Apex Prime Care Ltd

Apex Care - Totton

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**

Summary of findings

Overall summary

The inspection took place on 19 and 21 September 2016. The visit on 19 September 2016 was unannounced. We visited four people in their homes on 22 September 2016 to discuss with them the care they received. We subsequently spoke with ten staff over the telephone and 16 people who used the agency. Our last inspection of the agency took place in August 2014 where we found they were meeting all assessed standards of quality and care.

At the time of our inspection Apex Care Totton was providing care and support to 101 people in their own homes. People who were being supported by the service had various needs including age related frailty, dementia and physical health conditions.

There was not a registered manager in place although the agency had recently appointed a general manager. The nominated individual said the general manager would be applying to become registered in due course. 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.

The agency had expanded rapidly since April 2016 as they had taken over a number of other domiciliary care agencies. Staff who had worked for the previous agencies also transferred over to Apex Care Totton but some did not stay.This had resulted in the service becoming overstretched and at times they were not able to cover all people's care packages..

People involved with the service felt communication had been poor. When they had tried to contact the agency, the response had not always been reliable. The difficulties experienced had a negative effect both upon the confidence people had in the agency and in the way in which the service had been delivered. At times the lack of effective communication had compromised the health and wellbeing of people using the agency.

The management team acknowledged the quality of the service had been compromised because of the rapid expansion. They were working on improving their reliability and the standard of care and support they provided. They had apologised to people for the disruption experienced over the summer. At the time of our inspection some improvements had been demonstrated for example people were reporting staff were visiting more consistently at the time they expected them. However there were breaches in legislation in a number of areas:
There were not sufficient staff deployed to meet people's needs in a consistent and timely way. The agency was relying on some support from the local authority to ensure they could cover people's calls.
Staff did not have sufficient guidance to support people consistently when risks to people's health and welfare had been identified.
The management of medicines needed to be more consistent to ensure staff, where they provided support

with this, acted in in line with people's needs.
Staff were not provided with sufficient training or support to meet people's needs and people's capacity to consent to their care and support had not always been appropriately addressed.
People were not always provided with the gender of carers of their choice. People's documented care needs were not always accurate or up to date and so the agency could not be assured the care provided was appropriate, and met people's needs and preferences.
Quality assurance processes were not yet robust.

People felt safe with their care worker and most said they responded quickly to offer appropriate support when their health care needs changed. People highly praised their regular carers and care staff also demonstrated a real desire to do a good job. They were knowledgeable about the needs of the people they supported and clearly cared about them.

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 sufficient numbers of staff deployed consistently to meet people's care and support needs.

The provider had not ensured that risk assessments relating to the health, safety and welfare of people using the service were reviewed regularly.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

Is the service effective?

Requires Improvement

Staff had not received effective support supervision and training to carry out their role.
Consent to care was not always sought in line with legislation and guidance.
Staff generally ensured people had sufficient amounts to eat and drink and supported them to maintain good health, although they needed more guidance about how to support people with diabetes.

Is the service caring?

Requires Improvement

People expressed frustration with the quality of communication which had a negative effect upon their experience of receiving compassionate care.

People spoke highly of their regular carers and said their dignity and privacy was respected and promoted. Although people had been asked whether they had a preference about the gender of the staff to support them this was not always respected.

Is the service responsive?

Requires Improvement

People did not always have up to date plans of care and so staff could not be assured they were providing care and support which reflected people's needs and wishes.

The reliability of visits and the way in which complaints were managed had improved recently.

Is the service well-led?

Requires Improvement

The service had not always been well led.

There had not been consistent management arrangements and the registered location did not have the resources to develop the team.

Quality assurance processes were not sufficiently effective to drive improvement.

Apex Care - Totton

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.

The inspection took place on 19 September 2016 and was unannounced. This visit was undertaken by one inspector. The same inspector returned to continue with the inspection on 21 September 2016. Another inspector visited four people to assess the quality of care they received. An expert by experience contacted 16 people or their relatives, who were receiving care provided by the agency. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An inspector also spoke with ten staff on the telephone.

Before the inspection we reviewed the inspection we held about the service. This included information provided by the agency, concerns and complaints we had received and information provided by the local authority.

During our visits to the offices we spoke with the general manager, two staff, two area managers and with the nominated individual. We looked at care records held for seven people and at four staff records. We also reviewed other records relating to the service such as quality monitoring visits and information relating to staff recruitment and training.

Requires Improvement

Is the service safe?

Our findings

There were not always sufficient numbers of care staff deployed to consistently provide people with safe care and sufficient support to meet their needs in a timely way. This had at times impacted upon people's safety and wellbeing. These concerns were reflected in our conversations with people. For example one person said "some of them are very nice and are kind and caring but others rush and want to get to the next job because they are late and short staffed. I am paying for this service." And "That's the fly in the ointment, too many different carers it's quite muddling I am not happy with strangers I get nervous with people I've never seen before it's happened quite a lot since Apex took over."

Apex Care Totton had taken over a number of other agencies, their clients and their staff. Apex Totton had not always been able to retain staff and some who had worked for previous agencies had left. This meant Apex Care Totton had a shortfall in the number of staffing hours they could provide and so they had not been able to cover all calls at all times. At the time of our visits the management team said on average they currently had a shortfall of about ten care hours a week.

Apex Care Totton had taken steps to address this by reducing the number of clients they supported. This had at times led to people being given short notice that they needed to change their care provider which had caused some anxiety and inconvenience. The agency had been assisted by the local authority who supplied care staff to cover any identified shortfalls where people's health or safety could be compromised. Current staff also worked additional hours although this meant at times they were working very long hours. One care staff for example said they had completed 19 calls in one day from 7am to 10 pm with very few breaks. Another said "sometimes I feel rushed". The management team said they were actively recruiting staff and said five new staff had been invited to attend an induction the week following our visits.

Whilst it is recognised the provider is taking steps to address the shortfalls in the number of staff deployed, they were in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had not deployed sufficient numbers of staff to make sure they could meet people's care needs.

Staff recruitment records contained a range of information including a written application; references, including one from the applicant's most recent employer; a health declaration and a statement of terms and conditions. There were gaps in two people's employment histories. One was a gap of a number of years. Staff said this had been discussed at interview but this discussion had not always been recorded. Confirming a job candidate's past work experience is one of the most important background checks an employer can conduct and is a legal requirement. Staff said in future this would always be recorded.

All care workers had completed a satisfactory Disclosure and Barring Service (DBS) Adult first check. DBS Adult First allows employers to check applicants against the DBS Adults' Barred List. Dependant on the result of the check, this service allows an applicant to start work under supervision whilst waiting for their full DBS Certificate. A full DBS check which provides a criminal records check was also undertaken but had not always been returned before the person started work.

Some risk assessments were not up to date. The purpose of a risk assessment is to put measures in place to reduce the risks to the person so it is important these are completed regularly and they are accurate so they balance the needs and safety of people using the service with their rights and preferences.

Risks relating to people's safety and welfare were sometimes documented, although this often had been done by previous agencies. This meant at times risk to people's health and safety had not been updated for some time and there was a risk staff had not been provided with appropriate guidance to enable them to support people effectively.

One person had displayed some behaviours which could challenge staff. This had been recorded by the previous agency with staff reporting situations where they would need more guidance to support the person appropriately. The last entry into care records we saw for this was dated in April 2016 which said staff were going to involve specialist health care professionals. There was no further guidance in records to assist staff since this date. Another person had a bed rail risk assessment in place. The risk assessments said bed rails were to be used but there was nothing to suggest why and the person and their relative were unsure about why this was. They said falling out of bed had never been an issue. The risk assessment also said 'air mattress in place' but the person did not have an air mattress.

The lack of appropriate risk assessments was a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people using the agency managed their own medicines or their relatives supported them to do this. Where people needed support to manage their prescribed medicines, staff had been trained to help although refresher training in this area was not always up to date. Where staff had shown a lack of understanding about medicines management they had been immediately retrained. The agency differentiated between two different levels of assistance with medicines needed. One was where people needed support to prompt them to take their prescribed medicines and the other was where people needed staff to assist them to take or in the case of crèmes, to apply their prescribed medicines. There was no consistent method of recording this and so there was some contradictory information in people's records. Staff said "we have to write down the medication people have. Some don't bother."
Some people had body maps which recorded places where prescribed crèmes should be applied but this differed from information recorded in different parts of people's care records. This meant it was not possible to easily confirm the agency was providing the care and support which had been agreed in the person's plan of care.
This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014. The proper and safe management of medicines.

All people we visited and spoke with said they felt safe with their care worker. Staff were trained in safeguarding adults and said they would not hesitate to report any concerns if they suspected any harm or abuse. Staff were also aware of their responsibilities under whistleblowing arrangements. A whistleblower is a person who raises a concern about a wrongdoing in their workplace or within the NHS or social care setting. There was an on call system which worked outside of office hours. All staff and people who used the service had this number. General opinion was that the out of hours and sometimes the during hours office number had not always been easy to get hold of but this had improved in recent weeks.People said however this still needed to improve further so they could be assured any concerns would be responded to in a timely way.

Requires Improvement

Is the service effective?

Our findings

Most people said staff were competent and knew what they were doing. However one person said that on occasions when different staff visited they didn't always know what was to be done. They said "When the other agency needed to send a new care worker they usually visited a couple of times before with established care workers to see what I needed. This lot don't do that. It's so unfair on them".

New staff completed a four day induction in line with skills for care standards which ensure national minimum standards are met. These covered key health and safety areas such as moving and handling, infection control, safeguarding and fire safety. New staff shadowed more experienced staff to help them to understand their role and responsibilities.

Established staff we spoke with said they had received training in key health and safety areas although some of this needed to be updated. Staff who had transferred over from other agencies said this training had taken place during their employment with previous agencies. Nearly all said they had not been given any training since joining Apex Care Totton. Records confirmed most staff had some key health and safety training which was out of date. Senior managers were aware of this but said their present priorities were to cover visits. They said when they could cover visits consistently they would ensure staff completed refresher training.

The agency website says staff were skilled in supporting people who were living with various conditions such as Dementia and Parkinson's. Despite supporting people with these conditions most staff had not completed any specific training. Two staff said they would particularly like training in supporting with people living with dementia to enable them to provide more effective care. The agency had employed a training officer who was updating staff in training such as medicines management and moving and handling but this had not yet had a significant impact in terms of updating staff skills and knowledge. Regarding a particular medical condition one relative said "Some of the Carers are very good and they talk to her but some need retraining because they don't know what to do and this upsets her"

Nearly all staff said they had not received any supervision since working for Apex Care Totton although one staff said they had been observed supporting a person to move safely and said the feedback received about this had been helpful. Records also showed there had been some very recent visits to people's homes to monitor the quality of care and support staff provided

Staff said they had talks in car parks with managers or they had informal chats when they went to the office to pick up gloves. Most said it would be helpful if they had opportunities to speak with managers in private. One said "they just don't communicate well with us" and others agreed communication could be more effective. There was not a training facility or a private room for supervision in the Apex Care Totton branch and although the Southampton branch could be used for these purposes this had not happened in any regular way.

The management team said ideally they would expect to supervise their staff about once every three months. This had not happened because of staffing difficulties and they were aware this needed to improve. This was a breach of regulation 18(2)(a) as staff must receive appropriate support, training supervision and appraisal to enable them to carry out the duties they are employed to perform.

We looked at what consideration the agency gave to the Mental Capacity Act 2005 (MCA) and checked whether staff were working within the principles of the legislation. The 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.

Where people had capacity to consent to the care and support provided some had consent forms, these gave staff permission for example to administer their medicines. However when signed this permission had often been given to staff working for the person's previous agency. Others had not signed consent forms. Some people who may have had capacity to sign for themselves had family members sign on their behalf for aspects of their care. For example, two family members had signed agree to the support their relative was receiving. When asked why they were asked to sign rather than the person they said "I don't know." They went on to say one family member "wouldn't know what or why (they) were signing it".

The service provided care and support to people who sometimes lacked capacity to make certain decisions for themselves. However, we did not see any assessments in relation to a person's capacity to make their own decisions, where this may affect their health and wellbeing especially in relation to medicines and identified risks. We spoke to managers about this and they told us that the local authority did mental capacity assessments and best interest decisions.

The agency had not ensured care provided to service users must only be provided with the consent of the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people needed their meals and drinks prepared for them as part of their care package. Where this was necessary, staff provided appropriate support. Visits had recently been made more consistently at agreed times which helped to ensure people who needed support with breakfast lunch and dinner received this support more regularly when they needed it.

Staff described actions they had taken when they had found people to be unwell, such as on occasion phoning for an ambulance. People confirmed staff, where needed helped them to monitor their health. One person said "if they are a bit concerned about anything like my legs don't look good they will encourage me to contact the Doctor or the Nurse".

Some people staff supported had diabetes. For example one person managed their own blood sugar level checks and administered their own insulin. Staff recorded how much insulin they had taken and what their blood sugar levels were each day. Records showed these were very variable but there was no guidance for staff about what the appropriate range was and what action if any they should take when blood sugar level readings were higher or lower than usual. We discussed with the management team that greater clarity was needed regarding staff role and responsibilities where people were managing their own diabetes to ensure they all provided consistent care and support.

Requires Improvement

Is the service caring?

Our findings

A common theme people discussed with us was the standard of communication with staff in the office or via the out of hour's system. People needed to have effective communication with the Apex office especially when their carer was late or where they needed to change the timing or date of a planned visit. The general consensus was this had improved in recent weeks for example people said "in the last few weeks someone has actually answered the phone" However this was not reflected in all of the conversations we had with people. Although many people said there had been an improvement since the new manager had been in post, some people expressed frustration for example one said "I can't get through on the phone and last Sunday I didn't need a carer because I had visitors but one turned up- what am I to do?".

People said they were treated with kindness and were particularly complimentary about the older staff. They said "The staff are lovely, helpful and polite and are very kind towards me and nothing is too much trouble for them. "And "I could not ask for more with the carers they couldn't be better and they do the job without being told." The carers are absolutely 1st class. They treat me well and what I like is that the older ones have come back and I feel safe with them around because they have been doing it a long time".

People said staff were friendly and cheerful and it was clear people had developed good relationships with their regular carers. One said "(carer's name) is brilliant she has a lovely sense of humour and she is really efficient and knows what she is doing." Another said "They are cheerful and smile and say good morning I feel very comfortable with them. A relative said "The carers are brilliant, no complaints at all very professional and friendly they listen to Mum and have a laugh with her and get on with the job." Staff demonstrated a commitment to their role one said for example "I love my job and I like to build up a good relationship with the people I visit but sometimes you do not know what you are walking into and how able people are to communicate."

People told us staff respected their privacy and gave examples that staff ensured they pulled curtains and closed doors. Care staff were reminded to respect people's personal information and signed a confidentiality clause when they started to work for Apex. The importance of maintaining people's dignity and respect was explored with prospective staff during their interview.

Some care records contained information about people's preferred term of address, and staff were able to describe the needs of people they regularly supported. As part of the care assessment process people were asked their preference about whether they would prefer male or female carers to support them. The manager said this was respected where possible but at times people did not get care staff of their preferred gender. For example one person said "they sent a man recently which was a surprise when he let himself in with key safe but he reassured me and apologised and he is quite a gent". Others said it caused distress if a male care staff was sent to assist a female client with personal care.

There had been some recent quality assurance visits conducted by staff at the agency. The quality of support provided by care staff was generally described as being person centred, dignified and respectful. Records for the visit also noted staff encouraged independence.

Requires Improvement

Is the service responsive?

Our findings

Before the inspection, we had received a number of concerns from people and their families that some care visits had been late or had been missed. When we spoke with people they also told us this had been the case but most said this had very much improved recently. The lack of reliability had at times had a negative impact upon people's care welfare and comfort and a significant impact upon the confidence people had in the agency. At times calls had been so late or had been missed so people had needed to rely on family and friends to support them or they had not received any support.

We asked people about the current reliability of the service. Although in general people said their situation had improved they were still not confident about how reliable the agency could be because of their past experience. People said for example "Sometimes the carer is late. I call the office and usually get the answer phone so I call the emergency number. If that gets answered they don't usually know anything………then ten minutes later a carer will appear. They usually say "I've only just been given the call". Another person said , "Sometimes it can be over an hour late. It hasn't happened for about three weeks but it's always in the back of your mind. I'm happy now. If you had asked me if I was happy four weeks ago my answer would have been no…….. But things are getting better". Another person said "I have less late calls than I used to. My only gripe is I don't know when they are late because I don't know what time they are supposed to get here. Lately the staff are more regular. Before that it was all different ones and a few weeks ago no one came at all morning or evening and I had to call a neighbour."

Staff mainly said timing of calls still needed to improve but also agreed this had got better in recent days. One for example said "it has been horrendous but it has calmed down recently" Another called the reliability of the agency a "work in progress." Staff said they increasingly supported a regular group of clients and most received work schedules on a weekly basis which was an improvement as it meant they could plan their work more effectively. Any changes to schedules were e mailed to staff. Some staff said this was not always a very good system as it relied on them checking their e mails very regularly which not all did.

Staff and people who used the service generally agreed further improvements would be made if clients received a schedule so they would know who was coming to support them. This included times staff were expected and the times they were expected to stay. Although more people were receiving support from regular care staff the lack of written information to let people know who was calling and when had an impact upon people's confidence in the agency. One person using the service said "We've not had proper schedules for months now and I'm very poorly and handicapped…I need help. I don't know who is coming and what time they are coming. I want to stay in my own home but at this rate I might not be able to". Another said "It's different people who come I never know who is coming or who I can rely on it's a shambles". Another said " I don't know who is coming. Some of the older ones are okay and one day a man called x let himself in with the key safe I didn't know him until he said he was from Apex. It was very worrying."

A number of people had their care and support packages transferred from different agencies which had ceased trading to Apex Care Totton. Many people still had support plans which had been devised by their previous agency. These were not always reflective of people's current needs. This meant staff and people using the agency were not always clear about the support and care which had been agreed and what care and support needed to be delivered.

We asked people who received a service if they had a care plan. Representative comments were "they (the care staff) have a book they write in but I don't think I have a care plan." Another person said "I don't have a care plan, they have to ask me all I the time what I want and need it gets very tiring I'm 94." And another person said "We don't have a Care Plan at the moment we had one with (previous agency)" A relative said "I've asked for a bowel sheet to record things but we've not got one I want to know what's going on."

Although staff were able to describe clearly the support regular clients needed they also said it could be difficult going to a new client because they did not always know the support they needed. Staff also said they would like to be introduced to new clients. They said the agency was playing "catch up" with people's care plans as some were up to date and others still needed updating They said the lack of written care plans could be daunting for new staff especially if the client had a communication difficulty.

The management team were aware people did not always have up to date care plans and said they were in the process of rectifying this. We saw some updated copies of people's care plans which were stored in the Southampton office which were detailed and described the person's needs clearly. Managers said they had employed an additional staff member to help them to ensure people's care and support plans were up to date. People confirmed this work was in progress. One person said for example " I don't have a care plan but I did have a letter from them telling me they would give me one as soon as they can".

Although the agency were taking steps to rectify this at the time of our inspection people did not have plans of care to reflect their current needs and preferences They therefore could not assure themselves people were receiving person centred care that meets their needs and reflects their personal preferences whatever they might be. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the agency managed concerns and complaints. During the summer of 2016 the service had not always responded in a timely or effective way to concerns and complaints raised by people regarding the quality of the service provided. As well as late and missed calls, people also wanted to know who was calling and when. The lack of a timely response to these queries had prompted people to contact the service again to ask for an answer and sometimes they had raised concerns with Hampshire County Council and with CQC as they had not been satisfied with the agencies responses to their concerns. People's previous experience reflected that confidence in the system needed to improve to help people to be assured that any concerns and complaints would be taken seriously and responded to in a timely way. For example staff said although things had improved recently when they reported concerns they had previously felt no connection with office staff they were reporting concerns to as these could be put thorough to a number of different departments. One said they had been put through to the accounts team on one occasion.
The management team acknowledged complaints had previously not always been responded to appropriately but provided evidence that any outstanding complaint and concern was now being addressed in line with their complaints policy and procedures.

Requires Improvement

Is the service well-led?

Our findings

We visited the Totton office unannounced as we had received a number of concerns from people and family members of people using the agency from this location. Three staff were present in the office but they were not aware they were registered to provide the regulated activity from the location. They said they were a satellite of the Apex Care Southampton office.

Apex Care Totton is registered with CQC to provide the regulated activity personal care from the location in Totton. A location is a place in which, or from which, regulated activities are provided or managed. Apex Care Totton had a list of clients who were supported from the office and also a list of staff who supported these clients. No records regarding people or staff were being stored at this office but staff working from this office said they had access to electronic records so they were aware of people's needs.

The lack of clarity about the registered location in part explained some of the difficulties experienced by people using the agency. For example, when telephone calls were received by staff at the Totton office people said staff they were helpful and knew people they were referring to and their needs. However when people were put through to the Southampton branch whilst they tried to help they did not always talk with staff who knew people's needs.

Although there was a recently recruited general manager in post, there was no registered manager. Each registered location needs to have a registered manager.
The last registered manager for this location had deregistered in May 2015. The agency had management support during this time although it was provided by different people. The new general manager had made some improvements and had written to all people using the service introducing themselves and said they would visit them. They also apologised for the missed or late calls and for the lack of communication. They said they would ensure people received a visit sheet each week showing their visit times and the carers name. People were aware of the difficulties the agency was having. One person said "Since last May (2016) they have had four different managers and they have too many clients and not enough staff. The carers are also upset at the state of affairs.(The new manager) says he hopes to sort it out but he has been landed in a mess … Apex took on too much". Another person reflected some people's opinions that they had noticed some improvements within the last few weeks, saying "The service has got a lot better recently and seems to be settling down."

Staff morale was generally low. Some staff said this was getting better and they had recently felt more supported by the newly appointed general manager.
Senior people in the organisation said they were aware the location at Totton was not appropriate as they could not provide facilities for staff support and training and so they intended to move the location to different premises shortly which could provide these extra facilities.

We looked at what quality assurance processes were in place. Most people said they had not been asked for their views about the quality of care. One person said if they were asked "I would tell them the same thing I have told you there are plenty of things to improve on. It has been very poor care. In the last couple of weeks it has been lovely I have had a regular carer and she has been on time, stays the allotted time and has been very good helping me shower. Before that they were late and not coming at all and when they did turn up they were not interested but the new manager has changed it and I am quite chuffed now because I don't worry who is coming".

Although most people had not been visited by staff from the agency to check on the quality of care they received, there had been some recent visits to people's homes to check on the quality of care and support provided. We saw the records of these visits. In three out of four visits it was noted care staff were not wearing their ID badges. Two of the four visits noted there was no care plan or risk assessment in place and the other two noted that care plans needed to be updated. There were no actions recorded as needed as a result of these visits although the general manager said these issues would be followed up.
We were told care records such as medicine charts were audited by office staff. However we saw there were some gaps on people's medication records with no clear explanation for these omissions.

Whilst it is recognised systems were beginning to be established to monitor the quality of care provided. These were not yet operating effectively. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team were working cooperatively with the local authority to help to ensure they quality of care and support provided was more reliable. They had undertaken not to take on any new clients until they were confident they could meet existing client's needs.

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 The care of service users must be appropriate, meet their needs and reflect their preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care of service users must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments relating to the safety and welfare of people using the service must be completed and reviewed regularly. Staff must follow policies and procedures about managing medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Providers must operate effective systems and processes to make sure they assess and monitor their service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

There were not sufficient staff deployed to meet people's needs. Staff must receive appropriate support and training to enable them to carry out the duties they are employed to perform.