Here to Care Limited

Here2Care (Dartford)

Inspection Report

17 The Brent
Dartford
Kent
DA1 1YD
Tel: 01322 225513
Website: www.here-2-care.co.uk

Date of inspection visit: 6 May 2014
Date of publication: 28/10/2014

Contents

Summary of findings

Overall summary

Overall summary Here2Care (Dartford) provides care and support to adults in their own homes. It provides personal care to mainly older people and some younger adults.

When we visited 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 and shares the legal responsibility for meeting the requirements of the law with the provider.

The service had systems in place to keep people safe. However we saw that although some risks associated with people's care and support had been identified during assessments, there was not sufficient guidance in place for staff, to help make sure these risks were managed safely and consistently.

People told us they received their medicines safely and when they should. However there were shortfalls in the management of medicines.

People had been involved in developing their care plan. However although care plans showed the tasks staff were required to undertake, they lacked information about people's choice, preferences and independence skills in relation to their personal care routine, to help ensure people received a consistent and safe approach to their care and support. Some people received care and support from a very small number of regular care workers, others did not. Some people told us when they did not know the care worker this could make them feel uncomfortable particularly during personal care.

People we spoke with told us they were able to make their own day to day decisions about their care and

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service is not safe because we found when staff were involved in medicine administration the level of their involvement was not made clear in assessments and it was not always evident in medicine administration records when or if people had taken their medicines.

Some risks assessments did not contain sufficient guidance to ensure staff took a consistent approach and people remained safe. For example, when moving and handling people.

Staff understood the importance of supporting people to make their own decisions, but lacked the knowledge to link practice to the legislation, such as identifying when a formal assessment of a person's mental capacity might be required. However staff reported when people's health deteriorated, such as increased confusion, so the correct procedures for people that lacked capacity to make decisions would be followed.

People who used the service and relatives told us that people felt safe using the service or whilst staff were visiting their homes. One person said, "It all goes along quite well." Staff had a clear understanding of what to do if they felt people were at risk of neglect or abuse, so they could protect people from harm. We saw that when accidents or incidents occurred, any immediate action required was taken to ensure people remained as safe as possible.

Are services effective?

The service was not effective because nutritional assessments did not identify all risks associated nutrition. For example, if a person required a special diet as they were diabetic or they became unwell as a result of their diabetes. This meant people might not supported with the right diet or staff might not recognise the signs that a person was unwell or there might be a delay in calling health professionals to ensure the person remained healthy.

People we spoke with told us they were satisfied with the care and support provided. People said their needs had been assessed and this had sometimes involved family members at their request. Care plans had been developed from these assessments. We found that the care plans showed all the tasks staff were required to undertake on each visit although they lacked information about people's choices, preferences and independence skills. People told us that staff had the skills and experience to meet their needs and records confirmed staff had received the relevant training for their role.

Summary of findings

People we spoke with felt that they received care from a regular team of care workers, but some felt the number of different care workers who visited them at weekends could be a lot better. Records showed that not everyone who used the service received care from regular care workers. This made some people feel uncomfortable particularly when the care worker undertook their personal care.

Are services caring?

People spoke positively about the staff and felt that their privacy and dignity was maintained. They said staff were respectful.

The service had policies and procedures that had been read and understood by staff. These gave guidance on how to respect people's privacy, dignity and protect their rights. Staff demonstrated a kind and caring approach when discussing people that used the service during the inspection.

People's preferred names were recorded in their care plans and people told us that staff always used these names.

People could be confident that their information was handled safely as there were systems in place to manage information appropriately and staff understood their responsibilities about confidentiality. People we spoke with told us that they had opportunities to make their views known during regular care review meetings.

Are services responsive to people's needs?

People had a care plan in place, which was reviewed regularly or as people's needs changed.

People were given opportunities to express their views on the service provided. This was through visits, postal and telephone surveys. We noted that the majority of responses had been positive.

At the time of the inspection people we spoke with told us they had the ability to make their own decisions. Some people had family members to support them although there were no records of the arrangements. There were systems in place to support people where they were unable to make complex decision, to ensure decisions were made in people's best interest.

People who used the service told us they felt confident in complaining, but did not have anything to complain about. There was a complaints procedure, which required updating. Each person had a copy of procedure, which was usually located in their care folder.

Summary of findings

Are services well-led?

The service was not well-led because although the service undertook audits these had not been effective in identifying and addressing shortfalls found during this inspection in relation to care plans, risk assessment and medicine management.

Systems in place to monitor and manage complaints, accidents and incidents were not clear about what if any action had been taken, so that risks to people of future occurrences were minimised.

There were systems in place to monitor that staff had the necessary training and skills to meet the needs of people who were using the service. However records showed that monitoring was not effective as some staff had not received checks on their practice or individual meetings since 2013. Staff did feel supported by senior staff and the registered manager. The majority felt there was an open and supportive culture and all felt comfortable in taking any concerns forward.

The service was working at on-going recruitment to help ensure sufficient staff were recruited to meet the needs of people who used the service, in the interim staff were asked to work additional hours.

People who used the service told us their views were actively sought and solutions found to any problems.

The service had a set of values, which were covered during staff's induction, so they would be clear about the type and standard of care people expected.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 20 people who used the service and eight relatives or representatives by telephone to gain their feedback about the services they received. They told us they felt safe using the service. One person said, "I can't' fault it." People told us they and sometimes their relatives were involved in their assessments, care planning and review meetings.

People told us they were satisfied with the service they received. One person said, "On the whole it's very good, as good as they can be." Another person said, "I find them all right, great." People said, staff were kind, caring and respected their rights and dignity. One person said, "I've got X (care worker) she's good, very good and very caring." People said they did not have any complaints and had opportunities to express their views on the service provided. One person said, "I can honestly say I have not got anything to complain about at all."

People spoke positively about the staff and told us they were treated with kindness and respect. People told us their preferred name was always used by staff and this was recorded in their care plan.

People felt they were encouraged to be as independent as possible and that the care was delivered according to their wishes. Every person spoke positively about the staff whether they were their regular staff or not. One person said, "They [staff] are quite polite and they do what I ask." Another person said, "They all come smartly in uniform and know what they are doing." People felt as involved as they wanted to be. Some people told us they could speak for themselves, but others had relatives to represent them. People knew how to complain, but had no complaints. People told us that they were asked for their views and solutions were found to any problems.

Here2Care (Dartford)

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 was meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1. Our inspection team was made up of two inspectors and an expert by experience. The expert by experience had personal experience of accessing and caring for someone who uses this type of care service.

Before this inspection we reviewed information we held about the service. At our last inspection in September 2013 we had not identified any concerns with the service.

We visited the service office on 6 and 7 May 2014. During day one of the visit to the office we spoke with the registered manager. We also looked at people's care plans and other records. On day two of the office visit we continued to look at records, spoke with the registered manager, two staff members and made three home visits to people who were using the service. On these visits we also spoke with people's relatives.

Following the office visit we contacted 20 people who used the service, eight relatives and eight staff members by telephone.

We also sent out 60 postal surveys to people who were using the service, but we did not receive any responses.

Are services safe?

Our findings

Medicines management was discussed with people as part of their assessment. However although there should have been a set of 12 documents relating to medicine management we found that files examined did not contain complete information. This meant when staff read the records it was not always clear what tasks they should be involved in, in the management of a person's medicine, in order that people received their medicines when they should and safely. We saw that some people had chosen to manage their own medicines. One person said, "I only take one tablet at night and do it myself." The risks associated with this had been assessed and recorded to ensure it was safe. Where staff were involved in the administration of people's medicines their role was not always clear in the care plan. For example, whether they were required ask a person if they had taken their medicines or whether they actually had to assist in the administration. A list of people's prescribed medicines was included in their care plan folders. However the lists were not always up to date and did not include any prescribed creams that staff may have been applying as part of people's personal care routine. This left a risk that not all medicines would be administered.

There was a medicines policy in place for staff to refer to in regards to the safe management of medication. However this did not contain a clear written procedure to inform staff practice in how to handle, administer and record medicines safely. Records and discussions with staff confirmed that they had received medication administration training, in order that they had the knowledge to administer medicines safely. When we spoke with staff they were able to describe the procedure they followed when handling people's medicines, which followed a safe procedure.

People we spoke with told us they received their medicines when they should. They said there were no problems with their medicines. Where staff were assisting people with their medicine administration we found that a hand written medicine administration record (MAR) chart was in place. However these did not detail the actual medicines people were prescribed. Staff signed one box to indicate that all medicines had been administered, but this meant there was no record showing which individual medicines people had actually taken. We found we could not ascertain that people had always received their medicines in line with the prescribers instructions. This was because staff had not signed or entered a code on the medicine administration record on some occasions and records made by senior staff showed that some reviews of care had also identified that doses of medicines had not been given but signed for, or had not been given. Care records we examined indicated that medicines were administered by staff from monitored dosage systems filled by family members or doses left out by family members and not health professionals as recommended by the Royal Pharmaceutical Society as good practice. This showed there were no accurate records of the actual medication people had taken and left a risk that medication might not be given safely, or according to the prescriber's instructions. The above is a breach of Regulation 13 and the action we have asked the provider to take can be found at the back of this report.

We looked at risk assessments and found that these were not always written in enough detail to protect people from harm. We saw that some risks associated with the delivery of people's care and support had been identified, but there was little or no guidance in place to inform staff how to keep the person safe. For example, a letter from a health professional identified that one person was at risk in relation to "swallowing, gagging, acid reflux and vomiting following oral intake", but there was no risk assessment in place for this person. It was unclear from records and discussions with staff whether the person should be having a pureed diet, a soft diet or which foods were suitable for this person to eat, but we saw daily reports that reflected staff had prepared a microwaved meal of sausage and mash. Staff told us that the person's family purchased the food and they prepared it.

We found that for people who had epilepsy or were sight impaired the risks associated with these conditions had not been assessed. This meant staff might not know how to manage these risks safely. For example, if a person had an epileptic seizure, there was no guidance about how staff should manage this to ensure the person remained healthy and recovered safely. We saw that one manual handling assessment stated that equipment, such as an overhead ceiling hoist was in place, but there was no guidance to inform staff how to move the person safely. In discussions staff told us that they always attended this visit with an experienced member of staff who knew what to do as they had visited previously. Staff had received moving and handling training. We noted in another risk assessment that

Are services safe?

there was conflicting information about a person's ability to mobilise. A scoring system was used on risk assessments, but there was no guidance to show what the level of risk scores meant. People's safety was put at risk because risk assessments were not sufficiently detailed to guide staff or did not accurately reflect risks associated with people's care needs. The above is a breach of Regulation 9(1)(a)(b)(i)(ii) and the action we have asked the provider to take can be found at the back of this report.

People told us they felt safe using the service and whilst staff were present in their homes. We saw that the service had a clear safeguarding policy and procedure in place to help protect people who used the service. This included information about the types of abuse staff may encounter and the reporting process, including the local authority contact details. We spoke with staff that were able to demonstrate sufficient knowledge of safeguarding in order to keep people safe. Staff told us they had received safeguarding training and training records confirmed this had taken place.

We saw that that where the service had concerns about a person's safety senior staff reported appropriately to the local authority that had the lead for investigating safeguarding concerns. They then worked with the local authority to ensure people were kept safe. This meant staff were able to recognise signs of abuse or neglect and knew the procedures to report any allegations in order to keep people who used the service safe.

The people we spoke with told us they were able to make their own choices and decisions about their day to day care and support. Some people told us or we saw that they had family members to support them with their decision making. We were told by the registered manager that mental capacity assessments were completed by the service as part of people's initial assessment of needs and reviewed each time the care plan was reviewed. Care records included information about people's communication and abilities to make their own day to day decisions. This enabled staff to adapt their approach in order to encourage people who may find it difficult to make their own decisions.

We saw that where people did not have the capacity to consent to more complex decision making, the service had policies in place to enable senior staff to act in accordance with legal requirements. The registered manager told us that staff had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) training as part of their safeguarding training, in order to understand the legislation. The majority of staff confirmed they had received MCA and DOLS training. However in discussions staff understood the importance of supporting people to make their own decisions, but lacked the knowledge to link practice to the legislation, such as identifying when a formal assessment of a person's mental capacity might be required. Staff told us they would report any deterioration in a person's health to the office, such as an increase in a person's confusion, therefore correct procedures would be followed, in order to protect people.

Staff we spoke with told us and records confirmed that when accidents and incidents occurred staff reported them to the office and an accident/incident report was completed. These contained information about the accident. For example, we saw that a staff member had hurt themselves whilst on duty, the risk assessment had been reviewed and the registered manager told us that a piece of equipment at a person's home had been stabilised in order to reduce the risk of further occurrence. This meant that there were reporting systems in place, to help ensure that accidents were acted upon in order to keep people and staff as safe as possible.

Are services effective?

(for example, treatment is effective)

Our findings

People and their relatives told us they had been involved in an assessment of their needs and planning their care and support. We saw that some people or relatives had signed the assessments as a sign of their agreement with the content. However records did not identify who had been involved in the assessment of needs to ensure people who used the service and their representatives had the opportunity to express their views and were involved in the planning of their care and support.

People confirmed that senior staff visited them in their own home to assess and discuss their needs and any risks associated with their care and support at the start of using the service. The registered manager told us that where packages of care were arranged by the local authority, a temporary care plan based on information received from the local authority was put in place and then a full assessment of needs was undertaken within three days. Where people were responsible for the payment for their own care and support, assessments were undertaken prior to the service commencing. This helped to give a comprehensive picture of the person to make sure they received the right care and support.

People told us they had a copy of their care plan. We looked at 11 care plans. They included information about people's identified needs in areas, such as personal care and eating and drinking. People told us they had discussed their care routine preferences with assessors and care workers. However there was a lack of information about people's choices and preferences in relation to their preferred routines in the care plan. For example, they simply stated "I require to have a shower three times a week Mon/Wed/Fri all other days to have a full body wash" or they included words such as "help" and "assist" to undress or wash or shower, but did not detail how people should be helped. People told us they received care that reflected their preferences and choices. One relative told us, "The new ones we have to make aware of our circumstances and then there's no problem." One person said, "If I get a new carer I show and tell them what to do." In discussions with staff they told us when they visited a person they had not been to before they "usually" received some information from the office about the person, they checked the care plan and then talked to the person about what they wanted. One staff we spoke with said, "We don't really know their routine, we learn along the way." One staff member gave us an example where practice did not reflect what was in the care plan. This meant when the regular care workers were not working care and support would not be delivered in line with the person's preferences or the person would have to explain their routine to any new care worker that visited.

People told us that they were encouraged to be as independent as possible. People talked about being encouraged with their mobility and dressing. We asked people if staff encouraged them to be as independent as possible, their comments included, "Absolutely", "They [staff] are good in encouraging me to do things for myself" and "I am an independent sort of person and if I can do it, I do it." We saw that one review had identified that one person was not as independent as staff felt they could be. However there was a lack of information in most care plans about what aspects of a task people could do for themselves and what actual help they required from staff. This information could help staff to encourage or maintain people's independence, so people would be given the time to undertake tasks for themselves and maintain their independence skills.

A nutritional assessment had been undertaken for each person who used the service. We saw that assessments had identified the help people required with their meals and drinks, but they did not identify any associated risks or advice and guidance from health professionals. For example, where one person was a diabetic it was unclear in their assessment whether this was the case as this section had not been completed. There was also no mention of their being a diabetic in their care plan. We talked to a person who was a diabetic they told us this was discussed at their assessment and that "most of the time" staff followed good practice. However we found in discussions with staff their knowledge of the signs that a person might be unwell as a result of their diabetes was not clear.

The above demonstrates a breach of Regulation 9(1)(a)(b)(i)(ii) and the action we have asked the provider to take can be found at the back of this report.

Assessments contained information to ensure people received adequate quantities of food and drink, such as "I require a snack left for me for lunch time" and "prepare a snack (sandwich at my morning call for my lunch)".

Are services effective?

(for example, treatment is effective)

We saw that care plans had been reviewed regularly. One person said, "The people in charge in the office come from time to time to discuss my needs." Another person said, "They come from the office sometimes to do an assessment and review of how I am doing."

People told us that staff had the skills and experience necessary to meet their care and support needs. Staff we spoke with told us they felt they received appropriate induction and on-going training in order for them to carry out their role and responsibilities. One staff member said, "I enjoy the training and think we get sufficient." Another staff member felt they could do with further training in dementia as the numbers of people using the service with dementia had increased. Records confirmed that staff had received training for their role and in addition some staff had received specific training to meet people's identified needs, such as diabetes, management of a stoma, dementia and continence care. We saw that the service had a training plan in place. Staff told us and records confirmed that they received spot checks [unannounced checks made by senior staff to check staffs practice] and individual support meetings with their manager. One staff member said, "They [senior staff] are there to help us as well as make sure things are right for the clients." However the frequency of these varied and some staff had not had either since 2013, in order that they were supported to deliver care and support safely and to an appropriate standard.

People we spoke with told us they received care from a team of regular care workers, some felt that "weekends were not so good". One person said, "I don't know who is coming, but it's mainly the same ones." Another person said, "It's the same carer Monday to Friday and different on the weekend". We looked at records to establish whether people received regular care workers visit them. Records showed that although some people received regular care workers, others did not. For example, one person had 14 visits per week and in one week had seven different care workers. This made people feel uncomfortable in their own homes especially when receiving support with their personal care. The registered manager told us that this area of concern had been identified. She said staff worked a geographical area and there was an on-going recruitment drive particularly for weekend workers, so staff could work more effectively and people would receive improved continuity.

Are services caring?

Our findings

People we spoke with commented positively on the care and support they received and the kindness of staff. They told us that they had the privacy they needed and that the staff were respectful when they spoke to them. One person told us how staff ensured that the "door is closed, curtains drawn and explains everything they are doing during personal care." People's comments included, "Very pleased with them", "Absolutely, can't fault either ladies that come in", "Some more than others on the whole yes good", "We've been very lucky they have are all very good" and "We've got good ones." One relative told us, "Since they have been coming in I can see the difference, everything is clean and tidy and she (family member) looks well."

When we spoke with people about their personal preferences relating to their care and support, they were clear about what was important to them. They told us these had been discussed with staff during their assessment. Although we found these had not been recorded in people's care plans, people told us that the care they received reflected their wishes and preferences. We noted that people's preferred name was recorded in their care plan and people confirmed this was the name staff used.

People we spoke with felt their information was held and treated confidentially. One person said, "They (staff) don't talk about other people they go to." The service had a policy on confidentiality, which people received a copy of and staff had signed to confirm they had read and understood the document. In discussions with staff they demonstrated they understood the need to keep information about people confidential. For example, that they should not discuss other people using the service even if the person knew them, so information about people was treated in confidence.

People felt involved in the care and support they received. They were asked how they were treated by staff during care reviews. People's individual communication skills and abilities were discussed and recorded during assessments to enable meaningful communication between the person using the service and staff.

The service had policies giving guidance to staff on privacy, dignity and people's rights. We saw that privacy, dignity and people's rights were covered during staff's induction. Staff we spoke with were able to give good examples of how they respected people's privacy and dignity during their day to day work. For example, closing curtains and doors and allowing time alone where appropriate.

Where people received regular care workers, staff had taken the time to build up a good relationships with the person using the service and sometimes others involved in their care and support. People told us care workers quickly picked up on when they were not well.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People we spoke with confirmed they had a care folder. At the start of using the service people received their care folder, which remained in their own home. This contained a copy of their latest care plan, risk assessments and daily reports made by staff. People confirmed their folders contained information about the service and contact details, so they knew what they could expect from the service.

People were given the opportunity to express their views on the service provided and had regular care reviews. People told us that "people come from the office occasionally to request feedback from us." A member of senior staff visited people and reviewed their care needs and in addition a care quality officer visited people's homes and gained feedback when carrying out checks on staff. One person said, "X comes twice a year and goes through things. I asked them to do my hair so if they have time they do it now." The registered manager told us that the service also undertook two quality assurance telephone calls after a period of time to people who were new to using the service. Records showed that comments were positive. In addition, the service undertook an annual postal survey. We noted that the majority of responses were positive. This showed that people were encouraged to make their views about their care and support known.

Most people we spoke with told us that they were able to make their own decisions about their day to day care and support. Some people had family members who helped them with decision making. The registered manager told us that capacity assessments were part of the assessment process. Where the assessment identified that people were not able to make certain decisions the registered manager told us how the service had liaised with family members and agreed best interest ways of working, however these discussions and agreements had not been recorded. For example, one person was not given a choice of meals by care workers as this approach had cause them to refuse food altogether. Arrangements were made that the family purchased the meals and left one out to be cooked each day.

People told us they knew how to make a complaint, they had telephone contact numbers and would be confident to call, but did not have concerns. One person told us how they had mentioned the weekend timing of visits and it had been resolved. There was a complaints procedure in place. However the complaints procedure contained in each person's care folder did not have up to date information regarding the Commission, so the person would not have the right information to bring any concerns they wished to our attention. The complaints procedure contained timescales, so people were informed about how and when a complaint would be handled and responded to by the service. At the time of the inspection visit there were no open complaints.

People told us they did not feel social isolated since using the service. One person said, "[Using the service] it's like bringing the outside [world] in and we have a laugh and we giggle away."

Are services well-led?

Our findings

There was a system in place to record, monitor and evaluate complaints, accidents and incidents. We tracked an accident through the system and saw that for each event action to be taken had been recorded. However although it was clear the action to be taken had been reported to the right member of senior staff, it was not always clear what if any action that person had taken. The registered manager told us they monitored events for trends and learning to inform practice and reduce the risk of further occurrences however there was no evidence to confirm this.

There were audits in place and others were being introduced at the time of the inspection. For example, there was a health and safety audit, medicines audit and daily records made by staff had also recently been audited. However we found that systems were not always effective as in some cases shortfalls had not been identified, such as shortfalls in care planning, assessments of risk and medicines management that were identified during this inspection. We saw that where negative feedback about staff practice had been highlighted at people's care reviews staff were informed about this by telephone. However, it was not always clear if, or when, their practices had been monitored any further, in order to improve the outcomes for people who used the service.

People told us they felt staff were "well trained". There was a system in place to monitor that staffs training requirements remained up to date. The service had regular access to one of the organisations trainers and had training facilities at the office. This meant that all staff were receiving induction and on-going training to help ensure they had the skills and competency to carry out their roles and responsibilities. We saw that there was a system in place to monitor that staff received regular spot checks [unannounced checks made by senior staff on their practice] and individual meetings with their manager. However this system was not effective as records showed that some members of staff had not received either since 2013. This left a risk that any poor practice would not proactively be identified by the service, but relied on people reporting concerns.

The above is a breach of Regulation 10(1)(b) and the action we have asked the provider to take can be found at the back of this report.

Staff told us they normally worked in a small geographical area unless, due to holidays or sickness, they were required to cover elsewhere. Records we looked at and discussions with people who used the service showed that there had been a few occasions when people had not received a visit. Most people felt staff arrived on time although a few did tell us staff were occasionally late. One person said, "They (staff) do not always arrive on time it depends on how busy they are, but they are generally on time." People told us that staff stayed the full time or did all that was required. One person told us that staff were more often on time during the week than at weekends. Staff said that although travelling time was allocated "to a point" in between visits this was often "tight", which meant they may run late. The registered manager talked about how recruitment was on-going to ensure the service had sufficient staff to provide the care and support commissioned, so that staff would be recruited to match the needs of the service and people who used it, but in the interim this was managed with request to staff to work additional hours.

The service had a clear set of values which were displayed within the office and covered during staff's induction, so staff could be clear about the type of service expected and the standards people could expect from the service.

Most staff we spoke with all felt well supported by the registered manager and senior staff. The majority of staff felt there was an open and supportive culture about the service. They felt their concerns were taken seriously and acted on. One staff member said, "I know I can always go to X (senior member of staff)." Another staff member said, "Individuals in the office are good." One staff member felt that a notice displayed in the office reception that prohibited staff from accessing past that point, did not promote an open and supportive culture. However, they went on to tell us, "The office has never been as good as it is now."

People felt the service was well led and they would "recommend the agency to someone else." Staff told us they had confidence in the registered manager and her leadership and felt comfortable in bringing concerns to her attention. One staff member said, "One hundred per cent." Another staff member said, "On the whole I have confidence, I have found her (registered manager) to be emotionally supportive." Another said, "The manager is lovely."

Are services well-led?

The service had an emergency plan. We saw that this included what to do in the event of emergencies, such as severe weather, so that the service would continue without disruption to the people who used it.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People's care plans did not contain sufficient guidance to staff in order that care and support could be delivered in a safe and consistent way that would meet people's individual needs and reduce risks to people's health and welfare. Regulation 9(1)(a)(b)(i)(ii)

Regulated activity	Regulation
	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 13

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. Regulation 10(1)(b)