Healthcare Access Ltd

Healthcare Access Ltd Oxford

Inspection report

Mewburn Road
Banbury
OX16 9PA

Date of inspection visit:
14 June 2023

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07 August 2023

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

About the service
Healthcare Access Ltd is a domiciliary care agency providing care to people in their own homes in the Oxfordshire area. At the time of our inspection 19 people were receiving the regulated activity of personal care from the service.

Not everyone using the service received personal care. CQC only inspects where people receive personal care, which is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

At the time of the inspection, the location did not provide personal care for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

People's experience of using this service and what we found
Right Support: People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

Right Care: People, and their relatives were happy with the care they received from the service. People felt staff members were friendly and treated people with kindness and warmth.

Right Culture: Care plans contained detailed information about people, their likes and dislikes, however, did not always contain information specific to people's needs or how to manage conditions or risks as appropriate documentation was not always in place.

The provider did not operate effective quality assurance systems to oversee the service. These systems did not identify shortfalls in the quality and safety of the service.

Risk assessments were not always updated to accurately reflect people's risks. There was conflicting information about people's ability, and health conditions within their risk assessments.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (13 December 2021)

Why we inspected
The inspection was prompted in part due to concerns received about the service relating to care plans, staffing and medicines. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence the provider needs to make improvements. Please see the safe, effective, responsive, and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Healthcare Access Ltd Oxford on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to regulation 11 consent for care, regulation 12 safe care and treatment, regulation 14 meeting nutritional and hydration needs, and regulation 17 good governance.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Healthcare Access Ltd Oxford

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started 14 June 2023 and ended on 23 June 2023. We visited the location's office on 14 June 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection, we spoke with 3 people using the service, 7 people's relatives, 4 staff members, the care coordinator, and the registered manager. We reviewed a range of records relating to people's care and the way the service was managed. These included care records for 4 people, medicine administration records, staff training records, 3 staff recruitment files, staff supervision records, quality assurance audits, incidents and accidents, complaints and compliments records, and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People's risk assessments in areas such as their mobility, falls, diabetes, choking, equipment, and capacity were not always updated to accurately reflect people's risks. There was conflicting information about people's ability and their needs within people's risk assessments and care plans.
- Information about people's risks were not always documented or consistent within their care plan. 1 person's risk assessment stated they had a separate diabetic care plan which was not in place, it contained incorrect information about the support the person received with their diabetes management and their mobility. For another person there was conflicting information about the diabetic type and how this was managed.
- Falls incidents were not followed up or mitigated. 2 peoples care plans and risk assessment contained incorrect information. For 1 person, the incident tracker identified a falls risk assessment was required. There was no falls risk assessment. For another person records contained incorrect information about the risk of falls. Their risk assessment had not been updated to reflect these falls.
- Risk assessments had not been identified for people with swallowing or choking difficulties. We heard 1 person had a known swallowing difficulty, there was no risk assessment for this person. 2 people had dentures however, they chose not to wear these. 1 of these people lacked capacity. We heard from staff they were recommended soft foods. This was not detailed within their care plan. Staff were aware it was best practice to ensure the person was sat upright, however, there was no information available such as a risk assessment to mitigate the potential risk to these people.
- 1 person used bed rails to lessen the risk of falls. There was no risk assessment to mitigate the risk of this equipment. Not all assessments contained the necessary equipment people used.
- 1 person was at risk of pressure sores. Their care plan stated staff were to follow positioning guidance before supporting the person to bed. This was not available and staff were unaware of any positioning guidance.
- The provider had a process of recording accidents and incidents. We could see the provider had taken action on the incidents documented, however, not all incidents had been recorded therefore action had not been taken to mitigate the risk.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us they would take action to address the concerns raised during inspection.

Using medicines safely

● Medicine management required improvement. Not all people had medicine risk assessments. Risks around fire safety regarding flammable creams was not documented and records were not consistently recorded to evidence staff followed the provider's policy on medicine administration.

● The provider had a medicine policy however this was not used in practice. Staff were unclear about the levels detailed within the policy; they were not used within care plans. The registered manager was unable to correctly identify the levels of medicines as detailed within their policy.

● We were not assured the registered manager had mitigated the risk of harm to people receiving medication or ensured staff understood how to safely administer medicines. During the inspection we spoke to staff about administering and prompting people with their medicines. We heard 1 person struggled to take medicines due to their mobility and ability to swallow. Staff were administering medicines directly into the mouth of this person. There was no risk assessment to mitigate the risk of choking and this person did not have capacity to make decisions.

● Following the inspection, we asked the registered manager to share this person's risk assessments and care plan. The registered manager told us they did not have risk assessments for their medicines as this was a new change following a recent hospital discharge and therefore would not share this information.

● Medicine audits had started to take place following a recent quality audit by the local authority. Prior to this, audits were not implemented. We reviewed 4 medicine audits. Audits were not carried out effectively. 3 people's audits contained incorrect information about medication they were taking. Audits did not always demonstrate checks had been carried out. Discrepancies had been identified within notes, however there was no evidence these had been actioned as there was no system used to demonstrate this.

The provider had failed to ensure risks to people's medicines had been assessed and had done all that is practical to mitigate those risks. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who used the service and their relatives were happy with the support they received around their medicines. We heard "I enjoy the carers company they never feel rushed, they give me my medication in the morning, and they chat when they are writing up the call."

Preventing and controlling infection

● Training records indicated not all staff were trained in infection control.

● People told us staff did not always wear PPE when carrying out personal care. We heard "Carers will help my loved one to get out of bed and do the personal care not many wear full PPE", "Sometimes the carers wear gloves and masks if they are doing personal care mostly, they don't", and "The carers do not wear aprons and some wear masks not always covering their nose and mouth".

● We asked the provider to ensure action was taken to address this with staff.

The provider had failed to ensure staff were trained in infection control, and the risks relating to infection control were mitigated. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The service was not always able to evidence people were protected from the risk of abuse and avoidable harm. Concerns around 1 person's safety had not been recorded on the safeguarding log. The registered manager informed us of the action taken and told us they would ensure all communication is documented in the log.

● People and their relatives told us they felt safe. We heard "I am totally happy with the care" and "My loved one feels totally safe when they transfer from bed to commode wheelchair and chair and has never

complained the carers always make sure they explain what they are doing." future.
● The provider had policies and procedures regarding safeguarding people.
● Staff received safeguarding training. Staff we spoke with told us "If I go to a clients house and they are not their normal self, any bruises or concerns with the family I would report it to my manager." Staff were aware they needed to report concerns, however, were not always able to tell us how they would escalate their concerns further.

Staffing and recruitment
● People, relatives, and staff told us they felt there were sufficient staff to meet people's needs, however, often people were not informed if staff were going to be late. We heard "I have met a couple of carers and they are very polite and kind sometimes my siblings have mentioned that they are rushing around trying to fit everything in the allotted time", "[Staff] have never missed any slots sometimes they run late and generally do not ring unless it's going to be later than an hour" and "There have been a few occasions when the carers have come later than expected they eventually do turn up but do not let us know if they have got held up."
● Staff expressed concerns regarding their payments. We heard often these were not on time or correct. This is something the registered manager had been made aware of and had implemented new administration staff, however there were still reports of some concerns around payments.
● Staff were recruited safely; however, we noted some employment gaps which had been unaccounted for and saw some interview records not kept in a consistent format. The registered manager acted on this and told us they would document this information.
● The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Learning lessons when things go wrong
● We reviewed accidents and incidents recorded by the service. Records demonstrated the action required to mitigate the risk to people, however actions were not always completed.
● Team meetings discussed clients and ongoing concerns with clients, they did not always communicate lessons learnt following people's feedback. For example, 3 people had expressed dissatisfaction with care staff not informing them of being late. Within the lessons learnt document, the action was for staff to inform people, however we did not see this communicated with staff.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- We reviewed staff training and saw not all staff had completed relevant training to safely support people using the service. For example, people had not completed training for; nutrition and hydration, PPE, end of life care, dignity in care, dementia, catheter care, falls awareness, consent, diabetes, manual handling and incontinence.
- Staff supervision evidenced that staff brought outstanding training to the registered manager. These people had been working for the company for serval months. We could not always see the registered manager took direct action on this. We could not be assured all staff were suitably trained to provide care.
- Staff told us they felt their induction covered everything they needed and were able to ask for further training if they felt they needed it.
- Staff generally told us they felt supervisions were supportive meetings and took place regularly. The registered manager did not have oversight of when supervisions had been carried out or were required.

The provider had failed to ensure that staff were adequately trained to carry out effective care. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service did not always follow correct procedures where people may lack capacity to make decisions about taking medicines and consent to care.
● Medicines were locked away within people's homes. There was no documentation to support the agreement or rationale of this practice. The service had not evidenced they had promoted people's independence in managing medicines by assessing this individually. The registered manager told us they would act on this.
● There was conflicting information about people's ability to consent. For 1 person, they had a diagnosis of dementia and were at risk of forgetting to eat. The care plan detailed this person may forget to eat and is not always able to say when they need help. The registered manager told us this was a mistake within the care plan, that there were no concerns. Staff we spoke to told us this person's capacity fluctuated daily, often they were confused, forgetful, and couldn't remember who they had seen day. There was no documentation to support consent to care or medicines.
● Care plans and risk assessments contained conflicting information about lasting power of attorney. The registered manager told us all service users had capacity however, they were waiting to see documentation for those who had power of attorney. 1 person using the service was detailed as having capacity although they struggled with memory loss. This person's medicines were locked away. The consent for medicines was signed by the next of kin. Documentation did not evidence there was a lasting power of attorney to support with decisions for health. There was no capacity assessment or documentation to support the agreement or rationale of medicines being locked away.
● The service had not evidenced they had promoted people's independence in managing medicines or consenting to support by assessing this individually. The registered manager told us they would take action on this and sent evidence of this for 1 person following our inspection.

The provider had failed to ensure that suitable assessments around people's capacity were carried out. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who used the service and their relatives told us "The carers are fully aware of my loved one's health condition and are extremely respectful and gain consent" and "The staff are well trained and have the upmost respect and always seek permission and consent before doing anything."
Supporting people to eat and drink enough to maintain a balanced diet
● We received mixed feedback from people and their relatives. We heard "They [staff] always give a choice of food and [person] chooses what they want to eat and after every visit before [staff] leave a glass of apple juice and a glass of water." We also heard about concerns around weight loss for a person whilst using the service. The person had recently lost weight whilst using the service. They were now being supported by another healthcare provider and were reported to be eating and drinking well. We heard "Carers make the breakfast and do not stay with [person] whilst they eat many a time I have gone to the house and the breakfast has hardly been touched."
● Risks around eating and drinking were not always mitigated. 2 people using the service were required to use dentures, however, chose not to. There was no risk assessment or guidance within their care plans to inform staff how to safely support them to manage this risk.
● Care plans contained examples of peoples likes and dislikes for foods. However, it was not always clear whose responsibility it was to support people with managing dietary intake as there was conflicting information within people's care plans about staff responsibilities.

The provider had failed to ensure that suitable assessments around meeting peoples nutritional needs were adequately met. This was a breach of regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● We heard people's needs were assessed and regularly reviewed, however we found information was not always updated accurately to reflect people's needs. For example, 5 care plans contained incorrect information about people's circumstances, personal details, and their physical abilities. People were at risk of not receiving the correct support .

● We received positive reviews about people's involvement in their care plans from people using the service and their relatives, "The family are involved in the care plan and a care plan is in the home", "This [information about persons care] is all documented in the care plan which is kept in the house, our loved one prefers a female carer and only female carers attend" and "I know the manager they attend to review the care plan every 6 months they are very approachable and I really like [them]."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Care plans reviewed contained evidence people received ongoing support from healthcare professionals, such as dietitians, hospital specialists, members of the community mental health team and GP's.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives told us they felt well supported and cared for by staff. We heard, "The carers are very kind, caring and respectful", "All the carers who attend are kind, pleasant and show great compassion" and "They are so kind to me I have no concerns."
- Despite care plans not always containing information about people's relevant needs, staff showed a good awareness of people's needs and how to support them with kindness.
- Staff knew people well and were passionate about ensuring people felt valued and cared for.

Supporting people to express their views and be involved in making decisions about their care

- Questionnaires asked those using the service and their families where appropriate to provide feedback to the service. Feedback received was mixed and further meetings were held to discuss any dissatisfaction. We did not see an action plan to change care based on this feedback.
- People and relatives, we spoke to told us that they were assured if they had concerns, they could speak to the registered manager.
- Relatives felt involved in people's care. 1 relative told us "The family are involved in the care plan and a care plan is in the home they also have access to the notes and regularly read them to see if they have been recorded accurately."

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us staff seek consent, "[Staff] have the upmost respect and always seek permission and consent before doing anything" and "The carers are fully aware of my loved one's health condition and are extremely respectful and gain consent."
- People had choice about who support them. We heard from one relative "My loved one doesn't like male carers doing the personal care and I mentioned this and it had been actioned as female carers attend."
- Staff we spoke to were aware of how to protect people's dignity when they offered personal care. We heard "I would always ask, we have someone who washes their face, and I ask if [person] is okay, asking for consent is really important, when supporting someone to wash I ensure I close curtains and doors, and making sure they are comfortable."
- The provider followed data protection law. Information about people was kept securely so confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were regularly reviewed. Care plans did not always contain correct information about peoples changing needs. For example, some peoples risk assessment contained information which was not available within their care plans. This would not always allow staff to provide continued personalised care.
- We also heard from 1 relative they had asked for their loves one's care plan to be reviewed following changes to their health which was not reflective of the support staff were providing. They commented the registered manager was resistant to update the care plan, and this took some time to be resolved.
- Care plans did not always contain detailed information about how people would like to be supported. For example, for some people there was limited information about how to support them with personal care.
- Care plans did not always reflect people's health and social care. We some good examples of how some people's health care needs could impact them and what staff could do in order to support people. We saw information about healthcare needs had been missed from the care plan.
- There were some good examples of individualised care plans supported a person-centred approach which included their life histories.
- The registered manager told us they would take action to rectify the discrepancies found.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's individual communication needs had been assessed and recorded. Staff were provided with guidance on how to promote effective communication.

Improving care quality in response to complaints or concerns

- The services complaints log was reviewed, it contained 1 complaint which was actioned.
- This log did not include the complaints raised by service users' feedback regarding lateness and communication.
- We raised this with the registered manager who said they would take action to review their complaints log.

- People we spoke with knew who to contact if they had any concerns or complaints and were confident

complaints would be dealt with appropriately.

End of life care and support

- The service was not supporting people who were on palliative or end of life care. Within team meeting minutes, it identified someone was at the end of their life. We sought further clarity from the registered manager about this. They explained the person was not receiving end of life care.
- The management team told us they would work alongside other health professionals if care was needed in this area.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●The service carried out limited quality assurance systems. There was a system to audit people's medications and receive feedback. However, these systems were not always effectively operated. We observed these had not always identified areas for improvement. There was no overarching action plan and we could not always see where action had been taken.

● Staff lateness had been identified by people using the service and communicated to the registered manager. We asked the manager how they logged any missed visits following concerns occurred, to ensure appropriate action had been taken to prevent reoccurrence. There was no system to monitor late or missed visits.

● Systems and processes were not always effective in ensuring records were kept up to date. We found care plans held conflicting information within them. There was no system to audit care plans and risk assessments.

● Systems and processes had not identified when mental capacity assessments and best interest decisions were not completed. For example, mental capacity assessments had not specifically been completed for personal care, consent to care, medication or use of equipment.

● We reviewed records of staff meetings. Discussions around concerns, and updates of the service were discussed, however actions were not documented in regard to people's concerns.

● The registered manager was not always clear about their role. There was limited understanding of the process in regard to notifying the CQC of a death or safeguarding.

●The service had recently worked with the local authority to develop areas of improvement. A service development plan was in place however, this did not identify ongoing actions, target dates or the shortfalls we found during inspection. As reported in the other domains of this report we found issues in relation to people's care records not being kept up to date with the support they required.

The provider had failed to ensure adequate systems and processes were to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (1) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received mixed feedback from care staff about the management of the service. We heard "I would be able to raise concerns with my manager and feel these would always be actioned, the manager explains

things to me", " Sometimes you raise things [regarding staff and service user concerns] and nothing gets done", " I do feel [the manager] is approachable, but not fair to all staff" and " I don't feel supported."
● Staff supervision files were reviewed, and opportunities were provided to staff to raise concerns during supervision about people who use the service. We could not always see where action had been taken to address these needs and concerns.
● People using the service and their relatives were mainly positive about the manager. We heard "I would contact the manager and review I am very confident this would happen I have a good rapport with the manager" and "In my opinion the service is well run the manager is available and approachable."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The registered manager was aware of their duty of candour responsibility and had systems to ensure compliance. This regulation sets out specific requirements providers must follow when things go wrong with care and treatment. These include informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
● During the inspection, we did not see any incidents in which duty of candour was implemented.
● Staff knew how to whistle-blow and knew how to raise concerns with the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Staff told us they were updated about the service, through discussions at staff meetings and individual meetings with the registered manager. Some staff told us their views were not always listened to or taken into consideration.
● People and their relatives had opportunities to provide feedback through surveys. Most people felt if changes were required these would be actioned "If I felt a review was required as health needs have changed I would ring and arrange a meeting [the manager] is easily contactable and always responds".

Working in partnership with others
● The service worked in partnership with health and social care professionals to ensure people received support to meet their needs. this included the local commissioners and health professionals such as, the local GP surgeries and the local authority.
● People using the service told us the agency supports them to contact the district nurses where needed, and the service was proactive in ensuring appointments with the GP were made when 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	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not always have appropriate documentation in place. There was limited evidence that people's capacity to consent was taking into consideration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider has not ensured that risks to people's medicines had been assessed staff were adequately trained to carry out safe care.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Peoples nutrition and hydration needs were not always adequately met.

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 provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

We issued a warning notice.