Prime Care Associates

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At the inspection dated 15 and 16 of February 2017 we rated this agency as requires improvement. The office manager wrote us after the inspection telling us how improvements were to be made.

This inspection took place on 24 May 2018 and ended on 31 May 2018. The agency was given short notice of this inspection visit. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger adults.

A registered manager was in post. 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.'

The people we spoke with and who replied through questionnaires said they felt safe with the staff. The staff we spoke with said they had attended safeguarding of abuse training. Although two staff were not clear on the types of abuse they knew to report their concerns. The care manager said that at the next staff meeting refresher safeguarding training will take. Where staff suspected abuse by other staff they felt confident to report their concerns.

Risks were assessed and action plans were developed on minimising the risk. Individual risks to people included mobility needs and prevention of pressure sores. However, for one person the action plan on how to transfer was unclear as adequate equipment was not provided by the appropriate healthcare professionals. When the person then became frustrated guidance was not provided to staff on how to manage these situations.

Members of staff described how they managed situations when people became anxious during personal care and resisted their support. Guidance was not in place on how staff were to manage one person's level of anxiety when they became frustrated. The care manager told us during feedback that this guidance was now in place.

Where people were at risk from pressure ulcers their care plans listed the preventative measures. Daily reports were not detailed on the repositioning changes that took place on each visit. This meant risks were not assessed and monitored to ensure preventative measures were followed. The care manager said repositioning charts had been reinstated as staff had discontinued recording position changes.
Moving and handling risk assessments were detailed on each movement, the aids and equipment used and the number of staff needed. The staff we spoke with had attended training in moving and handling.

Environmental risk assessments were in place to ensure staff were able to deliver personal care in safe surroundings.

Incident and accidents reports were completed and analysed for patterns and trends. At the time of the inspection there were no accidents logged.

Audits were used to assess the quality of care were in place. The audit log listed the areas assessed and monitored each week which included audits of records, complaints and people at high risks. Action plans were then developed on shortfalls identified. However, the findings of this inspection in relation to the areas identified for improvement were not consistent with audit log. The care manager told us they were going to consider improving the process for auditing the quality of care. For example, care planning. The care manager told us clear auditing process were being developed.

The arrangements for medicines were unclear. Staff that administered medicines had attended appropriate training. Completed medicine administration records (MAR) were not always returned to the agency office which meant they were not always audited. Some medicines particularly topical creams were labelled "as directed". This meant staff were not given guidance on their application. The care manager told us during feedback that this information was now included in the MAR.

The people we spoke with said staff arrived on time and stayed for the allocated time. However people responding to questionnaire contradicted these comments. The people we spoke with told us they occasionally received late calls, but these were in a time frame of no more than thirty minutes. Staff said they mainly arrived on time and stayed for the allocated time. The care manager told us people were made aware that there was an acceptable half an hour each way for visit times. They said some people had expectations that staff arrive at the time they specified but this was not always possible.

People told us their care was delivered by the same carers. They told us the staff were caring and built relationships with them which made them feel they mattered. The staff we spoke with said people received continuity of care because regular staff visited.

New staff had an induction to ensure they were confident to perform their role. Staff were supported to maintain their skills and improving their performance. There were spot checks, one to one supervision and annual appraisals.

The people we spoke with told us they made their own decisions in relation to their health and welfare. Staff knew how to support people with the day to day decisions. Where people lacked capacity to make decisions clear documentation was not in place on who made the best interest decisions. We made a recommendation for the care manager to gain from a reputable source guidance on how to ensure the principles of the Mental Capacity Act 2015 were followed.

Where necessary office staff made GP appointments. Staff said they were kept informed about visits from healthcare professionals.

Some care plans had aspects of person centred care in relation to tasks. However care plans were not in place for needs associated to the area of personal care to be delivered. For example, where people did not communicate verbally guidance was not provided on how to communicate with the person. The care manager said this guidance was now in place. People told us they participated in the development of their care plan. We made a recommendation for the care manager to gain guidance of developing person centred care plans that reflects people's physical and emotional care needs.

People told us the staff were caring and felt able to express their views about their care. The staff respected their rights. There were no complaints received. People knew who to approach with concerns.

We found a breach of Regulation 12 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.

Medicine management systems needed improvement. Guidance on the purpose of medicines was not provided to staff. Protocols for 'when required medicines' and topical creams lacked guidance on when to administer these medicines. Staff signed medicines administration charts to show they had administered the medicines.

Some risk assessments were not in place for people that at times expressed their anxiety through behaviours that were difficult to manage.

People's we spoke with said had confidence that their visits would not be missed by the staff. However, some people said the staff did not arrive on time or stayed for the time allocated.

People said they felt safe with the staff. Staff knew the procedures for the safeguarding of vulnerable adults from abuse.

Is the service effective?

Good

The service effective.

Where people had capacity to make decisions they gave their consent for staff to deliver personal care. Where lasting powers of attorney were appointed these people were not documented.

Staff had access to a range of training to ensure they had the correct knowledge and skills to provide people with the appropriate care and support.

There were opportunities for staff to discuss their personal development with their line manager.

Is the service caring?

Good

The service was caring.

People told us that staff were kind, caring and respected their

rights.

Members of staff were knowledgeable about people's needs and how to meet their needs in their preferred manner.

Is the service responsive?

Good

The service was responsive.

Care plans were mostly person centred but lacked direction on how to deliver care where there were needs associated to the personal care identified. People were aware they had care plans in place.

People told us they knew the complaints procedure and who to approach with their concerns.

Is the service well-led?

Requires Improvement

The service was not well led

The quality assurance systems in place were not fully effective. Records were not always accurate and up to date

Systems were in place to gather the views of people and their relative's.

Members of staff worked well together to provide a person centred approach to meeting people's needs

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 May 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.'

Inspection site visit activity started on 24 May 2018 and ended on 31 May2018. It included visits to the agency office, questionnaires and phone conversations. We visited the office location on 24 May 2018 to see the manager and office staff; and to review care records and policies and procedures.

The inspection was carried out by one inspector and an 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.

Before the inspection we gathered information and reviewed Provider Information Records (PIR), notifications, previous reports and questionnaires. We used questionnaires to gather feedback from people, staff and community professionals. We spoke with three people and three staff by phone. During the site visit we spoke with one staff, the office manager, care manager, office manager and office administrators. The care manager was involved in the inspection. The registered manager was not involved in this inspection.

We looked at records about the management of the agency. These included audits of the service, the care records of five people. Other records looked at included recruitment files, staff duty rosters, policies and procedures and quality monitoring documents.

Requires Improvement

Is the service safe?

Our findings

At the inspection dated 15 and 16 of February 2017 we rated Safe as Requires Improvement. We said that medicine management systems needed improving. After the inspection the office staff wrote and told us that improvements were being made to ensure safe handling of medicines. At this inspection we found that more improvements were needed. For example, the medicine administration directions and auditing of administration records.

The arrangements for the safe handling of medicines were not well organised. The staff we spoke with said they had attended training to administer medicines and records confirmed they had attended this training. Medication administration records (MAR) were signed by the staff to indicate the medicines administered. However, directions for the applications of cream were not clear on the MAR's. For example, the personal profile for one person stated "apply cream to the affected are of skin every morning as prescribed for itchy skin". The comprehensive care plan devised by the social worker stated "apply to back each morning due to eczema". For another person the instruction on the MAR for the application of cream was "as directed". The patient information leaflet for this cream states to "apply the cream exactly as your doctor told you. You should check with your doctor or pharmacist if you are not sure." The care manager told us during feedback that this information was now included in the MAR.

The National Institute for Health and Care Excellence (NICE) Guidance recommend for topical creams that staff be provided with guidance on the frequency of use, thickness of application and areas of the body to apply cream. The standard labelling requirements for all dispensed items must include the name of the person to whom the medicine was to be administered and directions for use. This means the label on medicine must clearly written and unambiguous.

Daily notes for one person showed a course of ear drops were prescribed. The daily notes were not clearly written on when they had administered the ear drops. We asked for copies of the MAR to check the administration of ear drops. The care manager told us they were not available
Information provided before the inspection showed medicine errors had occurred. The care manager told us medicine errors related mainly to missing signatures for medicines administered. They said one to one discussions took place with staff that made one or two medicine error. Where staff made three or more errors disciplinary procedure were followed.

Risks to people were assessed and monitored to ensure their safety. People's individual risks included falls, mobility and the prevention of pressure sores. Where people had mobility needs the risk assessment detailed each movement. For example, the aids used by the person, the number of staff and the equipment needed to assist the person.

The care plan for one person gave staff guidance to assist them with repositioning as they were cared for in bed. The care plan stated "reposition me using my slide sheet and record on the turning chart." While the manual and handling care plan was detailed, guidance on repositioning was missing. The daily notes included some recording of position changes but this was inconsistent. For example, On the 1 April 2018

position changes for the 6pm visit was missing. On the 2 April 2018 there was no reposition recording for the 9am and for the 4pm visits. For the 6pm visit the staff had recorded that reposition took place but the position change was not detailed. The care manager told us specific repositioning charts which tracked each position change were kept in the person's home. It then transpired during feedback that staff were not recording repositioning. The care manager told us this had been reinstated.

For one person staff had highlighted in the "My support plan in brief" that "I can become confused and muddled/ anxious at times, I can become confused and cross at times and I can be verbally aggressive at times." During March 2018 the staff had documented in the daily notes when this person became anxious and resisted personal care. The staff we spoke with described how they managed situations when this person resisted support for personal care. However, the care plan did not give staff guidance on how to manage situations when the person became anxious. The care manager told us during feedback that the care plan had been updated. The care manager said the care plan included guidance to staff on how to manage situation when the person became anxious and resisted personal care. The care manager told us during feedback that this guidance was now in place.

Environmental risk assessments were completed to ensure people lived and staff worked in a safe environment. A member of staff told us environmental risk assessments were completed during introductory visits organised before agreeing to deliver personal care. They said during these visits the environment was assessed for hazards. The environmental risk assessment for one person listed the locations of service points such as fuse box. How staff were to gain access entry into a person's home.

Systems and processes that safeguard people from abuse and avoidable harm were in place. People told us they felt safe when staff were present in their homes. Training records showed staff had attended safeguarding adults training. The staff we spoke with said they would report their concerns to their line manager but two staff were not clear on the types of abuse. A member of staff also told us they would report poor practice witnessed by other staff.

Some people that responded through questionnaires told us the staff did not arrive on time or stayed the agreed length of time. One person we spoke with said their calls were always on time as they were prescribed time sensitive medicines. People we spoke with said the staff stayed the allocated time and if possible would sit down and have a chat with them. A member of staff we spoke with said there was enough staff available to meet people's needs. This member of staff said visits were not missed. They said "I always stay the proper time and sometimes I stay longer. I am not one for rushing around I do my job properly." Another member of staff said "[I] usually stay the correct time unless people say its ok for us to leave." They said before they left people were asked "is there anything else they want me do before I leave."

People we spoke with told us they occasionally received late calls, but these were in a time frame of no more than thirty minutes. They said the office staff would ring them to let them know if the staff were to be late. The service user guide informed people using the agency that there was an acceptable time frame of half an hour each way for visits. Information received before the inspection indicated missed visits had occurred. The care manager told us missed visits were generally due to staff not looking at the rotas provided. The care manager said another staff was sent to cover the visit as soon as they were made aware of a missed visit. They said when staff missed two visits they were invited to a meeting with the care manager. The log of missed visits showed that since January 2018 there were seven missed visits. The reasons for the missed visits and the actions taken were listed in the log. Disciplinary procedures were followed where there were three or more missed visits.

Accidents and incidents were reported by the staff. The care manager said there were few accidents which occurred while staff were present. The care manager said mainly staff "find people on the floor" when they arrive. They said preventative measures were taken to prevent accidents. For example. Liaising with occupational therapists (OT), GP and families ensure correct equipment was in place and falls were prevented.

Recruitment procedures ensured the staff employed were suitable to work with vulnerable adults. There were safe recruitment and selection processes in place to protect people. We reviewed the personnel file of the most recently employed staff and appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. New staff were subject to a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Good

Is the service effective?

Our findings

At the inspection dated 15 and 16 of February 2017 we rated Effective as Requires Improvement. We found that staff were caring for people whose liberty was restricted but Court of Protection orders were not gained for this. At this inspection we found staff had made some improvements when using equipment that restricted people's liberty.

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.

The care records were not clear on who made complex decisions for people that lacked capacity to make them. For example, the comprehensive assessment from the social worker stated one person had cognitive impairments. The staff documented in the personal profile that this person lacked capacity and highlighted in the "my support plan in brief": "I have limited abilities to make my wishes known" and I am not able to communicate my wishes". However, this information was not drawn together into a care plans. This meant staff were not given guidance on how they were to ensure MCA principles were followed when gaining consent to deliver personal care and administrations of medicines. The care manager told us the staff "spoke to the person through their wife" but their relative did not have the legal authority to make these decisions.

For another person staff had highlighted in the "my support plan in brief": "I have a poor memory". The staff documented in personal profile that they had capacity to make decisions. The care plan did not give staff guidance on how to support the person with decisions about their personal care and administration of medicines.

We recommend that the service seek advice and guidance from a reputable source on the MCA and how to follow the principles of the act.

The people we spoke with said they were involved in making decisions about their care, health and wellbeing. One person said "They give me enough independence so I can be involved in making decisions about my care." Two community care professionals said the care agency's managers and staff understood their responsibilities under the MCA.

Members of staff we spoke with understood their role to enable people with making decisions. A member of staff said they "always asked people if they were happy to proceed [with personal care] and if they would you like to do it yourself. Generally people are encouraged to self-care as much as possible." Another member of staff said they always asked "What would you like to wear today? I always ask I like people to choose their clothes. I do a lunch calls and I take out about four options for people to make a choice".

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 were being met. The care manager told us for some people bed sides were used and the appropriate occupational health care professional made the DoLS requests. However, copies of the DoLS authority were not available at the agency.

The needs of people were assessed before agreements to deliver personal care were reached. A member of staff said assessments were undertaken before personal care visits were organised. The care manager told us referrals for personal care were from the local authority's main contracted domiciliary care agency. They said for people funded by the local authority comprehensive care plans were provided. For all other referrals visit were made to the person's home to assess their needs and to ensure the staff were able to meet people's needs.

The staff were supported to develop their skills and knowledge to deliver effective care and support. The staff we spoke with said they had an induction when they started work at the agency. A member of staff said their induction included shadowing of more experienced staff before they worked alone. They said refresher training was attended to ensure they maintained their skills. Records showed staff attended training which included safeguarding of adults, moving and handling, first aid and dementia.

The staff were supported to fulfil the responsibilities of their role and to ensure people received their personal care from competent staff. Staff said there were spot checks and one to one supervisions with their line managers and appraisals were with the care manager annually. A senior told us they carried out three monthly spot checks which included checks that staff were wearing the correct uniforms and observations of staff practice. They said one to one meetings were arranged and included checks of documentation and discussions with staff on areas for improvement.

People were supported with their ongoing healthcare where appropriate. Staff told us they contacted the office staff whenever they observed a deterioration of people's health. They said usually people made their own appointments but where necessary office staff organised GP visits for people. A member of staff said that the GP "sometimes" recorded the outcomes of their visits in the daily reports.

There were people that required staff supported to maintain a balance diet. A member of staff said where they supported people with meals the person organised the delivery of microwave meals. They said usually their role was to microwave meals.

Good

Is the service caring?

Our findings

People told us their care was focussed on their personal needs and welfare. People that responded through questionnaires told us they were involved in decision-making about their care and support needs.

Staff told us how they ensured people were made to feel they mattered. Comments included "I have a caring nature and I develop relationships with people. Talking to people makes them feel they matter" "Getting conversations going talking about me and them" and "I will ask people, what would you like me to do today. Do you have any dislikes?"

People received their care in a compassionate manner. A senior said "It's important to me how staff interact with people. When people ask staff for them to do things I ensure this is followed. Some staff either have it or don't. Treat people like your family." Another member of staff said "I listen and maintain eye contact and watch their body language. I sit with people and give them my sole attention."

The care manager told us how they ensured people were treated with kindness and compassion by the staff. They said there was an ongoing process which included monitoring staff's performance and skills through one to one supervision, spot checks. People were consulted about the delivery of their care during review meetings and through questionnaires.

People told us they were treated with respect and dignity by all the staff. One person thought the staff spoke with the correct level of professionalism and without being "bossy". People that responded through questionnaires told us they received care and support from familiar staff. Staff told us how people's rights were respected. A member of staff said "people's confidential information was not discussed". Other comments from staff included "I don't rush people to accept care. I respect their wishes and document the care provided" and "I close the curtains".

People felt they were listened to about their care and any decisions that had to be made about their care. The care manager said people with diversity needs were "respected by the staff and respected their views on culture and religion". A member of staff said "I promote people's rights by giving them freedom of expression but maintaining confidentiality. Respecting their views on culture & religion. Supporting them with independence."

Good

Is the service responsive?

Our findings

At the inspection dated 15 and 16 of February 2017 we rated Responsive as Requires Improvement. We found that care plans were not always person centred and lacked detail. At this inspection we found care plans were more detailed about people's preferences.

People told us they contributed to planning their care and support. The people we spoke with were aware of having a care plan on meeting their needs. One person said "I'm definitely involved in my care plan."

Personal care plans were written in the first person and reflected people's preferences, their abilities to undertake the task and the support needed from staff. However, care plans were not developed where there were needs associated with the person's emotional, health and wellbeing. For example, how staff were to communicate with the person. The staff had indicated in the "my support plan in brief" for one person that "I am not able to communicate my wishes" and "I have poor eyesight". The moving and handling care plan for the same person stated "XX has a diagnosis of Parkinson's disease and Lewy body dementia, XX skin requires continual monitoring for breakdown," However the care plan did not give staff guidance on how to communicate with the person, the signs of skin breakdown and how the person's dementia may impact on the personal care being delivered.

For some people their preferences were recorded in relation to their likes and dislikes for activities and for food and drink. What a "good day and bad day" sections of the forms were not completed. Personal histories that included people's past employment, interests, family network and important relationships were not detailed. The care manager said that not all people want to disclose this information.

We recommend that the service seek advice and guidance from a reputable source, developing care plans.

The care manager told us care plans were developed "by experienced staff". The staff we spoke with said care plans gave them the information needed to meet people's needs. A member of staff said care plans also detailed people's "personal information and medical history". They said "I don't like going where I don't know what I am doing". A senior told us people's preferences and their personal care needs were gathered to build detailed care plans.

Care plans were reviewed annually or as people's needs changed. The care manager told us reviews meetings were joint with the social worker and main contracted agency used by the local authority. One person told us "I recently had my care plan reviewed by a senior member of staff, who asked me about any decisions that were going to be made."

Most people that responded through questionnaires told us they knew how to make complaints. The people that spoke to us told us they knew how to make complaints and one person said "I'd ring the office if I had a complaint, but I've had nothing to complain about." The Welcome Pack kept in files included the complaints procedure. There were no complaints received since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

At the inspection dated 15 and 16 of February 2017 we rated Well Led as Requires Improvement. We found not all areas identified for improvement at the inspection were part of the agency's action plan. For example, supervision of staff and medicine systems. At this inspection improvements were made in respect of staff supervision but more improvements were needed with medicine systems.

Systems and process were established to assess and monitor to improve the quality of delivery. There was a rolling rota of the specific audits to be done over a four week period. For example, in April 2018 audits were based on staff's training needs, complaints and medicine systems including medicine errors. The action plan included organising training and updating data protection procedures. In May 2018 the four week audit covered staff recruitment, audits of missed visits, safeguarding, documentation and personal protective equipment (PPE). The action plan detailed that recruitment of new staff had taken place; staff were given guidance to ensure visits were not missed and completed documentation was to be scanned and not archived.

Records were not always accurate and up to date. Where MAR charts did not have correct directions for administration the audit had not identified the shortfall. Where people lacked capacity records did not detail who made the specific decisions on their behalf. Care plans lacked detail for additional needs associated with the delivery of personal care identified. The care manager acknowledged that all completed documentation was not always returned to the agency office. The care manager said that since improving the way records were now stored where before this information had not been previously analysed or available for reference.

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

The people and their relatives that responded through questionnaires told us the agency staff asked their views about the agency. The people we spoke with told us they were contacted by senior managers to gain their feedback about the service including suggestions on improvements.

Questionnaires were used to gain feedback from people about the agency and one person told us they had recently responded to a questionnaire. The staff received positive feedback through questionnaires about the delivery of personal care. One negative comment was received about the times of visits. Where negative comments were received the care manager responded to the person formally by letter. The care manager told us where possible "I will try to provide continuity of care. Some people ask for the rota of staff that will visit and this rota will be sent to them". The care manager also said that during initial visits staff explain to people that every effort will be made to organise visits at the preferred times. However, there were times when people had to wait until their preferred slots became available. People were made aware that before visits were considered late there was an acceptable half an hour either way of visit arrivals.

A registered manager was in post. The staff we spoke with said the care manager had the skills and

experience to lead effectively. The care manager told us "we want to do as much as we can to keep our own staff but we want them do their work. Not everyone [staff] starts at the same point but the aim is for staff to end up at the same point." The comments from staff included "Care manager is brilliant. She is always there if I have concerns I can talk to her," "The management is always asking me how I am getting on and if I have any problems," "The management are approachable and are swift at sorting out queries".

Staff received feedback from managers in a constructive and motivating way, which enabled them to know what action they needed to take. Staff told us there were regular meetings to share information about policy changes and to discuss work practices. A staff meeting took place in August 2017 where changes of practice and the responsibilities of their roles were discussed.

The staff said they were supported by the care manager and felt valued by the organisation. The staff told us how the values and beliefs of the agency were embedded into practice. Staff told us the agency stood for providing good care to people in their homes. A member of staff said the values included "providing high standards of care in the community. I am a good carer. I feel part of a big family everybody backs everybody and they are all approachable. People ask me when I am coming back that says to me I am a good carer. People are not harmed because there is nothing pushed under the mat." The care manager told us and we saw recorded the values of the agency were "quality care through experience, reliability and dedication."

The care manager said resources were available and staff received the support necessary to develop the team and drive improvement. The care manager said there was learning. For example, systems were monitored and where necessary changes were made to maintain improvements.

The care manager told us continuity of care was important for the agency sustainability. This was achieved by the recruitment and development of staff skills for people to receive care from competent staff. Other areas monitored to ensure sustainability included missed visits, minimising the risk to people with complex needs and medicine systems.

Community professionals that responded to questionnaires told us the agency was well managed and there were systems to continuously improve the quality of care and support provided to people. The care manager told us there were good working partnerships. For example, there was regular contact with the mental health team.

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 17 HSCA RA Regulations 2014 Good governance Records were not always up to date or complete. Medicines for topical creams were labelled as directed. Protocols were not always in place for medicines, prescribed to be taken or applied as required. Risk management plans were not in place for people that expressed their anxiety through behaviours difficult to manage. Repositioning charts were not monitored to ensure staff were following risk assessment action plans. Care plans lacked guidance to staff on how to deliver care to areas associated with the delivery of personal care.