Carewatch Care Services Limited

Carewatch (Bentley Grange)

Inspection report

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11 December 2017
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20 December 2017
27 December 2017
05 January 2018
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Carewatch (Bentley Grange) on the 11, 15, 20 and 27 December 2017 and on the 5 and 8 January 2018. This was an unannounced inspection, which meant they did not know we were coming on the 11 December 2017. The further days were arranged so as to meet people who received care and support from Carewatch services at both locations.

Carewatch (Bentley Grange) is a domiciliary care agency. This service provides care and support to people living in extra care housing in a purpose built block of flats so that they can live in their own home 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.

Carewatch (Bentley Grange) is situated in Hailsham, East Sussex and has a satellite location, Cranbrook, which is situated in Eastbourne East Sussex. They provide personal care for people living in extra care housing in a purpose built block of flats. Extra care housing is designed for people who need some help to look after themselves, but not at the level provided by a residential care home. People living in extra care housing have their own accommodation and have care staff that are available when needed. The people supported by the service had a wide range of needs including dementia, care needs related to age and people who live with a learning disability.

The service had a registered manager. 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 registered manager had responsibility for both Bentley Grange and Cranbrook.

This was the first inspection for Carewatch (Bentley Grange) since registering under the new provider in August 2017'. Cranbrook was found to be running as an unregistered service in August 2017, it was subsequently attached as a location to the registration of Bentley Grange in December 2017 to ensure it was legally registered.

There was a lack of leadership and oversight of the service. The registered manager of Bentley Grange had taken full responsibility for managing both locations and had not been supported by the provider to do so. At the beginning of the inspection it was clear that the two locations were running separately and that communication between the two was not clear or transparent. There was a registered manager based at Bentley Grange location and a manager based at Cranbrook. The manager at Cranbrook had applied to be registered with CQC.

The registered manager did not have oversight and information of the people who received care and support at Cranbrook.

Communication between the two locations improved considerably during the inspection. However, as discovered during this inspection process the acting manager of Cranbrook left the organisation in January 2018.

Cranbrook
Audits had been undertaken in September 2017 by senior managers of Carewatch where considerable shortfalls had been found in care documentation, care delivery and in management of medicines. Support had been given by the local authority and senior management of Carewatch. However the necessary improvements had not been taken forward and actioned in a timely manner.

People's safety was put at risk, because risk assessments and risk management practices at the service were not consistent. Although the acting manager had considered some risks to people's safety they did not ensure all risks had been properly assessed. The management of medicines were not always safe. Storage of medicines in peoples' flats for those that lived with dementia were not always locked, placing people at risk of taking medicine without the required supervision. The provider had not made sure that people who required PRN medicines had their needs assessed. PRN guidance had not been completed. PRN guidance is needed to enable staff to understand when someone may need their PRN medicines. There were not enough staff to manage people's care calls properly, particularly when people needed the support of two staff. There had been a number of missed and late calls which meant that people did not get the call they wanted at the time they preferred. Recruitment processes needed to be improved to ensure that staff were suitable to be working with vulnerable people.

Not all staff had received the necessary training and supervision that ensured they were skilled and competent to care for the people they supported. Whilst staff received training in respect of the Mental Capacity Act (MCA) we found contradictory information in people's documentation and a lack of person specific capacity assessments.

Whilst there was a complaint procedure made available to people, family and visitors, complaints were not always recorded and responded to appropriately. We received examples and information throughout the inspection process that evidenced the complaint procedures had not been followed. The manager had not reported relevant safeguarding concerns to the local authority when they should have, and not all of the relevant incidents had been notified to CQC.

We did receive some positive feedback about the staff and people felt they were a good bunch, just not enough of them and not enough support for them.

One person told us "Very good staff, seem to know what they are doing." Staff demonstrated an awareness of people's needs and were kind in their approach.

Bentley Grange
People were very positive about the care they received. One person told us, "The staff are lovely, I wouldn't say a word against them. They come on time without fail."

There were systems in place to regularly monitor the service and make continuous improvements. These included audits, home checks (where staff are observed supporting a person) and satisfaction visits to people. Where results identified areas for improvement these were analysed and acted upon to ensure accountability. People told us the service was well run.

People told us they felt safe. They said they received a punctual, consistent and reliable service. People were

protected from abuse and harm because staff had completed training in safeguarding adults, and knew how to recognise and report safeguarding concerns. Risks to people's health and safety were well managed. Before people began receiving a service an in depth assessment was carried out to assess any risks to the person using the service and to the staff supporting them. Where people needed assistance with medicines, staff had received training and knew how to support people safely.

Staff had the skills and knowledge to meet people's needs effectively. Recruitment and induction checks were thorough. Reflective practice was encouraged to enhance staff skills and people's care. People's health needs were monitored and prompt action was taken to address any concerns or changes. The service had good links with local health and social care professionals and supported people to seek advice and treatment promptly when necessary.

People's needs were assessed and reviewed regularly to ensure people's choices, aspirations and preferences were met. Individualised care plans were drawn up with each person before the service started. The care plans contained easy to read and clear information about each task the person wanted support with but also the individual ways people liked their support and care delivered. The care plans explained how to support and encourage people to remain independent, support them to socialise and improve their health. People were confident they could raise any complaints or concerns with the provider and these would be dealt with promptly and satisfactorily. There were enough staff employed to ensure that people's needs were met. Staff received on-going training and support, which included a mixture of online training and attendance at internal training courses. There were safe recruitment systems to ensure that new staff were checked before starting to work in the home.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC.

The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicine practices were not safe at Cranbrook.

Cranbrook could not demonstrate that they had fully assessed the competence of staff before they worked unsupervised. Staffing levels at Cranbrook were not sufficient to meet people's needs.

Medicine practices were safe at Bentley Grange and there were enough staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The registered manager and staff had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware when restrictions were required. However, capacity assessments were not decision specific and some documents were contradictory at Cranbrook.

Not all staff at Cranbrook had had the necessary training to support people.

At both Bentley Grange and Cranbrook people were supported to access a range of health care professionals to help ensure that their general health was being maintained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Cranbrook had not ensured that all calls were on time and undertaken as planned. People and visitors did not always feel listened to.

People's dignity was always promoted and people felt staff were respectful.

Staff knew people well and people thought staff were kind.

Is the service responsive?

Requires Improvement

The service was not always responsive.

At Cranbrook not all complaints received had been recorded appropriately, investigated and the necessary action had not been taken in response to the complaints received.

Support plans did not always include detailed information about people's needs and how they were to be supported.

At Bentley Grange complaints were taken seriously and responded to as per the organisation procedure.

Support plans were person centred and included detailed information about people's needs and how they were to be supported.

Is the service well-led?

Inadequate

The service was not well-led.

There was overall a lack of clear leadership and oversight of record keeping in the service and manager roles and responsibilities were not clear.

Systems for monitoring and improving the service were inadequate.

Staff meetings were held regularly to ensure that staff were kept up to date on decisions and to give them an opportunity to share their views.

At Bentley Grange people and visitors told us it was well led. As a single location Bentley Grange was well-led.

Carewatch (Bentley Grange)

Detailed findings

Background to this inspection

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

We visited the two locations on the 11, 15, and 20 December 2017. We conducted telephone interviews to gain important feedback on the 27 December 2017 and on the 5 and 8 January 2018.

This was an unannounced inspection to follow up on concerns received about the Cranbrook location. The inspection team consisted of three inspectors on the 11 December 2017 and two inspectors on the 15 and 20 December 2017. The inspection process was extended due to continued requests from people and families who wanted to talk to us and further concerns raised.

Before our inspection we reviewed all the information we held about the service. This included the statement of purpose and registration documents. As this was an inspection that was brought forward due to concerns, a PIR had not been requested. This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make.

We considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We contacted the Local Authority to obtain their views about the care provided by the service.

During the inspection, we spoke with 15 people from both locations, the registered manager, the acting manager at Cranbrook, eight care staff and four relatives. We talked with people in the communal areas and by invitation in their flats.

We reviewed the records of the service, which included quality assurance audits, staff training schedules and policies and procedures. We looked at nine care plans and the risk assessments included within these and the medicine administration records for those who were supported with medicines by care staff along with

other relevant documentation to support our findings. We also 'pathway tracked' nine people. This meant we followed a person's life and the provision of care through the service and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

Cranbrook
Feedback from people and relatives was mixed. One person said, "I'm happy with the service, I feel safe, no issues." However we were also told by a relative, "It's a worry, when we expressed our concerns about care and they are ignored." Another relative expressed concerns about medicine safety and staff knowledge about medicines.

People's safety was put at risk, because risk assessments and risk management practices at the service were not consistent. Although the manager had considered some risks to people's safety they did not ensure all risks had been properly assessed. For example, there were two people who required moving and handling assistance from two staff for getting up in the morning, continence care and going to bed. At night there was only one staff member so the staff were assisted by the peoples' partners. However this was not reflected in the moving and handling assessment or in the moving and handling risk assessment. The partners had not had the necessary training to undertake moving and handling practices. We asked that this was immediately actioned with either, moving and handling training or the provision of a second member of staff until the necessary training had been undertaken. We also asked that care plans and risk assessments were immediately updated to reflect risk and actions taken. This had not happened within the agreed timeframe of 20 December 2017. This placed people and staff at risk from unsafe moving and handling practices. A senior member of the organisation actioned training for the life partners and a second care staff member until the training had been undertaken. We received confirmation following the inspection that this had been done.

People's health needs were not always fully explored and appropriately risk assessed. For example people who lived with diabetes did not have a care plan or risk assessment in place that guided staff in recognising the signs and symptoms of low blood sugar or high blood sugar levels and what actions they should take if they found the person unwell on their visit, especially on the first call of the morning. Staff we spoke with were not aware of the actions that may be needed by them on finding the person unwell. A staff member spoken with was unaware that the person lived with diabetes. We also found that people who were unable to communicate their needs did not have any guidance for staff to follow in respect of recognising pain, discomfort or unhappiness. We received confirmation on the 22 December 2017 that these care plans had been updated to reflect their communication and diabetic needs.

The management of medicines were not always safe. We looked at the storage of people's medicines and found that people had a secure storage facility in their flat for their medicines. However not all storage had been risk assessed for safety and kept locked. For example, the medicine storage for one person who lived with dementia was left unlocked which was a risk to their health and safety as they had controlled medicine for pain which if taken could be fatal. There was no evidence that this had been risk assessed and a best interest meeting held. The NICE good practice guidance states Oramorph (morphine sulphate) oral solution 10mg/5ml is a Schedule 2 controlled drug. CD storage and CD records are a good practice recommendation.

During the inspection process we received information that there had been two incidents, drug errors, involving these people which identified learning had not been taken forward.

After seeking permission from people we looked at five medicine administration records (MAR) kept in their flats. Some people needed medicines on an 'as and when' basis (PRN) such as pain relief. The provider had not made sure that people who required PRN medicines had their needs assessed. PRN guidance had not been completed. PRN guidance is needed to enable staff to understand when someone may need their PRN medicines. Staff confirmed that there were no PRN guidelines in place, and PRN medicines were often given and offered on a regular timed basis. One person who lived with dementia had been prescribed morphine and paracetamol for pain. These medicines were not supported by a protocol that informed staff of what the medicine was to be used for, indications for use and possible side effects for staff to be aware of. The MAR told us that they received morphine sulphate every night but no detail of how much they received as the dosage ranged from 2.5 mls to 5 mls and no evidence of the stock being checked. There was no rationale as to why this was required or whether it was effective. There was a potential risk of the person being over medicated if the person received a further dose.

During the inspection we received concerns from relatives that medicine practices were not safe. MAR records for people showed gaps for medicines such as antibiotics which had not been consistently given. This was referred to the manager to investigate.

Incidents and accidents were reported and investigated, but not always fully analysed to assess if there was any action that could be taken to prevent the incident from happening again. For example, one person had a history of repeated hospital admissions for the same medical condition. Although some action had been taken to try and prevent this from happening, the person had a recent emergency admission. The possible cause for this had not been fully considered so appropriate action which could have been taken had not been identified.

The above issues meant the provider had not ensured people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We were told there were not enough staff on duty to meet people's needs and keep them safe. One person told us, "Sometimes I get a late call, it is due at 9.30 but not always happening then" and, "No, there are not enough staff, they need more staff only four sometimes, quite frequently. I feel unsafe and worried about the frailer ones." Another person said, "The staff they have got are fine but they expect too much from them. The staff do put us first and the new management don't really recognise this."

Cranbrook supported 38 people. In the morning the organisation aimed for seven staff to manage the visits for personal care, however records showed that only 5/6 staff had been on four dates in December. The afternoon and evening staff numbers were set at four and at night there was one staff member. There were not enough staff to manage people's care calls properly, particularly when people needed the support of two staff. For example, one person told us they needed two staff to help them with their personal care needs. This was important for them, as it helped to prevent infections. However, the person had only been supported by one member for more than a week, because there was not enough staff available for two to complete the person's care calls. People, relatives and staff told us calls were frequently cut short or were late. One person showed us their care records and these identified that on the 18 November 2017, 2 December 2017, and 14 December 2017 that the care staff had not arrived. On four other occasions the care staff arrived at 9:45 am instead of 9am, and the person declined care as it was too late as there were other things they needed to do. We were told that they had informed the manager and made a complaint.

The manager told us there had been no missed or late calls in the last six weeks. Despite numerous opportunities during the inspection, the manager had not adequately demonstrated how they had assessed staffing levels to match people's needs. They had failed to recognise they were short staffed despite people reporting late and missed calls. People, relatives and members of staff said the main problem at the service was lack of staff.

On the first day of inspection we identified that one staff member had not completed their training booklet and was working independently without supervision. We were assured by the manager that the staff member would be withdrawn from working until they had completed their training and been assessed as being competent to work independently. On the third day of the inspection, 20 December 2017, we found the care worker was working independently and had not completed essential training and the training booklet.

The provider had not made sure they deployed sufficient numbers of suitably qualified staff. They did not have a systematic approach to decide what numbers of staff they needed on duty to meet people's needs and keep them safe at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practices at Cranbrook identified that organisational processes had not been fully followed. Most of the staff employed had transferred over from the previous provider, Housing & Care 21 under Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). TUPE rules protect employees' rights when the organisation or service they work for transfers to a new employer. We reviewed the records of new staff who had been employed by Carewatch Care Services Limited. We asked to see evidence of a disclosure and barring service (DBS) checks for certain staff on day one of the inspection. A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. These were not made available to us, so we returned on day two to review the DBS checks and completed files. One DBS raised questions about their suitability to care and we found no risk assessment to evidence that this had been discussed or recorded. Other required checks had also not been completed. Two files did not contain evidence of previous conduct where the care worker had previously been employed in adult social care and two other records did not contain evidence of a full employment history. We were told the files were in the process of being reviewed and updated. These were in place by the second day of the inspection. Ensuring that recruitment processes were safe was an area that requires improvement.

Bentley Grange
The service provided at Bentley Grange was significantly better than Cranbrook. People told us they felt safe using the service. One person said, "I feel very safe that they come and see me". They told us Bentley Grange provided a reliable service, telling us, "I feel safe, they turn up when they promise, always punctual"; "I can ring for help at any time"; "Help is always at hand"; "I get my medicines on time" and "They've never been late for my calls."

People were kept safe by staff who understood how to identify the signs of abuse and what action they would need to take if they witnessed or suspected that someone was being mistreated. This included an understanding of which external agencies they would need to alert. There was an up to date safeguarding policy in place which staff were aware of. Staff confirmed that they had undergone training in this area. Comments from the registered manager included; "The safeguarding training is very good, we always encourage staff to feedback any concerns, no matter how small. There is an on call service 24/7. We always take all the details however small, there is an open, friendly approach to encourage staff to raise concerns." Staff confirmed, "I can ring the management team at anytime, very supportive," and "If I have any concerns I

would report them immediately." People told us "Staff are very supportive and make sure I'm alright, my carer helped me when I was worried about family money, very kind." Records demonstrated the registered provider was responsive and appropriate referrals had been made by the service to the investigating authority when abuse had been suspected. The registered provider had organisational policies and procedures in place to guide staff in safeguarding adults from the risk of abuse.

The organisational recruitment processes were safe. All staff had had a Disclosure and Barring Service check (DBS). The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. All had full employment history, references and evidence of checks on identity. Staff were chosen very carefully and based on their values. Values were tested by thorough interview questions to check staff attitude, personality and match staff with clients. Records showed that the necessary checks had been undertaken prior to an applicant commencing their employment. This helped ensure the right staff were employed to keep people safe. Two references were checked and staff completed a Disclosure and Barring Service (DBS) check. These ensured the applicant did not have any criminal convictions or been barred from working with vulnerable people.

People were kept safe by sufficient numbers of staff and there was adequate cover for sickness and unforeseen events. At the time of inspection the service delivered care and support to 45 people at Bentley Grange. The visits ranged from 15 minutes to one hour. There were 20 staff employed and every morning there were six staff, which was reduced to three in the afternoon, four staff from 5pm until ten and one waking staff at night. The staff at night responded to calls and people told us that they were confident of getting immediate support. There was no-one that required booked night calls or two staff for moving and handling after 10 pm. We were told that if peoples' needs changed or they required more staff this would then be provided. Staff told us they worked flexibly as a team to meet people's needs so people were supported by staff they knew. People confirmed visits were never missed and they were notified if staff were running behind schedule. People had information about the staff who would be visiting so they knew which staff to expect on particular days. This information was available in large formats for people with sight difficulty.

Staff told us visits were a minimum of 15 minutes, they confirmed if they were running late they would let the office staff know and they would contact the person to inform them. One person told us, "The office will always let us know if there is a delay.

At times of sickness, holiday or when new staff started there were introductory meetings so people knew the staff that would be providing care. One person told us about a member of staff , "[She is always punctual and comes when expected. If she's not able to, another carer comes who I am familiar with." People all told us they knew and trusted the staff that supported them. Staff wore identification badges and people confirmed they would never have a staff member visit them they did not know. Staff told us, "We are asked to come in and read about people before the initial visit, we are introduced. It puts the client and us at ease." Bentley Grange had security measures in place to ensure that people who lived in the premises were safe. The front door was security coded and all corridors leading to individual flats had a security door opened only by a card.

Health and safety checks were undertaken to ensure people's homes, utilities and equipment were safe and in good working order. Staff knew to report any environmental concerns. Lone working procedures were discussed and it was confirmed that these would be re-introduced immediately. The registered manager said they had been in under the previous provider but not replaced by Carewatch as yet. This was immediately undertaken.

People were kept safe by staff who understood what action to take in the event of an incident and followed internal procedures for reporting and documenting these. Staff had received fire training and were aware of the exits in people's flats and emergency procedures to follow in the event of a fire.

We looked at people's support plans and risk assessments. A senior member of staff visited people in their flats and conducted risk assessments on the safety of the person's home environment as well as conducting a needs assessment around areas of support. This included the person's medical conditions, their personal care needs, whether they required domestic support and other areas related to the person's wellbeing. This information was then used to produce a support plan around the person's identified needs.

People were supported by staff who managed risk effectively. Staff told us, "We read people's care plans, check equipment, medicines and record everything." People had documentation in place relating to the management of risks associated with their care. The risk assessments were detailed and provided staff with specific information on all areas where risks had been identified. This included environmental risks within the person's home, as well as risks in relation to their care and support needs. For example we found one person's care record identified that they were registered as blind. The care plan was very clear and detailed about how to support the person in their life style choices to remain as independent as possible. In another care record we found specific details of risks associated with a person's mobility and in particular, their risk of falling. We found a specific risk assessment which explained the reasons why the person was at risk of falling as well as practical advice for care workers to help mitigate this risk.

Staff understood the importance of a person's choice, regardless of disability, to take everyday risks and to keep people safe but not be intrusive when they monitored them in their home. Staff balanced actively supporting people's decisions so they had as much control and independence as possible with ensuring their safety at all times. Staff gave examples of how they supported people to manage their own mobility as far as possible but being mindful of potential risks and ready to step in and support as required.

People were safely supported with their medicines if they required, and had care plans in place which detailed the medicine they were prescribed and the role staff were required to take. Staff who were responsible for administering medicines received thorough training. Training included explanation of medicine administration sheets, practical observation of administration, watching films about medicine administration and practical teaching sessions for example with eye drops. Staff competency was checked through shadowing, observation, knowledge tests and scenarios. Staff confirmed they understood the importance of safe administration and management of medicines. One staff member told us, "We have medication training every year I think. I've been observed doing medicines. Any queries I ask the manager. I document any refusals and report back to the office, who then contact the GP if necessary." Staff confirmed stock checks occurred each day to ensure people had received all of their medicines. Good records were in place in relation to specific medications for example body maps were used for topical creams.

Requires Improvement

Is the service effective?

Our findings

Cranbrook
The manager and staff had some understanding of the Mental Capacity Act 2005 (MCA). This legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. However care plans did not always refer to people's level of capacity for day to day decisions, and there was minimal evidence of capacity assessments for decisions about specific aspects of people's care in their care plans. Care documentation for specific people was contradictory and stated that they did not have the capacity to make decisions but then in other documents stated they did. There were also decisions made by a close friend of one person who did not have enduring power of attorney to make health and welfare decisions. There was no supporting evidence to support these statements. There had been no mental capacity assessment undertaken and no best interest meetings held. This included decisions made in respect of someone refusing bed bumpers over bed rails to help keep them safe. When we discussed this with manager he stated that the bed rails would not cause a problem due to the persons size. however it had not be considered that uncovered rails can cause bruising and skin damage, not just entanglement.

One person lived with a condition that made communication very difficult. From viewing the care plan, it had been presumed that this person couldn't make decisions of any kind. There had been no exploration in to developing a method to communicate, such as direct questions that needed a single word answer that could be made by eye or head movement or monitoring their body language. There was also no evidence that advice had been sought in assessing the person's mental capacity within the documentation. We asked a staff member how they sought consent from this person and they were unable to answer. They then said that it was generally presumed that the person accepted the care delivery because the partner had asked for the support. The provider had not ensured that care and treatment had been provided with the consent of the relevant person.
This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training programme showed staff had completed moving and handling training, it also stated staff had practical refresher training for medication, reporting and recording safeguarding, adult support and protection. However there was no evidence that all staff had completed mental capacity training, infection control, food and hygiene, health and safety or emergency first aid. There was also no service specific training such as diabetes, which staff needed as they supported people with diabetes. Staff we spoke with said that training had been discussed but not yet provided. One staff member said, "I think that training needs to be a priority, especially in dementia and diabetes. I haven't yet had my supervision to discuss this." There was a risk that staff were not suitably trained to meet the needs of the people they supported effectively.

Staff told us that they had not had supervision since the change of provider and one staff member said they had not had a supervision in a year. Staff said they had had two managers in six months and felt unsupported. The manager said they had had supervision but could not produce the evidence to support

this. There was some confusion over what supervision had been undertaken.

The manager said that competency assessments for administrating medicines had been undertaken. However this could not be confirmed as there was no documentation to support this and staff said they hadn't had one since last year when they were working for a different provider. They were sure they had completed observational supervisions but there was no written evidence to support this. This meant there was a risk that staff would not be properly supported to make sure they met the needs of the people who used the service .

We were told that staff were not able to work alone unsupervised until they had all the required training and felt confident to do so. However we identified that staff working unsupervised and had not completed their training booklet. The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff ensured that they received sufficient food and fluids. One person said, "They make my breakfast and ensure that I've got plenty of drinks nearby."

Care records showed that staff supported people to access appointments if needed and liaised with health and social care professionals involved in their care, if their health or support needs changed. Good working relationships had been built with people's doctors and district nurses. The manager sent a letter to people's GPs to advise they were involved when people started using Cranbrook. Staff were able to tell us that they recorded peoples mobility changes, memory changes and weight loss in daily records. They also informed the manager who then informed the GP. One staff member told us that a physiotherapist had been involved for one person whose mobility had decreased.

Bentley Grange
People's experience at Bentley Grange was much more positive. People received an effective service from staff that understood their needs and supported their well-being. All people spoke positively about the skills, knowledge and experience of the staff supporting them. Comments we received included, "Staff are well trained, "Another person said, "They know what they are doing and I have complete faith in them."

The service had developed a comprehensive induction programme for new staff. The organisation had a central training centre which supplied face to face and interactive training such as moving and handling. The programme included information on health and safety, safeguarding and covered a range of essential topics such as policies and procedures, infection control, health and safety, medicine administration, moving and handling, the mental capacity act and equality and diversity. New staff then went on to shadow more experienced staff to build on their knowledge and experience.

Staff told us, "The induction was interesting and I liked and needed that, I loved it. Felt I needed to do the workbooks and Care Certificate, all very helpful." During the probation period which was extended if the staff member needed extra support, staff completed work books and the Care Certificate, a detailed national training programme and qualification for newly recruited staff. Spot checks' were undertaken and staff practice observed to ensure competency. Observational checks included assessing staff communication and their interactions with people. Staff told us the induction process gave them the skills and confidence they needed to support people effectively. One staff member said, "I was in care before but a long time ago, the induction gave me back my confidence."

Staff said they felt very well supported by the registered manager and their colleagues. There were good

informal support networks and staff regularly visited the on-site office for a chat and support as they needed it. We were told, "The office is always open, the manager is calm and really supportive, nothing is too much trouble. They received three monthly supervisions (one to ones) and an annual appraisal. Reflective practice was encouraged for example we were told of a situation where a person was not always compliant with personal care and staff tried in different ways to prompt and assist with varying success until they found success by reflecting on past practice and putting it together. Staff said they discussed it at team meetings and came up with a plan as a team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). Staff had received training and demonstrated an understanding of the requirements of the MCA. When people lacked the mental capacity to make certain decisions, the service had followed a best interest decision making process. Care plans showed that the service had initiated these discussions when required and contributed to best interest processes for a range of decisions, including when the service had been concerned people were neglecting themselves or at risk from their environment such as falling out of bed.

People told us staff supported them to maintain their hydration and nutrition when it was required. Where there were concerns about people's food intake staff had gone above and beyond to cook homemade meals for them at home and bring them to them. For those people, staff had noticed weight loss, referrals to community dieticians were arranged promptly and support with meal preparation or meals was discussed and arranged. Bentley Grange had a restaurant facility which was not run by the service but if people needed support or observation, this was arranged as art of the care package.

Care records showed that staff supported people to access appointments if needed and liaised with health and social care professionals involved in their care, if their health or support needs changed. Good working relationships had been built with people's doctors and district nurses. The service sent a letter to people's GP's to advise they were involved when people started using Bentley Grange. Staff shared how people's needs had changed as their dementia advanced or they had aged and their health and mobility deteriorated. Additional visits were put in place promptly for people at these times.

Requires Improvement

Is the service caring?

Our findings

Cranbrook
Feedback from people and relatives about how caring staff were was mixed. A relative told us; "The staff are rushed and then can be a little slapdash, shaving is an issue, it's not being done, I've spoken to the staff and manager, and my relative is still not shaved." One person said; "I have had issues with staff not turning up or arriving three quarters of an hour late without informing me." Other people told us staff had a kind and caring approach. They said they were not rushed by staff and felt they were caring. People were happy with the way staff respected their privacy and dignity when providing care.

The information included in people's care plans was inconsistent and lacked specific care directives. While some care plans contained all the relevant information to enable staff to provide care in the way people wanted, some care plans did not. This had been identified by the local authority, who were working closely with the service. The manager acknowledged that the care plans had not been progressed as stated in the action plan but they were working to develop the care plans that ensured people were involved and had a say in the way their care was delivered. This continued to be a work in progress for the manager and staff. This was an area that required improvement.

The manager and staff were able to tell us about the people they cared for and spoke with them in a respectful manner. Staff described how they would support people to make day to day choices and understood the need to support people to make their own decisions. However due to staff being rushed at times, peoples care was not always to the standard people wanted and required. We were told things had improved and promises made but these had not been sustained. One person said, "Talk is easy, but I'm still getting missed calls with little apology from the management." During the inspection at Cranbrook with people's permission we took their concerns to the manager who said they would ensure that they visited them to discuss the missed and late calls.

People could not recall if they had been asked about a preference for gender of care worker when they started receiving care. People's assessments and review records did not include questions about this preference. We also identified that there was little documented about people's choices in respect of cultural and religious needs, for example 'Do they wish to go to church services.' One person mentioned that support in receiving pastoral support would be appreciated as they were worried and grieving over the poor health of a family member who lived with them at Cranbrook. On looking at the person's file it gave no insight in to their grief or worries, nor had arrangements been made to contact the hospital for information or assist in getting the person to the hospital to visit. This was brought to the managers' attention who confirmed that they would contact the hospital. Following the inspection we received information from a worried friend at Cranbrook that no assistance had been offered. The registered manager confirmed that they would ensure support is given.

There were also people who told us they were supported to make decisions about their care as much as they were able to. Other people such as health care professionals were involved in supporting people to make decisions about their care, where appropriate. One person said; "I think they see to my needs very well

and I have always felt involved". When talking about the quality of care they experienced another person said; "I am mostly pleased but it's up and down still."

Data protection procedures were in place so people knew their private information would be kept confidential and secure. All care plans and private information was kept securely in the service offices.

Bentley Grange
People told us "Staff are very nice, always kind and cheerful," "They care and are really helpful. Nothing is too much trouble." A relative also commented, "They look after my wife, but make sure I'm involved and alright."

We visited five flats where people received support from Bentley Grange Staff. All expressed their appreciation of the support they received. One person said, "I rate them highly, always a smile, we only need a little support but if I was unwell I know they will step in to make sure my wife is ok." Another person said, "They help me with a shower and I can honestly say they do it so well, they show me respect, never hurry me and always ensure my modesty is protected."

During our inspection we noted one person in the lounge was a little anxious. A staff member noticed as they walked past and they immediately offered support in a kind and caring manner. The response from the person was instant, a big smile that said thank you. The staff member soothed and reassured the person as an equal contributor to the conversation. They listened and offered sensitive and appropriate responses. This demonstrated staff considered their approach to people and ensured they were engaging with people in a respectful way. They then accompanied the person to their flat.

There was a caring and supportive ethos at Bentley Grange. This was felt by people, staff and visitors. One person told us, "The staff allow me to live independently in my own flat, it means everything to me" and a relative said, "I know my relative is safe, and living in their own flat." We saw staff welcomed and greeted people throughout our visit with friendliness and warmth.

People were involved in their care and support delivery. People's interests and preferences were noted and this helped people to build trusting relationships with staff. The manager endeavoured to match staff to people so as to build rapport and trust. If the match didn't work a discussion was held with the person and another member of staff introduced. These discussions had created trust between the service and people. One person we visited told us, "A really good bunch of people, if I'm not happy with something, I just mention it and it's sorted out." Another person said, "It's difficult for me to accept help, but they do it so I'm still able to have my say, we work out what works best." Staff were committed to promoting people's independence and supporting them to make choices. Examples were given of people whose health had deteriorated but they wanted to remain at home. The service worked flexibly to enable them to remain at home being cared for by people they trusted and loved.

During our visits, we saw staff had an understanding of people's individual needs around privacy and dignity. We observed staff knocked/rang on people's doors before entering and waited for a response. Staff spoke with people in a respectful way, giving people time to understand and reply. We observed staff demonstrated compassion towards people in their care and treated them with respect. One person said, "Always on time as promised." A second person told us, "They are kind and helpful." The registered manager told us that staff retention at the service was good. This meant people received a consistent service from a team of care workers they knew and trusted, and who had an understanding of their support needs. Consistency of staff meant strong relationships had been built with people and their families. We observed through our discussions with staff and family and during visits that people mattered to the staff, they were

treated with respect and kindness.

Care plans had personal details in them which enabled staff to deliver care according to people's wishes and supported them to have conversations with people, for example, travel, family and past interests. When people had fallen or become frailer, staff worked to rebuild their confidence and independence again so they could still do the things they wanted. Staff worked with the person's GP and health team to ensure their mobility was monitored and the risk of repeated falls reduced, such as looking at footwear and their environment.

People told us that care staff treated them with dignity and respect. One person said, "Staff respect me and my home." Care workers described how they respected people's privacy and dignity when supporting them with personal care, knocking before entering and making sure the curtains were closed. They told us how they supported people to do as much as they could for themselves, and we saw that care plans promoted this, for example, "(person) can wash face, brush teeth and top parts of their body independently." Another care plan stated, "Offer them the choice of clothes and assist with dressing." Staff wore uniforms so people were aware of which staff were in the building. This gave people a sense of security and peace of mind.

Data protection procedures were in place so people knew their private information would be kept confidential and secure. All care plans and private information was kept securely in the service offices.

Requires Improvement

Is the service responsive?

Our findings

Cranbrook
Whilst there was a complaint procedure made available to people, family and visitors, complaints were not always recorded and responded to appropriately. We received examples and information throughout the inspection that showed the complaint procedure had not been followed. One family had raised serious concerns in August and September 2017 about their relatives care and well-being. This was confirmed by emails sent to the manager of Cranbrook. As there had been no action taken and no improvement in the care delivery the complainant sent the concerns to the next level of management in September 2017. The complainant had no response to their concerns as of 24 January 2018. We forwarded these concerns to the registered manager to make contact and investigate their concerns. Another person contacted us during the inspection and told us that they felt their concerns in respect of a member of staff had not been taken seriously as the member of staff had continued to deliver care despite the manager assuring them that this would not happen.

Not all complaints received had been recorded appropriately, investigated and the necessary action taken in response to the complaints received. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not everyone who received support from Cranbrook told us that the care they received met their needs. One person told us, "They seem to be short staffed a lot of the time so sometimes I do not get the full time I should but that's ok if someone else needs them." One person said they had sat and discussed how they wanted their care and at what time, however they were usually about 20 minutes to half an hour late. One person said, "I know I chatted to someone but I don't think I have seen a care plan." It had been acknowledged that care plans needed to be improved to ensure that they identified people's individual needs and guide staff to meet them in the way the person wished. Care plans had not been reviewed and updated as stated in their action plan supplied following input from the local authority. We were assured that this was a priority going forward. This was an area that required improvement

Bentley Grange
People who received support from Bentley Grange told us that the care they received was personalised and met their needs. One person told us, "They always have enough time." A second person who received support told us, "They have always kept to the time, within ten minutes, and someone from the office will let us know, in a way it's reassuring to know that if necessary they will finish a job properly." No one we spoke with told us they had a missed visit.

People and relatives knew about their care plans and said they were accurate. People's care records provided staff with guidance on how to support people. Care records contained information about people's health, care, cultural and communication needs. Changes in people's needs were recorded and action was taken to meet them. Care records stated the hours commissioned for the delivery of care and support. The registered manager confirmed that the hours of support people received changed when their needs did, following discussion with all those involved. For example, one person's care records indicated that their

needs had increased and we found correspondence to the commissioner of the service, requesting authorisation for an increase in their care.

Detailed assessments and care plans were person centred and included medical details, risk assessments, information about daily routines, the support people needed with activities of daily living, and information about their background and interests. This ensured the correct level of care was provided. For example, when a person's cognitive ability declined, best interests meetings and alterations to care occurred quickly. This was confirmed by care workers who told us they reported any changes in people's needs or the adequacy of their visit times to their line manager when needed. Their comments included, "If the visit takes longer than the time allocated, we will take longer and report this back to the manager" and "If we need more time to do our work we report this to the office, we know that this will be taken forward by our manager."

Copies of the care plans and risk assessments were in the office and each person's home. There were signed forms consenting to the provision of care, guidance about how to make a complaint and contact details so people knew who to contact at the agency for advice or support. We saw care plans had been reviewed regularly which meant the information they contained about people's support needs was up to date. Care plans were reviewed frequently with people and as their needs changed. The care plans we read reflected the care of the people we met and staff feedback about people's lives, routines and hobbies.

The service provided regular additional information and updates to staff to ensure they were kept well informed about the people they were supporting and the service. This helped to ensure the support provided was responsive and flexible. Staff told us they were always kept informed about people's needs and any changes to people's care. The weekly office meeting included discussion about client reviews which were due and any changes. Systems ensured office staff had thorough notes of any calls from people, relatives or professionals. Any actions from enquiries were allocated to staff to increase accountability and ensure action was taken, for example if a doctor required information. The information held was analysed for themes and trends and provided a clear history of events.

Care records contained details of people's involvement in the community and within Bentley Grange in house activities. As part of the initial needs assessment, the staff undertaking the assessment spoke with people and their relatives about life style choices they were already involved in so they could continue to encourage these where they were able to do so within their visits. We found care records included details of people's recreational interests even where care workers were not involved in supporting them with these. For example, we saw details of one person's interest of gardening recorded and saw that they had been encouraged to get involved in the garden space. Care workers told us it was important to know about people's interests even where they were not specifically supporting them with these. One care worker told us "It's good to know peoples interests, so we can chat and it builds a relationship."

We spoke with people about their social life within Bentley Grange and found that they were supported to attend activities held within their building. We were also told that people received support when needed, to access the community whether for appointments, shopping or church.

The service had a complaints procedure which was made available to people supported and their family members. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. We saw the service had a system in place for recording incidents and complaints. This included recording the nature of the complaint and the action taken by the service. We saw complaints received had been responded to promptly and the outcome had been recorded. People who used the service and their relatives told us they knew how to make a complaint if they were

unhappy about anything. One person said, "I've never had to complain, the manager is approachable and I would raise an issue immediately." Other people told us they had complained and their complaints had been dealt with appropriately.

Inadequate

Is the service well-led?

Our findings

People at Bentley Grange told us they knew who the registered manager was and that the service was well managed. However the feedback in respect to Cranbrook was mixed. We were told, "It's been very disorganised since the takeover. Not sure sometimes what's going on." A number of concerns were raised about Cranbrook during the inspection process, which were referred to the management team to investigate.

Carewatch Care Services Limited had taken over the running of Bentley Grange and Cranbrook in June 2017.Cranbrook was found to be running as an unregistered service in August 2017, it was subsequently attached as a location to the registration of Bentley Grange in December 2017 to ensure it was legally registered. A manager had been recruited for Cranbrook and had been in the process of registering with the CQC. This meant that the two services had one registered manager at the time of the inspection and a manager at Cranbrook. The registered manager of Bentley Grange said they had not realised the legal implications of the responsibility of managing both locations. The provider had not supported the registered manager to take ownership of the second location. At the beginning of the inspection it was clear that the two locations were running separately and that communication between the two were not clear or transparent. The registered manager did not have oversight of staff or the care needs of people at Cranbrook.

Communication between the two locations improved considerably during the inspection. However, we were told during this inspection process, the manager of Cranbrook left the organisation in January 2018.

Cranbrook
Roles and responsibilities were unclear. Staff told us that communication needed to improve. Since restructuring the service, there was a lack of clarity of managerial roles within the service. The registered manager had not taken on full responsibility for Cranbrook. There were no clear lines of accountability for Cranbrook due to the lack of communication between the registered manager and manager. The registered manager had no overview of Cranbrook and this impacted on the progression for improvement. The shortfalls we found at our inspection demonstrated that the provider had not had a clear oversight of Cranbrook. We were concerned that the manager had not kept senior managers informed of staffing issues, missed calls and complaints.

We found that there was a lack of transparency in changes that were happening at Cranbrook. Staff and people told us in December that they had heard the manager was leaving on the 5 January 2018. We asked the manager and senior team if this was happening. It was denied strongly, however people contacted us by telephone to inform us that the manager left on the 5 January 2018.

The organisation had a range of quality assurance systems. These included health and safety audits, medication and documentation audits. We noted a quality audit had been completed in September 2017 by a quality manager employed by Carewatch. Findings from audits were fed back to the manager (but not the registered manager) and actions were set when there was a need for improvement. However the actions

needed had not all been met. For example care plans, risk assessments and medicines had been identified as an area that staff needed to improve. However we found that medicines were still not always safe and care plans and risk assessments were still not always accurate which placed people at risk from unsafe care. People's health needs were not always fully explored and appropriately risk assessed which could impact on peoples' safety. The mental capacity assessment of people were inconsistent and contradictory which meant that people may not be listened to and were not enabled to make choices. We were told by the manager there had been no missed calls but we found evidence of seven missed calls and five late calls in the past three weeks. This had not been recorded or reported to senior management. Complaints were not all recorded and dealt with as per the organisational complaint procedure. The lack of staff supervision and appropriate training had the potential to place people at risk from unsafe care and practices.

Staffing numbers had been identified as on-going problem and despite numerous opportunities during the inspection, the manager had not adequately demonstrated how they had assessed staffing levels to match people's needs. They had failed to recognise they were short staffed despite people reporting late and missed calls. People, relatives and members of staff said the main problem at the service was lack of staff. Accidents and incidents were not always recorded and response to accidents and incidents were not used as learning to improve practices within the service.

The lack of robust quality assurance systems and inaccurate record keeping had the potential to impact on the health, well-being and safety of the people they support. The registered provider did not operate effective systems to assess, monitor and improve the quality of services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not always ensured CQC were notified of all incidents or major issues related to the service in a timely manner. Incidents that had occurred such as missed calls leaving someone without care delivery should have been reported to the local authority and to CQC. This meant we had not received all the information about the service that is legally required.

Technology in the organisation was used to improve and monitor the service delivery. The call system allowed people to call and speak to someone at all times should there be a need. This gave people the confidence to live as independently as possible.

During the inspection process the communication between the two locations improved and it was confirmed that the registered manager spoke with the manager at Cranbrook on a daily basis and the registered manager received a daily report via the secure computer portal. On the 8 January 2018, we contacted the registered manager to ask what management systems had been put in place to ensure good oversight of Cranbrook. The registered manager informed us that they would be at Cranbrook for two/three days a week to ensure people and staff were supported and to complete the action plan.

Bentley Grange
Bentley Grange demonstrated good management and leadership with clear lines of responsibility and accountability within the team. During this inspection, we were able to speak with several members of the management team regarding the service. They were all able to discuss training, the varying needs of people, staff development and improvements needed. This showed the team were experienced, knowledgeable and familiar with the needs of people they supported.

The service had a range of quality assurance systems. These included health and safety audits, medication and documentation audits. Findings from audits were fed back to the registered manager and actions were set when there was a need for improvement. For example, a finance risk assessment was suggested to be

put in place for the safe management of monies. We saw that this was included in the risk assessments in people's care plans. Call visits were monitored by the registered manager and actions were taken when concerns were raised and recorded. We were told meetings took place for staff. Minutes for the staff meetings were available. Care staff told us they felt supported and meetings were planned but they did not always attend. However, one staff member told us, "The meetings are helpful, we discuss what's happening within Carewatch and Bentley Grange, challenges we face and what training would be helpful." A plan to involve people in the recruitment of staff had been introduced and was on-going. This will encourage people to be involved in the running of the service.

Technology in the organisation was used to improve and monitor the service delivery. The call system allowed people to call and speak to someone at all times should there be a need. This gave people the confidence to live as independently as possible.

The registered manager was committed to their role and had ideas of how to consistently strive to improve outcomes for the people supported. For example, in supporting people to maintain their independence. One person liked to go shopping and there was clear guidance on how this should be achieved safely by staff. For example ensuring the person was appropriately dressed, had the necessary identification and information should a problem occur when they were out.

The registered manager said spot checks were undertaken when staff completed their visits on a regular basis. Records seen and staff and people spoken with confirmed observations or spot checks in the work place had taken place. Spot checks were unannounced visits to observe staff work practices and were in place to confirm staff were punctual and stayed for the correct amount of time allocated. The staff member who completed the spot checks also asked people if they were happy with the service. One staff member told us, "We are observed delivering care and then we receive feedback, it's really helpful." This showed the registered manager had systems to monitor and maintain effective working practices.

The service sought feedback from people during reviews and spot checks but as yet a formal survey under Carewatch had not been undertaken.

The service had a range of quality assurance systems. These included health and safety audits, medication and documentation audits. We noted a quality audit had been completed following the change of provider by a quality manager employed by Carewatch. Findings from audits were fed back to the registered manager and actions were set when there was a need for improvement. For example, daily notes had been identified as an area that staff needed to improve. This was an area that was being monitored and evaluated. We saw call visits were monitored by the service and noted appropriate actions were taken when any concerns were raised, such as people feeling rushed. One person had shared that they felt rushed on a 15 minute medicine call. The registered manager had visited the person to discuss their feelings and also spoken with the commissioners in respect of this. This is under consultation with the local authority.

We saw evidence of partnership working. The registered manager told us that they attended provider forums to keep themselves up to date with the organisation and changes. The registered manager then cascaded the information to her team.

We saw evidence of engagement with people at Bentley Grange. Senior members of Carewatch staff visited Bentley Grange to meet with people. Visits were to discuss if the care and support was what people wanted and if any there were areas for future development. From the engagement session, actions included dementia awareness for relatives. This showed the registered provider had systems to consult with people who used the service.

The registered manager had ensured CQC were notified of any incidents or major issues related to the service in a timely manner. The registered manager discussed the regulations in terms of notifying CQC of any incidents or safeguarding concerns they may have. This meant we received all the information about the service that we should have done.

We noted the provider had complied with the legal requirement to provide up to date liability insurance. There was a business continuity plan in place. The registered manager's business continuity plan was a response-planning document. It showed how the management team would return to 'business as normal' should an incident or accident take place. This meant the provider had plans in place to protect people if untoward events occurred.

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 The provider had not ensured that care and treatment of service users must only be provided with the consent of the relevant person.Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that any complaint received was investigated and necessary and proportionate action taken in response to any failure identified by the complaint or investigation. The registered person had not established and operated effectively an accessible system for identifying, receiving, recording, handling and responding. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not made sure they deployed sufficient numbers of suitable qualified staff. Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (2) (a) (b) (c) (g)

The enforcement action we took:
warning notice and special measures

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:
warning notice and special measures