Derbyshire County Council

South Derbyshire Area Office (DCC Home Care)

Inspection report

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Date of inspection visit:
16 November 2018
19 November 2018

Date of publication:
05 February 2019

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

We inspected this service on 16 and 19 November 2018. This service is a domiciliary care agency. It provides personal care to older adults and younger disabled adults living in their own houses and flats and within an extra care facility. Not everyone using this service receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. There were 134 people receiving a regulated service at the time of our inspection.

There was a registered manager in the service. 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.

At our last inspection in July 2016 we rated the service Good. At this inspection we found improvements were now needed. The service is rated as requires improvement overall.

People did not always receive their care at the right time and people found that their care was not consistent as different staff, some who they did not know well, provided their care. People did not always receive their call and there was no evidence that any action had been taken to safeguard people when calls were missed. Staff were trained to recognise the various forms of abuse and encouraged to report any concerns. However, where people had calls missed, this had not been identified that this may mean they were at risk of harm or neglect. The quality monitoring systems did not identify where improvements were needed and missed calls, accidents and serious incidents were not monitored. We did not receive notifications of significant events to show how the provider had responded to events.

People did not always have care plans which recorded the care they were receiving and assessments of risks had not always been completed to ensure any risks were minimised. Care had not always been reviewed when this was needed which meant staff did not always have the information they needed to provide care safely.

Medicines were not managed safely where people received their medicines in boxes and checks were not made to ensure people had these as prescribed.
People felt able to complain but were not confident that their concerns were always actioned. The provider had not recognised that complaints were not recorded and responded to.

Improvements were needed to ensure that people were supported to have maximum choice and control of their lives and for staff to support them in the least restrictive way possible. People could make decisions about their care although improvements were needed to ensure where concerns about people's capacity was identified, assessments were completed and decisions made in their best interests.

People retained their independence and staff respected this. Staff developed caring relationships with the people they supported which were respectful and staff were kind and patient and took an interest in them and their family. People's privacy and dignity was maintained and people felt comfortable with staff they knew.

Recruitment systems were in place to ensure new staff were suitable to work with people. The provider had infection control procedures in place and personal protective equipment was available in people's homes for staff to use. Personal emergency evacuation plans had been developed to guide staff how to support people to leave their homes in the event of an emergency situation.

People's health needs were monitored and the staff worked with health care professionals and helped people to attend appointments where necessary. When people required assistance to eat and drink, the provider ensured that this was planned to meet their preferences and assessed need.

People were asked for their feedback on the quality of the service. The results of the survey were reviewed and people were informed of where the service needed to make improvements within a newsletter.

People felt the staff had the right skills to provide the care they wanted. Staff received training to understand how to support people and their competence was checked to ensure they had developed the skills they needed from the training. Staff received ongoing support and felt the management team was approachable and that they could talk to them at any time.

We found breaches 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?

Requires Improvement

The service was not always safe.

Risks to people had not always been assessed and information about how to provide care safely was not always available to minimise the chance of harm occurring to people and staff. Safe systems were not in place for when people received their medicines which had been dispensed in boxes. There was sufficient staff working in the service although they were not deployed to ensure people received safe consistent care. People did not always receive their call and action had not been taken to safeguard people. Systems were in place to recruit staff that were suitable to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought people's consent when providing support and people were able to make decisions about their care. Where people may lack capacity, this has not always been assessed in a timely way. Staff were provided with training and their knowledge and skills were checked. Where the agreed support included help at meal times, this was provided and food was prepared for people and staff supported people to meet their health care needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Care was not consistently organised to ensure people received care from staff who they knew. This meant people received care and support from staff that did not always understood their individual needs. People felt their privacy was respected, and they were treated with dignity and respect by kind and friendly staff and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People felt able to raise any concerns although were not confident about how these had been addressed. The provider had not responded to verbal complaints and improvements were not sustained. People had support plans which had not always been kept up to date and reviewed at a suitable time to reflect people's changing needs. Staff understood how to provide sensitive care for people who may need end of life care.

Is the service well-led?

Inadequate

The service was not well led.

Effective quality monitoring systems were not in place although to identify concerns or drive improvement. Systems were not in place to ensure people had safe care, care plans reflected people's care, medicines were safely managed and safeguarding concerns were identified. People and staff were provided with opportunities to feedback their views on the service. The provider worked in partnership with other agencies to understand how people may need their care provided.

South Derbyshire Area Office (DCC Home 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an announced inspection and we gave the service two weeks' notice of the inspection site visit. This was because some of the people using it could not consent to a receiving a telephone call or a home visit from an inspector, which meant that we had to arrange for a 'best interests' decision about this. This inspection was carried out by one inspector and two experts by experience. The experts by experience had knowledge of care services including domiciliary services.

The inspection site visit activity started on 14 November 2018 and ended on 19 November 2018. This included telephoning 23 people with their relative or friends and visiting seven people in their home with their consent. We spoke with seven staff and the registered manager, four domically care organisers and the office clerk. The inspection was also informed by feedback from questionnaires completed by 14 people using services, relatives and professionals. We visited the office location on 19 November 2017 to see the registered manager and office staff; and to review care records and policies and procedures.

The provider completed a provider information return as part of the Provider Information Collection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and what improvements they plan to make. We took this into account when we made the judgements in this report.

We looked at seven people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks. We reviewed statutory notifications the registered manager had sent us and information received from people that used the

service. A statutory notification is information about important events which the provider is required to send to us by law.

Requires Improvement

Is the service safe?

Our findings

People's care was not always assessed and risk assessments had not always been completed to demonstrate how care should be provided to keep people safe. For example, one person was supported to have a bath and moving and handling equipment was used. However, the office staff were not aware this personal care was provided and the care plan only recorded that they were supported to be washed. There was no information about how they needed to be supported safely with bathing and how any equipment was to be used, to ensure risks were identified and minimised. Another person had received hospital care and they told us they now needed additional support when walking and with personal care. The care plan had not been reviewed before staff provided care again and no longer reflected their current needs to keep them safe. The care was provided by a large team of staff, some of whom were not always known to the people. They told us, "The staff will do what is in the care plan; the staff that know me, know I need more help with walking but I don't feel it's right to tell the new staff." This meant people were placed at risk with how their care was delivered and potential risks for their safety had not been considered.

People had their medicines dispensed into blister packs or medicines in the original boxes from the pharmacy. People had a medication administration record which recorded what medicines people needed and when. Where people had medicines in the original boxes, we saw checks were not made on the number of medicines people received into the home. We saw strips of tablets had been mixed with strips from other boxes of the same medicine and were from different batches. Staff confirmed checks were not made to ensure medicines were still in date. The provider had not considered how they could make the necessary checks to ensure people had these medicines as prescribed and the current recording methods meant checks could not be made. This meant systems were not in place to determine whether people received their medicines as prescribed.

This evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff reported there were enough staff members available to meet people's needs and additional staff had been recruited to cover annual leave or sickness. However, we found concerns with how staff were deployed to ensure people received their support visit at the time they expected and some calls were missed. Staff had received training to understand and recognise possible abuse or neglect. However, we found that where people had calls that had been missed, the staff had not identified that potential harm may have been caused and not considered raising this as a potential safeguarding concern.

People had agreed when they preferred their support visit but we saw visits had been planned at different times. One person told us, "Staff can come at any time over a two hour period. This means it makes it difficult to have a routine and know when to get up and have breakfast first, or wait for the staff. Some days we have plans to go out and we have had to cancel these because the office staff have told us that is the only time staff are available." Care was not always consistent. People had designated staff who should provide their care but when the rotas were devised, these staff were allocated to work with other people. One relative told us, "Consistency is key and it is really difficult for us all if staff don't know us." We saw that

this meant people often had different staff provide care on different days.

Personal emergency evacuation plans had been developed to guide staff how to support people to leave their homes in the event of a fire or some other emergency situation. Staff told us they knew this information was recorded to support people to evacuate from their if this was needed. Some people used technology and equipment to promote their independence and had pendant alarms so that they could alert staff when assistance was needed and to help them feel safe.

People's homes were assessed to ensure staff had guidance to follow to protect them from identified risks. The assessment included whether there were concerns with the layout of the home, whether there was adequate space and any loose fittings or trip hazards and information to gain entry to the people's homes. The staff told us this meant they had a better understanding of reducing potential harm and keeping the person and themselves safe.

Staff had access to personal protective equipment to help reduce the risk of cross infection. The provider had infection control procedures in place and personal protective equipment was available in people's homes for staff to use. The staff team had received training about the control of infection and people were satisfied that staff understood how to maintain infection control and told us their uniform was clean and they had not concerns about hygiene procedures.

When new staff started working in the service recruitment checks were carried out to determine whether they were suitable to work with people. Recruitment checks had been carried out to determine their suitability to work with people including police checks, references and identity checks.

The management team operated an on-call system to provide additional support for staff and people who used the service as needed. If a staff member was delayed due to an emergency or caught up in traffic they contacted the on-call who would either provide additional cover or re-arrange call times as appropriate. We saw where the duty member of staff received a call, they had recorded the concern and any action they had taken.

Requires Improvement

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. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

When people requested to use the service, there was a process in place so that their needs were assessed. Working in partnership with the people's relatives and health and social care professionals, a decision was made about how they could meet people's wishes and expectations and considered consent to care. Where it had been identified that some people lacked capacity a copy of the capacity assessment by a social or health care professional was available. The staff reported there no people were subject to Court of Protection orders and no one was subject to any restrictions. The Court of Protection exists to safeguard vulnerable people who lack the mental capacity to make decisions for themselves. These decisions may relate to the person's finances or their health and welfare.

Where people's needs changed and concerns were raised that they no longer had capacity, the staff told us they would make a referral for an assessment to be completed. This meant there could be a delay for the assessment to be completed and a decision made in their best interest. Where people reported there were authorisations for others to make decisions on their behalf through a Lasting Power of Attorney (LPA), copies had not been seen to evidence these were registered. A LPA is a legal document that lets others that people to make decisions on people's behalf when they no longer have capacity.

We recommend that the provider seeks advice; training and guidance from a reputable source, to assess capacity and ensure decisions are made in people's best interests.

New staff members completed an induction when they commenced employment. This included training identified as necessary for the service and becoming familiar with the provider's policies and procedures. There was also a period of working alongside more experienced staff members until they felt confident to work alone. People were asked whether they were comfortable with a member of new staff shadowing and one relative told us, "The office staff will phone and let us know and ask if this is alright before they come out." The staff explained that before working alone, they would be assessed to check they were safe and competent to provide people's care. For example, with moving and handling and medicines. Staff were supported to complete nationally recognised vocational training and the care certificate; this sets out common induction standards for social care staff. It has been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care.

Staff were provided with support through individual supervision. They were encouraged to reflect on their practices and how they supported people. During supervision, the staff explained that they discussed their work practices, any concerns and further development. Unannounced spot checks were also completed to check whether staff continued to work with people safely. They told us this included checking their knowledge of people's support, whether they supported people in the way they wanted, used protection equipment to maintain infection control standards, arrived at the correct time and whether they were suitably dressed. Where concerns were raised this was discussed during supervision and used to support further learning. Staff told us that they felt they were supported in their roles and could speak with their manager about concerns or queries outside of these supervision sessions.

People were confident that staff had received the training they needed to enable them to provide their care. One person told us, "The staff know what they are doing and don't hurt me when they are helping me to move." Another person told us, "You can tell the staff have done their training and they are very professional." Another person told us, "The staff are well trained and do everything that I need to the highest standards." Staff spoke positively about the quality of the training. One member of staff said, "The standard of training is really excellent, we have all had moving and handling and safeguarding training and if people have a specific health need like Parkinson's, then we have training around that area." Some people had additional training for areas of interest, for example for dementia. One member of staff explained that following this training they now supported other staff to develop and learn these skills. They said. "Everybody has the basic training for dementia, but having the dementia champion training means I can now support other staff to learn about how living with dementia can affect people and about what it's like 'standing in their shoes'."

The staff explained they now supported more people with rehabilitation and support was provided when people came out of hospital for an agreed period. Staff reported that these visits focused on supporting people to regain their independence and confidence. One member of staff told us, "The focus of these visits is different from the support visits we previously did and we have to remember that we need to stand back and encourage people to be responsible for their own care." Staff explained that some staff had previously been provided with opportunities to develop their skills and knowledge for re-ablement of people and would welcome this training for all staff who provided this service.

People were supported to maintain a healthy diet as part of their support plan. People had choice and flexibility about the meals they ate and were responsible for providing the food for staff to prepare. People chose what they wanted to eat and staff helped to prepare this to meet their individual preferences. We saw some staff had received training to support people to manage their diabetes and check people's blood sugars daily. The staff had received training from health care professionals who had checked they were able to safely complete this support. One person told us, "The staff know what is safe and if there are any concerns they act straight away. The staff are very good at noticing if I'm not well and if I need a snack. I'm confident that the staff team know what they are doing an understand what I need."

Staff supported people to access healthcare appointments as needed and liaised with health and social care professionals involved in their care if their health or support needs changed. This included GPs, dieticians, speech and language therapists, chiropodists and diabetic nurses to provide additional support when required. We saw where people were unwell or had injured themselves, the staff helped people to contact emergency services to ensure treatment was provided.

Requires Improvement

Is the service caring?

Our findings

People had mixed views about how they were supported as some people had different staff visiting them who they had not been introduced to or they did not know well. People's views about how well the service was staffed had an impact on their views and how they felt that care could be improved. One person told us, "It's a bit daunting when they first come. It helps if it's the same people." People told us that staff did not always know how they preferred their care to be delivered and they felt uncomfortable when receiving personal care. One person told us, "I don't see how the staff can know my likes and dislikes because I never really get the same ones." Another person told us, "When I have new staff, they always ask what I want and get better over time as they get to know me." Another person told us, "The new staff used to do shadowing before they worked alone with me but not lately. I just get a name on a rota (so I haven't met them before)."

Where people received care from staff they knew well, they told us they felt comfortable and safe. One person told us, "The staff are different and do things in different ways but they are all caring and do their job well. They always ask how the family is too which is nice." Another person told us, "They are all marvellous and I look forward to seeing them. It is nice to talk to someone. I really enjoy seeing them as they are so cheerful, friendly and are always willing to listen." One relative told us, "The staff who know [Name] well manage their care very well." Another relative told us, "The staff are lovely; the regular staff in particular. One lady will sing and it gets [Name] dancing which they really enjoy. They are lovely, caring, kind people who genuinely want the best for [Name] and they will do little extras to help too."

Where people received support within the extra care facility, people knew the staff well and felt they had been able to develop good relationships with them. People told us they felt comfortable when staff visited them and they knew how they wanted to receive any support and care. One person said, "The staff visit me at the right time and always help me and check I'm alright. They know me really well, so would spot if anything wasn't right."

Staff understood when people needed or wanted help when making decisions about their care and support. People told us they provided help in a way that was sensitive to their individual needs and encouraged support and involvement. People told us that staff protected their privacy and dignity by making sure they were covered when receiving personal care and by ensuring that doors were always closed and that curtains were drawn. People said that staff were always thoughtful and did not speak about other people in their presence and listened to what they had to say.

Paper versions of people's support plans were held in their home and an electronic copy was stored at the provider's office. Information about people was kept securely in the office. The registered manager ensured that confidential paperwork was regularly collected from people's homes and stored securely at the registered office.

Gender specific care and support requests were respected. For example, where a person did not wish to receive support with intimate care tasks from a person of the opposite gender this was clearly documented and respected. At the time of this inspection there was nobody using the service who had culturally specific

needs. The staff told us that if they were not able to meet a person's specific diverse needs they would not take on the care package.

People could retain their independence and some people were supported following a discharge from hospital to regain their independence and confidence. One person told us, "My shower is done well and they help me to dress but let me do what I can for myself too." One member of staff told us, "It can be hard to step back to watch people, but that's what we are there for. It takes a longer time but it's important people have that so they can become stronger and more independent."

People felt the staff treated them with dignity and respect and listened to what they had to say. One person told us, "My care is honestly very good. They do all that they can to help. I really can't complain. I am treated with respect and they always ask my permission for everything. They never take me unaware." Another person told us, "They are courteous and respectful of my privacy."

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support that was responsive to their needs. People's care plans detailed how they wished staff to provide their care, although we saw where this had changed, the support plan was not always updated to reflect people's current support needs.

Daily records were completed by staff and these records evidenced the details of the care provided, food and drinks the person had consumed as well as information about any observed changes. We reviewed a sample of these and found they were personal to each individual and provided an overview of the support visit. These records were reviewed by the office staff but it had not always been identified that staff were delivering care that was not planned and risks had not been assessed in all areas to ensure people's safety.

The system recorded when staff visited people and whether they stayed for the agreed time. We saw the calls were generally the agreed length of time and people were visited within half an hour of the time recorded on the rota which had been sent out to people. However, the visit was not always planned for a time which had been agreed with the person and often visited at different times throughout the week. People received a rota which informed them of the time of each visit. However, some people told us that some visits could be blank and they were not informed which staff would be visiting them. Staff confirmed that this was due to staff cover not being available at the time to rotas were sent to people; people did not receive any updated information about the staff cover either in writing or verbally. People told us where staff may be late, they generally received a telephone call to explain and staff apologised. However, some people reported they had missed calls and these had not always been identified and they had not always been contacted with an apology or explanation.

There were arrangements in place for people and their relatives to raise complaints, concerns and compliments about the service; people had a copy of the complaints procedure in their home which was available in different formats. People had mixed views about whether any concerns would be taken seriously. Some people felt that when they had raised a general concern they had not received any feedback following the investigation. One person told us, "I have complained several times about the lack of consistency of care. After I have complained, it gets sorted and I have the same staff for a while but then it starts to change again." Another person told us, "I did complain about the number of carers but it has just got even worse lately. They said that they couldn't do much about it." The provider had only one complaint recorded. We saw this formal written complaint, had been investigated and included an investigation and people were provided with a response and outcome. However, where people had raised any complaint verbally, there was no record of how the provider had responded.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

People were supported to pursue activities and interests that were important to them. The provider arranged services for people to be supported with their interests or to assist people when out, for example, when shopping, going to work and being involved with leisure activities. During these support visits,

personal care was not provided and therefore this support is not regulated by us.

Consideration had been given to how information was available to people in an accessible format to ensure this was meaningful to people. All organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers. The provider had access to services which could provide information in large print, different languages and alternative formats. Staff explained that during the initial assessment, people were asked how they would prefer information and this was recorded to ensure they had information they could read and understand. People felt the information was provided in an accessible format.

There were no people receiving end of life care at the time of this inspection. However, the staff understood the importance of gaining people's views about their wishes in relation to end of life care. Where people had any specific wishes, this was recorded in the care plan. The staff understood that some people were reluctant to discuss this sensitive topic, however felt it was important where people had specific views, to record this so they could respect their wishes.

Inadequate

Is the service well-led?

Our findings

Quality monitoring systems did not identify whether people had missed calls, safeguarding concerns had been raised, or to review accidents and incidents. Live monitoring of support visits was not always carried out and staff were not expected to contact the office to record that they had arrived for their first call. This meant checks were not carried out to ensure staff had arrived to provide people's care unless people contacted the office personally. Where people had calls missed, there was no system in place to monitor these or to identify where harm may have been caused and make a safeguarding referral. Staff informed us that they were aware of missed calls but no information was available about how often these occurred or how lessons had been learnt to ensure improvements were made.

The provider had an electronic call monitoring system which was used by staff to log into and out of each support visit. Where calls were late, people had mixed views about whether they knew about this. Some people told us the office staff would telephone them to inform them the staff would be late. Other people told us they had calls missed completely and nobody had contacted them to inform them. One person told us, "We have been let down twice with no one turning up and we just had to manage dressing and washing each other. It was a struggle." Another person told us, "There are very occasionally missed calls which is difficult to sort out especially out of hours. I wish they would inform me of what is happening so I don't sit here wondering." A relative told us, "Unfortunately there have been occasions when no staff visit. I would say this happens once a month. They don't inform us which is a bugbear of ours and causes real problems. It is the same if they are late, every day is different." It had not been identified that missing calls could place people at risk and these had not been investigated or reported under safeguarding procedures. The staff confirmed that people were assessed whether their call needed to be made at specific times to keep safe. At weekends calls were not monitored by office staff and relied upon people informing the duty officer if calls were late or missed. This meant people may be placed at risk from calls which were late or missed.

Staff were aware of the reporting process for any accidents or incidents that occurred and there was a system in place to record incidents. However, accidents and incidents were not monitored or analysed for any trends so that further occurrences were minimised. The staff were not able to provide evidence of how many accidents had occurred for people who used the service and how improvements had been made to minimise risks for people. Where people had a serious injury, we had not received a notification of this, as required, to show how people received prompt care and any action taken.

Complaints had been made and these had not been recorded or reviewed to demonstrate how the provider had responded and how improvements were made. Medication audits had not identified safe systems were not in place for medicines which were dispensed in boxes, to ensure checks could be made that people had received their medicines as prescribed. There was a process for auditing records coming in from people's homes; daily records, timesheets and medication records were reviewed, however we found this had not identified where people had support plans which did not reflect how staff were providing care and how risks had been assessed to ensure people were safe.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain

events that happen in or affect the service. We identified that notifications had not been completed. For example, where people had been involved in a serious incident and needed hospital care and where it had been identified that people may be at risk of harm and a safeguarding referral had been raised. The last quality visit by a service manager had identified that a notification for one person had not been sent to us, but no action had been taken to make improvements. This meant the provider had failed to report incidents relating to any possible impact on people's needs which meant we could not check that appropriate action had been taken.

This evidence demonstrates a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider distributed annual quality assurance surveys to people who used the service and these were in an easy read style. The results and comments were analysed and a report produced for the registered manager. A new newsletter had been developed and reported the findings of the recent survey. We saw this included information that the survey had identified that people did not always know how to complain and included this information for people.

There was a registered manager in post. The staff felt part of a supportive team and told us the registered manager was approachable and listened to them. There was a team of Domiciliary Care Organisers (DCOs) who provided staff with support on a daily basis and staff spoke highly of the support they provided. The staff felt that the management team was approachable and that they could talk to them at any time. Team meetings and senior staff meetings were held and provided staff with an opportunity to raise any ideas or concerns or keep up to date with any developments. They said that the management was always open to suggestions from the staff team and that they listened to everybody and always provided them with opportunities for improvement.

The provider worked in partnership with key organisations to support care provision and service development. This included working with local specialist advisors and clinical professionals in supporting people with their care needs.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and on their website where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their report and rating in the office and on their web site.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to ensure the registered person assessed, monitored and improved the quality and safety o the services provided.