

# Calderdale Metropolitan Borough Council

# Support in Mind (Dementia)

# Team

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The Support in Mind service at Calderdale Council provides a specialist home care service to support people living with dementia within Calderdale. The service's office is based in Halifax.

The inspection took place between 6 and 24 October and on the first day of the inspection we arrived unannounced as we were unable to get in contact with the provider. At the time of the inspection there were 15 people using the service.

A registered manager was not in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed, had applied to be registered with the Care Quality Commission and was going through the registration process.

We were unable to speak directly with people who used the service as they were not able to communicate their experience of the service with us. However, we did speak with relatives and carers of people who used the service to get their views, as well as contacting health professionals and staff.

Relatives provided positive feedback about the service and said it provided high quality care which met people's individual needs and requirements. Relatives said care was delivered by kind, compassionate and competent care workers.

Medicines were not managed in a safe way. A lack of accurate records made it difficult for us to establish whether people had received their medicines as prescribed.

Relatives and health professionals praised the safety of the service. Safeguarding procedures were in place and we saw evidence these were followed to keep people safe. Risks to people's health and safety were assessed. Staff we spoke with demonstrated a good understanding of what they needed to do to minimise any risks to individuals, however, some risk assessment documents required additional information adding to them.

There were sufficient staff deployed to ensure people received a consistent and reliable service. Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people.

Overall, we concluded the service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) although documentation did not always provide a clear audit trail that the service was acting appropriately.

Staff received a range of training and support and demonstrated a good knowledge of the subjects and

people we asked them about. There was a low turnover of staff and people received care from the same group of care staff which helped the development of specialist knowledge about individuals.

Although some aspects of the service supported the claim that the service provided specialist dementia care, there was a lack of strategy to ensure proper dementia care planning and to enable the service to keep up-to-date with the latest developments in dementia care.

Relatives told us people's healthcare needs were met any changes in health were quickly communicated to them. Staff demonstrated a good knowledge of how to act if people's condition changed.

Relatives told us staff were kind and considerate and treated them with dignity and respect. Staff had a good knowledge of the people they were caring for, including their individual likes, dislikes and personal preferences. The service had enabled people to stay living in their own homes for longer and maintain their independence.

People's needs were assessed and plans of care put in place. However, some plans of care contained inaccurate information or were not thorough and person centred enough.

People received consistent care and support and the times that they needed it. Staff stayed for the correct amount of time and relatives told us the required care and support tasks were carried out.

A system was in place to log, investigate and respond to any complaints. Relatives we spoke with told us they were very satisfied with the service.

The provider had not submitted all required notifications to us such as allegations of abuse and notification of a serious injury.

We found a positive culture within the service, with staff demonstrating a dedication to providing a high quality and caring service. Relatives praised the overall quality of the service provision and gave numerous examples of how the service had delivered positive outcomes for people and exceeded their expectations.

Systems to assess, monitor and improve the service were not sufficiently robust and there was a lack of proper systems to formally gather and act on people's feedback about the service.

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

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not consistently safe.

Medicines were not managed in a safe way, records had not been fully completed and contained insufficient information about medicines being administered.

Risks to people's health and safety were assessed, and staff were aware of the action they needed to take to mitigate the risks. However, the written risk assessments required more detail.

There were sufficient quantities of staff deployed to ensure people received a safe and reliable service.

There were sufficient quantities of staff deployed to ensure people received a safe and reliable service.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

Improvements were needed to care planning to demonstrate the service planned and co-ordinated high quality dementia care.

Staff received a range of training and support and demonstrated a good understanding and knowledge of the people and tasks we asked them about.

Health professionals provided good feedback about the service. Staff demonstrated they knew what to do if people's health deteriorated.

### Is the service caring?

**Good** ●

The service was caring.

People experienced continuity of care workers. This helped the development of positive relationships between staff and people.

People were cared for by kind and compassionate staff that were motivated to provide a caring and person centred service.

### Is the service responsive?

The service was not consistently responsive.

Relatives told us people received high quality and person centred care. Daily records and discussions with staff led us to conclude people received a good quality and consistent service. However care records did not always reflect people's individual needs.

A system was in place to log, investigate and respond to complaints. People demonstrated a high level of satisfaction with the service and said their needs were met.

**Requires Improvement** ●

### Is the service well-led?

The service was not consistently well led.

Feedback about the overall quality of the service was unanimously positive  
Relatives, staff and health professionals praised the way the service was organised and run.

There was a lack of formal systems in place to seek people's feedback and audit and check the quality of the service.

**Requires Improvement** ●

# Support in Mind (Dementia) Team

## **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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place between 6 and 24 October 2016. The inspection team consisted of three adult social care inspectors. On the 6 and 18 October 2016 we visited the provider's office where we reviewed documentation and spoke with the registered manager. Due to the needs of people using the service we were unable to speak with anyone that used the service. On the 19, 21 and 24 October we made phone calls to relatives of people that use the service and staff.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with seven relatives, five care workers and the manager. We looked at elements of seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the service. This included information from the provider, notifications and contacting the local authority safeguarding and commissioning team.

Prior to the inspection we sent questionnaires to people, staff and health professionals to ask them for their views on the service. We received responses from five health and social care professionals, three staff members and one person who used the service.

As part of the inspection process we reviewed the Provider Information Return (PIR), which the provider completed. This asks them to give key information about the service, what the service does well and what improvements they plan to make.

## Is the service safe?

### Our findings

We found shortfalls in the way medicines were recorded which meant we could not be assured medicines had been administered as prescribed and in a safe way. In one person's care records it stated that the service did not provide support with medicines, however, daily records showed staff had administered antibiotics and eye drops. There was no Medicine Administration Record (MAR) providing details of these medicines and when they had been given. Two other people's daily records recorded medicines being given which were not on MAR's. Some people had medicine profiles in place which stated the medicines they were prescribed and how often they were to be given. However, these did not always match the medicines listed on the people's MAR's making it difficult to establish which medicines people had been supported with.

Where MAR's were in place, we found some of these were poorly completed. For example, one person had been prescribed paracetamol, but the dose or frequency had not been recorded and codes were used incorrectly making it difficult to establish why the person had not received their medicines. Another person had been prescribed a pain relieving tablet to be given 'four times daily' but there was no dose or time of administration recorded to identify when this medicine had been administered as the MAR stated only am, lunch, tea and bed. This meant we could not be assured sufficient time had been left between doses. Where people had been prescribed 'as required' medicines such as pain relief there were also no instructions present on when to administer these types of medicines risking inconsistent administration.

Where medicines were arranged in a dosette box, we identified staff had only signed the MAR once at every visit to indicate "all medication in the monitored dosage system had been administered." There was no information attached to each MAR to confirm what medicines had been administered. It is a requirement to ensure that care providers maintain a complete record of the medicines people have been supported with

The new manager had identified many of the issues with the medicine management system through a recent quality audit. The manager was in the process of addressing the actions arising from the audit, for example, the failings had been discussed at a recent staff meeting to aid improving staff practice and documentation. This proactive approach by the manager gave us assurance that the issues would be promptly addressed.

Staff had received training in medicines management. Basic medicines management competency had been undertaken, however, the manager had recognised these was not fit for purpose and was in the process of implementing a new medicine competency framework which was due for implementation in October 2016.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We concluded there were enough staff deployed at the right times to ensure people received safe care and support. People and relatives told us the service provided a reliable and timely service. We reviewed staff rotas and saw they were appropriately planned with travel time allocated between calls. Staff we spoke with told us rotas were realistic and they were able to spend the required time with people without rushing. Our

review of daily records confirmed this and showed staff consistently provided a service to people at the right times. The manager told us that the service currently had four vacancies but the impact of these was being managed by staff working additional hours; cover from team leaders and on occasions borrowing staff who worked in other areas of the service. The manager demonstrated to us the service carefully planned its service provision around staff availability and for example would not commit to taking on further care packages unless there was spare capacity to provide a service. This was confirmed by staff we spoke with. This provided assurances the service carefully planned care delivery to ensure people's needs were met.

People and relatives told us staff arrived at the correct times and nobody told us that any calls had been missed. We reviewed daily records and found this was the case with calls consistently taking place. A missed call log was in place which showed a low number of missed calls, for example two had occurred within 2016. Following these clear actions had been put in place to prevent a re-occurrence and to help ensure learning from the event.

Relatives told us they were confident their relatives were safe using the service and health professionals spoke positively about the safety of the service. Staff told us they were happy working for the service and did not raise any safety related concerns. We found the manager and staff had a good understanding of safeguarding matters, for example, how to identify abuse and raise an alert with the local authority. Staff received regular training updates in safeguarding as part of the mandatory programme of training. We saw where safeguarding incidents had occurred, appropriate liaison and referral had taken place with the local authority safeguarding team to help keep people safe.

Relatives told us that overall staff were competent in delivering care and support in a safe way. Staff demonstrated that they knew people well and the risks associated with their care and treatment, although care plans and risk assessments did not always fully reflect this level of knowledge. Risk assessments were in place which covered area of potential harm including moving and handling, skin integrity and the environment. We identified these were of variable quality with some assessments required more information. For example, one person's moving and handling care plan identified how to support the person to get into the bath, but not how to get out. Their assessment had also not been updated to reflect the fact they had experienced recent falls. We also found some information within the initial assessment undertaken by the social worker about people's safety had not always been transcribed into care plans. The manager had recognised that risk assessment documentation needed developing and had a plan in place to address.

A system was in place to log, investigate and learn from any incidents and accidents. These were recorded on incident forms and included medication errors, missed calls or any injuries people had sustained. Whilst we found action had been taken to address incidents such as holding supervisions with staff, the preventative action taken could have been recorded in a clearer manner on the incident form. We did not identify any concerning trends or themes with regards to incidents occurring within the service.

We looked at three staff files and found recruitment checks had been completed before staff started employment. We saw two written references and a criminal record check had been obtained through the Disclosure and Barring Service (DBS). There were detailed interview records and proof of identity documents for each applicant. There were completed application forms for two of the staff, but not for the third staff member. The references for one staff member were from work colleagues and not the employer or line manager of their previous employment. We raised these matters with the manager who said they would address these issues straightaway.



## Is the service effective?

### Our findings

Relatives told us the service provided effective care. One relative told us, "Absolutely superb" and another relative told us, "Generally good, in parts very good." A number of relatives told us how positive health and support outcomes had been achieved by the service. For example, telling us how the skills and familiarity of staff had been effective in managing behaviours that challenged. Relatives praised the skill and competency of staff and said they were appropriate to manage the needs of people living with dementia. One person did tell us they felt staff required further training in some specialist areas but that this was being addressed by management.

Staff we spoke with demonstrated a good level of competency and knowledge about the subjects and people we asked them about. This knowledge of people was built up by the service ensuring a good level of continuity of care staff who visited people. Staff demonstrated to us they knew about people's histories, care and support requirements in detail. This helped provide assurance that effective care was provided.

Staff received a range of regular training and support. New staff received a thorough induction and undertook a period of shadowing to ensure they were familiar with the people they were caring for and the tasks required. New staff without previous experience were required to complete the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provide safe and compassionate care. It is aimed primarily at staff who do not have existing qualifications in care such as an NVQ (National Vocational Qualification). Staff received regular training updates in subjects such as moving and handling, safeguarding, equality and diversity and the Mental Capacity Act (MCA) 2005. This was monitored by the team leader and manager through a training matrix. We looked at this and found this was largely up-to-date. Nearly all staff had received some specific training in dementia which was completed face to face or via distance learning. The registered manager had recognised that this training was not robust enough to match the service's claim that staff were specially trained in dementia. A business case had been submitted to the provider for more in-depth training to be provided to staff in dementia care.

Staff told us they received regular support and supervision. This included scheduled and unscheduled supervision to discuss specific concerns or care practice. We saw supervisions and appraisals took place, some of these were overdue but the new manager had identified this and had developed a plan and schedule to address this.

The service's statement of purpose described the service as a Specialist Dementia Team. We found some aspects of the service supported this claim, such as the provision of a non-rushed service, which was tailored around people's individual needs, and ensuring continuity of care staff going into people's homes. Relatives we spoke with told us they believed the service provided good quality dementia care and was effective, for example, in managing behaviours that challenged and the emotional and social aspects of care. However, there was a lack of a dementia care strategy involving keeping staff trained and up-to-date with best practice guidance and the latest developments in dementia care, in order to support the delivery of high quality and innovative dementia care. Care plan documentation did not demonstrate a comprehensive

enough assessment of people's needs in areas such as communicative, emotional and psychological needs, behaviours that challenged, decision making and future planning which is especially important for people living with dementia. For example, one person's care plan made reference to the fact they may need reassuring when they become distressed but did not provide further details of how to do this.

We recommend the service consults best practice guidance on the provision of high quality dementia care in order to develop and implement a suitable strategy of care.

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 when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to DoLS.

We spoke with staff, who demonstrated that they understood how to gain consent and act in people's best interests where they lacked capacity. A health professional we contacted also told us they thought staff had a good understanding and application of the Mental Capacity Act. However, we found there was often a lack of reference to people's capacity within care and support plans where they experienced limited or fluctuating capacity and a lack of reference to best interest processes and advanced care and support decisions. Although staff we spoke with spoke confidently of what they would do if people refused care and support interventions, care plans did not contain instructions on how to support people who we identified often refused interventions. This risked inconsistent decision making by staff.

We recommend the service consults guidance on the Mental Capacity Act (MCA) 2005 to ensure it can robustly evidences how it is acting within the Act and in line with associated guidance.

Relatives told us that the service provided appropriate support in relation to eating and drinking. One relative told us how they were impressed by careful and unrushed approach which had resulted in their relative eating more. Information was present within care and support records about people's culinary likes, dislikes and preferences, although in some cases more information could have been recorded. Daily records provided evidence of the support provided.

Health and Social Care Professionals we spoke with praised the service and said it provided high quality care that met people's individual needs. One professional told us, "I have used Support in Mind to provide care for a number of my cases where personal hygiene intervention, medication concordance and resistance to support has been an issue. They have worked really well to make progress with people in relation to this, better than mainstream carers and their approach really does make a difference to people being able to reside on their own home for longer." Staff spoke confidently about the action they would take if people were feeling unwell or their condition had changed which included liaising with district nurses, the person's GP, district nurses and informing the person's family. Staff demonstrated they knew people well and therefore were able to identify if the person was not themselves. This helped ensure their healthcare needs were met. However, during the inspection, we found it difficult to establish what action, if any, had been taken following deterioration in people's health due to lack of appropriate records being kept. On the second day of the inspection, the manager introduced a communication sheet for any contact with external health professionals and families to be recorded on in order to provide a clear audit trail of any interventions.

## Is the service caring?

### Our findings

Relatives we spoke with praised the service and said it provided good quality care. They said that staff were kind, caring, compassionate and treated people well. One relative said of staff, "They are friendly, kind, like your own family, like sisters." Another relative said, "Marvellous." A third relative said, "Absolutely 100%, they go above and beyond what they should do, care is delivered by a small number of staff who do everything expected in a friendly and professional way." A fourth relative told us, "Absolutely superb, it's the carer's personalities that make the difference."

One relative told us a particular positive feature of the service, was the emotional support and advice they received as a carer for someone living with dementia, from kind and understanding staff. Relatives said that staff were respectful of people's properties and always cleaned and tidied up after themselves. Staff also said this was the case, and said a particular good element of this service was that they weren't rushed so could clean up properly and "Have more time with people to chat." Relatives also said the management and team leaders were also friendly and approachable. They said they were able to get through to them when they needed to and they addressed any points raised in a constructive and caring way.

There was a culture within the service to ensure people were treated with dignity and respect. Dignity and respect were discussed at team meetings and through the supervision process. We saw that the manager had identified that some language recorded in daily records did not always demonstrate respect towards people that used the service and had addressed through a recent team meeting. This demonstrated the manager recognised the importance of ensuring care records were maintained in an appropriate way.

Health professionals we contacted told us they thought the service provided dignified and compassionate care. For example, one professional told us, "I have always found the SIM (Support in Mind) carers to be kind, respectful, understanding and caring for all the service users they are involved with. Another health professional told us, "Support in Mind team offer a valuable service. I have heard nothing but praise from service users and their families who have used this service. The staff are always willing to go that extra mile. This goes for the team leaders too. Nothing is ever too much trouble and it is clear that good relationships are built up with the service users their families/friends and other professionals they work with."

Strong positive relationships had been developed between people and staff. Daily records of care and support showed that people received a good level of continuity with the same care workers delivering care and support to people. New care workers were introduced to people prior to care delivery to ensure people received care from familiar faces. Information was present in people's care plans about people's likes, dislikes and personal preferences. For example, their past careers, interests and how they liked to spend their time. This helped staff in the provision of compassionate and personalised care delivery and demonstrated the service had taken the time to understand people prior to care delivery. We spoke with staff about people's life histories and personal preferences. The answers provided demonstrated that staff knew people well and this provided us with assurance, along with positive feedback received from relatives, that good positive relationships had been developed between people and staff. One relative told us "They know [person] inside out." Relatives told us staff were very familiar with people's preferences, likes and

dislikes. For example, one relative told us how staff knew what television programmes their relative liked, so always suggested putting a programme of interest on during care visits.

Staff we spoke with demonstrated a commitment and dedication to providing a caring, compassionate and social experience to the people that used the service. For example, one staff member told us, "I love working with older people, I leave with a smile after each visit, I like to make each person happy and respect them as a person." Another staff member said, "We try to include and involve people as much as possible, take the ladies magazine so we can sit together and read, I take jigsaws, anything I can to help." Relatives confirmed that staff interacted with people and showed them photographs and other items to stimulate conversation and develop relationships.

Relatives told us the service had been successful in maintaining people's independence by keeping the person in their home for longer. One relative told us how they were impressed with the service and that without it they were sure their relative would be in a nursing home. Some information was present within care plans about how to ensure people's independence was maintained, although this could have been made more person centred.

Relatives told us that they felt involved in decisions made in relation to care and support. They said they were consulted regarding any changes to care and support. Staff demonstrated to us that they put the needs of the people using the service first and consulted with them on day to day care tasks. Relatives told us communication was good and they were contacted should there be any changes in their relative's health or emotional wellbeing. One relative told us, "They always ring me if any issues."

## Is the service responsive?

### Our findings

Relatives praised the standard of care provided by the service. They said it was appropriate and met their relative's individual needs. This view was also shared by health professionals who we contacted. For example, one health professional told us, "From my experience with the SIM team I have found they are very forward thinking about the care they deliver. They think creatively about the support, liaise with the social workers and families re any approaches, suggestions they have which will improve the quality of life for the people they serve, upholding dignity and human rights."

We looked at people's care records and found they lacked detail about the care and support people required at each call and how they preferred this to be delivered. There was some information recorded about what was important to people and their likes and dislikes but this was limited. There was a lack of information recorded about people's emotional and psychological needs, how to manage refusals or behaviours that challenged or about any contact made with health professionals and families. We found entries made in the daily records about the support provided were not fully reflected in people's care plans. For example, the daily records showed staff were applying creams to one person which were not included on the person's medicine administration record (MARs) or detailed in their care plan. Although the care plans showed the start time of calls, they did not reflect the length of the call or the number of staff required to attend. The manager had identified that care plans were not fully person centred and required the addition of further information. They told us they, "Wanted to develop care plans to have that golden nugget that key piece of information about the individual as a person."

This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities 2014) Regulations.

Relatives told us that staff arrived at on time and stayed for the agreed amount of time. We looked at records of care to establish whether people were receiving care at the times they needed it. Overall, we found a good level of consistency with staff arriving on time and staying for the correct amount of time. Care records demonstrated staff sometimes overran the call to ensure care tasks were completed. In one case we identified the teatime and evening calls were on occasion closer together than specified within the care plan, we raised this with the manager to investigate.

Information about people's social needs was present within plans of care. We saw from reviewing daily records, speaking with staff and relatives staff were good at meeting people's social needs by chatting to them, providing companionship and undertaking activities with them such as reminiscence, talking about current events, television or music. One staff member told us how one of the people they cared for had a keen interest in travel, so they brought travel magazines for them and photos of places they had been to stimulate and engage them in conversation..

People we spoke with told us they were generally very satisfied with the service provided. One person told us that whilst they were overall happy with the care, they had some concerns, but they had found the management to be willing to listen and receptive to their comments and hoped these issues would now be resolved. We saw the service had a detail complaints policy and the new manager had provided people with

information about herself alongside a photograph and contact details so they could raise any concerns. We saw four complaints had been received in 2016 and there was evidence to show these had been investigated and the outcome communicated to the complainant.

## Is the service well-led?

### Our findings

A registered manager was not in place, the last manager deregistered with the Commission in May 2016. A new manager had been recruited who had been working at the service since August 2016. The new manager had applied to be registered with the Care Quality Commission and was currently going through the registration process. The manager was supported by a team leader and deputy who undertook day to day management of staff and management of operational issues

The provider not had reported statutory notifications to us. For example, recent safeguarding alerts had not been reported to the Commission and a serious injury from June 2015. We sent a warning letter to the provider stating we would take further action if notifications were not promptly reported to us in the future.

We found a good, positive culture within the organisation. Staff demonstrated they were proud working for organisation and demonstrated good spirit and morale. There was a low turnover of staff which helped build the staff team's experience and knowledge. We found staff demonstrated a very good knowledge of the people and topics we asked them about. Relatives spoke very positively about the overall quality of the service describing it is good or excellent. One relative said, "High quality, good service, can't say enough positive feedback." It was evident from speaking with relatives, health professionals and staff that people had experienced some high quality and person centred care, however, documentation did not always reflect this.

Relatives praised the way the service was managed and said the team leader was approachable, and dealt with any issues they raised. Staff also praised the team leader and said they were approachable and they felt able to raise any issues with them. One staff member told us the team leader was, "Dedicated to finding solutions to any problems and ensuring good communication with people" and another staff member told us, "Best I have ever worked with, can go to them with any issues. She knows people really well, that helps." Some staff made reference to the absence of leadership and direction at a more senior level, but they felt these issues were now being resolved with the appointment of a new manager.

Systems to assess, monitor and improve the service were not sufficiently robust. The service had received a lack of provider governance, support and oversight. We saw this had been recognised by the service and new provider monitoring systems had been put in place. This would ensure that information on events occurring within the service would be reported robustly to senior management. However, these systems were not fully embedded at the time of the inspection.

During the inspection, we identified a number of issues with the quality of the service, some of which the new manager had already identified. However, these deficiencies should have been prevented from occurring in the first place by proactive systems operated by the provider to assess, monitor and improve the quality of the service. Limited quality assurance systems had been operated. For example, there had been no audits of daily records, medication records, or care plans and a lack of spot checks on staff practice. The new manager had recognised this and started to put systems in place. They had recently conducted a medicine audit which had identified the concerns we found during the inspection which had been fed back

to staff at a recent meeting. They had recently introduced a number of new monthly audits including an audit of daily records, MAR sheets, safety and care plans. However, none of these had yet been completed.

We found a lack of systems in place to record people's feedback in relation to the service. For example, only four visits had taken place to people's homes to record their views within 2016 and actions from these had not always been signed off. There was also no survey or questionnaire sent to people to gather their views on the quality of the service. .

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

The new manager had recognised a number of deficiencies with the service including many of the issues we identified during the inspection. They had put an action plan in place to provide a clear and structured approach to making improvements. This gave us confidence the issues we raised would be addressed by the service. The new manager had increased the frequency of staff meetings to ensure significant improvement had been made to the service. A recent meeting had been held in October 2016 and there was evidence that a number of points had been raised with staff to improve documentation and practice. Staff we spoke to confirmed these meetings had taken place and recognised that improvements were needed to some elements of care documentation.



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<br><br>(1) (2g)<br>Medicines were not managed in a safe or proper way.   |
| Regulated activity | Regulation  |
| Personal care      | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>(1) (2a) (2c)<br>Systems and processes were not established and operated effectively to ensure compliance with the regulations within this part.<br><br>Systems to assess, monitor and improve the quality and safety of the service were not fully in place.<br><br>A complete and accurate record of each service user's care and support was not maintained. |