

Neil Tucker

Welcome Home

Inspection report

Cliff View Gardens
Warden Bay
Sheerness
Kent
ME12 4NH

Tel: 01795510884

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 27 and 29 March and 4 April 2018. The inspection was unannounced on the first day. We told the registered manager when we would return to complete the inspection.

Welcome Home is registered with CQC as both an accommodation based care home and a community based domiciliary care agency (DCA) which delivers personal care to people in their own homes. The domiciliary care agency is run from an office within the grounds of the care home with a separate staffing group to the care home.

People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during the inspection of the care home. The care home provides care and support to up to five adults with a learning disability. Five people were living at the service at the time of our inspection. People had complex care needs, including learning disabilities, autism and physical health needs such as epilepsy and diabetes. People had limited verbal communication so were unable to speak directly to us.

A domiciliary care agency provides personal care to people living in their own houses and flats in the community. The Welcome Home care agency provides a service to any adults who require support. At the time of the inspection approximately 45 people were receiving personal care in their own homes. The provider also provided care and support to four people with a learning disability living in a 'supported living' setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements within supported living. CQC does not regulate the premises used for supported living. Not everyone using Welcome Home supported living service receives 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.

We have reported on the services provided by the care home and the care agency separately under the evidence sections of the report. Where the evidence we found related to both services we combined the reporting. We have reported on the evidence found within the supported living service under the care agency as this is where the regulated activity 'personal care' is reported.

A registered manager was in post within the service. 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.

At our last inspection on 20, 22 and 23 June 2017 we found breaches of Regulations 11,12,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Three breaches had continued since the previous inspection relating to, people's basic rights and consent to care and treatment; staff

support, training and supervision; management, leadership and monitoring of the service provided. One further breach was identified relating to the management of risk and safe medicines management.

We asked the provider to take action to meet Regulations 11 and 12. We took enforcement action against the provider and the registered manager and told them to meet Regulations 17 and 18 by 04 September 2017.

The provider sent us an email on 24 August 2017 telling us the action they were in the process of taking to comply with Regulations 11, 12, 17 and 18. They did not confirm a date with us when they would be meeting the regulations by.

At this inspection, we found the provider and registered manager had made some improvements to all the identified areas within the service, although further improvements were required and work was still in progress to meet the regulations.

Care home

Although some individual risk assessments were in place and these had been reviewed since the last inspection, we found that many risks identified through care planning had not been assessed to ensure guidance was in place for staff to keep people safe.

Improvements had been made to ensuring people's rights were upheld within the basic principles of the Mental Capacity Act 2005 (MCA 2005), however these needed to be developed further. We have made a recommendation about this.

Improvements had been made to the safe administration of people's prescribed medicines. These were now better organised and a system was in place to make regular checks to prevent errors and omissions.

The registered manager was in the process of recruiting new staff to the care home, however, there were suitable numbers of staff to provide the care and support people were assessed as requiring.

Staff knew people well and spent time with people individually, responding to their individual needs. Care plans were person centred with detailed information about each person. Improvements had been made to the recording of people's activities and interests. The registered manager was continuing to make improvements to these.

People's privacy and dignity were respected and they were supported to maintain and increase their independence skills. People living in the care home were relaxed and smiling, responding to staff chatting and singing.

Fire alarm testing and servicing of fire equipment and utility systems such as gas and electrical continued to be carried out at the appropriate intervals by suitably qualified technicians. Fire evacuation drills were now undertaken and recorded appropriately.

Care agency

People's prescribed medicines were not always managed safely. Incidents had not always been investigated appropriately to ensure action was taken to avoid similar incidents happening.

Staff changes had meant the care agency management team could not always deploy staff appropriately to ensure people received the care and support they preferred and had been assessed as requiring.

Poor feedback was received from people and their relatives regarding the management of the service provided by the care agency. A consistent approach to providing a good quality service had declined due to changes in office staff.

Most people either took care of their own health care needs or a family member or friend helped them. Staff reported concerns to health care professionals or family members as appropriate. Some people required assistance with eating and drinking and preparing meals. This was clearly recorded in their care plan for staff to follow.

Feedback was sought about the service provided during the review with action taken to address concerns.

Care home and care agency

Some improvements had been made to the quality monitoring systems and checks were in place for some areas. However, the provider and registered manager had still not developed robust and consistent systems to evidence their management oversight of the service as a whole.

Although some improvements had been made to the supervision and development of staff, further improvements were necessary as staff had not received the levels of support expected and stated within the provider's policy. Staff meetings continued to not be prioritised as a means of staff support and team building. Staff training updates had not been completed by some staff to ensure they continued to have the skills necessary to undertake their job role.

Care plans were in place describing the care and support people required following an assessment of their care needs. Care plan reviews had not always been carried out regularly and where a review had taken place, changes had not always been made to people's care plans to reflect changes in care or circumstances. We have made a recommendation about this.

The registered manager continued to practice safe recruitment procedures to ensure people were protected from being supported by unsuitable staff.

Staff understood their responsibilities in protecting people and keeping them safe from harm. They knew who to report concerns to and who to go to outside of the organisation should they need to.

A complaints procedure was in place. No complaints had been made in the care home. Some informal complaints had been made regarding the care agency and these had been recorded and responded to individually.

Staff found the registered manager and management team were approachable and supportive.

During this 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 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?

The service was not always safe.

Individual risks were not adequately assessed and mitigated to keep people living in the care home safe from harm. Risk assessments in the care agency were completed and up to date.

The administration of peoples prescribed medicines were not always managed safely in the care agency. Medicines administration in the care home had improved.

The coordination and deployment of staff in the care agency needed to improve. Suitable numbers of staff were available to support people living in the care home.

The registered manager had a robust staff recruitment process in place to ensure only suitable staff were employed to provide care and support to people.

Staff understood their responsibility to safeguard people by reporting any concerns they had.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff had not received regular supervision or an annual appraisal to support their personal development. Evidence was not provided to show that staff had updated their training.

Improvements had been made to the documentation of mental capacity assessments in the care home and further work was continuing.

People's care needs had been assessed and care plans developed to provide the care and support people needed.

People receiving support from both the care home and care agency were supported to access appropriate health care professionals when necessary to maintain their health and well-being.

Requires Improvement ●

The food provided in the care home offered variety and choice based on people's likes and dislikes. In the care agency people had assistance with food preparation and eating and drinking when required.

Is the service caring?

The service was caring.

There were good relationships between people and staff in the care home, built on knowing each other well. People were positive about the staff who provided their care in the care agency.

There was an emphasis on supporting people to maintain and increase their independence where possible. People were treated with dignity and respect by staff.

Relatives visited regularly in the care home with no restrictions and people were supported to visit their relatives when they wished.

People receiving a service from the care agency were involved in the planning of their care and support. The relatives of people living in the care home were included in their loved ones care plans.

Good ●

Is the service responsive?

The service was not always responsive.

Care plans were person centred, including important individual information about people. Care plans had not always been regularly reviewed or changes in circumstances captured when they were reviewed.

People living in the care home were able to access community activities and follow their individual interests.

A complaints procedure provided the information people needed to make a complaint. People and their relatives told us they knew how to make a complaint.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

People who received care and support from the care agency and

Requires Improvement ●

their relatives told us clearly they did not think the service was managed well.

Although some improvements had been made, a consistent and robust system continued to not be in place to regularly assess and monitor the quality of service people received. The provider had increased their involvement in the service although this was not enough to provide a comprehensive oversight of the service they provided.

Records relating to people's care had not always been completed effectively. Improvements had been made but further improvement was needed.

The provider asked for the views of the service from people and their relatives.

Staff were happy working at the service and found the registered manager to be approachable and committed.

Welcome Home

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 service had previously been rated 'Requires improvement' and we had carried out enforcement action. We returned to check if improvements had been made.

This inspection took place on 27 and 28 March and 4 April 2018. The first day of the inspection was unannounced. The inspection was carried out by one inspector and an expert by experience who has experience of family members living in a care home and receiving care from a domiciliary care agency. The expert by experience made telephone calls on 28 March 2018 to people who received a service from the Welcome Home care agency and their relatives.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke with 14 people who used the DCA and supported living service and with 11 relatives of people across all three services, to gain their views and experience of the service provided. The people living in the care home were not able to verbally communicate their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke to the registered manager, the manager of the care agency, the deputy manager of the care home and five staff including senior care staff. We received feedback from one health and social care professional and one local authority commissioning officer.

We spent time observing the care provided and the interaction between staff and people. We looked at eight people's care files, medicine administration records, 14 staff records including recruitment documents, as well as staff training records, the staff rota and staff team meeting minutes. We spent time looking at the

provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

Is the service safe?

Our findings

At our last inspection, on 20, 22 and 23 June 2017 we found that the registered provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was in relation to, individual risks to people's health and welfare had not been appropriately identified and reviewed and people's prescribed medicines were not always managed safely in the care home. We also made a recommendation in relation to the regularity, recording and monitoring of fire evacuation drills in the care home.

At this inspection we found improvements had been made to the safe management of medicines administration within the care home, however people's prescribed medicines were not always administered safely within the care agency. Although some improvements had been made to the management of risk, further improvements were required in the care home. Fire evacuation drills had been undertaken in the care home and the documenting of these had improved.

The people living in the care home were not able to speak with us to tell us if they felt safe. We saw that people were happy and relaxed, laughing, smiling and communicating well with staff, using their own communication methods. People's relatives told us they were very happy with the care their loved ones received and felt they were safe. The comments we received included, "[They] are always happy. We would know if [they] were not happy, definitely safe living there"; "[They] are very well looked after and I am more than happy with the care"; "I see [relative] regularly and [they] are always happy to see me but also always happy to go back home"; "[Relative] is living in a place I am very happy with" and "I can go to bed at night knowing [relative] is safe and happy".

We spoke to people who received care in their own home from Welcome Home care agency and they told us they felt safe. The comments we received included, "I do feel safe thank you, I simply couldn't do without them"; "On balance I would say that I feel safe and confident with the carers and have no concerns"; "I feel safe enough with them here, better than being on my own"; "Yes they are very helpful, and I feel completely safe in their hands" and "All good thank you, safe as houses with the girls who come, no problems really at all". People's relatives also spoke to us and said, "Yes I feel safe knowing that mum is being cared for by some lovely carers" and "On balance I would say it is pretty good".

Care home

People were not always protected from the risks associated with their personal care and treatment. Although some individual risk assessments were in place in the care home, the assessments did not cover some risks identified through care planning. One person had a bed guard attached to the bed to keep them safe, preventing them falling from bed. However, the risks associated with bed guards, for example, entrapment, product faults or staff error had not been assessed to provide guidance for staff how to prevent the person being harmed from the bed guard. Another person had epileptic seizures. Guidance was in place through the care plan for staff to follow should the person have a seizure. However, the risk was not highlighted through an individual risk assessment to make sure staff followed the specific measures required to keep the person safe. Individual care plans identified some risks and described how staff should

progress with safe care and support. Some people had behaviour that others may find challenging at times. Individual guidelines were in place providing staff with step by step advice how to support the person if a situation arose. An individual risk assessment had not been completed to control the risks associated with the behaviour as described. The behaviour guidance in place for one person had been written in December 2015 and had not been reviewed since then.

A risk assessment covering multiple risks was in place, including slips, trips and falls, swimming and activities. However, some of these areas required individual detail to control the hazards identified. The risk assessments that were in place were confusing as three different formats had been used. The registered manager told us they were not happy with two of the formats used as they did not provide the detail they felt was required. The registered manager had developed a simpler risk assessment, however, these had not been fully completed and missed the detail required to show the measures that needed to be in place to prevent harm.

Care agency

People's prescribed medicines were not always managed safely in the care agency. Incidents had not always been reported and investigated appropriately. Staff administered one person's prescribed medicines as they were not able to self-administer. The person was visually impaired and forgetful. Their relatives ordered and returned the person's medicines and also administered their medicines on occasions. The care plan stated staff members employed by another agency also administered a prescribed painkiller on occasions if required. Although this was recorded in the care plan, responsibilities were not clearly defined and the risks associated with this approach were not assessed. Welcome Home care agency staff recorded when they had administered medicines on the provider's electronic recording system. Sometimes staff had recorded that they had not administered the person's medicines as a relative had administered them instead. The person's medicines were dispensed in pharmacy filled blister packs but some were kept in original boxes. It therefore may not always have been clear if the person had been given medicines by a relative or another agency unless staff were told by these persons. An incident had occurred on Tuesday 20 March 2018 when a member of staff noted from the medicines administration record (MAR) that the previous days medicines had not been administered. The staff member did not immediately realise and popped Monday's medicines from the blister pack instead of Tuesday's. This meant two reportable incidents had occurred. The member of staff did contact the office when they realised what had happened. The office staff did complete an incident form, however, no further investigation had been carried out by the care agency manager of the registered manager. We spoke to the registered manager and the care agency staff about this. They said they would arrange a meeting with the person's relatives to ensure a system with clearly defined responsibilities was put in place to make sure the person was kept safe from the risks associated with the administration of their prescribed medicines. Not managing medicines safely or learning from errors exposed people to the risks of continued harm.

The failure to assess and mitigate individual risks and to ensure the safe administration of prescribed medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care Home

Improvements had been made to the management and administration of people's prescribed medicines in the care home. All staff who were responsible for administering people's medicines had their competency checked by the registered manager as well as undertaking on line medicines training. The ordering, storage and returns of medicines were now well planned and documented. Medicines administration records (MAR) were neat and legible which meant errors were more easily identified. People had an individual care plan and a risk assessment to address the support required with the administration of their medicines. Care plans

included guidance and reminders for staff, such as the individual support each person needed when taking their medicines, using disposable gloves to prevent infection and remembering to sign to say they have administered the medicines to keep people safe. Some people had medical conditions which meant they were required to take medicines with them whenever they went out in case emergency administration was needed. For example one person had epileptic seizures. It was essential they had their emergency medicine with them at all times when outside of the home in case they had an epileptic seizure. Their care plan described what staff needed to do, the medicine they needed to take with them and how to administer the medicine if needed. At the last inspection in June 2017, staff were not following the procedures in place when signing to take the medicines off the premises. At this inspection, processes had changed and staff were now completing the appropriate records, ensuring the person was kept safe. The deputy manager checked the medicines records each day to make sure safe practice continued. This meant any errors or concerns could be investigated and addressed straight away. Daily audits of medicines were undertaken by the deputy manager, checking the stock of medicines to ensure they tallied with the records. MAR's were checked to make sure there were no gaps or other errors. Where areas for improvement were recognised through the daily audits, action had been taken to address these. Staff told us the management of medicines had improved. One member of staff said, "Medicines are much improved. They are better organised and the paperwork and checks made are much better".

Where people were prescribed medicines 'as and when necessary' (PRN), guidance was available to staff in both the care home and the care agency to know when to offer people their PRN medicines. For example if people were able to say if they were in pain and needed Paracetamol or if staff were required to assess if a person was in pain as they were unable to verbalise this.

Care agency

The provider employed a manager to run the day to day operation of the care agency. There had been staff changes in the care agency which had caused a negative impact on the planning and coordination of staff. This and staff vacancies meant the registered manager and office staff were struggling to successfully deploy staff. This was reflected in the comments from people and their relatives. People told us, "It is not perfect by any means, the timings are really very bad"; "It can be a bit hit and miss with timings I have to say" and "We do sometimes worry that they are not coming so call the office and that can get us in a state sometimes". People's relatives told us, "Time keeping really is not good, not good at all"; "Things can be erratic, a bit of a toss-up with timings" and "No, I don't think they have enough staff to go round so everything is rushed and consequently not done thoroughly as they're rushing for their next appointment".

Staff were also unhappy as they did not receive a rota so they did not know when and where they would be working, often until the night before they were due to work. Staff told us their work was allocated on a day by day basis. The office staff confirmed this was an on-going problem.

This is an area we identified as needing further improvement.

Individual risk assessments were recorded to identify hazards within people's own homes and the risks associated with their personal care. During the care agency's initial assessment of people's care needs, an assessor visited people at their home. The assessor checked the home environment, both inside and outside to identify any hazards that would create a risk to the person or staff while they were receiving support. Individual risk assessments were recorded alongside the care plan to identify the risks associated with the personal care tasks and to put measures in place to prevent harm. One person was at risk of choking when eating or drinking as they spent a lot of time in bed. Staff were guided to ensure the person was sitting upright in bed whenever they were assisted with food and fluids. People who required support from staff and / or equipment to move around the home had a moving and handling risk assessment to identify any

hazards to people or staff and put measures in place to help to keep them safe. Aids such as a hoist, wheelchair or walking aids were recorded, including how staff supported the individual using the equipment, any risks associated and how to control the risk.

Care Home

Although the registered manager told us they had staff vacancies they were in the process of recruiting to in the care home, there were suitable numbers of staff on duty to make sure people received the care and support they required with their assessed needs.

Detailed personal emergency evacuation plans (PEEP's) for people living in the care home were now in place to keep each person safe in the event of a fire or other emergency where evacuation of the premises would be required. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the care home in the event of a fire. A fire alarm test was carried out each week to check the alarm system worked as it should across the home. The registered manager made sure fire evacuation drills were undertaken regularly and these were recorded more appropriately than at the last inspection in June 2017. All the appropriate maintenance and servicing of utilities and equipment had been carried out regularly. Such as gas safety, electrical wiring checks and legionella and asbestos surveys.

Care home and care agency

Staff working both in the home and the care agency had a good understanding of their responsibility to protect people from abuse. Staff could refer to guidance about abuse through the provider's safeguarding procedure as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us they would have no problem raising any worries they had with the registered manager and they were aware of who to contact outside of the organisation should this be necessary. A member of staff said, "There are never any issues to give concern. I would definitely speak up if there were and I am confident all other staff would too".

Safe procedures continued to be in place in order to make sure staff were suitable to work with adults who required care and support. New staff went through an interview and selection process. The registered manager made sure gaps in employment were explored and recorded and references had been requested before new staff could start in post. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with vulnerable people. People were protected from the risk of receiving care from unsuitable staff.

The registered manager made sure staff had appropriate personal protective equipment (PPE) such as disposable gloves, shoe covers and aprons when carrying out personal care tasks. This meant that people were protected from cross infection. Care agency staff visited the office to pick up supplies to keep in their car or their bag so they always had the equipment they needed.

Is the service effective?

Our findings

At our last inspection, on 20, 22 and 23 June 2017 we found that the registered provider was in breach of Regulations 11 and 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. These were in relation to, sufficient evidence had not been provided that people's basic rights and consent to care and treatment had been upheld; staff had not received the appropriate support, training and supervision to ensure they were able to carry out their role well. Both breaches were in relation to the care home.

At this inspection we found that some improvements had been made in both areas, however, further improvements were needed and staff support, supervision and training had declined in the care agency.

We spent time observing life in the care home through the day and saw staff displaying their skills and experience when supporting people and communicating and chatting with them. Staff used their knowledge of people to give choices to suit the understanding of each individual person. Relatives of people living in the care home told us they were kept updated about their loved ones care. The comments we received were, "They (staff) always keep me updated, for example best interests meetings and reviews. We used to have one review a year but they have told me there are going to be two now, one every six months"; "[Relative] always looks well. Any slightest illness and they take [them] to the doctors. They always let me know. They take good care of them".

Most people who received support from the care agency in their own homes thought staff had a good understanding of their role and knew how to support them. The comments we received included, "I couldn't do without them, they will just put their hand to anything I require of them to make my life easier to manage"; "They all know just how I like things doing and I think it is also written in my care plan"; "They do things the way I like them done"; "We often chat about the way we would like things done and we are listened to until the carer changes and we have to go through it all again"; "Not overly confident that they know what to do when but at least I can say if I don't agree with what is happening" and "They do enough to say they have been but no more". Relatives were also mainly confident in the ability of staff, they told us, "The staff are very understanding and always respond appropriately. They even spotted a sore on his heel and dealt with it before it got any more serious"; "I think they know what they are doing and support mum well enough" and "They seem fine, nothing to worry about, they all get on with it and know what they are doing I think". One relative thought staff did not have the training to support their loved one in the way they would want.

The provider used an electronic record keeping system to support the development of all records within both the care home and the care agency. Both services were now using the system regularly for recording of documents such as care assessment, care planning and care reviews. A tasks tab on the electronic system was used effectively to give staff the information they needed on a daily basis as well as the tasks they need to carry out, record and sign off.

Care home and care agency

At the last inspection, we made a recommendation about staff support. Some improvements had been

made to the support and development of staff, although the improvements were limited and further investment in staff was needed. Although staff told us new staff received an induction where they shadowed more experienced staff for a period of time until they got to know people and felt confident in their role, we found no evidence that this was the case. No records were kept of new staff induction and there were no records to show staff had completed a probationary period to make sure they were suitable to work in the role they had been employed to do. Staff had not received the support they would have expected by way of one to one supervision meetings with their manager. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The provider's policy stated staff would receive six supervision sessions a year. Of the five staff files we looked at in the care home, in the nine months since the last inspection in June 2017, one staff member had received no supervision, one staff had one supervision meeting recorded, two had two supervisions recorded and one had three. We looked at five staff files in the care agency. Two staff had received no supervision, one staff had one supervision meeting recorded and two staff had received three supervisions. Staff had still not had the opportunity to take part in an annual appraisal of their work in either the care home or the care agency. An annual appraisal supports staff to reflect on their work over the previous year, to celebrate their strengths and to identify areas for improvement and development over the next year. One member of staff told us, "I don't get supervision often but I do feel supported as I can speak to [the registered manager] if I want to".

Although some improvements had been made to the staff training, the evidence provided showed that some staff had continued to not keep up to date with the training requirements of their role. The training matrix we were given showed some staff had not completed training. We asked the registered manager about this who told us this was not correct as information was missing. The registered manager said they had up to date training information for each staff member in a separate staff file. We asked for this to be sent by email, however we did not receive this information. The training matrix for the care agency showed that out of 20 staff, only three staff had completed dementia awareness training even though staff supported people living with dementia in their own homes; three staff had undertaken health and safety training; six staff had completed infection control training; 10 had completed safeguarding vulnerable adults training and 10 had completed moving and handling training; The training matrix showed that in the care home, 11 out of 19 staff had completed safeguarding vulnerable adults training; 14 out of 19 staff had completed MCA 2005 training and five staff had still not completed epilepsy awareness training even though people living in the care home had epileptic seizures.

The failure to provide the appropriate support, supervision and training as is necessary to enable staff to carry out the duties they are employed to perform was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care Home

The registered manager had carried out some mental capacity assessments in the care home since the last inspection in June 2017. However, some important areas that required an assessment to make sure people's basic rights were upheld had not been considered. One person had a bed guard to keep them safe from falling out of bed. A mental capacity assessment had not been undertaken to determine if the person had the capacity to consent to the restriction, or evidence of the decision to use a bed guard having been made in the person's best interests. Mental capacity assessments were in place to assess people's capacity to consent to taking their prescribed medicines and for staff to administer their medicines. Where the assessment had concluded the person did not have the capacity to make this decision, a best interest's decision making process had not been followed to ensure it was in the person's best interests to administer their medicines. Improvements had clearly been made since the last inspection in June 2017, however further improvements were required to ensure compliance with the MCA 2005.

We recommend the provider and registered manager seeks advice and support from a reputable source to ensure people's rights under the Mental capacity Act 2005 are upheld and recorded appropriately.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager understood their responsibilities in making sure people's rights were upheld. Appropriate DoLS applications to the supervising authority had been made and kept under review.

The provider's electronic system was now being used to greater advantage in the care home since the last inspection in June 2017 and many records were now uploaded for staff to access via mobile phones or an electronic tablet. Care plans continued to be in paper format in the care home and these had more detailed person centred information and described people's preferences as well as their support needs. The electronic system did not capture the person centred detail required to fully understand people's complex health and care needs as well as the paper based care plans did. However, the system was used to a good advantage by staff recording the detail of people's daily life and the observations made. Information was recorded by staff as soon as they had completed tasks. The food people had eaten and the drinks staff gave them were entered onto the system straight away. Staff recorded people's mood through the day, if they were happy or sad. Informative descriptions of trips out such as to the shops, for a walk or for longer leisure activities were recorded on their return to the home. This meant the registered manager and staff had up to date information at their finger-tips to promote good communication to monitor people's progress or concerns.

People had a named key worker, however there continued to be little evidence of their involvement with the people they were keyworker for. A keyworker usually acts as a focal point for a person and their relatives, coordinating support outside of their day to day care needs. We spoke to the registered manager about this who agreed they had focussed on other areas and not developed key-working further. They assured us they planned to ensure keyworkers carried out their role in order to further improve the outcomes for people.

People's care plans included personalised information regarding their physical, mental, emotional and social needs. Each care plan described how to support people to live their day to day life, such as assistance at meal times, showering/bathing, assistance with medicines administration, mobilising, activities and communication. One person was not fully able to voice their needs through speaking. Their communication care plan described how staff could best support them. A list of words the person could say was recorded including a detailed account of what the person was asking for when using each word. For example, 'When I say 'mote mote', this means car and I would like to go out in the car'.

People's health and wellbeing was protected by staff offering enough food and drink. People's care plans clearly recorded their likes and dislikes around food and drink. They also showed if people had specific dietary requirements such as a low sugar diet or needed their food cut up into small pieces or a soft consistency for easier and safe swallowing. The assistance people needed at mealtimes was clearly recorded and provided the information to enable staff to provide the correct level of care. One person's care plan showed how they liked their food to be presented on the plate and which types of food they could eat independently. Another person's care plan recorded they liked garlic bread, cheese on toast and sweet and sour chicken. People were asked individually if they would like a drink throughout the day. One person was given a choice of drinks and chose hot chocolate. As other people were busy at that time they were given their preferred choice of drink later when they were ready. People's individual preferences, likes and dislikes for food and drinks were taken into account on a daily basis.

People were supported to maintain their health and wellbeing by regularly accessing appropriate health care. Health care professionals had been involved in people's care where necessary. Records showed that people had regular checks with their GP, epilepsy nurses, dieticians and speech and language therapists. A record was kept of people's appointments with health care professionals, detailing what the appointment was for, what was discussed and the advice given. One person had a Percutaneous Endoscopic Gastrostomy tube (PEG). A PEG is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach. This is done by a medical practitioner as a medical procedure. A care plan was in place giving detailed guidance to staff how to care for the PEG to make sure the advice of health care professionals and safe procedures were followed. Step by step guidance meant new members of staff would be confident in providing the appropriate care of the PEG tube and site. Staff were encouraged to look at further reading material to increase their knowledge. Details of where to find the books was included.

Care agency

People's care plans were recorded on the electronic system and provided staff with the individual information necessary to support people in their own home. An assessment was carried out with each person when they were referred and before their care commenced so the registered manager could be assured staff were able to meet the person's needs. The assessment identified the care and support people required and this was used to develop the care plan. The information recorded in the care plan included the personal care people required staff assistance with, such as bathing or showering; moving from their bed to a chair and vice versa; assistance with meals and administering medicines. The care plan also recorded further details to assist staff when providing people's care, such as people's communication needs; family involvement and previous medical history.

People who were supported by the care agency in their own homes had their capacity assessed at the initial assessment stage and recorded on the provider's electronic system. The information was immediately available for staff to see when supporting the person. The assessor recorded where people had a problem with their memory at times or if they were living with dementia and required the support of a family member to help them to make decisions. People signed to say they gave consent to receive the care and support as described in their care plan.

Most people made their own health appointments or had a family member or friend who helped them. The care agency supported people when needed to make appointments and occasionally supported them to attend health care appointments. The care agency's liaison with health and social care professionals was good and used to make sure people's needs were met and changes in circumstances and needs were reported.

Some people required the support of staff to assist with nutrition and hydration. Where this was the case, a care plan was in place detailing the support required. People's likes and dislikes around food were recorded. The meals people required support with were documented including whether assistance was required to eat their food as well as cooking their meal. Nutrition and hydration care plans were detailed with the information staff would need to support people well, making sure they received the food and drink they required to maintain good health. One person's nutrition and hydration care plan stated, 'Please make tea, but also make and encourage [Name] to drink lots of water/juice, encourage to drink a whole glass of water when taking medication. Lots of water is important, if [Name] becomes dehydrated this will lead to confusion/dizziness'. Where required, people were supported to maintain their health and well-being through the appropriate support to eat and drink.

Is the service caring?

Our findings

The relatives of the people living in the care home were positive about the staff and very happy with the care their loved ones received. The comments made by relatives included, "They (staff) are very kind and caring, they know [relative] very well"; "When [relative] visits [they] are always really clean and tidy, clothes always spotless and hair kept well"; "I hope [relative] stays there" and "I am really pleased with the care".

People and their loved ones who received care and support within their own home from the care agency thought most staff members were kind and caring. The people we spoke with said, "I would say the staff all know me jolly well and are very caring and kind"; "I think the staff have got to know us well and take an interest in us too"; "No worries about them I would say they are very kind and caring" and "Good care, good service. Kind and caring, there you are that is what the service is, a caring service". People's relatives gave us their views, "All the staff are very kind and always go out of their way to make him feel at ease and comfortable"; "When my [relative] came out of hospital he couldn't walk but they have been very supportive and helped me nurture him back onto his feet"; "They are good enough I would say" and "[My relative] gets totally confused by them all, but they can be good and kind with her just depends who we get on the day".

Staff supporting people in the care home clearly knew people very well. There was lots of chatting and laughter in the lounge area. Although people could not have a full conversation, staff knew people's communication methods and how to engage them individually. People were smiling and laughing and some were singing along to favourite songs. Staff had access to an electronic tablet so they could help people to choose the songs they wanted to listen or sing along to. Staff were singing along too, encouraging people to join in. One person liked to sit on the floor and had access to activities they could enjoy independently. Staff were sitting on the floor with them encouraging their involvement. One member of staff told us, "The care here cannot be faulted. All staff are good, they are all very committed".

Staff told people what they were going to do before they started and asked people what they would like. For example one person was going out to a GP appointment and a member of staff told them they were going to see the doctor and then asked if they were ready to put their shoes on. As the person was not able to do this themselves, the staff member helped to put on their shoes and told them they would be setting off soon.

People's bedrooms were individually decorated to suit what staff understood to be their preferences for colour and décor. Each bedroom had en suite shower and toilet facilities so people could be supported with their personal care in the privacy and comfort of their own personal space. People's rooms had personal belongings, photographs and pictures to reflect their known preferences.

Although people had complex care needs which included some requiring support with their mobility, staff encouraged people to be as independent as possible. One person was supported by a member of staff to walk to the bathroom using their mobility walker, the staff member walking alongside and guiding them to make sure they were confident. Another person was supported to walk to their bedroom with two members of staff, one on either side of the person. One person's care plan described the support they required when visiting the bathroom. The care plan stated, 'Please encourage me to put the light on myself' and went on to

describe in detail how to do this. The care plan continued, 'I am able to flush the toilet myself but if you are with me I will expect you to do it. Please encourage me to do this myself'. One person was getting their own cup out of the cupboard to make a drink with help. The person had also been supported by staff to make their own salad in the morning and stored it in the fridge for use later in the day.

Staff supported people to visit their family members as often as they and their families wanted. Staff also supported people to have visitors in their home surroundings whenever they wished. One person visited their close family member on a regular basis. Staff took the person to the family home in the person's own car and their relative brought them back when they were ready.

Where people living in the care home were not able to be fully involved in the development of their care plan due to their limited communication difficulties, this had been clearly recorded. Where and how the information had been gathered to inform the care plan was detailed. For example, information from relatives, staff who knew people well or health and social care professionals.

Staff maintained people's privacy and dignity when carrying out their personal care. Staff supported people to their bedroom or bathroom and did so quietly and without fuss. Making sure people's privacy was respected was addressed in their care plan. Staff were reminded to knock on people's bedroom door before entering, make sure blinds and curtains were closed and if a healthcare professional such as the GP was visiting, to make sure they were seen in the privacy of their bedroom.

People's cultural and spiritual needs were addressed in their care plan, including when they had not been brought up within a religious faith and continued to not follow a religion. This meant staff had the information they needed to be able to support people with their spiritual needs where appropriate.

Care plans addressed end of life plans for each individual. Plans were based on speaking to a range of people involved in each person's life, including family members and health and social care staff.

Care agency

A crisis situation had developed for one person who was supported by the care agency. The office staff spent much of the day trying to get the right support for the person to ensure they remained safe within their home. This involved contacting and liaising with other agencies such as the local authority social services department and relatives. Staff were clearly concerned and showed a caring attitude together with a professional approach to make sure the situation was dealt with to ensure the safety and support of the person.

We heard many caring exchanges with people and relatives by the care agency office staff throughout the day.

People and / or their relatives were fully involved in the assessment, development and review of their care plans. People signed their care plans to say they had been involved. One relative told us, "Yes, we have meetings and reviews every 6 to 7 weeks and we go through the care plan discussing likes and dislikes"

Is the service responsive?

Our findings

We spoke with relatives of people living in the care home and asked if they could raise concerns. The comments they made included, "I have never had any concerns. I would be more than happy to raise them if I did"; "I know who I would speak to. I have [registered manager's] personal number and also the number of the home" and "I have no need to complain. I would not want [relative] to go anywhere else".

The people we spoke with who received a care service from the care agency told us they knew how to make a complaint and who to speak to. The comments we received about making a complaint included, "Yes I know how to make a complaint I simply pick up the phone and do so"; "Not bad in the office if I call to complain about anything"; "I know how to complain but I wouldn't say I have had to I have just needed to check times and say if we are needing a change in anything and they do listen to me" and "If I need to complain or am the slightest bit worried I am straight on the phone to the office".

Care home and care agency

The provider had a complaints policy in place for the care home and care agency giving the information people or their relatives needed to be able to make a complaint if they wished to. External agencies to contact if people were not happy with the response to their complaint were included, such as the Local Government Ombudsman (LGO) or the local authority. The care home had not received any complaints since the last inspection. The care agency manager told us people did sometimes make contact with the care agency office, usually by telephone, to raise concerns about their care and support. People said they did not want to raise a formal complaint. However the care agency kept a record of these and the action they had taken. For example, people made contact to say a staff member was late, or had not arrived. Office staff had recorded their action, such as contacting the staff member.

People living in the care home had written care plans that were person centred providing the information staff would need to provide people's assessed care needs in the way they preferred. The smallest details were written into the care plan as a step by step guide through each person's day. This meant that new staff had the information they needed to provide good support while getting to know people. One staff member told us, "The care plan files are very good. I found them invaluable in providing the information I needed to be able to support people". Care plans were broken down into morning routine, afternoon and evening routine and night time routine. Personal information was therefore easy to find when needed. One person's care plan recorded that they did not have a specific time to get out of bed in the morning, 'Staff to be led by me. Sometimes I get up and then I want to go back to bed. I will say, 'bed''. Specific detail was also given about how the person liked to have their blankets placed on their bed at night. Another person's care plan showed they preferred staff to assist them to have a wet shave with a razor, detailed guidance gave the information staff needed to carry out the task with success.

Although changes to people's care and support needs were recorded each month, the changes were not always reflected in the care plan. For example, one person had been prescribed an antibiotic cream for a period of time. Although this had been recorded on a 'care plan changes' sheet, details of how and where to administer had not been incorporated into the care plan which could have meant the cream was not

administered as prescribed. Another person's records stated no changes to the care plan since November 2017. However, staff told us the person had been having disturbed nights and the registered manager had identified a possible cause. A GP appointment had been made for a check-up. This was not recorded or reflected in the care plan. This meant that people's care needs might not be met as the information in the care plan was not always updated to reflect changing needs.

People receiving care in their home from the care agency had care plans that provided important personal information to enable staff to understand some of the person's life and what was and is important to them. One person's care plan documented how many children they had, where they lived and how often they visited. It also recorded the person had a dog which was very important to them. The care plan also stated '[Person's name] lives alone and enjoys company, please sit and have a chat with [Name], time permitting'. One person had a visual impairment that meant they saw only shapes. The details of how their visual impairment affected them and the action staff could take to support the person while at the same time promoting their independence were clearly recorded.

Regular reviews of people's care plans had not been undertaken to ensure their most up to date needs were being met. The member of staff previously responsible for this task was no longer working in the care agency. Another member of staff had been transferred from the care home to carry out this role, however this had taken some months. In the meantime, people had not had their care plans reviewed, although staff had completed some reviews in recent weeks. Care plan reviews should have been carried out every 10 - 12 weeks, however, one person had not had a review of their care plan since September 2017 and another since October 2017. This meant that people's care needs might not be met as the information in the care plan was not always up to date.

This is an area we have identified as requiring improvement.

Care Home

Each person living in the care home had been supported to have the opportunity to get their own car through the Motability scheme. The Motability scheme enables disabled people to get mobile by exchanging their mobility allowance to lease a new car, scooter or powered wheelchair. This meant people could go out individually as well as with others if they wished.

Although people went out often, taking part in either individual activities with staff support or going out together as a group, the registered manager was aware the records staff kept to evidence activities were not always completed and up to date. The registered manager had introduced different ways to capture people's interests and to show their involvement. For example, an activities board for each person, with pictures of the activities they were planning to take part in each week was now hung in their bedroom. A list of people's interests both indoors and out in the community was in the process of being developed to go alongside the activities boards so staff could help people to choose from a list of options each day. The list was being added to for spring and summer. For example, if the weather was very poor which meant people could not pursue the plans they had in place, staff could encourage other interests, even if the staff member was new and did not know the person well. One person's care plan recorded that they had a favourite film they liked to watch. The person was feeling unwell on the day of inspection and stayed in bed for a while. They were watching the film in their bedroom as it comforted them to have the familiar film on. The person also liked going out in their car and liked going to buy a favourite magazine.

Two people went out together for the day and as it was raining, staff chose an indoor activity they knew both people enjoyed. On their return, the staff who supported them to the activity spoke about the fun they had, including both people in the conversation even though they were not able to join in verbally. Staff had taken

photographs to show to help share the experience. One person went to a local day service once a week, supported by a member of staff for the whole day to make sure the person received the care and support they required while at the same time being able to enjoy socialising with others. The member of staff supporting them to attend the day service made sure they had changed their clothes in order to look clean and smart before setting off. One member of staff said, "Activities have improved. We could do better though and I think the plans will be better in the spring and summer".

Is the service well-led?

Our findings

At our last inspection, on 20, 22 and 23 June 2017 we found that the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was in relation to, quality monitoring systems had not been developed to ensure the registered provider and the registered manager had proper oversight of the quality and safety of either the care home or the care agency.

At this inspection, we found that the provider and the registered manager had made some improvements by introducing some monitoring systems that were working well. However, consistent auditing systems to ensure the clear management and oversight of the service by the provider and registered manager had not yet been evidenced.

When we spoke to the relatives of people living in the care home about their views of the service they were overwhelmingly positive and more than happy with the care and support their loved ones received. They described a staff team who knew their relatives well and a homely environment where their loved ones were happy. The other comments we received included, "[The registered manager] is very approachable and knows everyone well"; "It is the best thing we have done for [relative]. We were very nervous to start with but no problems then or since" and "[Relative] has been able to leave home like their brother and sister and I couldn't be happier".

The majority of people receiving care and support in their own homes from the care agency did not have positive comments to make about the management of their service. We were told, "I think that they do have their work cut out for them and sometimes that shows with the office's response to queries"; "They do get in a terrible muddle in the office"; "Yes they are well led I think, the phone gets answered promptly although you never know who you get in the office and usually it will be someone new"; "I am not happy with the office at all they just cannot organise things properly at all, not by any measure"; "Too many complaints from the staff for the office to be well led I feel" and "I do call the office about time keeping but they just say they will try to change things and they don't".

People's relatives were equally concerned about the management of the care agency, "The office is hit or miss. You never know if you are going to speak to someone who will actually take note and hear what you are saying or not, very frustrating"; "The problem is the office and they never keep us up to date with changes"; "No continuity at all, none whatsoever. Nothing is ever followed through and notes are never passed from one person to another" and "The problem is the management in the office".

Care home and care agency

Although some improvements had been made to the quality monitoring and auditing systems, further work was still required by the provider and registered manager to make sure consistent systems were used to measure the quality and safety of the service. Health and safety systems were not protecting people from the risks of potential harm. Weekly health and safety checks had not been completed in the care home since 30 January 2018. One member of staff was responsible for carrying out health and safety checks but had not been available and the registered manager had not allocated the task to another member of staff. The

registered manager told us they were trying to simplify the form to make it easier to use and had not yet completed this.

The registered manager told us they had tried more than one auditing system to monitor the quality and safety of the services. They had not found any system to be as effective as they wanted and had not continued to use them, instead, deciding to devise their own. The provider or registered manager had not completed the development of an effective system. This meant that systems had not been used consistently by the provider and registered manager in order to have a clear oversight of the action needed to improve the services and to sustain improvements. Where issues had been found, no action was shown to have been taken to rectify the concerns identified. For example, the provider had carried out one visit in November 2017 when they noted that, 'Risk assessments need to be more in depth'; 'More work required by manager' regarding mental capacity assessments; staff meetings, 'Need to improve, more staff meetings required'. However, no action plan was completed to determine the action needed, who was responsible and when the improvements needed to be made by. Therefore, when we visited to carry out our inspection we identified these areas as still requiring improvement as no action had been taken to address the shortfalls.

The care agency manager had started to audit care plan reviews, staff supervisions, staff training and staff recruitment files since the last inspection in June 2017. Some of these were more effective than others. The auditing of staff files was not robust as it consisted of a tick box form which did not give any meaningful information or action plans to identify and make improvements. We spoke to the registered manager and care agency manager about this who agreed they needed to develop a system that would ensure issues were identified and evidence where action was taken to improve the quality and safety of the service.

The registered manager told us on the last day of inspection they had decided on the auditing tools they planned to use and would be starting to use these straight away.

People were not supported by staff who had the opportunity to develop communication and team culture. Staff had not been given the opportunity to attend staff meetings to build team networks and support. The registered manager and management team had not prioritised this as an important way to provide updates, support staff, encourage a learning forum and promote the provider's values and expectations. Only one staff meeting had been held for care home staff since the last inspection in June 2017. The records of this meeting showed a discussion had taken place between all attendees and the registered manager had used the opportunity to undertake staff coaching around epileptic seizures and blood glucose monitoring. No evidence was shown of any staff meetings for care agency staff. The provider had started to hold meetings for the management team and senior care staff, held in September, October and November 2017. However, these had not continued. The records gave every limited detail of the discussions held and if any action had been agreed.

Most staff working in the care agency had fed back clearly in a staff survey undertaken in July 2017 that they were unhappy that staff rota's were not completed and distributed in good time for them to plan their work and personal lives. Many staff had also raised in the staff survey that staff meetings were not held regularly enough. These two areas continued to be an area of concern eight months later. There was no evidence that the provider had contacted staff to let them know what they planned to do to improve the situation. There was no evidence that the provider had listened to what staff had said and taken action to improve. This meant that the provider had a lack of understanding about how to improve the service by listening to staff views.

Care agency

The electronic recording system used within the agency created an 'alert' if staff had not clicked to confirm

they had carried out people's assessed care tasks. The alert was raised on the system so office staff could see the raised alert and deal with the issue by ringing staff to find the reason immediately. However, alerts were not always followed up as it was not always clear which office staff were responsible. A staff member had been transferred from the care home to monitor the alerts and a system had been put in place. This was an improvement from the previous inspection in June 2017. However some 'red' alerts were not being prioritised. The registered manager had identified this as a problem and had plans to review the monitoring system. The alerting system had not flagged up a medicines error when a person's medicines had not been administered. The staff member had clicked in error to confirm the task was complete on the electronic system. The incident was reported by a member of staff the next day, however, no investigation was carried out. There were faults in the monitoring and recording systems that needed to be addressed.

Due to the absence of a coordinator in the care agency, all staff were dealing with telephone calls about rota and staffing concerns which took them away from their own job role responsibilities. This resulted in other areas of their roles not being kept up to date or actioned as seen through this report. There was no plan or rota in place to ensure a coordinated approach was taken to answering the telephone and to deal with queries. People and their relatives told us clearly they did not have confidence that their queries were dealt with appropriately and they did not have confidence in the management and leadership of the care agency.

A member of staff said, "The paperwork does let us down, but that is improving".

The failure to ensure records were kept up to date, to have systems in place to manage the service successfully and to regularly assess and monitor the quality of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and the management team monitored the daily records made by staff on the electronic recording system in both the care home and the care agency. Systems were set up to check records weekly, although if any concerns were raised about a person's health and wellbeing this could be changed to daily or to intervals decided by the registered manager. For example, the monitoring carried out weekly in the care home included, seizure charts; food and fluids; skin care; urine output and bowel movements and activities.

The registered manager used the electronic recording system to send messages to all staff in either the care home or the care agency. For example, the registered manager noted one person living in the care home had not drunk the recommended amount of fluids one day. They were able to send a memo to all care home staff making sure they encouraged the person to drink more. Staff were expected to confirm they had read the memo. The registered manager was able to continue to monitor the person's fluid intake through the system.

The registered manager told us they had made some changes to the management structure to support the management and leadership of the service. A deputy manager had been appointed to the care home in recent months and the registered manager was in the process of training them. The new deputy manager had been appointed from within the staff team of the care home. The registered manager said they hoped the appointment would eventually free them up to concentrate on the management and leadership of the whole service and make further improvements.

Staff spoke positively about the registered manager and the management team, telling us they were supportive and approachable. One member of staff said, "[The registered manager] is very supportive. I know I could ring anytime and they would be here, even in the middle of the night, if it's about the people living here". Another member of staff told us, "[The registered manager] works really hard and tries to get it

all right".

People living in the care home were not able to engage in giving their feedback of the service they received. The provider asked relatives and friends of people for their views of the service by sending a questionnaire in July 2017. Four were completed and returned. Comments were positive with no areas raised for improvement. One relative had asked for updates on specific areas of their loved ones care and these had been given. People receiving a service from the care agency were asked to give their views of the service provided during each care plan review. The comments we looked at were mainly positive, people saying they were happy with their support.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report and ratings in the reception area.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths without delay. Notifications had been received by CQC about important events that had occurred since the last inspection.

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
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to assess and mitigate individual risks and to ensure the safe administration of prescribed medicines.
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure records were kept up to date, to have systems in place to manage the service successfully and to regularly and consistently assess and monitor the quality and safety of the service
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to provide the appropriate support, supervision and training as is necessary to enable staff to carry out the duties they are employed to perform.