at all for the whole day." Staff said they were aware of the issues, and often needed to cancel visits because they did not have staff to cover them. They said they did not consider these to be 'missed visits' because they had informed the person in advance, or had arranged for family members or friends to cover.

The failure to deploy a sufficient number of staff to meet the needs of those using the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People were not always supported to take their medicines safely. Staff were not reporting recording errors in line with established procedures. When staff gave people their medicines they recorded this on the person's medication administration record (MAR). On the following day, if a staff member noticed the MAR had not been completed the registered provider's medicines policy considered this to be an incident which should be reported to their direct line manager. Staff were then to record this on the registered provider's database so the registered manager could carry out an investigation. We saw numerous MAR records with errors which hadn't been reported or recorded on the database. For example, there was an incomplete MAR for one person who needed medicine for their epilepsy on 22nd June 2018. Although this had been picked up on an audit of the records on 12th July 2018, the gap in recording had not been recorded on the database in accordance with the registered provider's procedure. This meant the registered manager could not take action to see if the person had actually received the medicine, and seek advice from health professionals if they had not. Another person's MAR showed medicines had not been recorded for three dates in April 2018. None of these had been recorded on the database by staff the following day. A different person's MAR showed gaps in recording for two consecutive days in May 2018 which had not been reported the following day.

We looked at other care records which staff completed as part of their role, which included a hand-written record of the support they provided each day. We checked these with a sample of errors we had found. Staff had written notes such as 'gave meds' or 'medicine given' on the days there were gaps on the MAR. However, none of these written records included detail of the specific medicine or dosage given.

The registered manager had not taken sufficient steps to ensure lessons were learned when things went wrong. We spoke to the registered manager about our concerns relating to medicines. They showed us their medicine error reporting file, which showed only two medicine errors had been reported in the previous 12 months; one where a member of staff had reported a gap in the MAR for the previous day, the other where a person had dropped their medicine on the floor. Both had been investigated. The registered manager said they had identified concerns around recording and reporting errors through audits carried out by senior staff. As a result, all staff were sent a letter in June 2018, explaining the procedure and the importance of accurate recording and reporting. However, one person's MAR we reviewed, which covered August 2018, identified there were 13 gaps in recording, by seven different staff members. None of these had been reported in line with procedures and the registered manager had not investigated any to make sure the person was receiving their medicines safely.

The failure to ensure medicines were provided to people in a safe way was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People were protected from abuse by staff who were trained on how to identify and report it. Staff received training in how to identify safeguarding concerns such as physical, emotional or financial abuse. Staff knew how to report concerns if they had any. One staff member told us, "I would report it to [manager]. I think they would take it seriously." The registered manager kept a log of safeguarding concerns raised by staff. The registered manager was aware of their responsibility to report any concerns to the local authority, and records showed they were involved in investigating concerns in a transparent way.

Risks to people were assessed, and staff took action to reduce the risk of harm in order to keep people safe. Each person had their own risk assessment which identified how they might be at risk, and action needed to reduce that risk. When one person was identified to be at risk of falling, their risk assessment indicated staff should ensure the person had their pendant alarm bracelet on before they left the visit. Identified risks were reviewed yearly. Environmental risks were assessed to keep people and staff safe. The locations of the electrical, gas and water mains were recorded on the persons records. Where a rug had been identified as a

trip hazard, guidance was provided to staff to remove the rug when entering the property. People were protected by the prevention and control of infection. Staff were provided with gloves and aprons, and we saw these being used during our inspection.

Staff were recruited safely. The registered provider carried out pre-employment checks, which included obtaining a full employment history. References were sought and checked. Staff completed Disclosure and Baring Service (DBS) check before they began working with people. DBS checks identified if applicants had a criminal record or were barred from working with people that need care and support. Where issues were identified, a risk assessment was carried out to ensure staff were safe to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that staff were skilled in carrying out their roles and the service was effective in meeting their needs. One person said, "They always ask me what I want, and leave me with a drink when they go." Another said, "Staff are well trained. I'm prone to dislocating my hip so the carers are trained in order to move and assist me properly and safely." Another said, "The manager spoke with occupational therapist and a nurse when they set up my care plan."

People's needs were assessed but their care and support was not always delivered in line with current legislation. Each person's needs were assessed before the service commenced to make sure staff could meet them. However, in some cases new referrals had been accepted without ensuring there would be sufficient staff to meet people's needs. This is an area for improvement.

The assessment considered the person's ability to make decisions about their care independently, their physical, mental and emotional needs. It also considered their preferences, such as when they wanted to receive their care. The assessment also took into account any additional support a person might need to ensure their rights under the Equality Act 2010 were respected, such as their religious or cultural needs. Assessments took place with family members or friends if needed, and took into account information from other health and social care professionals involved in the person's care.

Staff had the skills, experience and knowledge to deliver effective care and support. Newly recruited staff completed a week-long induction programme before they could start working with people. Staff confirmed they shadowed more experienced colleagues after they had completed their induction, and were only expected to work alone with people when they felt confident to do so. Permanent employment was subject to passing a probation period. Established staff members completed ongoing training to ensure their skills kept up-to-date with best practice and changes to legislation. This included subjects such as fire awareness, infection control and moving and handling.

Where people had specialist needs, training was sought to ensure staff could meet their needs. One person needed specialist support to eat via a piece of equipment. The registered manager told us, and records confirmed, that each staff member involved in the person's care had received training specific to the person and the equipment before they started to provide support.

People were supported to eat and drink enough to maintain a balanced diet. People's ability to manage their meals was assessed before the service began, and staff only provided support if this was needed. Staff considered people's special dietary requirements and preferences, and these were reviewed each year. Staff referred to local health professionals if they thought people needed support, such as when staff noticed they might be at risk of choking. For example, one person was assessed by a health professional to need their drinks thickened to a particular consistency. Staff confirmed they were aware of this, and records confirmed the guidance was followed.

Staff were working with other organisations to deliver effective joined up care and support for people. Staff

told us they would often visit people in hospital to carry out pre-assessments before they went home to ensure they were able to meet their needs. This would be followed up by a home visit. If a person already receiving a service went into hospital, staff would provide health professionals with a copy of their care plan and list of medicines if they consented. When they were discharged, staff would check to see if their needs had changed before they returned home.

People were supported to have access to healthcare services and receive ongoing healthcare support. We saw staff had made referrals to health professionals in a timely fashion. These included to a chiropodist when staff saw one person had long toe nails. Another person was using a hospital bed when they returned home from hospital, but wanted to use their own bed instead. Staff referred to the occupational therapist for guidance to make sure they were helping them safely. We saw staff had made referrals to district nurses when required.

The Mental Capacity Act 2005 (MCA 2005) 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.

The service was following the principles of the Act. Some people receiving support were living with dementia, but staff knew this should not restrict them making some decisions about their care. One staff member told us, "We try to explain things to [person]. He still has freedom of choice with his meals and what he wants to wear. Sometimes he forgets to eat so we remind him. If he gets upset that his family didn't visit, we reassure him that they did." Staff knew the importance of asking for people's consent to receive care, and people recorded their consent in care records. When there were concerns about people's ability to make specific decisions, the registered manager followed the MCA 2005 by carrying our mental capacity assessments and holding best interest meetings with people involved in their care and support.

Requires Improvement

Is the service caring?

Our findings

People told us they were supported by staff who were caring. One person said, "They seem to enjoy coming here as much as I like them coming." Another said, "The carers are very good, very kind. They are gentle and understanding when helping me with washing and dressing." Another person added, "They chat along and talk about common interests, they really do make the effort"." However, we did not always find the service to be caring.

People were not always treated with dignity and respect because they did not always know which staff member would be visiting them, when they would be arriving, and some were anxious that staff would not arrive at all. The lack of available care staff meant office-based staff often needed to carry out some care visits. This in turn meant communication from the branch and people about changes to support was reduced. For example, people did not always know who was visiting and were not always able to choose who they were supported by. One person told us, "I used to get a list in advance to advise who is coming the following week but they've stopped doing that. I'm not sure why." Although care coordinators told us they tried to inform people if staff were running late, feedback we received suggested this was inconsistent and left people feeling anxious. One person told us, "My main carer usually rings if she is going to be late. She used to ring the office for them to tell me but they never did so she rings me herself now." When support could not be provided it had a negative impact on people as reported in the safe domain of this report.

If people received regular support from a consistent group of staff, the feedback we received was more positive. Once staff arrived, they had enough time to support people in a compassionate and personal way. Staff were required to log when they arrived and left a visit, and this information fed through a database which was monitored by care coordinators. Staff were staying for the expected amount of time, and feedback from people indicated visit times were not cut short if staff were running late. One person told us, "I know they're really busy, but when they are here they give me time and I don't feel rushed at all." Another said, "The carers are wonderful. I think they have a lot on their plate but they truly are wonderful". Staff had time to respond to people's emotional needs. One person told us that staff noticed when they were upset, adding, "For example, today I am having a bad day with my legs so they give me extra tlc. I certainly feel better than I did this morning before she came." Another said, "My main carer knows when I'm a bit down and will always gee-me-up."

Staff supported people to express their views and be involved in making decisions about their care. People were involved in reviewing their care. One staff member told us, "If we think someone's needs have changed we can ask for a review so we are sure we are doing it right." When people wanted support from their friends or relatives this was arranged by staff so they were able to fully understand their care. The service manager knew how to arrange support for people from external advocacy services if needed.

Care staff were mindful of people's dignity when carrying out care. One staff member told us, "We always knock on the person's door and shout out to let them know who it is. When carrying out care we will make sure the door is pulled shut and close the curtains." Staff made sure to ask people if they wanted to be supported, and people told us their decisions were respected by staff. One person said to us, "They are

always respectful and gentle to me."

People's private information was kept safe. Computers and laptops were password protected so they could only be accessed by authorised staff, and care records were locked away when they were not being used by staff.

Requires Improvement

Is the service responsive?

Our findings

People told us they found staff to be responsive to their needs. One person said, "They chat along with us and talk about common interests, they really do make the effort." Another said, "I know how to complain. I call the office if they are late and haven't told me." Another said, "They do what I need them to. I'd let them know if I needed anything else." However, we didn't always find the service to be responsive.

People did not always receive support which was personalised to their preferences. One person who was living with dementia had been identified as a vegan during an assessment carried out by staff in July 2017. Their records indicated they did not eat meat, dairy or animal fats. When we spoke to the person they could not tell us they were a vegan, but were able to tell us they did not eat cheese because it contained animal fats. However, in care records dated 28 July 2018 the person's dietary preferences had changed from vegan to vegetarian. Staff confirmed that they identified the person as a vegetarian, and supported them with their shopping. We saw non-vegan cheese in the person's fridge and staff confirmed they made the person meals which included cheese and onion pasties. When we raised the concerns with staff they were dismissive, telling us the person changed their mind a lot and besides they enjoyed the cheese and onion pasties.

People did not always receive support at the time they wanted it. We received a significant amount of feedback from people about poor timekeeping of staff, as mentioned in the Safe domain of this report. Although people were asked what time they wanted support to be provided as part of their assessment, rotas were drawn up around staff availability rather than the person's preferred time. Following our inspection we were sent information showing when staff had been scheduled to visit people. This showed, for example, one person having visits scheduled for times from 8.30am to 11.20am in one seven day period in October 2018. Other rotas showed scheduled times varied on a daily basis. People told us the inconsistency was having a negative impact on them. One person said, "I get told by carers that there aren't enough. It's mainly at weekends and in the evenings. One weekend I asked for a 7am visit because I wanted to take my daughter to an event. They didn't turn up until 10am, so we needed to cancel it. It's in my care plan that I need a routine, but it doesn't always happen and it's affecting my mental and physical health."

The failure to provide person centred care which reflected the person's personal preferences and needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People told us they knew how to complain, and formal complaints had been responded to appropriately. However, improvements had not always been made as a result of complaints. The registered manager kept a log of complaints which included complaints about timekeeping of staff, and of staff not arriving for calls. Although the complaints had been responded to by letter in line with the registered provider's policy, steps had not been taken to learn lessons from the complaints received, for example by increasing the number of staff available, or by reducing the number of people being supported by the service.

The failure to take action to respond to failures identified by a complainant was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Other records we reviewed showed other people received care and support which was responsive to their needs. People were involved in planning their care and people had their own care plan which considered the support that was needed. People's abilities were taken into account. For example, one person's care plan indicated how they were to be involved in showering, and what support staff needed to provide. Some preferences were recorded, such as what the person wanted for breakfast.

The registered provider was not always meeting people's communication needs because they were not meeting the Accessible Information Standard. The Standard was introduced on 1 August 2016 and sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. We found the registered provider had not taken sufficient steps to ensure information such as care plans were available to people in a format they understood. We identified a number of people who had been assessed to have a visual impairment. This meant they may have difficulties reading documents. Staff told us they were able to arrange for documents to be made available in different formats, such as large print or braille. However, staff were not able to confirm that this had been done. When we spoke to one person, they told us they were not able to read their care plan and it had not been offered to them in a different format. They told us they would have preferred it if it had been. Others we spoke with were unaware they had care plans, with one telling us, "There is a book they all write in, but I don't have anything to do with that."

We recommend the registered provider seek guidance from a reputable source regarding providing information to people in a way they understand.

Although nobody was receiving end of life support at the time of the inspection, the registered provider had procedures which ensured people would be supported at the end of their life to have a pain-free, dignified death. The registered manager said end of life discussions would be held with health professionals, the person and family members, and when the time was right staff would draw up end of life care plans. Templates showed these would include discussions about the persons preferences such as if they would prefer to be buried or cremated

Inadequate

Is the service well-led?

Our findings

People told us they did not always find the service to be well-led. One person said, "I often call the office to see where people are, and weekends are a worry. But nothing has changed and it's still a worry for me." Another said, "I've not been asked my opinions about things, I've never been asked for my feedback."

Governance systems were not effective in ensuring that shortfalls in service delivery were identified and rectified. Quality assurance audits of had not been effective in identifying the issues we found during our inspection. These included failing to identify the impact of insufficient staffing levels had on people using the service. Additionally, we found there was insufficient auditing of people's care records. This meant the registered provider could not be assured that people always received care and support that was personalised to their needs and preferences. Furthermore, where audits were being carried out, such as those examining people's medication records, we found issues being identified were not being followed up with sufficient action to ensure lessons were learned and improvements made.

Some other information was reported to the regional director on a monthly basis, such as information on staff recruitment, complaints and safeguarding concerns. However, the information requested and provided was insufficient to identify issues raised during our inspection so the regional director did not have oversight of our concerns. For example, the report identified taking on new contracts as a 'positive', but did not highlight that there were not enough staff to meet people's needs. Additionally, the registered manager was only required to report back on the number of complaints received, rather than any trends in the types of complaints, such as those relating to missed visits or late visits. The registered provider also employed a quality manager to visit services to assess and report on quality concerns. This assessment took place at the same time as our inspection, meaning at the time of our inspection the registered provider did not have oversight of the concerns we had identified.

People were asked about their views and opinions of the service they received, but information gathered was not used to improve the service. The registered provider had carried out a survey of people in April 2018 and had received a response from about half of the people they supported. The results of this survey showed identified themes similar to those we found during our inspection, including concerns about late calls, missed visits, not enough staff to meet people's needs and poor communication from the office-based staff. However, this information was not being used to make improvements needed. The registered manager confirmed they were aware of the results but could not identify any actions taken following the survey which had a positive impact on people.

Failure to assess, monitor and improve the quality of the service in the carrying on of the regulated activity was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We found they had informed CQC of notifiable events in a timely manner. They kept up to date with best practice and changes in legislation by attending local groups and forums with other registered managers. They subscribed to newsletters such as those produced by CQC and the Kings Fund. They had nationally recognised qualifications in leadership and management within health and social care settings.

The registered manager worked in conjunction with health and social care professionals to help people receive joined up care. This included working with health and social care professionals such as district nurses, GPs, occupational therapists and the local branch of the Red Cross, which was contacted if people needed access to, for example, wheelchairs to access the community.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The provider had conspicuously displayed their rating on their website.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1)(c) The registered manager did not make sure people received care that reflected their personal preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(2)(g) Staff were not following policies and procedures about managing medicines.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16(2) The registered manager had not taken steps to learn from complaints made about the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(2)(a) The registered manager did not use systems

and processes to effectively monitor the quality and safety of the service being delivered.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) There were an insufficient number of staff to meet the needs of those using the service