

CCS Homecare Services Ltd

# Glenister Gardens

## Inspection report

31 Glenister Gardens  
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Tel: 02085737828

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20 July 2016  
25 July 2016

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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?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The announced inspection was carried out on 19, 20 and 25 July 2016. The provider was given two working days' notice because the location provides a domiciliary care service and we wanted to make sure someone from the management team would be available to speak with us. This was the first inspection of the location under their current registration with the Care Quality Commission.

Glenister Gardens is a supported living service for adults with learning disabilities with a range of needs. The provider offers care and support to people who require help with day to day routines including personal care, meal preparation, housework, accessing the community and companionship. People using the service live in their own flats and each person has a tenancy agreement with the landlord. There is one communal room on the ground floor. The service has care workers on duty at all times. At the time of our inspection there were seven people receiving personal care.

The service is required to have a registered manager. 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 area manager had submitted an application to CQC to register as the manager of the service.

The majority of risks were assessed and action plans put in place to minimise them. However, risk assessments in relation to the environment were not carried out comprehensively to minimise the risk people faced such as the risk of falling from a height.

Staff understood medicines management procedures and provided the support people required to take their medicines safely. However, discrepancies in the medicines stock recording had not been identified so action had not been taken to address this. PRN (as required) procedures were not robust enough to clarify when PRN medicines should be given.

Staff understood and respected people's rights to make choices about their care and knew to act in their best interests but the service did not fully understand the principle around depriving people of their liberty. We have made a recommendation that the provider review guidance in relation to the Mental Capacity Act (2005) for people living in their own homes.

Although the provider had comprehensive monitoring systems in place, some aspects of the service were not being monitored effectively so shortfalls were not always identified and addressed in a timely way.

Procedures were in place and being followed by staff to safeguard people against the risk of abuse.

Staff recruitment procedures were in place and being followed. There were enough staff to meet the needs of people using the service. Staff received training and supervision so they had the knowledge and skills to

provide the care and support people required.

People were supported with eating and drinking to maintain their nutritional intake. Staff recognised changes in people's healthcare needs and knew the processes to follow so people received the input from healthcare professionals that they needed.

People told us staff were caring and treated them with dignity and respect. Staff shadowing procedures did not always ensure that people's privacy was adequately maintained.

Care records reflected people's individual needs and wishes and staff understood these and cared for them in a person-centred way.

People's care and support was planned and reviewed when any changes were identified so people's needs continued to be met.

Procedures for raising complaints were in place and were followed. Complaints were recorded and responded to, however relatives did not always feel improvements were consistently maintained.

The majority of people were happy with the way the service was being managed. Staff found the team leader and area manager to be supportive and approachable. Meetings with relatives and people were to take place to improve communication and address any issues raised.

We found breaches of one 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 the 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?

The service was not always safe. The majority of risks were assessed and action plans put in place to minimise them. However, risk assessments in relation to the environment were not carried out comprehensively to minimise the risk people faced such as the risk of falling from a height.

Staff understood medicines management procedures and provided the support people required to take their medicines safely. Discrepancies in medicines stock recording had not been identified and so action had not been taken to address this.

Procedures were in place and being followed by staff to safeguard people against the risk of abuse.

Staff recruitment procedures were in place and being followed. There were enough staff to meet the needs of people using the service.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective. Staff understood and respected people's rights to make choices about their care and knew to act in their best interests but the service did not fully understand the principle around depriving people of their liberty.

Staff received training and supervision so they had the knowledge and skills to provide the care and support people required.

People were supported with eating and drinking to maintain their nutritional intake.

Staff recognised changes in people's healthcare needs and knew the processes to follow so people received the input from healthcare professionals that they needed.

**Requires Improvement** ●

### Is the service caring?

The service was caring. People told us staff were caring and treated them with dignity and respect. Staff shadowing procedures were did not always ensure that people's privacy was

**Good** ●

adequately maintained.

Care records reflected people's individual needs and wishes and staff understood these and cared for them in a person-centred way.

### Is the service responsive?

Good ●

The service was responsive. People's care and support was planned and reviewed when any changes were identified so people's needs continued to be met.

Procedures for raising complaints were in place and were followed. Complaints were recorded and responded to.

### Is the service well-led?

Requires Improvement ●

Some aspects of the service were not well-led. Systems were in place to monitor the quality of the service however these were not always effective and shortfalls in risk assessment and documentation had not always been identified.

The majority of people were happy with the way the service was being managed. Staff found the team leader and area manager to be supportive and approachable. Meetings with relatives and people were to take place to improve communication and address any issues raised.

# Glenister Gardens

## 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 legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 19, 20 and 25 July 2016 and was done by one inspector. The provider was given two working days' notice because the location provides a domiciliary care service and we wanted to make sure someone from the management team would be available to speak with us.

Before we visited the service we checked the information that we held about it, including any notifications sent to us informing us of significant events that had occurred at the service. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority for feedback. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we viewed a variety of records including recruitment and training details for three staff, care records for four people receiving personal care, medicines administration records for three people receiving personal care, monitoring records, policies and procedures, the business continuity plan and other documentation relevant to the inspection.

We spoke with the provider, the area manager, the team leader, the human resources manager, nine care workers, three of whom were shadowing experienced staff as part of the company induction process and one agency care worker. We also spoke with three support workers who were employed directly by people to provide them with support during the day. In this report we refer to staff directly employed by people or their relatives as 'support workers' and 'care workers' are the staff employed by the provider.

We spoke with six people using the service and three relatives of people using the service. We also received written feedback from three relatives of people using the service. Three of the people we spoke with were not in receipt of personal care and the written feedback included two from relatives of people who did not

receive personal care. This information was used in general terms when looking at trends and themes within the service.

# Is the service safe?

## Our findings

Although the majority of risks had been identified and assessed, the risk assessments in relation to the environment where care was to be provided were not comprehensive. Risk assessments had been carried out for individual risks such as self-neglect, finances, accessing the community, health and wellbeing and mobility. These were person-centred and reflected the risks to each individual and the action to be taken to minimise each risk. There was also a generic house risk assessment document used to assess each person's flat and this covered environmental risks but was not personalised to each individual, so the different levels of risk for each person were not identified. The team leader said she had identified that the windows in the flats on the ground floor did not have restrictors and had asked the landlord to address this as there was a potential security risk. The window restrictors in place in the first floor flats could be easily overridden so windows opened wide, which we saw in one of the flats we visited, posing a potential risk to people of falling from a height. There were no risk assessments in place to address this risk or a management plan to minimise the risk. The team leader contacted the landlord during the inspection and requested that the window restrictors be reviewed.

Systems were in place to ensure people received their medicines safely, however these were not always being followed. To minimise the risk of medicines errors, the service had introduced a medicines stock check record document. We viewed two in use for 'as required' medicines and noted discrepancies with the number of tablets recorded as being in stock. Following the inspection the area manager carried out investigations and was able to account for all the tablets and had identified shortfalls in documenting that explained the discrepancies. The area manager also put action plans in place to address the findings. Protocols for the use of 'as required' medicines were in place, however two viewed did not contain the strength of the medicine and needed to be reviewed to ensure the information was clearly recorded.

The above paragraphs show there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives confirmed staff provided the support people needed with their medicines. Staff told us they had received theory and practical training in the administration of medicines and this was updated every year or more frequently if required. Competency assessments were carried out prior to staff administering medicines, to ensure they had understood the training and the processes and procedures to follow. Certificates for training were available in the online staff records we viewed. There was a medicines management policy in place and the Standard Operational Procedures handbook also had a section for the management of medicines and both documents were comprehensive. A record of the medicines each person was taking was available in their care records. Medicine administration record charts (MARs) were in use and listed each medicine and when it was to be administered. The team leader explained one member of staff was responsible for overseeing medicines and always wrote out the new MARs, for continuity and the team leader checked the documents. Each person had a lockable cupboard in their flat to store medicines. There were two metal medicines cabinets in the staff office that could be used for medicines storage if required.



Systems were in place and being followed to protect people from the risk of abuse. People said they felt they were supported safely. One person said, "Yes, very safe" and relatives also confirmed they felt their family member was supported safely. Policies and procedures for safeguarding and whistleblowing were in place and an easy-read safeguarding policy was displayed in the communal room and the office. One person told us they felt safe and that they would speak with staff if they had any concerns about abuse. Staff had received safeguarding training and said they would report any suspicions of abuse to the team leader or area manager. Staff were confident managers would take appropriate action to address any concerns but were also clear about whistleblowing procedures. Staff knew they could contact outside agencies such as the local authority or the Care Quality Commission if the provider did not take action. The area manager accessed the London Multi-Agency Adult Safeguarding Policy and Procedures and this was available to staff. Systems were in place for the safe management of people's monies. The provider operated a system whereby each person's expenditure was recorded and receipts obtained and then a monthly invoice was sent to the person's financial appointee for payment. The records we viewed were clear and the process was being followed by staff.

There was a fire risk assessment in place and there were personal emergency evacuation plans (PEEPs) in each person's care record that identified the support each person would require in the event of a fire.

Recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service. Application forms had been completed and where applicable the information included an employment history with explanations for any gaps in employment. Pre-employment checks included two references including one from the previous employer, a criminal record check such as Disclosure and Barring Service checks, health questionnaires and proof of identity documents including the right to work in the UK, plus a photograph of each member of staff was available. Where agency staff were used by the provider, a document was available that included a photograph and employment and training information to verify the required employment checks had been carried out. Staff were able to tell us about the pre-employment checks that had been carried out as part of the recruitment process and said the process had been thorough. One said, "I've loved the process from recruitment through induction to shadowing."

There were appropriate numbers of staff employed to meet people's needs. Care workers were allocated to provide the care and support people required with their personal care and the times when people received this care were identified on the personal care rota. Where people were identified as needing two staff to provide personal care, two staff were allocated and staff confirmed they worked together to meet these people's needs. People talked about their key workers and were positive about the good relationships they had formed with them. There were care workers available in the service throughout the 24 hour period. Some people had been assessed as needing care and support at specific times during the day and others required one to one support. The service employed permanent and bank staff plus they had some regular agency workers to cover any shortages.

## Is the service effective?

### Our findings

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. Staff understood the importance of allowing people to make decisions for themselves where they were able, and also of acting in a person's best interest. Capacity assessments had been carried out with regard to the control of substances hazardous to health (COSHH). This was to identify if people had capacity to understand the difference between COSHH products such as washing up liquid or bleach and, for example, a juice drink. Where someone was assessed as not having capacity, an action plan was in place to minimise any risks. The team leader knew where family members were appointees for people's finances and/or health and welfare and we saw where this was recorded in people's care records.

Risk assessments for any restrictions on people's liberty were in place, for example, use of sensor mats, use of bedrails and one to one supervision to keep people safe. These identified that the restrictions were in use to maintain people's safety. People were able to enter and exit their flats and people were able to exit the building if they so wished, accompanied by staff where this had been identified as necessary for their own safety. The provider had recognised that this could be seen as continuous supervision and control and wanted to make sure that where people might have been deprived of their liberty that this was being done lawfully. Deprivation of liberty safeguards applications had been made to the local authority, however these do not apply to people living in their own homes and were therefore not appropriately made. The staff were not aware that any applications to deprive people of their liberty in a supported living setting needed to be made to the Court of Protection. The area manager contacted the local authority during the inspection to clarify this and said they would follow this up with the local authority to discuss best interests assessments where applicable.

We recommend that the provider review practices where people might have been deprived of their liberty in accordance with guidance on the Mental Capacity Act (2005), for people living in their own homes.

Care staff received training to provide them with the knowledge and skills to support and care for people effectively. All staff undertook induction training and told us this was thorough and covered each aspect of providing people with care and support. They then shadowed experienced staff for two weeks to learn how to care for people's individual needs. The majority of care workers had completed the Skills for Care induction programme. The service had introduced the Care Certificate, an induction programme for care workers new to health and social care and this was being undertaken by newer staff. Care staff told us they received training and updates to keep their knowledge and skills up to date and training was recorded on the training matrix. We viewed a sample of training certificates and these included moving and handling theory and practical, first aid awareness, fire safety, infection control and food hygiene.

Staff said their induction training included information about the different conditions people with learning disabilities may have. Staff said that in addition to this, people's individual diagnoses were discussed to give

them knowledge about how to care for individuals. One care worker also said they had looked up information on the internet about specific medical conditions, to improve their knowledge and understanding. Staff said the provider reviewed any incidents and if additional training was identified then this was arranged. For example, staff had recently undertaken training in positive behavioural support to increase their knowledge in this area.

Staff said they had individual supervision sessions with the team leader every two months and we saw these were scheduled and had taken place. Staff said these sessions were helpful and used to look at their skills and identify any areas for development and training. One care worker told us, "Everything [about care] I've learnt, I have learnt from here."

The care records included care plans for people's nutritional needs and people had personalised weekly meal planners in place. Where people had received input from a dietician this information had been recorded, for example, where someone was at risk of choking, instructions for food to be cut up into small pieces and time taken to ensure each mouthful was swallowed before giving more food was included in the care plan. Staff were available to provide support with eating and drinking to those who required it. We received mixed feedback from relatives in relation to dietary plans being adhered to. Staff said they encouraged people to follow their meal planners and to eat healthily, whilst respecting their right to make choices. The area manager and team leader were happy to meet with people and relatives to discuss any issues. The weather was hot during the inspection and we heard staff encouraging people to have regular drinks. We heard them check for someone going out into the community that they had their drink bottle with them and had money available should they need to buy extra drinks when they were out.

Information about people's healthcare needs was included in people's care records. Staff said if they had any concerns about a person's health they would take action to get people the healthcare input they required, such as by arranging an appointment with the GP. We asked staff the action they would take in an emergency situation, for example if they found someone collapsed on the floor and they were clear to contact the emergency services. We saw people had 'patient passports' in their care records, which were for when people went to hospital. These contained comprehensive information about the person including their diagnoses, health and care needs and other information to help hospital staff care for and understand their needs.

# Is the service caring?

## Our findings

The majority of people and relatives we spoke with and received feedback from felt the care workers were caring towards people using the service. Comments included, "A lot of staff genuinely care and like [person] and there is a good relationship.", "My key worker respects me. I can talk to my key worker" and "It's good, it's nice." We received mixed feedback about the continuity of care, with some people and relatives feeling people should have the same small team of care workers and others who were happy with the system in place. The team leader said she did schedule the rota so people had regular time with their key worker but she would review the rota allocations to see if improvements could be made for continuity of care.

Two care workers were 'dignity champions' for the service and their role was to ensure people were treated with dignity and respect. One of them told us it was important "to treat people as we would like to be treated." We asked staff what they felt was important when caring for people. Comments included, "A person-centred approach for that person.", "I'm very passionate about my service users, they are my first priority.", "I respect privacy and dignity, I give them choice. I know when they are happy or unhappy.", "Remembering they are in your hands and I try to put myself in their shoes." "It's their own personal space" and "Communication between us and parents is very important." We also received positive feedback from agency support workers about the input the permanent staff provided for people. One told us, "I think [person] is cared for very well and [person's] care here is of a high standard. I can't fault it and if my [relative] needed care I would be happy for them to be here."

We asked the team leader how they matched people with care staff. They said they respected people's religious and cultural needs and also where someone stipulated a gender preference for care workers this was recorded and met. People and relatives confirmed where people had a preference, for example for a female care worker, this was being met. Staff confirmed they were allocated sufficient time to provide the personal care and support people required.

During the inspection we observed staff communicating with people in a cheerful, friendly manner, listening to them and providing gentle advice where appropriate. There was a good atmosphere and staff took the time people needed to support them. Staff were clear that they always asked people before carrying out personal care and gained their permission to do so. Some areas of concern were raised by relatives in relation to dignity and privacy, for example, new care workers shadowing experienced staff during personal care giving. Whilst it was accepted that new staff needed to learn, some of them were due to work elsewhere within the provider's services. We discussed this with the provider, area manager and team leader who were receptive and said they would review the shadowing process to ensure only staff who would be providing personal care to people using the service were included in this.

Care records were comprehensive and identified the care and support each person was to receive and what was important to them in their lives, so staff had the information they needed to provide the care people wanted to receive. We saw people and, where appropriate, their appointees had input with the care records and they had signed to show they had been involved with the care plans. We asked a key worker how they involved a person with their care records and they said they read it to them and gave them time to

comment, then discussed it to ensure they had understood the content. Care workers confirmed they read the care records and made sure they understood the care people needed.

## Is the service responsive?

### Our findings

Care plans were person-centred and identified people's needs, wishes and interests. Staff said they read these so they knew how to provide the care each person wanted and needed. Reviews were carried out so that any changes could be identified and the records updated to reflect these. People and relatives confirmed they were involved with reviews. One relative said, "They are always being updated." Daily reports were completed on each shift and there were also weekly and monthly progress reports. These provided a clear process for recording the care and support people received and their progress over a period of time. Staff were clear about the importance of promoting people's independence. Comments included, "It is supported living to encourage people to be as independent as possible.", "We are all doing our best to meet people's needs. We are professionals and here to do our jobs" and "The company develops and improves skills for staff and people."

One of the care workers on each shift was identified as the care co-ordinator and had the responsibility for overseeing the shift and dealing with any matters that arose. We attended staff handover and staff were clear about each person's care and support needs and how these had been met. They knew what each person was doing and any appointments that were coming up, for example healthcare appointments, so plans could be made to ensure the person was ready on time and supported to attend. We asked the support workers if the care workers responded to them. Comments included, "Very welcoming, very friendly, very warm, very helpful. They are great" and "I'm really happy here and they keep me informed. Nobody is afraid to ask." One support worker said that when they had a recent query in relation to a person's medical condition the care worker had responded clearly and provided them with the information they required.

We asked staff about people's religious and cultural needs and how they were supported to meet these. Staff were able to discuss this and identify any dietary needs people had to meet their religious and cultural needs. Staff told us people were able to attend places of worship, either independently or with their families. In addition to time allocated for personal care, people had hours allocated for day to day support and some employed their own support workers. This was so people had the support they needed to access the community and companionship when in the service. The hours for each person were determined by the assessments carried out by the local authority and were separate from the personal care provision at the service.

One care worker had responsibility for arranging in-house activities and had a cookery morning with some people who made 'wraps' for lunch and enjoyed doing this. One person told us there was a coffee morning each Thursday and this also included a Bingo session, which they liked. We were also told parties were arranged for people's birthdays and to celebrate significant days and festivals such as Christmas, Valentine's Day, Easter and Halloween. A barbeque was being arranged and one of the people designed a poster on a Caribbean theme. Some relatives felt there should be more communal activities and outings arranged by the provider and the team leader said they would be happy to discuss this to ensure people's wishes were known and the costs involved discussed, so everyone was informed.

People told us they would speak with staff if they had any concerns. We received mixed feedback from

relatives about the response they received to concerns they raised. Some reported they were happy and felt the service responded well, while others felt their concerns were not always addressed and they were not happy with the initial reaction they received. Some relatives were in the process of arranging meetings with the area manager and the team leader to discuss issues. The team leader told us they had sent the complaints form template out to people's family members so they could complete this if they wanted to raise any concerns. The provider said they were open to having meetings with people and their relatives to discuss any issues and work together to resolve them. Feedback from the local authority was positive and they felt the provider was responsive to issues they raised and worked to address and resolve them.

The service had a complaints procedure and this was comprehensive. Copies of an easy-read version were displayed in the service. We viewed the complaints file and saw complaints had been recorded, investigated and responded to. We asked the team leader how complaints were audited and she explained they are sent through to the provider and the company safeguarding officer reviewed the documentation. She said they ensured all aspects of the complaints had been covered and they also monitored complaints for any themes or trends.

## Is the service well-led?

### Our findings

The service had a team leader who had day to day responsibility for the service and an area manager who visited the service each week and provided support to the team leader and the staff team. The provider had deregistered as the manager in March 2016 and the area manager had applied to become the registered manager. Both the area manager and the team leader were experienced in the care and support of people with learning disabilities. The majority of people we spoke with were happy with the way the service was being run. Comments included, "If I get worried I tell the [team leader] and she listens.", "The [team leader] is very good" and "The [team leader] has reassured me to talk to her and not keep things in."

The provider had a comprehensive system in place for auditing and monitoring the service. Monthly audits were carried out in respect of each person using the service and included care records, medicines storage and records, finances, the environment in each person's flat, personal care and service user presentation, weekly progress reports and monthly satisfaction surveys. The audit was comprehensive and the care worker who carried them out explained that any shortfalls identified were put on an action plan for the key worker to address with a two week timescale, after which any shortfalls were highlighted with the management team for action. The provider carried out an annual audit and the quality assurance manager provided support and input to assist staff who carried out the monitoring for the service.

During the inspection we viewed some daily food monitoring charts and found they were not always being completed, however this had not been reported to the team leader. Action was taken by the team leader at the time of inspection to highlight this to staff and to make the document more robust by including staff signatures. This finding along with the shortfalls in recording for medicines and with the lack of environmental risk assessments to fully ensure the safety of people highlighted that the system for monitoring and assessing the service was not always effective. The provider was receptive to our findings and said they would be addressed. The service had an improvement plan document and this was a working document, with information being added as any new areas of work were identified. This included additions made at the time of our inspection and the area manager said each point would be addressed.

We viewed satisfaction surveys for June 2016 and the majority of people had expressed satisfaction with the service. The team leader explained that where a survey identified areas that were not satisfactory then people were given the opportunity to express their specific concerns and the complaints procedure was followed to investigate them.

We received mixed feedback from relatives regarding their experience of the way the service was being managed, mainly in respect of the response they received to issues raised and the effectiveness of improvements being made and maintained. During our inspection we provided feedback to the management team and this included areas of concern that had been raised with us as part of the inspection process. They were responsive and identified areas that could be promptly addressed, for example, increasing the flexibility for morning care provision to fit in with variable transport timings and reviewing shadowing arrangements in respect of personal care provision. They also said they would offer to meet regularly with each relative to give them the opportunity to express any concerns with a view to finding a



satisfactory resolution going forward.

There was a Friends of Glenister Gardens group for relatives of people using the service. The team leader said this had originally been set up with monthly meetings at the service and representatives for the provider had attended. At the time of our inspection meetings at the service were being held quarterly. The provider said they would review this to see how communication with relatives could be improved, such as by offering more frequent meetings at the service and introducing a newsletter to keep people and relatives up to date with what was going on at the service. There were monthly meetings held for people using the service and people were encouraged to express their views and make suggestions about the service, for example, ideas for activities.

Feedback from the local authority regarding the senior management was positive and they found the provider was receptive, implemented improvements and was developing the service. Care workers said the team leader and area manager were supportive and approachable. Comments included, "Very approachable and can always speak to her. Her door is always open.", "Very understanding, very supportive. She does not stay in the office, she provides support to people" and "The managers are very good." There were monthly staff meetings and these covered a wide range of topics around people's care and support and related matters.

Policies and procedures were in place and the provider reviewed these to keep the information current in line with relevant legislation and good practice guidance. We saw documents dated March 2016, indicating a recent review. The provider had a Standard Operating Procedures handbook that was comprehensive and included the procedures to be followed for each aspect of a person's care, support and daily lives. Care workers spoke about the document and said they used it in their work to ensure they understood and were following procedures correctly. Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person did not always assess the risks to the health and safety of service users of receiving care and did not ensure the proper and safe management of medicines.</p> <p>Regulation 12(1)(2)(a)(g)</p>