Comfort Home Care Ltd

My Homecare Huddersfield

Inspection report

Heritage Exchange, Wellington Mills
Lindley
Huddersfield
West Yorkshire
HD3 3HR

Tel: 01484766620

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This announced inspection took place on 12 December 2018. We gave 48 hours' notice of our intention to visit the provider's office to make sure people we needed to speak with were available. At the time of our inspection 41 people were receiving support from the service.

My Homecare Huddersfield is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, including people living with dementia and younger disabled adults living in the Huddersfield area. Not everyone using My Homecare Huddersfield receives a service which is a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

This was the first time this service was inspected since registering on 27 March 2017. During this inspection, we found one breach of regulation in relation to consent to care.

At the time of this inspection the service had a manager who had not registered to manage the service; they were also the nominated individual for the service. The previous registered manager had left the service less than a month before our inspection and we saw evidence that the provider was actively trying to recruit another manager. It is a legal requirement that the service has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 provider was not compliant with the Mental Capacity Act 2005 (MCA). The manager had a good understanding of how to support people who required best interest decisions made on their behalf, however, they were not completing decision specific mental capacity assessments and best interest decisions. We recommend the provider researches and implements best practice guidance to ensure specific decisions made in people's best interest are appropriately completed and recorded.

People's medicines were not always managed safely. We found medicines administration sheets were not always completed as required and changes to people's medicines were not double signed and dated to prevent any errors. There were no protocols in place in relation to the correct management and administration of 'as and when required' medicines. We found medication audits were being completed however these were not always effective in identifying the issues found at this inspection. Staff were trained in the safe administration of medication and their competency to complete this task regularly assessed. We recommend the provider researches and implements best practice guidance to ensure people's medicines are always managed safely.

The provider's management of risks and care planning required improvement. We found some risks to

people's care had been assessed and details of the support required were in place, however, some other risks had a very succinct assessment and did not give enough guidance to staff. We found there was limited information in relation to the care of one person who required end of life care. Staff had a good understanding of how to support people safely and knew what to do if they had concerns about people's safety.

Most people told us they felt safe due to the support they received from staff. Staff and management had completed safeguarding adults training and knew how to keep people safe and report concerns.

Staff were recruited safely. There were always enough staff to provide people with the care and support they needed. We received mixed views from people in relation to the continuity of the staff supporting them and the manager told us this was an area they were aware needed improvement and they were working on it.

People and their relatives felt staff had appropriate skills and were competent. Staff had a good understanding of the people they supported and had access to ongoing training and supervision to support and improve their practice.

People told us the service they received from My Homecare Huddersfield was important to keep them independent and safe living at home. People and their relatives told us staff were consistently kind, caring and compassionate.

People were supported to have a balanced diet that met their individual dietary needs. They were supported to access healthcare services to maintain their health.

We received mixed views about people's involvement in reviewing their care. People told us they were treated with respect and their dignity and privacy was maintained and staff could tell us how to promote this.

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication needs were assessed.

People told us they would feel comfortable to raise issues or concerns and that the management team and staff were friendly and approachable. The manager appropriately investigated and analysed complaints and incidents.

People, their relatives and staff were complimentary about the leadership and management of the service. There were several systems in place to monitor the quality of care however these had not always been effective in identifying and addressing the issues found at this inspection. We recommend the provider researches and implements best practice guidance in relation to effective quality assurance processes.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always managed safely and the provider's management of risks and care planning required improvement.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding people's safety.

There were safe recruitment policies and procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was aware of their responsibilities under the MCA, however, improvements were required in completing specific assessments and best interest decisions for people who lacked capacity.

People were cared for by staff who had received training and had the skills to meet their needs.

People were supported to eat a balanced diet that met their needs and to access healthcare professionals when required.

Is the service caring?

Good

The service was caring.

Staff knew how to promote people's privacy and dignity.

People told us they were supported by staff with whom they had positive relationships with.

We received mixed views about how people and their relatives were involved in reviewing their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personalised care that met their needs.

People's care plans were detailed and provided staff with personalised information about people's care but improvements were needed in the care plans for people receiving end of life care.

There was a process in place to deal with any complaints or concerns if they were raised.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were several quality assurance processes in place to check the delivery of care, however, these had not always been effective in identifying and addressing the issues found at this inspection.

There were links with external organisations to share good practice and maintain staff's knowledge and skills.

People, relatives and staff were consistently complimentary about the leadership and management of the service.

My Homecare Huddersfield

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 was a comprehensive inspection. The inspection was carried out by one adult social care inspector.

This inspection took place on 12 December 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure management would be available to talk with us.

Inspection activity included visiting the office location to speak the manager and office staff; and to review care records, policies and procedures and quality assurance documents. We carried out telephone interviews with people who used the service, their relatives and staff.

Before the inspection, we reviewed all the information we held about the service including notifications received by the CQC. A notification is information about important events which the service is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during our inspection. We requested and received feedback on the service from the local safeguarding teams and commissioners.

We spoke with four people using the service and four relatives of people using the service. We spoke with seven staff; this included the manager, care coordinator and care workers. We looked at care records for three people using the service including support plans and risk assessments. We analysed four medicine administration records. We reviewed training, recruitment and supervision records for three staff including competencies and recent observations of their competencies. We looked at various policies and procedures and reviewed the quality assurance and monitoring systems of the service.

Requires Improvement

Is the service safe?

Our findings

Most people and their relatives told us My Homecare Huddersfield were providing a safe service. When we asked if people felt safe, most people said "Yes, I do [fell safe]." One person told us they did not always felt safe and told us about a recent incident which was being investigated by the local safeguarding team. The manager was also investigating this incident and told us how they were managing the risks related to this incident.

Relatives comments in relation to people's safety included, "Yes, for the most part;" "Yes, I think they [My Homecare Huddersfield] are quite good" and "[My relative] is safer now, they [My Homecare Huddersfield] are a good team."

People's medicines were not always managed safely. When we reviewed people's medicine administration records (MARs) we found several gaps in recording. We discussed this with the provider and we were reassured by the information provided that the gaps in recording were not because people had missed their medication but due to issues with record keeping. Other issues with record keeping included poor recording when people had declined their medication and medication instructions. We found changes in people's medication were handwritten by one staff member only and not dated. This meant that the risks with making an error when transcribing people's medication instructions and dosage were not being managed appropriately. The provider's medication policy did not detail how changes in people's medicines should be recorded, however, the manager told us they would expect staff to double sign and date any changes made.

There were no protocols in place in relation to the correct management and administration of 'as and when required' medicines and it was not always clear in the MARs if a medication was to be given only when required or not. For example, the MARs for one person who was living with dementia and whose communication care plan indicated difficulties in communication, showed they had been prescribed with a medication to help manage constipation. Records on MARs evidenced this was not being given every day, however, there was no indication this medication was to be given regularly or only 'as and when required.' We spoke with the manager and care coordinator and they told us this was a PRN medication however there was no protocol in place to guide staff on when to administer this medicine. When we checked this person's daily records we saw that the days they had requested and been given this medicine matched, however, we could not be assured staff had always offered to administer this medication when required. People living with dementia might have variable levels of cognitive and communication abilities to communicate pain and discomfort and it is important staff have the necessary guidance to support people. We discussed this concerns with the manager and they told us they would immediately put a PRN protocol for this person and review the PRN medicines for other people being supported.

The provider's medication audits had identified some of the gaps in recording we found at this inspection but not all. The actions taken to prevent this happening again had not been effective because this concern was found in consecutive months. We also found that some of the staff completing the medication audits also delivered care and this could impact on the impartiality of the quality assurance process in place. We shared these concerns with the manager and they told us they would review their processes. Staff were

trained in the safe administration of medication and their competency to complete this task regularly assessed. We recommend the provider researches and implements best practice guidance to ensure people's medicines are always managed safely.
Risks to people were not always managed safely. We saw care records included risk assessments in relation to people's personal care, mobility and environment. We also saw specific risk assessments related to people's specific needs or support such as use of the bus, bed rails and specific equipment to help people to move, however, these were not always very detailed. For example, one person had an epilepsy risk assessment, however, this did not give enough level of detail of how an epilepsy seizure would present and how long staff should wait until contacting emergency services. We spoke with staff who supported this person and they were able to give us more detail of the support they would provide in such an occurrence because they had been given detailed information by this person's relative. One person who was known to have falls did not have a specific risk assessment or care plan in relation to this. One person who required end of life care and had difficulties with their communication needed support from staff with repositioning in bed to relieve pressure; their care plan indicated, "reposition and place a pillow to make [person] comfortable" but there were no details of how staff should do this or where to place the pillow. We spoke with the manager about these concerns and they told us they would update people's risk assessments and care plans.

Staff had a good understanding of how to support people safely and knew what to do if they had concerns about people's safety. One staff member told us how they would support people after a fall and that they would always report this to the office to ensure all had been done to prevent this happening again. We saw the manager was recording and managing incident and accidents appropriately, with analysis of patterns being done and when needed, changes to people's care implemented.

The provider had a safeguarding policy and procedures in place, staff had been trained in these and were able to tell us the signs of abuse that they would look out for and what steps to take if they had concerns. One staff member told us they would "Ring the office immediately" if they had any safeguarding concerns. Concerns about people had been raised with the local authority safeguarding team and CQC had been informed.

People shared mixed views about staff arriving on time. We asked people if they received late care visits; one person said, "Quite often;" another person said, "No, [carer workers] are always on time;" and other person commented, "No, usually very good with times." Relatives also gave us mixed views about staff arriving on time. The provider had an electronic call monitoring service in place which recorded when staff had started and completed a care visit. The manager told us office staff monitored these regularly throughout the day and audits were completed on a monthly basis. We spoke with the manager about people's comments about receiving late visits; they told us what had happened in those instances and that they were planning to introduce a "new step in the system to make clients and carers aware of changes to times so things are not missed" and they were starting to "generate a list and mark off when changes are agreed."

People and relatives told us care workers stayed for the full length of the care visit. Staff told us they felt they had enough time to spend with people. One staff member said, "A lot of calls are 20 to 30 minutes' calls, we don't do 15 minutes' calls, we have time to spend with people and we cook proper food, like bacon and eggs." The manager told us there was always a senior member of staff available to answer the phone during out of office hours. Staff confirmed this was available to them.

The provider was managing the risks of cross infection appropriately. Care workers had completed training in infection control prevention. Staff told us they have access personal protective equipment (PPE) including gloves and hand gel. People did not report any issues with the standard of hygiene when receiving

care.

People were supported by staff who were safe to work with them. Staff files contained the information required to aid safe recruitment decisions. Appropriate checks helped the provider ensure that only suitable applicants were offered work with the service.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they felt care workers had the skills and competence to do their job. People told us, "Yes, they [carers] are competent, they know me well" and "Yes, they do, they ae actually excellent. I have had other companies and they had to go because they were not right."

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

During this inspection we found the provider was not compliant with the MCA because decision specific mental capacity assessments and best interest decisions were not completed for people who required them and this was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The registered manager understood the principles of the MCA, they described us how important it was to check if a person can understand, weight up and communicate information in particular when setting up a new care package. They initially told us no one being supported by the service lacked the capacity to make decisions about their care. However, when we reviewed people's records, we saw the provider had not followed the appropriate process to assess the capacity of people who were living with dementia or a learning disability. We also saw various example of relatives signing consent forms without evidence that they had the legal authority to do so by holding a lasting power of attorney for health and welfare. We spoke with the manager about this and they told us they would address the issues found and discussed at inspection. Furthermore, the manager told us, "All our current service users' files will be reviewed to ensure there is an assessment documented around MCA, going forward we are planning on introducing a prompt into the care plan checklist to ensure a MCA is not missed and as mentioned above all new/updated care plan will be approved by the manager."

Staff we spoke with confirmed they had completed training on the MCA and demonstrated they knew the MCA's principles and how to apply them. For instance, one staff demonstrated they knew that assessment of capacity is decision specific, "If you knew one of your clients was not compus mentus, you would check their care plan, they might be able to make simple decisions but not more complex ones." Another staff member demonstrated they understood that even when people might lack capacity they should be supported to make a decision, "You have got to be able to give clients the support to help them made decisions, if they can."

New staff had completed a period of induction before they started working on their own. This included online, classroom training and shifts shadowing more experienced member of staff. The provider had an on-going programme of essential training, which included food hygiene, fire safety and person-centred planning. Records confirmed care workers were up to date with their training and their competency to work

were people was being assessed. Staff's training was mapped to the Care Certificate. The Care Certificate provides care workers with standardised training which meets national standards. Staff also received specific training for the needs of people they were supporting such as training in learning disability, epilepsy and end of life care. However, we noted that not all regular staff supporting one person who had epilepsy had received specific training in this area.

Staff said they received regular supervision with the manager or the care coordinators and felt well supported in their roles. Records confirmed staff had regular access to a combination of field observations, supervisions and appraisals. These enabled staff to be provided with feedback about their practice and identify further learning and development needs. Staff told us that these meetings were supportive but if needed they felt confident to speak with the manager or one of the care coordinators at any time.

People's nutritional needs were met. One person told us, "They [carers] prepare breakfast for me and it is to my taste" and another person said, "My [relative] prepares my meals, puts them in the freezer and they [carers] put them out and into the microwave." Care plans provided details of dietary needs and preferences and any support required from staff. For example, one person's plan indicated, "I have a smooth pureed diet, like thick custards and yogurts, my [relative] will have the meals ready, carers will use a normal spoon to feed me, I have a plastic glass to drink out of." The care plan for another person indicated, "[Person] needs full assistance with eating unless is finger foods, [person] loves eating out and her favourite place is Pizza Hut, [person] eats halal diet and does not like ice cream."

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication and sensory requirements were assessed and included in their care plans. For example, the care plan of one person indicated, "[Person] does not use language, would not have an understanding of information offered so would not be able to give an answer, but [person] makes noises and gives facial expressions; [person] knows some Makaton." This enabled staff to adapt their communication when working with this person.

People were supported to access healthcare services to maintain their health. Care records showed regular contact with district nurses, GPs and social workers to discuss and arrange support which improved people's health. During our visit to the office we heard one of the care coordinators being in contact with a GP surgery to request a home visit.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. Comments from people included, "They [staff] are caring, they do everything I asked them to do, nothing is too much trouble." Relatives also praised staff for their caring attitude towards their loved ones. Their comments included, "They [staff] are very good on helping [relatives];" "I think [relative] likes them [staff], [relative] seems to talk about them like if they are friends;" "They are very pleasant, very obliging."

We received mixed views about how people felt involved in setting up and reviewing their care. One person said, "I don't think I have [been involved], they always ask me but not formally." Another person said, "I've been involved, they came to assess me with my [relative] here." We also asked people if they had read their care plan; one person said, "Yes, it is in here [at home]." Records we reviewed showed reviews of people's care were being done periodically. The manager told us people and, if appropriate, relatives were always involved in the initial assessment and during reviews. The manager told us they were reviewing the frequency they were conducting reviews of people's care due to rapid changes in people's needs requiring more regular reviews of people's care. The provider had recently gathered people's views through a survey. The results indicated the majority of people had answered they felt they choose the care they needed.

Our conversations with people, relatives and staff showed good relationships were established and this had a positive impact in all involved. People's comments included, "They [staff] are so kind and helpful." One relative commented, "They are friendly, more so, they are very, very helpful." Another relative told us about the positive impact receiving care from the provider had on their loved one's confidence to access the community more regularly. Staff spoke about people they supported with warmth and compassion. One staff member told us how they supported one person who at times displayed behaviours that might challenge others by "speaking softly and stroking [person's] hair." Another staff member said, "I enjoy it so much, I like meeting people." The provider had recently gathered people's views through a survey. The results indicated that every person receiving care looked forward to their care visit from staff.

People's dignity and privacy was respected. People told us staff respected their dignity when being supported with personal care. Staff we spoke with demonstrated how they provided care which was respectful and promoted people's privacy and dignity according to their preferences. For example, one staff member said, "[When delivering personal care] I ask them what they want, I support a lady who does not like to have her curtains closed so I try to keep her covered with a towel over the lap and the chest." Another staff member said, "We close curtains and sometimes we use a towel [to cover people]." People's care plans indicated people's preferences of the gender of staff supporting them and daily notes confirmed this was being followed.

The manager and staff had a good understanding of protecting and respecting people's human rights. Staff had received equality and diversity training. People received care and support which reflected their diverse needs in relation to the seven protected characteristics of the Equalities Act 2010. The characteristics of the Act include age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to

contradict this.

We saw sensitive personal information was stored securely. People's care records were stored in a locked cabinet in the office and the manager explained us how the information used on staff's electronic monitoring system was kept secure. The application used by care workers on their phones to access people's information was only accessed through a password that staff could not share and if the app was not used for a few seconds, the systems automatically logged off to avoid the risk of unauthorised people accessing to people's private information. People's records showed their permission was sought before their confidential information was shared with other healthcare professionals and we saw this documented in some care files. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the General Data Protection Regulations (GDPR) law. The GDPR law came into effect on 25 May 2018. It is Europe's new framework for data protection laws. It replaced the previous 1995 data protection directive.

Requires Improvement

Is the service responsive?

Our findings

People received a flexible and personalised service that was responsive to their needs. One person told us, "They do everything I want, I could not have wished for better." Relatives said, "They are a good team, my [relative] shouts sometimes and they calm her down, they are patient."

People and relatives gave us mixed views about the consistency of their care team. One person said, "I have had a lot of different carers recently, it is nice to have the same ones because they know you." Other people told us they received support from a regular care team. Relatives said, "There has been a lot of new staff recently" and "They all vary who can came, the only time it is the same carer is only at lunch time." During our conversations with people and relatives we also asked if they were informed in advance who was providing the care and they told us they were not informed by the office. We spoke with the manager about this and they told us this was an issue that they had already identified in their care continuity audits and they were; "planning on carrying out an exercise to identify all current carer to client ratio taking into consideration the care workers availability, location, client relationship and the rounds that the calls are on; furthermore, the care coordinator is aware of these issues and will make immediate changes where possible."

People's needs were assessed before they started to use the service, however, when we reviewed the care plan for one person who required end of life care we noted that there was not enough detail about how their health condition impacted their needs and communication. We spoke with the manager and the care coordinator about this and they told us that had been difficult to gather information from other healthcare professionals. After our inspection visit, the manager told us they were going to update care plans and the "manager will check and approve them to ensure detailed information is present including communication" and "further training will be provided to staff that are involved in writing care plans."

Most of the care plans we reviewed during inspection were centred on the specific needs and preferences of people. For example, the care plan for one person who difficulties in communicating stated, "[Person] loves listening to music and [person's] facial expression show this when [person] likes the song, [person's] eyes sparkle and [person's] face light up with a smile." We saw other examples of how people liked to be supported, for instance, with their personal care and our conversations with staff confirmed care plans were being followed and respected.

People were supported to develop and attend activities of their interest. Records showed people's social interests were being assessed and some people being supported with accessing the community during the week and weekend. For example, one person's care plan indicated they attended a day centre during the week and enjoyed going out on weekends and daily notes confirmed staff were supporting with this. The manager told us they had organised a fundraising walk in partnership with the local Alzheimer's society and we saw evidence of staff and people attending this event.

People and relatives told us that the management team and staff were responsive to their needs should they need any urgent assistance or if there were changes in their support requirements. One person said,

"They called my doctor and an ambulance and they stayed with me until I was OK." One relative commented, "The good thing about them is that they had been very flexible."

The provider ensured people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard (AIS). The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Each person's preferred method of communication was highlighted in their care plans, which showed people's communication needs had been considered. The manager also showed us an easy read version of the service user guide and told us this could also be made available, on request, in different languages and in braille.

People and relatives told us that if they had any concern they would not hesitate to speak with care coordinators or office staff or the manager. People also told us they felt confident that their concerns would be listened and acted upon. One relative told us they had raised a concern about the level of cleanliness of their relative's bathroom once and "They did something about it." Complaint records demonstrated the manager had responded appropriately and in reasonable time when concerns or complaints had been raised.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they felt the service was well managed. Comments from people included, "Yes, I do [think it's well managed];" "Yes, definitely;" "We have no complaints, [I give them] a score 9 out of 10." Relatives views were also positive and comments included, "Yes, it appears to be [well managed], no problem."

The service had a manager who had not registered with CQC to manage the service.The previous registered manager had left the service less than a month ago and we saw evidence that the provider was actively trying to recruit another manager. It is a legal requirement that the service has a registered manager in post.

The quality assurance systems in place were not effective in ensuring the best delivery of care. The service carried out various quality audits of records including audits of medication accidents and incidents and daily log audits, however, these had not been effective in recognising or improving the issues identified at this inspection. For example, issues with lack of PRN protocols and poor recording of changes in people's medication had not been identified. The lack of compliance with the MCA had not been identified by the manager during their checks. We recommend the provider researches and implements best practice guidance in relation to effective quality assurance processes.

People, relatives and staff praised the management of the service. People said, "I met with the manager, I like him, he is very good to me;" "All I can say is how happy I am from the carers and from the office, I can ring them if I don't understand something, this company is to be recommended." Relatives said, "[The manager] is approachable, he will come and talk to us if need be" and "I go and pay at the office, they are all very nice." Staff told us they felt the management of the service was approachable and listened to them. One staff member said, "I have mentioned a few things [to the manager] a few times and he listens to me." Another staff member said, "They [office staff] are quite helpful." During the inspection the manager was open about areas for improvement and responsive in implementing changes when we identified issues. Throughout the inspection and after the inspection we requested records and information and this was provided within the agreed timescales. All staff we spoke with were helpful and co-operative.

Staff told us they enjoyed working for this company and the work they delivered Comments from staff included, "I am quite happy;" "I am happy working here" and "I enjoy the caring work."

The provider used a survey to gain feedback from people. People we spoke with confirmed they had been asked for their opinion about the care they received. The results from last survey indicated most people were satisfied with the standard of care received. During and after the inspection, the manager told us about the areas they were planning to improve such as continuity of care teams and informing people who which staff team were scheduled to support them.

There were systems to ensure effective communication including phone calls and staff meetings to update staff. During this inspection, we saw evidences of regular staff meetings which covered office and care staff. We read team meeting minutes and saw relevant discussions were being held in relation to the care

delivered, staff training and good practice. Staff told us they either attended or had been invited to attend these meetings and found them useful for their jobs.

The provider was working in partnership with other organisations. Records we reviewed confirmed the provider was in regular contact with healthcare professionals when needed and had participated in an activity in the community to raise funds for the Alzheimer's society.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to notify CQC of relevant events such as changes of the registered manager and safeguarding incidents. At this inspection, we found the provider was compliant with this regulation.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not completing decision specific mental capacity assessments and best interest decisions for people who required them. Regulation 11 (1) (3)