Bramley Home Care Limited

Bramley Homecare Ltd

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 25 and 26 June and was announced.

Bramley Homecare Ltd provides domiciliary support services and 24 hour care to people in their own homes. The agency provides care and support to older people and people diagnosed with dementia. At the time of our inspection there were 63 people receiving personal care from the service. There was a central office based just outside Shaftesbury.

Not everyone using Bramley Homecare Ltd received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager 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.

People did not consistently receive safe care because staff were not all aware about the risks people faced or how to manage these. Staff had good relationships with people, but care plans did not identify people's risks or provide staff with clear guidance about how to manage these.

People's capacity to consent to decisions about their care and treatment had not been assessed, or decisions made in peoples best interests in line with the Mental Capacity Act 2005.

Quality Assurance measures were in place but consideration was needed to ensure that the frequency and content of these provided sufficient oversight of the service people received and could effectively identify issues and drive improvements.

Care Plans were not person centred and lacked detail about people's histories, what was important to them and how their conditions and risks affected them. Staff who completed initial assessments, care plans and reviews had not received training in areas relevant for this role and this was being arranged following the inspection.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns.

People were supported by enough staff to provide effective, person centred support. Staff were recruited safely with appropriate pre-employment checks and received training and support to ensure that they had the necessary skills and knowledge to meet people's needs.

People received their medicines as prescribed and staff worked with healthcare professionals to ensure that people received joined up, consistent care.

People were supported from the spread of infection by staff who understood their role in infection control and used appropriate Personal Protective Equipment (PPE).

People were supported to have enough to eat and drink. People's preferences for meals were well known and staff offered people choices about what they ate and drank.

People received personalised end of life care from staff who understood their wishes and preferences and ensured that these were respected.

People and those important to them were involved in planning the support they would receive and were asked for their views about the support and any changes to people's needs. Reviews identified where people's needs had changed and reflected changes to the support provided in response to this.

People were supported by staff who respected their individuality and protected their privacy. Staff had undertaken training in equality and diversity and understood how to use this learning in practice.

Interactions with people were kind and caring and we observed that people chatted with staff and were comfortable with them in their homes.

People were supported to access healthcare professionals when required and the service worked with external agencies where needed.

Staff were confident in their roles and felt supported by the office team. Feedback indicated that the office were approachable, listened and took actions where necessary.

During our inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Care Plans did not reflect individual risks people faced or provide staff with clear guidance about how to manage these.

People were protected from the risks of abuse by staff who understood the potential signs and how to report concerns.

People were supported by enough, safely recruited staff to meet their care and treatment needs.

People were protected from the spread of infection by staff who understood the principles of infection control.

People received their medicines as prescribed and these were recorded accurately.

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Capacity and best interests decisions had not been made or recorded in line with the Mental Capacity Act 2005.

Staff received training and supervision to give them the skills they needed to carry out their roles.

People had access to health care services when required.

People were supported to receive enough to eat and drink.

People's needs and choices were assessed and effective systems were in place to deliver good care and treatment.

Is the service caring?

Good

The service was caring.

People were supported by staff who were compassionate and kind.

Staff knew how people liked to be supported and offered them appropriate choices.

People were supported by staff that respected and promoted their independence, privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were listened to and felt involved in making decisions about their care. Where changes were required, these were acted on and reflected in care plans.

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to

People were supported to receive person centred end of life care which respected their wishes and preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems were in place but did not provide consistent oversight of the service delivery.

Care Plans were not person centred and lacked detail about people's histories, what was important to them and how their conditions and risks affected them.

People, relatives and staff spoke positively about the management of the service and told us that they were able to speak with the office when they needed to.

Feedback was regularly sought and used to make changes to improve the support people received.

Bramley Homecare Ltd

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.

The inspection took place on 25 and 26 June and was announced. The provider was given 48 hours' notice. This was so that we could be sure the registered manager was available when we visited and that consent could be sought from people to receive home visits from the inspector.

The inspection was carried out by two inspectors on day one and one inspector and an assistant inspector on day two. Phone calls to people were completed by 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. They had experience in dementia care and care at home services. We visited the office location on the first and second day to see the registered manager and to review care records and policies and procedures. We also visited people in their own homes on the first day.

Before the inspection we reviewed all the information we held about the service. This included notifications the service had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
We visited eight people in their own homes and discussed the delivery of care. We had telephone conversations with 11 people and two relatives.

We met with the registered manager who was also the nominated individual, and the office manager. A Nominated Individual has the responsibility for supervising the way that regulated activities are managed within an organisation. We spoke with nine members of staff.

We reviewed 10 people's care files, policies, risk assessments, complaints, quality audits and the 2018 quality survey results. We looked at three staff files, the recruitment process, staff meeting notes, training, supervision and appraisal records.

We asked the registered manager to send us information after the visit. This included an updated care plan, risk assessment and service action plan. The registered manager agreed to submit this by Thursday 28 June 2018 and did so via email.

Requires Improvement

Is the service safe?

Our findings

People did not consistently receive safe care because risks people faced were not consistently understood by staff and care plans did not provide guidance for staff about how to safely manage risks. One person had a severe allergy and told us that they would require staff to provide immediate treatment and call emergency services if they had an allergic reaction. The person's care plan indicated that the person had a prescribed treatment for the allergy but did not indicate what the allergy was and gave no details for staff about managing this risk and what they needed to do to support this person if they had an allergic reaction. The management team explained that the person received only limited support and therefore the probability of staff needing to administer the treatment was low. A staff member who regularly supported this person told us that they had not received any guidance about how to administer the emergency treatment. The registered manager told us that the person was able to self-administer this treatment but this was not correct. The person explained that they would require staff to administer this immediately and contact emergency services. This meant that the person would be at high risk if they had an allergic reaction while staff were present. The registered manager amended the care plan for the person to reflect this risk and provided pictorial guidance about how staff should administer the epi pen if this was needed.

One person had been diagnosed as diabetic. This was mentioned as a medical condition, but was not included in the eating/drinking section of their care plan. The care plan did not provide staff with information about the signs of high or low blood sugar levels associated with diabetes or what actions to take if the person was not presenting as they normally would. Staff received training in diabetes and the management team advised that staff knew how to recognise the signs and symptoms and provide appropriate support for people, however existing risk assessments did not include this.

Another person required a thickener in their fluids to drink safely. This was not reflected in the dietary requirements of the persons care plan and two of three staff we spoke to were not aware of the need for thickener, where it was kept or how much was required. One staff member confirmed that new staff would "probably not" know about the person's thickener or where it was. The service explained that the person was able to instruct staff about how to use the thickener and that staff rarely needed to assist with this. The registered manager told us that they would review risk assessments to ensure risks to people were safely managed.

Two people were at risk of choking. Staff were not consistently confident about how to respond if a person choked with comments including "I'll be honest, I'd panic as I wouldn't know what to do" and "probably sit (name) up and try to get it out, if I couldn't I would ring 999". The registered manager told us that the choking risk for one person was managed through the provision of pureed food. Although this would have assisted to minimise the risk to the person, this did not demonstrate a safe, person centred risk assessment to effectively manage this identified risk.

The management advised that despite staff comments, they should know what to do in the even that someone chokes and explained that staff received training in basic emergency aid

People's risk had been assessed as high, medium or low. We asked which tools had been used to determine this assessment. The registered manager informed us that this was a judgement they made as they did not use assessment tools. Risk assessments lacked detail and did not tell staff how to manage risks or how to care for people. For example, one person had been identified as a high risk of falls however had no information to tell staff what they needed to do to mitigate the risk. Staff who regularly visited people understood individual risks, but again, care plans did not provide any actions for staff to take and if a new staff member had visited a person, there was not sufficient detail to explain how to safely manage the risks people faced.
The registered manager told us that they would improve risk assessments to reflect people's individual risks and provide clear guidance for staff. This was included on an action plan the registered manager sent to us following the inspection and was planned to be completed by the end of July 2018.

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

People and relatives felt safe with the support they received from Bramley Homecare Ltd. Comments included "I feel very safe with them", "(name) is totally safe with them (staff)" and "they are such lovely people, why wouldn't I feel safe". People were visited by regular staff and staff generally had enough time planned in their rotas to arrive at people's houses on time. No-one reported any missed visits and the co-ordinator explained that people were advised that staff could arrive within 15 minutes of the planned visit time and reminded about the office contact numbers to ring if a staff member didn't arrive for any reason.

People were protected from the risks of abuse by staff who understood the potential signs to be aware of and how to report these. One staff member explained that they would report any concerns to a team leader and would look for changes in people's behaviours. They gave examples of a person flinching, being aggressive or quiet when this was not normal behaviour for them. Another member of staff explained that they would look for signs of emotional or financial abuse if people lived alone. Safeguarding concerns had been raised when the service had been concerned about people living on their own.

Recruitment procedures were in place to keep people safe. Records showed staff had completed application forms, which included an employment history. When a person has gaps in employment it is important to know the reasons why, to keep people safe. We identified some small gaps in employment in older recruitment records which we brought to the attention of the registered manager. Staff files included identification checks, application forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. Checking gaps in employment had been identified as an area for improvement at an internal monitoring visit in February 2018 and the registered manager confirmed that these were now in place for new staff recruited to the service.

Bramley Homecare Ltd had contingency plans to provide safe care in the event of an emergency. For example, extreme weather conditions. A traffic light system was in place to manage the risks to people. If a person was red they were at high risk if staff were unable to provide support and therefore were high priority for a visit. If a person was green, they were a lower risk with either support from their families or low level needs. A major incident plan was in place.

People were protected from the risks of infection because staff followed infection control procedures. Staff had access to appropriate Personal Protective Equipment (PPE) and told us how they used this to prevent the spread of infection. We observed staff using this with people in their homes and people told us that staff always wore gloves and aprons when supporting them with personal care.

People received their medicines as prescribed and they were recorded on Medicine Administration Records(MAR) in people's homes. Where people required support to apply creams, these were also recorded on MAR. Staff received training in the safe handling of medication. One person explained that they trusted the staff members who supported them with their medicines and a relative explained that staff assisted their loved one to apply creams. We saw a member of staff assisting a person to take their medicines and explaining what the medicine was for.

Staff understood their responsibilities to raise concerns or report incidents and these were used to learn and drive improvements. A staff member told us how they would record and report if someone had a fall. Accidents and incidents were monitored regularly and any actions taken were recorded. For example, one person had been unable to open the door to staff. The person had not been injured but staff had used this incident to drive improvements. They had discussed options with the person to prevent the situation from happening again and had included use of a personal alarm or a key safe to enable safe access.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People did not have their capacity assessed in line with the Mental Capacity Act (2005). The registered manager told us that no-one currently receiving a service had a current capacity assessment. We found that some people required their capacity to be considered with regard to specific decisions. For example, one person was unable to communicate their needs or wishes. There were no assessments in place to consider their capacity with regard to the support they received. Another person had bed rails in place on their bed. Their care plan identified a risk with regard to the use of bed rails but the person's capacity to consent to the use of these had not been considered. The registered manager told us that they were not completing capacity or best interests decisions in line with the MCA. Following the inspection they sent us an action plan which included plans to start MCA assessments and provide MCA training for team leaders. This was planned to be completed by the end of August 2018.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved in initial assessments about their care and treatment, but these did not reflect all areas of the person's support. For example, support with religious or cultural needs were not consistently recorded. The service advised that people do not usually like to discuss this aspect of their lives when they are first being discussed. They explained that they had changed the visit times for one person at the request of their family member, to enable them to access their local church.

Where people had long term health conditions, care plans did not indicate how they affected the person or what support they might require. This was important because the initial assessments formed the basis for people's care plans and gaps in information could impact on the completeness of information about people's ongoing care and treatment needs. Following the inspection, the registered manager sent us an action plan which identified that pre-assessments would include details about people's religious and spiritual needs and information about their life histories. This was planned to be completed by the end of June 2018.

Staff received relevant training for their role. Some training was considered to be essential and topics included moving and assisting, first aid and safeguarding. Staff told us they had discussed training ideas in their previous staff meeting and felt they had good training opportunities. Other topics which had been completed or were being offered included bereavement, spirituality and Parkinsons training. People felt that staff had the correct training and skills to support them. Comments included "They are trained well, no complaints here" and "they are 100% highly skilled".

Staff received an induction which included an introduction to the service with mandatory training including but not limited to: Manual handling, Fire safety, Infection control and Safeguarding. New staff shadowed more experienced staff members and told us that they had been in to the office to discuss how they felt their shadowing had been before lone working with people.

Staff received support through regular supervisions and an annual appraisal. Staff told us they found this support effective to discuss their current performance, concerns and objectives for the future. One staff member told us how they had requested to complete a national qualification and this had now been arranged.

People had grab sheets in place to ensure that essential information was effectively communicated if a person moved to another service or needed to go into hospital. Details included any allergies and medical history and contact details for those important to people and their GP.

Technology and equipment was available that increased people's independence and safety. Examples included pendant alarms which people could use to call for assistance in an emergency, and key safe's which staff were able to use to keep people's homes secure.

People were supported to eat and drink a balanced diet and had choices about their meals. We observed a staff member offering a person a choice about what they wanted to eat and comments from people and relatives included "I can have what I want, they (staff) make me drinks as well", "(name) chooses themselves what they would like". Another person explained that meal preparation was "a joint effort really" because they liked to do as much as they could for themselves which staff supported.

People were supported to receive prompt access to healthcare services when required. People's records showed contact with GP's and district nurses was made promptly by staff. A member of staff told us "If I need anything including district nurses or GP I call the manager and they arrange straight away".

Good

Is the service caring?

Our findings

People consistently told us that staff were kind and compassionate. Comments included "they are very kind and caring….I don't know what I would have done without Bramley", "they are marvellous people (staff) – they are more like my friends than carers" and "we always have a laugh". One person told us about a specific member of staff and explained "(name) come in with a smile on their face and gets on with the job…..goes out of their way to care". Staff spoke with us about people in a caring and compassionate way and we observed that people were comfortable with staff in their homes.

People's cultural and spiritual needs were respected. For example, one person had requested visits at a different time so that they could attend their local church. This was respected and visits planned at the times requested.

People were actively involved in making choices about all aspects of their care and treatment. Staff understood how to offer people choices about their support. One staff member explained that they always "ask what (persons name) would like me to do and how they want things done". We observed a member of staff offering a person a choice of whether they left their front door closed or locked at the end of a visit. The person expressed their wish which was followed.

Staff were respectful of people's homes and privacy. We observed that staff entered people's homes in the way they wished and people's preferences around this were known by staff. People told us that staff were respectful and comments included "It's a two way thing. I always have a towel round me to they don't see anything because that's fair to them" and "I will say (to staff) It's ok now….they will go and I have privacy". Another explained "I respect them (staff) and their job and they are very respectful to me".

People's confidential information was stored securely. Staff understood their responsibilities to protect identifying information when they spoke with us and information shared with staff electronically was anonymised to protect people's identities. People's care plans and other records were electronically stored on secure systems with password protection.

Good

Is the service responsive?

Our findings

People and those important to them were involved in reviews and discussions about their care and support. Reviews were held every three months either by visiting people or telephoning them. People were asked about their support and any changes they wished to make and feedback indicated that changes were made when these had been requested. For example, one person explained that they had felt that their visits were not long enough and had requested they be extended. They told us that this was sorted out very quickly following the review. Another person explained "There was one person (staff member) I couldn't gel with so I told the team leader and (name) was taken off straight away".

People and staff were treated equally and as individuals. The registered manager told us how they had supported people with protected characteristics under the Equality Act and gave examples of supporting from the Lesbian, Gay, Black or Transgender community. Bramley Homecare Ltd staff all received training in equality and diversity and the registered manager explained how they worked with staff and people to ensure that there was no prejudice and people and staff received individualised support and were protected from discrimination.

The service met the Accessible Information Standard for people. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Communication needs were understood by staff but needed to be better reflected in people's care plans. For example, one person's care plan stated that they had 'hardly any sight' but did not give details about support needed from staff. We observed that staff understood how to support the person including reading their weekly visit rota to them and letting them know if they had any letters which they then asked their family to read. For another person with hearing loss, staff had developed pictorial sheets to assist the person to communicate and reported that this was working well and reducing the person's frustration around how to communicate.

Communication between staff and the office was effective which meant staff were able to be responsive to people's changing needs. Updates were texted to staff daily to ensure that they had up to date information about people. Staff told us that this was helpful and ensured that they could be pro-active about any changes in people's needs.

Complaints were recorded and responded to in a timely manner and within the timescales set by the service. Records included who had raised a concern, how this had been addressed and responded to and any actions from this. For example, one person had requested a change to the times of their call to enable them to meet their religious needs. This was responded to and we saw that the persons planned visits were at the changed times they had requested.

Bramley Homecare Ltd provided end of life care for people when this was required and ensured that people's preferences and wishes were understood and respected. Staff had been trained in a national framework for end of life care and advance care planning was discussed regularly in meetings and supervisions. Where people had medical decisions in place, these were recorded and staff took time to

speak with people and their loved ones about what would be important to them towards the end of their lives. A staff member explained "they train us on stuff I hadn't thought of like syringe driver (system for administering pain relief) which was helpful to understand and interesting". They went on to explain how they had discussed end of life wishes with a person following training which had prompted the person and their family to have a wider discussion about their wishes and preferences.

Compliments were recorded and reflected the positive impact Bramley Homecare Ltd had on people and their families, some of whom had received end of life care from the service. Comments included "The care and compassion you provided was outstanding and you made what was a fairly difficult time for me and (name) so much easier….at all times (name) was treated with respect and more importantly as a friend by them all (staff)" and "I am thankful your team were so helpful and accommodating……(staff name) went the extra mile in supporting us too, guiding us with important decisions. Without this support I fear things would have been untenable at home".

Requires Improvement

Is the service well-led?

Our findings

The oversight arrangements for the location were not robust enough to ensure all the regulatory standards were being met. The registered manager had recognised and understood that improvements were required and had started to make changes to drive these improvements.

The register manager explained that there were some imminent planned changes to the management structure at Bramley Homecare Ltd. The existing registered manager was moving to another service owned by the same provider and the office manager had submitted an application to CQC to become the registered manager of Bramley Homecare Ltd. The new manager planned to recruit an assistant manager and had identified some responsibilities with regard to audits and oversight of areas of the service.

Quality assurance systems were in place but did not provide consistent oversight of the service. The office manager carried out four audits of people's care plans and Medicines Administration Records (MAR) each month. During 2018, 11 people's records had been audited. Although the audits had picked up and driven changes where needed, this meant that the majority of records had not been audited this year. Where audits had taken place, there was no detail recorded to indicate what details had been checked to ensure consistency and efficiency of the audits. The registered manager and office manager told us that they would consider how frequently MAR needed to be checked to ensure safe administration and planned to alter the frequency of audits accordingly. Where MAR had been checked, we saw that recording errors or improvements had been noted, followed up with staff and used to improve practice.

The registered manager explained that there were plans to recruit an assistant manager and this would increase capacity to audit information more frequently. They were considering how often this information needed to be monitored to provide full oversight of the care delivered to people and drive changes and improvements. The registered manager sent us an action plan following the inspection which identified that they were reviewing the dependency of people and would use this this to build a timescale of audits to ensure full oversight. This was planned to be completed by the middle of July 2018.

The registered manager had started in post in October 2017 and had identified that care plans required improvements. They explained that they had reviewed and improved care plans for most people and had approximately 20 care plans outstanding at the time of inspection.

The newer care plans were not person centred and lacked detail about people's histories, what was important to them and how their conditions and risks affected them. Staff often knew most of these details through time spent with people. However, improvements were needed to care plans to ensure that they were holistic and provided all relevant information about how to effectively support people in ways they wished. For example, we looked at one person's care plan and then visited them at home. Their care plan provided very little detail about how their diagnosed condition affected them, their religious beliefs or what support they needed to manage risk. The person spoke with us and provided lots of details about these areas which gave us a clear picture of the person and what was important to them. The registered manager told us that they would ensure that care plans were changed to be person centred and reflect individual

needs, likes, dislikes and preferences.

Staff who undertook initial assessments, wrote care plans and completed reviews had not had relevant training for this. For example, staff spent time with the office manager before carrying out assessments and reviews, but had not received training in care planning. An internal monitoring report dated 26 March 2018 stated 'Further and ongoing training for the Administrator regarding care plan writing is still required as it is quite noticeable that there is a lack of experience in this area'. Following the inspection the registered manager identified that Bramley Homecare Ltd would source training in care planning and person centred care for the relevant staff.

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

People and staff fed back through surveys and reviews. The 2018 surveys had been responded to by 40 people and 16 staff. Responses were overwhelmingly positive with people answering questions with 'excellent' or 'good'. Examples included 'were carers friendly and polite?' and 'do you receive helpful, friendly and professional customer service from the office?'. The survey was followed up with a letter to people to provide a summary of the feedback received.

The staff survey did not provide any areas for general feedback or comments and we saw that half the responses were not positive about questions related to the performance of Bramley Homecare Ltd. Other responses were positive about areas including 'my role' and 'my manager'. We discussed the survey with the registered manager. They told us that they would consider what information they wished to gather from staff and alter the survey to ensure that feedback provided information which could be used to identify gaps and trends and drive improvements.

Feedback was positive about the office at Bramley Homecare Ltd with comments including "The office are very good and deal with things straightaway", "as far as I'm aware I think it's well managed. Things get quickly resolved" and "Service is well managed. They are fantastic". Staff and people told us that they were able to get hold of someone out of office hours when needed and that office staff were helpful and friendly.

Staff had clear roles and responsibilities and this provided a clear management pathway. For example, team leaders supported small groups of staff and were the first contact point. They held regular meetings with staff to discuss people and any updates or changes. Team leaders then met regularly with management to discuss and share information.

The registered manager received support from the provider who visited regularly and also attended managers meetings where practice and improvements were discussed. Bramley Homecare Ltd had regular internal inspections completed by the registered manager. These were planned six monthly and used to identify areas of good practice and areas for further focus. We saw that the internal inspection in February 2018 had identified that further improvements were required in care planning, risk assessments and audits. For example, the internal audit had identified that no audits had previously been in place. A follow up internal inspection had taken place on 26 March 2018 which identified that audits were now in place for care plans and MAR. However, consideration had not been given to whether audits were sufficient to provide a robust overview of the service delivery.

Staff meetings took place regularly and were used to discuss areas of practice. We reviewed the last meeting notes which identified that confidentiality, dignity training, out of hours communication and accurate medicines recording were discussed.

The service worked positively in partnership with other organisations to provide positive outcomes for people. We saw that the service had worked closely with an Occupational Therapist to ensure that a person had the correct sling to be moved safely and comfortably. The service had also referred people to Dorset Fire and Rescue for checks of their homes. For one person who smoked, this partnership working had meant that advice and equipment was put into place which reduced the potential risks of smoking in their home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent to decisions about their care and treatment had not been assessed, or decisions made in peoples best interests in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not consistently receive safe care because staff were not all aware about the risks people faced or how to manage these. Care plans did not identify people's risks or provide staff with clear guidance about how to manage these.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality Assurance measures did not provide sufficient oversight of the service delivery. Existing systems did not effectively identify issues or drive improvements.