

Danbury Care

# Danbury Care

## Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

# Summary of findings

## Overall summary

On 2 September 2016 we inspected Danbury Care and found them to be in breach of two regulations under the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014. The breaches were in relation to the lack of systems for the monitoring of the health, safety and welfare of people (Regulation 17) and the lack of supervision and training of staff (Regulation 18). We rated the service as 'Requires improvement'. The provider sent us an action plan outlining what improvements they would make.

On 29 March 2017 we returned to the service to assess whether improvements had been made. We found insufficient action had been taken to improve and meet the outstanding breaches of Regulation 17 (Good governance) and Regulation 18 (Staffing). In addition, we identified a breach of Regulation 19 (Fit and proper persons). You can see what action we told the provider to take at the back of the full version of the report.

Danbury Care provides a domiciliary care service and is registered to provide personal care to people in their own homes. On the day of our inspection, there were 57 people using the service and 15 care staff supporting them.

A registered manager was in place. 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.

Systems were not in place to oversee the effective quality assurance and management of the service for people who used it and the staff. People were at risk because the provider did not have robust systems in place for the safe recruitment of staff.

Information in people's care plans and risk assessments were not sufficiently detailed or up to date to understand their needs and to minimise risks to their health and wellbeing. People knew who to make a complaint to at the service and complaints were dealt with verbally but no information was recorded as to the outcome and learning from people's feedback or views.

Improvements had been made for the training, support and supervision for staff but there was not a programme in place for the training and support of all staff to equip them with the necessary skills and knowledge to work with vulnerable people

Staff had a good understanding and knowledge of safeguarding procedures and were clear about the actions they would take to protect the people they supported. People were treated with kindness and respect by staff and their dignity was maintained. Staff gave people choices and supported their independence. People gave their consent to care and support and their rights were respected.

People's health needs were met as staff liaised well with health and social care professional. People were

supported to be able to have their meals as and when they wanted them which met their nutritional needs.

Staff understood people's needs and caring relationships had developed as staff engaged and involved people in their care arrangements. People were satisfied with the staff who provided their care and support. However, the provider did not demonstrate that they were committed to the delivery of good care for people due to multiple failings within the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe.

Staff had not been recruited appropriately or safely and people were at risk of harm.

Risks to people's health and wellbeing were not assessed and recorded.

The procedure for the management of medicines was not sufficiently robust.

There were enough staff to meet people's needs.

Staff were aware of safeguarding procedures and keeping people safe.

**Requires Improvement** ●

### Is the service effective?

The service was not effective.

Staff had not received the training and supervision they needed to provide them with the necessary knowledge and skills to carry out their responsibilities.

People's health, social and nutritional needs were met by staff who understood how they preferred to receive their care and support.

Consent from people or their relatives was obtained before support and care was provided.

People were supported to access healthcare professionals when needed.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring.

Although staff treated people well and were kind and caring in the way they provided care and support, the provider did not demonstrate a caring attitude towards the wider delivery of good

**Requires Improvement** ●

care for people.

Frontline care was good but the service overall was not considerate in its systems and processes ensuring continued good care for people. .

Staff treated people with respect, were attentive to people's needs and maintained their privacy and dignity.

People were involved in making decisions about their care and the support they received.

### **Is the service responsive?**

The service was not always responsive.

People care and support was not always adequately assessed and recorded.

People received care and support that met their needs which was reviewed.

People's choices were respected and their preferences were taken into account by staff providing care and support.

There were processes in place to deal with people's concerns or complaints.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not well led.

Quality assurance systems and audits were not in place to monitor the management of the service.

The views of people who used the service and the staff were not obtained to make improvements to the service.

Staff demonstrated a commitment to providing a service that put people first.

**Inadequate** ●

# Danbury Care

## **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.

We undertook an announced inspection on 29 March 2017 at the offices of Danbury Care and followed this up with telephone calls to people who used the service, staff and professionals. The provider was given 48 hours' notice because the location provided a domiciliary care service and we needed to be sure that someone would be in. The service was inspected by one inspector.

Before the inspection we reviewed the action plan provided by the registered manager after the previous inspection, information we held about the service including any safeguarding concerns and statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

On the day of the inspection we spoke with the registered manager and office administrator at their office location. We reviewed four people's care records, ten staff recruitment and training files and looked at quality audit records. After the inspection, we undertook phone calls to five people who used the service, two relatives and four members of staff.

# Is the service safe?

## Our findings

People felt safe with the care and support from the staff who visited them in their home. One person said, "They are so lovely to me, I always feel safe when they are here." A relative said, "They come when they say, so I am not left wondering if they will turn up, I would hate to have to worry about that." However, despite the views and experiences of people we found that systems were not in place to keep people safe.

People were not protected by the service's recruitment procedures as checks were not undertaken in line with legal requirements to ensure that staff were safe to work with people who used the service. Recruitment records for two staff members showed that a Disclosure and Barring Service (DBS) check had not been completed before they started to work with people alone. One staff member confirmed that their DBS check had not yet been received but that they were working on a rota with people on their own. The registered manager had not completed a risk assessment or put any safety precautions in place. We were concerned that these staff were working without appropriate checks in place and asked the provider what they were doing about safeguarding people. They confirmed with us by email that both staff were not working with people on the rota until satisfactory checks had been received.

The registered manager had not verified one staff member's references and assured themselves that they were satisfactory or obtained details of the reasons for the gaps in their employment which had not been accounted for. Another person's file did not contain a photograph or identification to vouch for who they were. People could not be assured that staff were of good character before they were employed and involved in supporting people which placed people at risk.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk assessments in the care files we saw at the last inspection were satisfactory. However, we had concerns about the risk assessments which had been completed for new people using the service. It was noted that the quality of the assessments varied and depended on who had completed them.

The assessments were not sufficiently detailed to ensure people's health, wellbeing and safety was maintained. Some of the information recorded in the care files was conflicting and confusing and did not provide relevant and up to date guidance for staff about people's needs. For example, it had been recorded in one section of the risk assessment that the person's mental capacity was poor and they needed their medicines to be administered for them. However, in another section, it stated that no risks had been identified and that the person's understanding was good. Another example we found included information about a person's need for help with their medicines. However, no information was recorded for staff about the process of helping the person with their medicines, why this help was needed and the risks involved. Staff would not be able to provide the correct care in a safe way to meet the person's needs.

We saw in a care file for another person that their needs had changed from an assessment provided by a professional. We did not see that their care plan had been updated with this information pertaining to their

changing needs and the introduction of the use of equipment and the associated risks. This is an area which needs improvement.

We remained concerned about staffing levels as people experienced late calls regularly and recruitment was proving difficult, although the provider was doing all they could to recruit new staff. Better analysis of late and missed calls needed to take place to ensure people were not left without care for extended periods of time and shortfalls addressed to ensure safe care delivery at all times.

The registered manager told us that they had recently employed four new staff members who were at different stages of employment. Some staff told us that due to a number of staff leaving recently, they had been requested to work additional shifts on top of their contracted hours. They stated that they did not mind doing this on occasions but it was becoming more difficult as one staff member said, "The office rings and begs us to do extra shifts and you don't want to let people down, so you do it."

Most people told us that they thought the service was short staffed and whilst staff generally turned up on time, they didn't mind if they were a little bit late. One person said, "Sometimes, they [staff] swop around and the times alter a lot. This is usually Mondays for some reason. They [staff] need to come at a regular time for me as I have another appointment on a Monday and occasionally it clashes." Another person said, "I had heard the service was short of staff at the moment as they [staff] always mention it."

We saw that the rotas were organised in advance and showed that staff knew who they would be seeing and at what times. The service was using agency staff to try to cover some of the shifts. It was evident from the phone calls being made by the office administrator on the day of the inspection that there was difficulty in covering the rota but that it was being covered.

We looked at the paper and electronic log which recorded all communication into the office including any concerns, accidents, incidents and, late and missed calls. We noted that between 1 January 2017 and 13 March 2017, 21 people had called in to ask where their staff member was as they were late usually between 15 minutes to an hour. The office administrator told us that they reassured the person that they were on their way and rang and told the staff member that the person had called. The registered manager told us that it was a difficult time and recruitment was in process but that by using agency staff they were able to cover the rotas to ensure people received a service.

We were told by the registered manager at the previous inspection on 2 September 2016 that the medicine policy and procedure was in need of a review. This would ensure the update met current guidelines and staff would be reminded of their responsibilities. At the inspection on 29 March 2017, we requested a copy of the updated policy and procedure. The registered manager printed off a copy of the policy which they had given us at the last inspection. The document had not been updated and did not contain the details of the new Medication Administration Record (MAR) which had been implemented.

Most people self-administered their medicine and others had family support around them. People told us they were satisfied with the help they received with their medicines and if they didn't need help now they would be happy with the staff they knew to assist them in the future. One person said, "I trust them completely and know they would always look out for me."

We saw that the new MAR had not been developed following current professional guidance, for example there was no space or prompt on the MAR for the recording of creams, drops, patches or inhalers. We were told by staff that they were using the new MAR and it worked to some extent but as there were no boxes to input the prescribers instructions and any special instructions, such as PRN 'as required' medication such as



anti-biotic medicines or pain relief. Although no recording errors were found on the MAR forms, some of the MAR were not as legible as they should be. This meant that an errors would be hard to monitor and people may be at risk of their medicines being given incorrectly.

On the training programme sent to us after the inspection, over half the staff had not received training related to the safe administration of medicines. Not all staff had been assessed as to their competence to administer medicines safely to people using the service. People who used the service could be at risk of harm of not receiving their medicines safely. This is an area which needs improvement.

Staff understood their roles and responsibilities regarding safeguarding people and protecting them from harm. They were able to demonstrate how to report concerns should they see or hear anything which concerned them. Staff shared information and any concerns they had with the coordinator, the registered manager or reported to the office. The staff felt confident that action would be taken if and when they reported any actual or suspected harm to anyone.

## Is the service effective?

### Our findings

At our inspections carried out on 2 September 2016, we found that there was not a system in place for the induction, training, supervision and appraisal of staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us in their action plan that they would have two coordinators, a dedicated in house trainer in place and that supervisory checks would ensure that the training and supervision system was working by 24 December 2016.

Whilst some improvements had been made, we found at our inspection of 29 March 2017 that these were not sufficient to ensure that all staff were fully trained, supported and appraised in order to undertake their role effectively.

The system for the training and induction of new staff was still not thorough, consistent or well planned. The service had provided some training to staff after the last inspection but not to all staff. The registered manager had not undertaken or updated their training in line with current good practice in order to provide up to date training to staff.

The registered manager told us that the training they provided to staff was in the form of watching DVD's and completing a question and answer sheet to test their knowledge which they then marked. This was confirmed by staff who offered different opinions as to how useful this. They told us that their induction had been short and informal. One staff member said, "I had a chat with the manager, watched some DVD's and answered some questions, it was all very quick." Another said, "The best part was shadowing other staff and I learnt more than watching a DVD." Of the four new staff, only two had had observations of their competence in assisting a person with personal care as part of their induction.

We did not see that new staff had been offered the opportunity to undertake a planned induction programme such as the Care Certificate or equivalent (this is a best practice training course to ensure staff have the necessary basic skills to work in a care setting) when they started work. In the 10 staff files we looked at, an induction process was found to be in place for four staff and only for two new staff. Only two staff had had their competence checked when undertaking the use of a ceiling hoist and a stand up hoist which people used as part of their induction.

No external organisations were used to provide any training or offer specialist advice. No practical training was offered to staff to accompany the theory such as for moving and positioning people, using equipment safely or continence care before they assisted people in their own homes. We did not see any checks in place to ensure that staff were competent, skilled and knowledgeable when using equipment at the right time and in the right way.

The office administrator was in the process of gathering all the information from staff files and adding onto the computer system so that it would create a reminder when training needed renewing. The copy they gave

us only showed dates in the future and did not provide an understanding of how many staff had been trained and in what subject. After the inspection visit, the office administrator provided us with a spread sheet of training undertaken by staff so we could understand who had and who had not received training. This showed that out of 17 staff, four of those staff had not received any training at all. Over half the staff team did not have training in first aid, food hygiene or fire safety and a quarter of the staff did not have training in moving and positioning people, safeguarding adults from abuse or infection control.

As identified at the last inspection, training and guidance in the Mental Capacity Act (MCA) 2005 for all staff had still not been provided. The registered manager told us that they had handed out the MCA policy at a recent staff meeting but agreed that this was the copy which had not been updated and still contained incorrect information. This meant that although staff had been provided with information this was out of date and not appropriate.

Some improvements had been made to the supervision of staff. Supervision was undertaken by a coordinator who visited a staff member whilst at a person's home. We saw from the records that some visits had been completed for new and existing staff. However, there was no system to know when supervision sessions were due and how often these should occur. The template used for the supervision was a checklist and included if staff were wearing their uniform, used protective clothing, and were respectful of the people they were visiting. Minimal information was recorded about the staff members' performance, any learning or training needed or their views and feelings about their work.

An annual appraisal had been completed by the registered manager for only one staff member since the last inspection. One staff member was unsure what an appraisal was and said, "I don't see the manager hardly at all, so not sure what I would talk to them about." One meeting between the registered manager and the individual coordinators had taken place with a list of topics but none of the discussion about the meeting had been recorded. Whilst staff were informally supporting each other to do their work, the registered manager was not overseeing the management of the staff and the provision of support and supervision, training and appraisal.

These failings were a continued breach of Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014.

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. We checked whether the service was working within the principles of the MCA.

Staff were aware of the MCA and the majority knew how it applied to people living in their own homes. They knew how to support people with decision-making about everyday tasks but were not confident in how they might know if a person was being deprived of their liberty and freedom. Staff had not been provided with the knowledge and training in regards to supporting and caring for people whose capacity to make decisions was limited or inconsistent and this could have an effect on their wellbeing and rights.

People's level of capacity to make choices and decisions was noted in their care plan. People had also signed to consent to their care where appropriate. People told us that their consent was sought before any care and support was provided. One person said, "I am always asked before [staff member] starts even though they know the ropes." Staff acted upon people's wishes and decisions and offered them choice about meeting their needs.

People were supported to have sufficient amounts to eat and drink and to maintain a balanced diet. A small number of people who used the service required assistance with the preparation of their meals and staff enabled them to have food and drink of their choice and it was prepared how they wanted it. One person said, "[Staff member] always gives me a choice and will tempt me with things if I don't feel hungry."

Referrals were made quickly when people's health needs changed. We saw that appointments were made on people's behalf with professionals such as their GP, occupational therapists and district nurses where there was a need identified. We saw examples of referrals to occupational therapists which had resulted in better transferring systems for one person and in the review of a person's care needs, support in looking at their bedrails.

## Is the service caring?

### Our findings

Although frontline staff delivered good care to people, the service overall did not demonstrate that they cared about the people they supported. The provider continued to fail in multiple areas and this did not convey a caring attitude towards the care of people. Failures in recruitment and training of staff as well as poor quality assurance and governance placed the quality of people's care at risk.

People told us that staff were very kind, caring and considerate. They were happy with the care and support they received. One person said, "We couldn't wish for better." Another person told us, "The staff are always cheerful and bright and warm and friendly. Very lovely people."

Staff helped to build and maintain people's independence and confidence. Many of the staff had been working with people they supported for many years. They had got to know each other and had built up positive working relationships. One relative told us, "We have had the service for a while now and can't say a bad word about it." Another relative said, "I don't know what we would do without them. They are absolutely wonderful, they all pull together and I can say that without thinking about it."

People told us that staff helped them to maintain their dignity and privacy. Examples included, respect for their home and respect and privacy when providing personal care. One person said, "[Staff member] always helps do some tasks which are not that nice, but they do them without batting an eye lid and make out that it is all normal. They make an undignified thing, dignified and that attitude makes it more bearable."

In our discussions with staff, we got an understanding of their attitude and respect for the work they undertook. Their approach was person centred and met people's individual needs. Staff told us, "The people I work with are lovely." And another said, "I am just getting to know people and already like what I am doing."

We saw written records, which people had signed their agreement to. This showed that they and their families were involved in making decisions about the care and support they received. People felt listened to and able to talk through with the staff any concerns they had and were respected and valued. They told us that the coordinator took time to ask their opinion about how they found the service and they were able to say if things were not right. One person said, "I mentioned about the times and the next day they came earlier as we wanted." Another person told us, "The Coordinator is so attentive, they always do extra and make sure things are just right."

The written content, style and tone of the daily notes was written in a sensitive way and showed a respectful familiarity and good rapport with people who were valued by the staff.

## Is the service responsive?

### Our findings

The service provided to people by frontline staff was person centred and included them in decisions about the time they wanted, the tasks they wanted and needed assistance with and the way they wanted their care provided. People told us that their needs were met in a timely way and they had consistent staff who responded to them individually and with respect. However, the provider was not always in touch with the daily requirements of people's care needs and this showed in the variation in care plan documentation across the service.

The care plans covered aspects of a person's individual needs, circumstances and preferences, including use of their preferred name, details of any personal care and support required and duties and tasks to be undertaken. However, there was inconsistency in the way the assessment of need was carried out and the quality of the information recorded and completed. Whilst some care plans were more comprehensive than others and contained details of the medicines people were taking and risk assessments, how many calls and at what times in the day or evenings visits were required, some did not and others had minimal information contained in them to fully understand and respond to the persons' needs.

We discussed the care files with the office administrator who told us that when the assessments were completed and given to them, they were typed up and a copy went to the person's home as well as in the file in the office. Some of the files were in disarray and they agreed it was difficult to understand which was the most up to date care plan as some had not been dated. They told us that they were in the process of organising them but had not as yet got round to it. Improvements were needed in this area.

Despite some changes to the staffing rota with new staff being recruited, people and their relatives were sympathetic to this fact and were happy to have additional staff in their home shadowing and learning about their care needs. One person said, "Everyone has to learn one way or another."

People and/or their relatives were involved in discussing their requirements and we saw that the assessment of need had included a person's mobility, nutritional needs, use of equipment and some details of their medicines.

Everyone told us that the staff responded to their needs in an individual way and respected their preferences, likes and dislikes and views and opinions.

Information was provided to people about the service in response to an initial enquiry from an individual or a referral from a health or social care professional. Information about people and their requirements was discussed during the initial assessment period and prior to the service being agreed. Decisions about the service to be provided were made in agreement with the person so that the service was tailor made and person centred.

Reviews of people's care were carried out by the coordinators and they had recorded some of their views and these had been signed by the person or their relative. For example, "Happy with the service," and, "All

good, would like regular staff," and, "No changes needed at this time."

In addition, daily notes recorded were held in people's homes which allowed staff to share information with each other so that the care and support people received was responsive to their daily requirements. We saw previously completed copies which provided an understanding of the care which had been provided.

People told us that they knew who to contact if they had any concerns or complaints. Some people told us they would inform the registered manager as they knew who they were. Other people told us they would go to the coordinator as they said that on-going contact with the coordinator meant that problems or queries were resolved quickly before they had to contact the office. If they needed to call the office for anything, the staff always responded to them in a friendly and polite way.

The office administrator told us that they logged people's concerns and calls on the computer system and they passed this information onto the coordinator or registered manager. Other than the communications recorded on the electronic system, the only complaint we saw recorded was a missed call and the office administrator told us that it was a mix up on the rota, they apologised immediately and offered to find a replacement but the person declined. We did not see details of any other complaints made by people who used the service or staff.

## Is the service well-led?

### Our findings

At our inspection carried out on 2 September 2016, we found that the service had failed to have systems or processes in place to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager told us in their action plan that they would have additional staff employed, a training programme from manager through all levels of staff would be in place and management training would be updated and rolled out starting with the Mental Capacity Act 2005. In addition a computerised record keeping system would be in place.

At the inspection on 29 March 2017, we found that there had been some improvements made but a training programme for all staff including the registered manager was not in place, adequate training on the MCA 2005 had not been undertaken and the undertaking of a quality assurance system was inadequate.

A registered manager was in post who managed two coordinators and two office staff. The registered manager told us that the newly recruited coordinator worked on the rota undertaking caring duties but had some hours set aside for administration and training. The other well established coordinator also worked on the rota in a senior caring role and managed the care staff in addition to their duties.

The provider had not maintained accurate records in respect of people's safe care and treatment. They had not assessed, monitored and improved the quality and safety of the service provided to people. These included areas of concern in regards to risk assessments to meet people's needs, systems for overseeing the recruitment of staff without the necessary employment checks in place, and the provision of an effective training and support system for staff.

We asked the registered manager to show us what quality assurance systems they had improved. They told us that they had not had the time to focus on this side of things as they had been busy recruiting staff and undertaking assessments. This meant that they had not focussed on the improvements needed and had not understood their responsibilities of meeting the necessary regulations.

The policies, procedures and management processes we identified at the last inspection had not been reviewed and updated. This meant that staff had not received correct and up to date information to enable them to undertake their roles and responsibilities or to follow the provider's policies and procedures. These included medicine administration and management and the Mental Capacity Act (MCA) 2005. There was no evidence that the registered manager had updated or refreshed their own training and knowledge in order to maintain and improve standards of staff practice in line with current guidelines and good practice.

The provider did not have safe and effective systems in place to evaluate and improve staff practice including the delivery of robust training to ensure the continual safe and appropriate delivery of care to people. The registered manager had not been consistent in overseeing, supervising and managing staff performances. Staff had received some training and some supervision, but this was inconsistently applied. The quality of both the training and the supervision process was inadequate and insufficient for staff to be



competent and valued in their role. What we saw as evidence in the systems to guide, support and value staff was minimal, if recorded at all.

One staff member told us, "I get on with my job and enjoy it. I don't need training as I have done this work for years so know what it's all about." Another said, "The training is a bit of a shambles to be honest, just watching a DVD and answering a few questions doesn't equip you for ensuring people are moved in the right way and that you can use equipment alright."

People's care plans and risk assessments had not been audited to ensure they were completed and provided adequate and correct information to provide care for people safely. Whilst people's care plans were kept in a locked filing system, people's daily records were not kept secure so as to ensure confidentiality.

Staff were not always supported to question practice and there was not a system in place to encourage staff to discuss their views and opinions. One staff member said, "I sometimes don't feel able to raise issues with the registered manager as they don't listen and get back to you about things."

The registered manager had arranged two staff meetings after the last inspection. We saw the notes of the meeting which identified what had been talked about. However, no views or ideas from staff about the issues and topics raised or how the service could be improved by their involvement was recorded and no action plan compiled as to how any issues raised had been addressed.

A system of obtaining feedback from people who used the service, staff and professionals was not in place to enable improvements to be made to the service. Whilst the coordinators undertook reviews of people's care and these were recorded in their files, there were no processes in place for their views or experiences to be part of improvements to the service.

The registered manager was more visible in the service in some areas more than others. For example, they had responsibility for the assessments and support of staff in one particular geographical area whilst the other coordinators covered the other two. Therefore, staff in the area that the registered manager oversaw were in contact with them on a more regular basis than other staff.

There was lack of leadership and understanding of the provider's responsibilities as the registered responsible person in accordance with regulation. It was only through the care and commitment of frontline staff that people had not come to any harm, The provider's quality assurance and governance practices did not safeguard people from the risk of unsafe care and treatment.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new computerised record keeping system was in place. This was used for the collection and storage of information for example recording telephone calls and email communication about people who used the service, relative, professionals and staff. The office administrator was in the process of collating staff members training certificates and setting up a process for when people's care arrangements were due for an annual review and who would complete them.

Staff we spoke with were able to share with us their enthusiasm and commitment for their work. We were told by staff about the caring and considerate way the long standing coordinator worked and how supportive, knowledgeable and dependable they were. One staff member said, "If I have any worries, they

will be who I go to, even though they don't cover my area." Another said, "I am glad they helped me in my induction, and were patient and kind" And another said, "[Coordinator] is the person who holds Danbury Care together."

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 19 HSCA RA Regulations 2014 Fit and proper persons employed  There was not a system in place for the safe recruitment of staff.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  The training and supervision systems for supporting staff did not provide them with the skills and knowledge in carrying out their roles.

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The service did not have a robust system in place for the overall effective management of the service.

### The enforcement action we took:

We issued a Warning Notice to the provider and registered manager as they were in breach of three of the Regulations. They did not have a system in place for the safe recruitment of staff, or suitable induction, supervision or training processes and their auditing and monitoring of the service did not safeguard people and staff.