Unity Community & Care Services Limited

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Inspection report

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Ratings

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

Overall summary

This inspection took place on the 2 and 3 February 2015 and was announced. Unity Community and Care Services provide personal care for people living in their own homes. The service is provided to mostly older people who have needs related to physical frailty or dementia. When we visited there were 28 people receiving a service.

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 and associated Regulations about how the service is run.

Summary of findings

We last inspected the service in June 2014 and September 2014. In June 2014 we had concerns about people's care and welfare, how quality was assessed and monitored and the quality of record keeping. We took enforcement action in relation to people's care and welfare and required that the provider made changes by 5 September 2014.

We asked the provider to take action about the other areas of concern and they sent us a plan showing that they would have addressed them by the end of October 2014. We inspected the service again on 24 September 2014 to check that changes had been made in relation to the care and welfare of people. We found that the service had not improved enough and asked the provider to send us a detailed plan to ensure improvements would be completed. The provider told us the detailed plan would be completed by the end of December 2014.

The service was not well led. At this inspection we continued to be concerned about the assessment and monitoring of quality. Whilst some systems had been put in place to monitor and check the service, this was not well enough developed to assure and control quality in all aspects of the service.

The requirements for the supervision, appraisal and professional development of the care staff were not met. Although the basic skills of staff were checked from time to time there was insufficient supervision and support to ensure learning and development met the needs of individual staff providing care. Some people told us they thought staff needed more training to meet their needs.

The service was not using the formal framework and guidance relating to mental capacity to ensure best interest decision making. Neither senior staff nor care staff had a sufficiently well-developed understanding of how to ensure people had given their valid consent where they may be unable to make decisions due to mental capacity. This meant there was a risk that some people's care may not be in their best interests.

The registered manager had not ensured that notifications were made to the Commission of incidents and allegations relating to people using the service.

Improvements had been made in relation to people's care and welfare. At the last inspection, the service was not being delivered on time and there were missed visits. This left people at risk and in need of safeguarding. Risk assessments were inadequate to guide staff and ensure people were protected from risks associated with their personal care. At this inspection we found the service visit times had significantly improved in the month prior to the inspection. The improvement was reflected in people's comments about the service. People told us their service was more consistent and reliable. The system for monitoring calls was effective and had helped to eliminate missed calls and reduce the number of late visits. There was a greater transparency about the time spent with each person as the system to monitor this was more effective. People told us they were now getting informed in advance of their visits and also being contacted if their care worker was going to be late or changed.

Most people had received visits by managers from the service for their care and support needs to be reviewed. This meant the care plans were more detailed and up to date and included more information about people and their relevant home circumstances. Risks associated with people's needs had also been reviewed and described in more detail, so they could be effectively managed. Community health and social care professionals worked closely with the service to assist in the assessments of individual risks, for example relating to skin care, moving and handling and medicines. This was reflected in some of the care plans and helped to ensure people were kept safe and the risk of avoidable harm was reduced.

Record keeping and administration had improved. Some improvement was needed in how discussions and assessments relating to individuals, such as phone calls, were recorded to make sure this information was used to keep care plans and risk assessments up to date.

The service helped people to get access to healthcare when needed. The staff showed awareness of when people needed specialist help and ensured this was arranged promptly.

We found the service was not meeting the all the required standards in relation to staffing, obtaining people's consent to their care and in making the required notifications of incidents to the Care Quality Commission.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The safety of the service had improved however further improvement in the consistency of the service was required for people to feel confident and safe.

There were risk management plans in place to reduce the risks of avoidable harm however this had not been sustained over a period of longer than four weeks at the time of latest inspection.

Infection control was being practiced by staff, relevant training took place and personal protective equipment was readily available and in use.

Staff reported concerns and understood their role in safeguarding people.

Medicines were administered safely.

Is the service effective?

Requires Improvement

We identified concerns with the supervision and professional development of staff.

Senior staff and care staff did not understand the requirements of the Mental Capacity Act 2005 and 'best interest decision' making. People's capacity to consent to their care and treatment was not formally assessed. People's representatives were involved in people's care plan however best interest decisions were not evidenced.

People were supported to access health professionals and ensure their physical healthcare needs were met.

The delivery of the service had improved and this was demonstrated by visit times and what people told us about their experience.

Is the service caring?

Requires Improvement

People told us they were treated with dignity and their privacy was respected, however for some this had only recently improved.

Some people or their representatives were involved in their care plan however some people did not feel they had been involved.

Is the service responsive?

Requires Improvement

The service sought people's views however some people told us that their feedback had not been sought and described an inconsistent response from the office.

Care plans which described people's needs following assessment or review had been improved. People's backgrounds and preferences were recorded which helped guide staff to provide individually sensitive care.

Summary of findings

Is the service well-led?

The service was not meeting the standards for assessing and monitoring the quality of the service as not all aspects of service delivery were adequately checked, such as the performance of staff.

Some areas of practice, such as valid consent to care and treatment, were not well understood by the registered manager.

The service failed to keep the commission notified of incidents and allegations.

Staff and people did not always feel that their views were sought or acted upon.

Improvements had been made to the timeliness of the service, to care plans and in risk assessments.

Requires Improvement

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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 2 and 3 February 2015. The provider was given 48 hours short notice as we needed to find out who was receiving a service so we could speak with them about their experience. The inspection team consisted of an inspector 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. This expert had experience in using services for physical disability and caring for someone with dementia.

We had not asked the provider for a Provider Information Return (PIR) before this inspection. The PIR is form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we looked at the improvement plans of the provider and gathered information from the local authority about recent reviews of the service and information from recent safeguarding investigations. We looked at information from the local safeguarding team, the service commissioner and community healthcare professionals. We spoke with 14 people using the service and five relatives of people. We spoke with the registered manager, the nominated individual and another manager within the service. We interviewed five members of care staff. We reviewed a number of records including six care plans, the duty rota and associated records about the allocation and confirmation of visits which had taken place. We looked at other management records including quality checks and telephone logs.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of 25 September 2014 the service continued to be non-compliant in meeting people's care and welfare needs. We had particular concerns about the lack of risk assessments and guidance to staff about people's care needs, which meant there was a risk people were not protected from avoidable harm. The service was also failing to ensure care visits were delivered on time or they were being missed altogether, which placed people at risk. We asked the provider to take action. At this inspection we found there had been sufficient improvement to ensure people's needs were met safely. Improvement was still required to ensure this was sustainable, as we were only able to check the improvement over the last four weeks.

At the last inspection we found that risk assessments were neither detailed nor up to date. At this inspection there had been a review of risks for each person and care plans and risk assessments were detailed. For some people's care plans, the service worked closely with local community healthcare professionals where people's needs were high. For example, assessments had been completed by occupational therapists, in relation to moving and handling for two people.

One of the managers told us that the service had developed an approach to risk management which quickly identified people assessed as high, medium or low risk, using a colour code on their care plans at the office. This helped staff to understand risk at individual level and overall risk in the service. We saw the system for this and an example of someone who needed two members of staff to assist them to move safely and who lived alone who was assessed as high risk and the care plan file coded accordingly. One of the managers told us this helped raise awareness of risk and prompted care staff to be appropriately briefed before they visited people.

There was an improved system for responding to staff when they reported issues to the office that they found on their visits. Care plan reviews were arranged at the office to discuss staff reports and observations and whether changes were needed in the care, or if other professionals should be contacted for advice. This helped to ensure changes were acted upon promptly and risks were managed safely.

Of five care plan files we looked at, three had skincare risks identified within the care plan. Written guidance was included in the care file about what to look for. Daily notes showed that staff routinely recorded their observations of people's skin condition following their visits. We found examples where changes or concerns had been promptly reported to the appropriate healthcare professional by either the care staff or the office, and subsequent advice was followed by care staff. One relative told us how bruising on their relative was immediately noted and reported to community nursing staff for nursing assessment.

One person who lived alone was at risk from being burnt by the heating in their home. This was reported by staff to the managers at the office who contacted the appropriate agencies for advice and assessment on the same day about how this risk could be managed safely. We noted that this was not recorded on the person's care file but on a separate phone log and that there was no outcome recorded from this action. This meant there was a risk of information being missed in the on going review of the person's needs and any associated risk management. The service immediately agreed to address this recording issue to promote safety and risk assessment.

Staff understood what keeping people safe meant. Extra safeguarding training had been attended for all staff in December 2014. The management team had all attended several safeguarding meetings with the local authority as part of responding to safeguarding investigations. They told us this had increased their understanding of safeguarding people, safeguarding protocols and risk management. Staff had been sent an updated safeguarding policy and procedure. One member of staff told us that they would always report any concerns to the office as soon as possible if they were worried about someone. They were able to describe scenarios of possible abuse to us. They told us that if they remained concerned, they would report this outside the service to the appropriate body, such as the local authority social services team or to the Police.

We spoke with people about whether they felt safe with the service; nearly all people told us that they did. For example, one person told us their relative had two care staff to assist with mobility however that the care staff did not always arrive together and sometimes one carer did not wait for the other to arrive before assisting their relative. We asked the registered manager about this and they told us they had been aware of this issue and that the staff who had

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Is the service safe?

been doing this had now left the service. Another person told us they had not felt comfortable with one care staff; however we confirmed this member of staff had now left. Another person told us that they were very nervous and had worried before about not feeling safe however now they felt safe and "the staff are very good." In our discussions with the registered manager, they told us that they had identified quality and safety issues related to specific staff which had now been addressed.

The service was being delivered to people with a greater continuity and in accordance with their agreed care plan, which meant they were at a reduced risk of harm. The service had agreed after the last inspection in September 2014 not to take new care packages until the improvements had been achieved and standards were being met for people already receiving a service. At the last inspection people were not safe because their visits for personal care were either very late or missed, with particular consequences for people who lived alone and relied on the service. This was because the visits were poorly planned, risk management was poor and there were insufficient staff to carry out all the visits. At this inspection there was an improvement in the planning of the service and in the level of staff to meet people's needs and keep them safe. Staffing levels had been assessed in line with the reviews of care plans which had taken place and took account of the needs of people using the service. We found that the service was being delivered safely.

Staff and people told us the service had improved recently. The service's action plan stated that travel between visits would be reviewed to minimise the chance of delays and improve service delivery. The four weeks preceding the inspection date showed an improvement in visit times and in the overall delivery of the service. One member of staff told us, "I feel a lot less rushed now and have time to spend with people." Another member of staff told us they were much 'less stressed', the routes were much improved and they got their rota a week in advance which allowed them to check the routes and that the visits allocated to them were feasible. One person told us, "I feel things have improved lately."

People were protected from the risks of infection through the use of personal protective equipment such as gloves and aprons. Staff were able to tell us about how they carried out regular hand washing and used gloves to reduce the risk of infection. However one person told us that although their regular carers always put on disposable gloves and apron, some carers who came in the evening did not always do this and they expressed concern about contamination to their relative whilst personal care was being given. We raised this with the management of the service who told us they would address this immediately with the relevant staff. Another person told us, "there has been a big improvement in the service we are receiving although there are a few hiccups. The staff now wear disposable gloves and aprons which they keep on when helping my relative to wash and dress. They do everything as they should and tidy up after themselves."

Medicines were administered safely. At the last inspection we had concerns that some people who needed help to take their medicines may not be receiving this on time. We were also concerned that guidance to staff about administration of medicines was not always clear and the medicine's records may not reflect accurately what medicines had been taken, which was not best practice. At this inspection we looked at the visit times of people who needed assistance with medicines and found that because visit times had improved, this ensured that medicines were administered in accordance with the plan of care. We noted that the updated care plans also included updated information about people's medicines and the level of assistance required.

People who lived alone and needed help were identified as a priority in an assessment of risk by the service. The service worked with the GP and community nurse for one person where they were at risk of not taking their medicines, to ensure their medicines plan could be delivered safely. We looked at four spot checks of staff carried out by management, including for a person who lived alone and needed daily assistance with medicines. These checks included observation of how care staff administered medicines. Staff were assessed on how they understood the medicines tasks needed for each person, correct completion of the medicine record and whether the medicines list and home remedies advice was up to date. It was recorded by the manager that in all the checks we looked at there had been no errors.

Requires Improvement

Is the service effective?

Our findings

Mental capacity assessments were not meeting the requirements of the Mental Capacity Act 2005 (MCA). People and staff were not protected by the effective use of the MCA. Three people were described as having mental impairment however decisions about their care, for example for care workers to administer medicine were not considered as 'best interest' decisions. Staff, including senior staff, were not knowledgeable about the Mental Capacity Act 2005.

Staff had recently undertaken MCA training. They told us how they encouraged people to make the decisions on a day to day basis and respected their decisions. However they did not have awareness that mental capacity was formally assessed or of best interest decisions which may be made. For example, one member of staff described someone as having dementia and therefore unable to understand decisions. However this person's care plan showed they did not have dementia or a mental impairment and were therefore able to make their own decisions.

Records showed that people's mental capacity was referred to in their assessment however not formally assessed. One person told us, "some carers are not knowledgeable or experienced enough to meet my relative's needs and don't know how to encourage her out of bed when she decides she doesn't want to get up or wash." Two care plan files showed people who had been considered not to have mental capacity, according to the file. Their relatives were asked to sign the care plan and related documents. However there was no record of steps taken to establish that such care plan decisions about people's care and support were in their best interests. Because the service had not considered which aspects of care were essential in someone's best interest there was a risk their rights may not be upheld as decisions were not made within the framework of the MCA.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed mixed views about the effectiveness of the service. Some people reported an improvement and others that staff needed more training. For example one person said, "I feel that some of the carers aren't trained long enough. They should shadow for longer." Another person told us, "all staff come with someone when learning. They have improved very much. Most staff are good but you get the odd one who shouldn't be in the job but you just grin and bear it." Another person told us, "I don't think the staff need more training. My carer is excellent and such a good help to me."

We had concerns about the supervision and professional development of staff. Staff had received training and told us this had been useful. Staff had received extra training arranged by the service or from community healthcare professionals to help them to carry out their job effectively. This was based on skills and knowledge gaps noticed by people, community healthcare staff and the registered manager and reported by staff themselves. People therefore benefitted from staff who had improved and developed their skills and competency levels over the last three months. Training sessions included topics such as 'back to basics' training in personal care, medicines awareness refresher training, in the use of a specific piece of equipment needed by someone, continence awareness and in food and hygiene. Although further training had been booked, the records relating to staff training failed to reliably illustrate a programme of on-going improvement in staff skills. One member of staff, employed for over two years with the service had not been supported to achieve qualifications during this time, although this had been started. One of the managers told us that a training plan was in development.

The registered manager told us staff had appraisals and supervisions. (Staff supervision is an opportunity for staff to talk with their line manager about their developmental needs and any issues that affected the way they do their work). Whilst the registered manager was clear that these supervisions needed to be carried out and we saw an up to date schedule for this, they were unclear about the purpose of supervision or appraisal. The registered manager showed us spot checks relating to staff competency, carried out through observation either by them or another manager who used a checklist to record whether basic competencies were met. We noted that in all the spot checks we looked at, staff were found competent in all tasks. Three members of staff told us they did not receive formal supervision. We discussed appraisals and supervisions again with the management team who told us they supported staff informally through regular discussions

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Is the service effective?

in the office however that these discussions were not recorded. A member of staff told us they had been frustrated and demotivated in up until a months ago by what they felt to be poor performance within the service which was not managed or dealt with.

We found that the service was not adequately supervising staff. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were helped to get access to healthcare as required. Where people were found to have a medical or health problem the service advised them or their relatives who to seek help from. Where they lived alone the service contacted the health care professional on their behalf. For example we saw that the nurse had been promptly contacted for assistance for someone who needed help with catheter care.

Risks which related to people having enough to eat and drink and having fresh food in the house, where the service was responsible, had been reviewed and recorded. One person who needed help to ensure they ate a balanced diet was being supported by the service to eat. The care staff worked with family members and used the daily care notes to provide this support and monitoring. Two other people were supported to have enough to eat and drink and the service also ensured that shopping for food was done. The care plan included specific instructions about this, including information about the shopping arrangements and prompts for care staff to monitor the freshness of food in the house, and to dispose of out of date food.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring. It was not always clear how staff were guided to communicate in a meaningful way with people who had mental health problems such as anxiety or dementia or who may be in pain. For example, one person was described as becoming moody when tired, however there was no guidance to staff about this. Another care plan which indicated that someone had memory loss and disorientation, also stated there were no difficulties with communication. This meant people may not always feel understood and that their needs were met in a caring way.

At the last inspection the care plans reflected a very task orientated approach to the delivering the service. At this inspection the care plans reflected a more person centred approach by the inclusion of more personalised information and some description about people's likes and dislikes. Nearly all the care plans and associated records had been signed by either the person or their relative.

Although people described their care as improved, not everyone felt involved with their care reviews or understood what it was. One person told us about this that "I had no input to my plan, the professionals arranged it all. The service has improved or rather they are trying to improve it. I would say over the last couple of weeks they have been really trying." Another relative told us, "the care staff always leave a note for me letting me know important little details, as well as writing in the daily care book. This helps me know what is going on." Some people's representatives felt involved in the care plan. One told us "we were involved as much as possible in my relative's plan. We also asked for additions which were made. My relative is happy with the carers. She wasn't last year as she had too many carers but she is happy now." Another person told us, "we had a review in 2014 and I did put forward some suggestions but they have not come into effect yet."

People we spoke with told us they were treated with respect and that their privacy was respected. One relative told us, "staff chat away to my relative and me. They are careful to protect my relative's privacy when helping them with personal care. Now we have more regular carers and they are getting to know us and vice versa." Another person told us, "we make a connection with our morning carer, the rest are not so talkative and is always in a rush." Another said, "when they shower my relative they always wrap towels around him for privacy and try to encourage him to do things for himself."

People told us they had telephone and written contact with them about who would be visiting over the last few weeks. They said they now received a list in advance and that this was usually who came, unless a care worker was away on unplanned sick leave. People told us they were usually contacted if the carer was going to be late or there was a change, which was an improvement and they experienced the service as more caring because of this. Someone told us, "it was bad for a long time but that has been sorted out and if they are late they ring now." Another person told us, "we do get a regular carer in the week but every weekend we get a carer out of a pool who we recognise. It is nice having regular carers who know where everything is."

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. One person told us, "over the last month it has been better." Some people told us their service was flexible and staff were very willing to help, for example if they needed to go to an appointment. We found an example of the service responding at very short notice to someone in distress. We found evidence that changes in people's condition was being monitored, particularly around their healthcare needs and relevant professionals were contacted promptly.

The registered manager told us they had achieved the action plan target for all care plans to be updated. They told us that 20 people had been visited at home by a manager for the purpose of updating their care plans. The remaining six people had spoken to their care staff and the manager over the telephone for their care plans to be updated. The five care plans we looked at contained detail about people's background and preferences which helped guide care staff in providing a personalised service. A detailed checklist for carers was included for each visit to instruct staff in carrying out their role and ensure people's needs were met as set in their care plan. One staff member told us they felt the care plans were 'much better' and helped them deliver an improved service. Another member of staff told us the care plans were much more useful since they had been updated as they explained more clearly the help required by people.

The service had sought people's views about the service using a survey and there was evidence they wanted to find out what people thought of the service, however people did not all feel their views had been asked for or understood. We saw a survey carried out by the provider in January 2015 which demonstrated that people had been asked eight questions about their satisfaction or otherwise about the service. Over half responded, using tick boxes, and indicated they thought most aspects of their service was good, very good or average. A few people had written comments stating they had found a recent improvement or with other comments. We saw evidence that comments were addressed with the people who made them. There were mixed views expressed by people about whether they were asked for feedback about the service. Three people told us said they could not always contact the office, either they could not get through or their messages were not answered. They said they had not been asked for their views. We saw the service had responded to a request from a relative to provide more details about the visit timings and that the service had devised a detailed report about this.

People's care needs had been reviewed and care plans had been updated. The care plans had been made more people centred with the inclusion of information about the person's background and their choices. Not all aspects of people's needs were well described or how they were to be met. For example, one person was described as 'moody' by their relative however there was no specific guidance to care staff about how to approach this. Another person was described similarly, again by a relative, however with no specific guidance to staff about how to approach this or how the person felt about their care and support. In the care plan of another person who was known to decline care visits sometimes, there was minimum guidance to staff about what to do if they refused to have assistance as set out on the care plan. We spoke to two members of staff about each person. They demonstrated they had got to know people to some extent, and adapted their communication and approach based on their experience and the development of a relationship with the person. Reliance on this approach however and an absence of written guidance may have led to inconsistency in people's experience of care and support, when different care staff supported them. Another care plan had repeated a medical diagnosis in several sections of the care plan record however there was no definition about this or what it meant for the person's care.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well led. The service had not kept the Commission notified of incidents or allegations of abuse and the registered manager were not aware of their legal responsibilities in relation to this requirement. The registered person is required to notify us of incidents as defined in the legislation, including serious injuries to people and any allegation of abuse. This is so we are made aware of important events affecting people's welfare. Over the last six months eight safeguarding investigations had taken place relating to people receiving a service from Unity Community and Care, none of which were formally notified to us.

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

At the inspection of June 2014, the service was not meeting the standard for assessing and monitoring the quality of the service. We asked them to take action to address this. Whilst there had been some improvements, such as in the daily monitoring of visits which ensure visits were not missed or late, not all areas of the service were being adequately assessed and monitored. These included the monitoring of mental capacity assessments, best interest decisions, and in the effectiveness of staff supervision and training.

This was a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection in September 2014, senior staff had reviewed roles and responsibilities within the senior team and agreed changes in roles. The service was also being delivered to less people, due to an agreement by the service not to take new care packages, allowing the overall risks to be reduced. The registered manager told us that operating a reduced service gave them more time to embed improvement actions. This appeared to have been effective since the first week in January 2015 in delivering changes required, such as the reviews of care plans and an improvement in risk management. But as these changes were not embedded at the time of inspection, there was a lack of confidence expressed by some people and some staff. One person told us "I have never met the managers or spoken to them. I do think they are trying to improve the service and the last couple of weeks I feel (the management) are trying harder." A relative told us, "no I don't think the agency is well led. Whilst the service has improved a little, it still requires improvement." The staff we spoke with told us that they did not have confidence that they would always get a response from the registered manager if they spoke with them about concerns. Local community healthcare and safeguarding professionals told us about significant time spent with the service providing training and guidance to staff, meetings with management and in safeguarding investigations relating to individuals over the last six months. They reported to us that they did not yet have confidence in the service to provide care and support for new people with high needs.

Overall we found the leadership of the service had improved and there was a culture of openness in exploring gaps in service and how to address these. This has resulted in improvements. However there were gaps and inconsistencies in the knowledge of the management about some areas of practice, such as mental incapacity, mental health and wellbeing and in statutory notifications. This led to some areas where the required standards were not being met. At the inspection of June 2014, records were found to be not meeting the expected requirements as they did not ensure that people received safe and appropriate care. We asked the provider to take action to address this. At this inspection we found that the organisation of records and recording had improved. Care plan files had been reviewed and information was set out within a more comprehensive format. Staff told us they found the new care plans helpful. Telephone calls to the service were being logged and actions were recorded. This helped to reduce the risk of unsafe or inappropriate care. However we noted the record of professional involvements or relative's discussions were recorded in a separate 'calls log' and not transferred to the individual care file. The service agreed immediately to ensure this was recorded in the person's care file to ensure a robust and consistent record of advice given and action taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Arrangements were not in place to ensure people's mental capacity was formally assessed in accordance with the MCA 2005 Act and ensure that staff were acting in accordance with people's consent in relation to the care provided for them.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not have adequate arrangements for ensuring staff received appropriate training, professional development, supervision and appraisal. Staff were not being suitably enabled to obtain further qualifications appropriate to the work they performed. Regulation 18 (2) (a) (b).

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person was failing to notify us of incidents related to injury or allegations of abuse. Regulation 18 (1), (2), (b), (e), (f).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The system for assessing and monitoring the quality of care people received was not adequate because it did not cover important areas affecting the delivery of the

This section is primarily information for the provider

Action we have told the provider to take

service. These areas were the quality of staff training and supervision and whether individual decisions about care provision were being made in people's best interests, according to the law.