

David Adeolu Adekola

Wurel House

Inspection report

135 London Road
Sittingbourne
Kent
ME10 1NR

Tel: 07879648163

Date of inspection visit:
18 August 2022
07 September 2022

Date of publication:
24 November 2022

Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Inspected but not rated

Is the service effective?

Inspected but not rated

Is the service well-led?

Inspected but not rated

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service

Wurel House is a small four bedroom supported living service providing personal care to people with a learning disability. The service also provides domiciliary care to older people living in their own houses and flats in the Swale area of Kent. At the time of our inspection there was one person living at the supported living service and 14 people receiving domiciliary care in the community. All 14 receiving a domiciliary care package received support with personal care. This is help with tasks related to personal hygiene and eating. We also considered any wider social care provided.

People's experience of using this service and what we found

This was a targeted inspection that considered medicines, risk management, infection control, staff training and recruitment, assessment of care needs and management oversight of the service.

Right Support

Staff did not support people with their medicines in a way that promoted their independence and achieved the best possible health outcome. People could not be sure their prescribed medicines were always managed in a safe way. Staff had not received medicines training and had not been competency checked.

Right Care

Individual risks were not always assessed and managed to keep people safe. Care plans and risk assessments were inconsistent and did not always detail the relevant information staff would need to meet people's assessed care and health needs. People could not be assured new staff were adequately checked to ensure they were suitable to work with people to keep them safe. We found no evidence that people had been harmed however, systems were either not robust enough to demonstrate staff recruitment was effectively managed.

Right Culture

Within Wurel House supported living service, people and those important to them, were involved in planning their care. Staff were able to communicate well with the person living at Wurel house supported living service, despite staff not receiving Makaton training to help them communicate. The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection.

The service was not able to demonstrate how they were meeting some of the underpinning principles of

Right support, right care, right culture.

Relatives expressed frustration and concerns in relation to the frequency, length and duration of community care visits. However, most relatives gave us positive feedback about their loved one's care and support from the care staff. They told us, "The carers have been wonderful, they are really caring and they do a good job"; "They are very good"; "They are very friendly" and "The girls are very helpful."

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

Rating at last inspection and update

The last rating for this service was inadequate (published 29 June 2022) and there were breaches of regulation. The provider was issued with Warning Notices for breaches of four regulations and requirement actions for breaches of five regulations. The provider completed an action plan after the last inspection to show what they would do to meet the requirement actions and by when to improve.

Why we inspected

We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified continued breaches in relation to medicines management, risk management, infection control, staff deployment, staff training and support, governance arrangements to monitor and improve the service at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

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

Special Measures

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Inspected but not rated

Is the service effective?

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Inspected but not rated

Is the service well-led?

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Inspected but not rated

Wurel House

Detailed findings

Background to this inspection

The inspection

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

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 9 (Person-centred care), Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team

The inspection was carried out by one inspector.

Service and service type

This service provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The provider of the service was also the manager of the service.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We gained feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us

they had not visited the service or received any comments or concerns since the last inspection. The local authority told us they had visited the service within the last month.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with one person who lived at the supported living service about their experience of the care provided. We also spoke with six relatives of people who received personal care from the service in their own homes. We spoke with six members of staff including the provider, care coordinator and support workers and senior support workers.

We observed staff interactions with one person at the supported living property and observed care and support in communal areas.

We reviewed a range of records. This included five people's care records and four medicines records. We looked at one staff file in relation to recruitment and nine other staff files in relation to staff supervision and training. A variety of records relating to the management of the service, including checks and audits.

Is the service safe?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

At the last inspection in March 2022, the provider had failed to protect people from risks related to fire and the environment. Risks related to people's physical health needs had not been assessed and care had not been planned to keep people safe. Accidents and incidents had not always been recorded and reviewed. This placed people at risk. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection, the provider was still in breach of Regulation 12.

- At the last inspection, risks relating to people's care and environment had not been well managed. There were no risk assessments in place in relation to people's care, support, physical health needs, safety, moving and handling, COVID-19, environment, oxygen use and catheters. Risks to people had not been identified and mitigated.
- At this inspection, some improvement had been made as risk assessments had been put in place, however they were not robust or consistent. Risk assessments contained unclear guidance for staff on how to meet people's needs safely. One person's care records evidenced that they could sometimes display anxiety and behaviour towards staff when their personal care needs were being met. This included biting, hitting and kicking which had been identified in an assessment. There was no guidance or risk assessment in place to detail safe ways of working with them to minimise anxiety and protect staff.
- Two people had been assessed as being at risk of developing pressure sores. The assessment did not detail what measures had been put in place to reduce the risk of pressure sores occurring. The provider told us that a member of the senior management team kept a record of actions taken to address risk. Staff did not have access to the relevant information relating to people because the information was not available to them in the care plan or risk assessment. This potentially put people at risk.

The provider had failed to protect people from risks. People's physical health needs had not been assessed and care had not been planned to keep people safe. This placed people at risk. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection, the provider had not assessed the risks of people falling out of windows, windows at the supported living premises did not have window restrictors. There were also fire safety concerns. At this inspection, window restrictors had been fitted and the risk to people falling had been mitigated. Fire safety concerns had been addressed which reduced the risk to the person living at the supported living premises and staff working there.
- At this inspection, one person's care records evidenced that they were cared for in bed. The bed had bed rails with bumpers. The records evidenced that the person had got their legs trapped between rails, despite the bumpers being in place. There was no evidence that the provider had reviewed whether the bumpers and bed rails were suitable for the person or that they had liaised with others such as relatives, healthcare professionals or bed suppliers to review their suitability and minimise the risk of entrapment. After the inspection, the provider told us they had reported the incident to the person's occupational therapist as this had happened twice.

Staffing and recruitment

At the last inspection in March 2022, the provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was no systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvements had been made at this inspection, the provider was still in breach of Regulation 18.

- At the last inspection, the deployment of staff in Wurel House domiciliary care was not adequate to ensure people's needs were met. The staffing rota did not have start times, call times and length of calls listed. At this inspection, although rotas were in place showing start times, call times and call length, people's daily records evidenced that they did not receive care and support as planned. Several relatives reported to us that their loved ones had experienced delays in receiving support to get up, washed, dressed, eat, drink and support with continence care. They detailed that their loved ones were supported to go to bed early because the bedtime call was between 18:00 and 19:00 and then sometimes they did not receive their morning call until as 10:00. This meant in some cases people were having 16 hours between care visits.
- At the last inspection, relatives reported to us that their loved ones had experienced delays in receiving support to get up, washed, dressed, eat, drink and support with continence care.
- At this inspection, we found the same. One person's daily care records for 30 July 2022 evidenced that their morning care visit was carried out in 10 minutes and this included supporting the person with a full body wash, drying, checking and changing continence pads and repositioning the person with a slide sheet. The person had been assessed as requiring 45 minutes for care in the morning. In addition, their lunch call was 6 minutes long, their tea call was 7 minutes and the last call was 8 minutes long. All of these calls were much shorter than the time that had been assessed as necessary to provide their care.
- Comments from relatives included, "This is the biggest bone of contention I have with them; it is never the same carers day to day or the same times. For example, on Saturday they arrived for the morning call at 08:45 and Sunday 07:38, the Sunday before it was 07:30. It impacts on me I have to be up and I never know when they will come. The latest call sometimes is 18:45 and sometimes as late as 20:45. 20:45 is better as it means [loved one] is only going 12 hours between care visits but sometimes it can be as long as 15 hours, it is a long time to be laying in a wet pad" and "There are still issues with the time, the main issue is the bed time call it is too early and it means I need to change [loved one] in between the bed call and morning call, I can't do this on my own."

- A staff member told us, "It is impossible with the real rotas to fit in all the care calls. Staff would not be finished until 02:00. It would be physically impossible to do full length care visits. There are 17 hours of care visits which they fit in to a 12 hour shift."

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was no systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a continued breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

- The service had enough staff at Wurel House supported living service, including for one-to-one support for the person who lived there.

- At the last inspection, staff were not always recruited safely because the provider did not have a robust recruitment system. This meant employment histories, DBS checks and employment references were either not completed or held unclear information. At this inspection, staff had not always been recruited safely. There were missing recruitment records for some staff. One new member of staff's file was missing their employment history. The previous employment in their application form was blank and stated to review the staff member's CV. There was no CV. The provider had not explored each staff members' full employment history. The provider could not be assured that all staff were suitable for their roles.

A robust approach to recruitment was not taken to ensure only suitable staff were employed to provide care. This was a continued breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection in March 2022, the provider had failed to manage medicines safely which put people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection, the provider was still in breach of Regulation 12.

- At the last inspection, people were not supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely. The provider did not have effective systems in place to manage medicines effectively, this put people at risk of harm. Prior to this inspection we received concerns regarding medicines for one person running out and the person becoming constipated as a result. At this inspection, medicines administration records (MAR) for one person showed gaps and inconsistencies for July 2022 and August 2022. MAR charts were confusing to staff because the chart did not start on the first day of the month, this had led to errors.

- At this inspection medicines had not been given as prescribed. One person was prescribed a medicine which needed to be administered 20 minutes before meals. We observed staff administer the medicines 13 minutes after the person had eaten their meal. We checked with the staff member and they confirmed that the person always had their meals first and then their medicines afterwards. We checked the person's daily records between 10 July 2022 and 17 August 2022 and found that they had consistently had breakfast, lunch and dinner before their medicine. This put them at risk of harm.

- At this inspection, one person's medicines had been dispensed from the pharmacy in their original

packaging and boxes. However, staff at Wurel House, had taken the medicines from the original packaging and filled a compliance aid with the medicines. We checked the compliance aid on 17 August and found errors. At the previous inspection in March 2022 we found the same issue, which had caused a staff member to miss giving doses of antibiotic medicines that had been prescribed. This put service the person at risk of not receiving medicines as prescribed.

- At this inspection, people prescribed 'as and when required' (PRN) medicines did not always have the appropriate protocols in place to support staff to know how or when to administer these medicines. We were not assured these medicines would be given appropriately or staff would know when to escalate concerns. After the inspection the provider created some PRN protocols for people.
- People's daily records evidenced staff had been applying creams, topical MAR charts were in place to evidence what creams had been applied and where the creams had been applied. However, the prescriber's guidance of how often to apply had not been included to ensure staff were administering medicines safely. This meant the provider could not be assured that people had been applied their prescribed creams according to the prescriber's directions.

The failure to manage medicines safely demonstrates a continued breach of Regulation 12 (Safe Care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At the last inspection in March 2022, we were not assured that the provider used effective infection, prevention and control measures to keep people safe. Staff had not completed food hygiene training and had not followed correct procedures for preparing and storing food. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection, the provider was still in breach of Regulation 12.

- At this inspection, we were not assured that the provider was using PPE (personal protective equipment) effectively and safely. We observed staff not wearing masks on the first day of our inspection. Staff working in the community reported that they are not always wearing masks when working in people's homes. They also confirmed they were not wearing aprons when providing personal care. This put people at risk of harm and increased the risks of healthcare related infections. A relative said, "They have asked me if they need to wear masks and I am happy for them not to if they are vaccinated." However, this was not in line with government guidance about Coronavirus.
- At the last inspection, staff had not completed food hygiene training and had not followed correct procedures for preparing and storing food. This was a potential risk to people. At this inspection, this had not changed. Training records evidenced staff had not completed this training despite supporting people to prepare and cook foods.

This demonstrates a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At this inspection, we were assured that the provider was accessing testing for staff. The provider had followed government guidance on testing in health and social care settings.
- At this inspection, the service used effective infection, prevention and control measures to keep the supported living premises clean and the person living at the premises safe. The service had arrangements to keep the supported living premises clean and hygienic. Cleaning schedules that had been implemented

after the last inspection had been completed intermittently.

Is the service effective?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Staff support: induction, training, skills and experience

At the last inspection in March 2022, the provider had failed to ensure staff had the appropriate training to ensure people's needs were met. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection, the provider was still in breach of Regulation 18.

- At the last inspection, people were supported by staff who had not received relevant and good quality training in evidence-based practice. At this inspection, records showed that some staff had received some training. However, only two staff had completed learning disability and autism training. The staffing rota showed that four staff regularly worked with a person who had a learning disability. From 1 July 2022, all health and social care providers registered with CQC must ensure that their staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. This new legal requirement was introduced by the Health and Care Act 2022.
- At the last inspection, staff had not received training to meet people's assessed needs. At this inspection, we found the same. The provider had not ensured that staff had received training to safely meet people's assessed needs. Staff had been administering medicines to people without training and without being assessed as competent to do so. Training records evidenced that no staff had received any medicines administration training. This put people at risk of harm.
- At the last inspection, one person's risk assessment showed that they communicated using some Makaton sign language and had difficulty expressing themselves. The risk assessment showed that all staff should receive basic Makaton training. Staff had not received Makaton training to help them communicate more effectively. At this inspection, no staff had completed Makaton training. The provider had developed some flash cards with Makaton signs to help staff communicate. We did not observe any negative impact of this on the person because staff were communicating in other ways.
- At the last inspection, some staff employed to work in the community had not received any induction and had not shadowed experienced care staff to develop their skills and knowledge of the service and the people they supported. At this inspection, one new member of staff employed since the last inspection had

not received any induction and had not done any training prior to participating in care visits with people. The staff file evidenced that they started in April 2022 and some training had been completed from the end of May 2022.

The failure to ensure staff had the appropriate training to ensure people's needs were met is a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Feedback from staff was mixed, some staff told us that they had received training, supervision and support. Comments included, "Since being at Wurel House I've done CPR training if you can call it that, it was at the office and lasted about 20 minutes, [trainer] went through the do's and don'ts and we used the resus doll"; "I did medicines training a few years ago in a previous job, I have not done it at Wurel House. I have done a first aid practical, done fire safety training and I have done my care certificate" and "I have had three supervisions with [provider]."
- Relatives told us, "Staff are very good, I can't fault them, they are very professional"; "She's always happy to see them and they all chat and laugh. If something was wrong [loved one] would tell me"; "They are what I would call Rolls Royce carers. They are pretty good. I can't fault the carers I have here"; "Staff are very competent" and "They listen, they respond very well, they are always smiling and chatting."

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

At the last inspection in March 2022, the provider had failed to provide care and treatment to meet people's assessed needs, this was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Enough improvements had been made at this inspection, the provider was no longer in breach of Regulation 9 in relation to assessing people's needs. However, there was an area for improvement.

- At the last inspection, people's needs were not always assessed. Prior to people receiving a service from Wurel house domiciliary care their needs were not thoroughly assessed. At this inspection, assessments of people's needs had improved. Assessments had taken place and care plans and some risk assessments had been created as a result of this. However, it was not always clear that people had been fully involved with the assessment process, none of the assessment documentation had been signed. This is an area for improvement.
- At the last inspection, information about people had not been assessed or recorded. For example, information about allergies and whether they had a DNACPR order (do not attempt resuscitation) in place. This meant that staff did not have all the information they needed to provide safe care and support. At this inspection, information about people's DNACPR status had been recorded.
- At the last inspection, the assessments and re assessments of people's needs had not led to goals and action plans being set to support people with learning disabilities to develop and improve their skills and maintain certain levels of independence, this meant there were no clear pathways to future goals and aspirations, including skills teaching in people's support plans. At this inspection, improvements to support plans and goal setting had taken place, actions to meet goals were in progress.

Is the service well-led?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection in March 2022, the provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served the provider warning notices and told them to meet Regulation 17 by 30 June 2022. We went back to the service to check that the warning notices had been met. Not enough improvements had been made at this inspection, the provider was still in breach of Regulation 17, which meant some risks to people remained unmitigated.

- At the last inspection, governance processes were not effective and did not help to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service.
- At this inspection, although the provider had introduced audits to monitor the service, these were not robust. Audits were not detailed or sufficient to alert the provider to concerns and issues within the service. Audits and checks completed in May, June and July 2022 had not picked up on some of the issues identified in this inspection. For example, the medicines audits had not identified the issues with medicines. Audits of care plans had not picked up that a risk assessment and care plan regarding anxiety and distress which led to some aggression towards staff was not in place.
- At the last inspection, records were not returned to the office frequently enough to enable the management team to monitor and check care and support had been delivered to meet people's assessed needs. No audits of care records had been completed. At this inspection, although records were returned to the office frequently to enable the management team to monitor and check that care and support had been delivered to meet people's assessed needs, there was no evidence to show these checks had been carried out. As a result, people had been receiving short and hurried care visits at inconsistent times. Action had not been taken to identify and resolve this.

- At the last inspection, records in the service were poor. At this inspection, records in the service were of poor quality, were inconsistent and did not include a complete and accurate and contemporaneous record of care provided. The staff list the provider gave CQC was not complete, six staff names were missing. Some daily records for the domiciliary care files we viewed lacked detail about how long the visit was for and end times of care visits were missing. One person had a catheter in situ and staff had not adequately recorded their urine output.

- At this inspection, the provider had failed to give us information when asked about care packages and then provided inaccurate information about care packages. The provider had been asked for the full list of people receiving care. The provider gave CQC an incomplete list, people living in the Medway area were missing. The provider told us, that staff had left giving little notice and they had urgently handed back the care packages due to the local authority because they were unable to staff the care visits. We checked the information with the funding authority and found that this was inaccurate. The funding authority confirmed with CQC that the provider had not handed the packages back and confirmed that Wurel House were still providing care. The provider had not communicated with people and relatives about this. Relatives told us that the staff working in Medway were on holiday and were returning to work on 05 September 2022. We received information from a staff member who told us that the staff members returned to work as planned on 05 September 2022.

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had failed to ensure records were accurate, complete and contemporaneous. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection, the provider's understanding of current regulations, good practice had improved, the provider had been following the gov.uk guidance in relation to COVID-19 testing for staff and had been completing the capacity tracker. The provider has also sought support and guidance from Skills for Care. Skills for Care supports adult social care employers to deliver what service users they support need and what commissioners and regulators expect.

- Since the last inspection, the provider had notified CQC of important events such as deaths that had occurred.

- Since the last inspection, the building works at the office at Wurel House had been completed and staff had access to people's care records.

- Despite the evidence found, relatives told us, "I have not got any complaints. I would 100% recommend them"; "If I needed to complain I would complain to the manager, the number is in the folder. Our first care package was with a different care company. Now we have Wurel House I can see the difference. Wurel House is far more professional" and "[Provider] visited us at the beginning and gave us his card, I am quite confident with them."

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate a robust approach to recruitment to make sure only suitable staff were employed to provide care. Regulation 19 (1)(2)(3)