Surrey Homecare Limited

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Inspection report

Mabel House
1 Weston Green
Thames Ditton
Surrey
KT7 0JP

Tel: 01372462118
Website: www.surreyhomecare.co.uk

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

Summary of findings

Overall summary

The inspection took place on 12 February 2018 and 13 February 2018 and was announced. Our last inspection was in December 2016 where we rated the service 'Requires Improvement' and identified one breach of regulation in relation to record keeping and governance.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe and Well-led to at least good. At this inspection, we found that despite some improvements having been made the provider had not met the legal requirements. We found a further breaches of regulation in relation to risk management, medicines and consent.

Surrey Homecare Limited is a domiciliary care agency providing both live-in and hourly support to people in their own homes. The service provides support to older people, people with physical disabilities and those with long term medical conditions. They also provided support to people living with dementia. At the time of our inspection, there were 96 people receiving 'personal care'.

Not everyone using Surrey Homecare Limited 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.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a lack of oversight of incidents such as falls that meant that patterns and trends could not be identified. Medicines records contained gaps and these had not been addressed with staff. Some staff were not up to date with medicines training which meant that the provider could not guarantee people would receive their medicines safely.

People's legal rights were not protected because staff did not follow the Mental Capacity Act 2005 (MCA). Staff had administered medicines covertly to one person without any documentation in place to assure that person's legal rights. Where people were unable to consent to their care themselves, the provider had not followed the correct legal process as outlined in the MCA. There were gaps in staff training and in areas such as medicines and the MCA, staff training was not up to date. We also found that a number of staff had not had a recent one to one supervision.

We found that improvements made since our last inspection had not fully addressed our concerns. Checks of records were not always taking place and there was no system in place to robustly monitor people's care experience. Where we identified a significant concern in relation to consent, the provider's own checks and audits had not identified this to address it. Shortfalls in medicines records and documentation had not been

robustly addressed by the provider's auditing systems.

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

Most people told us that staff were punctual and stayed for their call times. However, we did receive feedback that some staff were rushed and noted that the provider's system for scheduling calls did not always allow for travel time. We recommended that the provider reviews their staff deployment to address this.

Care was not always planned in a person-centred way. Whilst there were some areas of good practice, the level of detail in people's care records was not consistent. We recommended that the provider reviews people's care plans to achieve consistency in this area. People's care was being regularly reviewed and care plans reflected people's strengths, in order to promote their independence. People's food preferences and dietary needs were recorded and they told us that staff prepared them meals in line with this.

People spoke highly of the staff that supported them and told us that they got along well. We observed pleasant caring interactions between people and staff during visits. Staff knew people's needs well and told us that they got appropriate support from management. Staff were respectful of people's privacy and dignity when providing support to them in their homes. Staff involved people in their care and people received an assessment that documented their needs before they received a service.

Staff liaised with healthcare professionals where required to ensure that people's healthcare needs were met. Risk assessments reflected people's needs and actions for staff to keep people safe. Staff responded appropriately to incidents to ensure people's safety. There was a complaints policy in place and people told us they knew how to complain. Records showed that complaints had been responded to appropriately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were shortfalls in record keeping that meant there was a lack of analysis of incidents. Shortfalls in records regarding people's medicines had not been addressed and some staff had not received recent medicines training.

In some instances staff were not allowed enough time to complete care calls on time. We made a recommendation about the provider's deployment of staff.

The provider carried out appropriate checks to ensure that staff were suitable for their roles.

Staff understood their roles in safeguarding people from abuse. Where incidents occurred, staff took appropriate action to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's legal rights were not protected because staff did not follow the correct legal process as outlined in the Mental Capacity Act 2005.

There were gaps in staff training and some staff had not received one to one supervision.

Staff worked alongside healthcare professionals to meet people's needs. People's needs were assessed and staff made use of equipment and adaptations at people's homes to meet their needs.

People were prepared food in line with their preferences and their dietary requirements.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Calls were not scheduled in a way that would always enable staff to spend time interacting with people.

People were supported by kind staff that they got along well with. Staff knew people well.

Staff supported people in a way that encouraged their independence and promoted their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were inconsistencies in the level of detail in people's care plans. We recommended that the provider reviews their documentation to address this.

Care was regularly reviewed and people were asked for feedback on their care.

Complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of response to our previous concerns and there was a continued lack of oversight at the service. Shortfalls in records were not identified and addressed.

Staff felt supported by management and had regular meetings.

The provider had submitted notifications to CQC where they were required to do so.

Surrey Homecare Limited

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 13 February 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because we needed to be sure that someone would be in.

Inspection site visit activity started on 12 February 2018 and ended on 13 February 2018. It included telephone calls to people and their relatives and home visits to observe caring interactions between people and staff. After the inspection we received further documentation from the provider. We visited the office location on 12 February 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with the registered manager, the nominated individual, two team leaders and four care staff. We spoke with eight people and one relative on the telephone. We also visited two people and observed the care that they received and how staff interacted with them. We read care plans for nine people, medicines records and the records of accidents and incidents. We looked at records of

complaints and the provider's surveys. We looked at six staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits and also minutes of staff meetings.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe with the staff that supported them. One person said, "I feel totally safe with them [staff]. I know and like them all." Another person said, "Of course I feel safe, they [staff] are my friends." Another person told us, "Oh yes I feel safe, you couldn't fault them on safety." A relative told us, "I feel [person] is safe with the staff. I've never had any cause for concern."

At our inspection in December 2016, we identified shortfalls in record keeping that meant that there was not always clear guidance for staff on how to manage risks. We also recommended that the provider reviewed their responses to incidents to reduce the risk of them reoccurring. At this inspection, we found a continued lack of oversight of records relating to risk and medicines.

The systems to monitor risks were not robust enough to ensure people's safety. The level of analysis of accidents and incidents was inconsistent and had not always happened in a timely manner. Analysis of incidents took place by geographical area and some had not taken place for over two months. For example, we saw evidence of analysis of incidents for one area that covered the previous month. The registered manager was unable to find the analysis for another area and sent it to CQC after the inspection. This analysis had taken place retrospectively which showed it had not been completed in a timely manner. This meant that patterns and trends could not be identified and addressed promptly, to minimise the risk of them reoccurring.

Records regarding people's medicines were not always complete. We identified gaps on medicine administration records (MARs) where staff had not recorded the reason why people had not taken their medicines. Staff did not routinely use codes on MAR charts to denote why people had not received their medicines. This meant there were not clear records of when people had received their medicines or whether there was a reason why they had not done so. Checks in place were not identifying or addressing gaps in record keeping. We identified multiple gaps on people's medicine administration records (MARs). In most cases, these MARs had been signed off as checked by office staff. There was no formal medicines audit that documented the actions taken and gaps on MARs continued. This showed that responses to shortfalls in recording were not robust enough to prevent them reoccurring. Training records also showed that some staff had not received refresher training in medicines for over three years.

The lack of oversight of accidents and incidents and the shortfalls in medicines records and training was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where individual accidents or incidents occurred, appropriate actions were taken to keep people safe. Whilst we identified a lack of analysis, we did find that the staff took appropriate action in response to incidents. Records of individual incidents showed that staff took immediate action to ensure people's safety and further measures were taken to prevent accidents happening again. For example, staff noted signs that a person may be developing a pressure sore. Staff applied creams to the person and documented the sore. Staff then contacted the tissue viability nurse (TVN) from the community district nursing team so that the person could receive treatment.

Staff were not always deployed in a way that meant people received their care as scheduled. Most people told us that staff attended their calls punctually, but we did receive feedback from two people that staff appeared rushed and were occasionally late. The provider told us that they had found recruiting staff a challenge and they had a plan to address this. They were recruiting new staff at the time of inspection and had recruited new staff in the area where we received negative feedback. We looked at the provider's system for scheduling people's care calls and saw that in this one area time was not scheduled to allow staff time to travel. In most instances, the impact of this was reduced because people lived close together and their needs were often met within the call times. However, this increased the likelihood of people not receiving their care on time.

We recommend that the provider reviews their systems for deploying staff to ensure staff arrive at the times expected.

Risks to people were managed safely. Personal risks to people had been assessed and documented with plans for staff on how to keep people safe. For example, one person had a risk assessment for mobility that identified that they were at risk of falls due to frailty. A plan was implemented for the person to be supported to move with two staff. It contained instructions on equipment that the person used and the process by which staff should transfer them. We observed this person being supported to move by two staff and they followed the guidance in the risk management plan. The person looked safe and confident moving into their chair with equipment and support from staff. The person also told us that they felt safe when being supported in this way. Care plans contained risk assessments for risks such as falls, malnutrition and pressure sores.

The provider carried out appropriate checks to ensure that staff were suitable for their roles. At our inspection in December 2016, we identified gaps in staff employment histories. We recommended that the provider took action to address these gaps. At this inspection, we found that the provider had obtained full employment histories from staff. Staff files also contained evidence of references, right to work in the UK and DBS. DBS is the disclosure barring service. This is used to identify potential staff who would not be appropriate to work within social care.

Staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding and were knowledgeable about the procedures for reporting suspected abuse. One staff member said, "I'd report it to my line manager or the office. I could whistle blow and call CQC or the safeguarding team." Records showed that where staff had concerns, they had raised them and the provider had worked with the local authority safeguarding team recently to address concerns regarding one person.

Systems were in place to manage the risk of the spread of infections. Staff had been trained in this area and they followed best practice. People told us that staff washed their hands before and after providing care to them. During a home visit, we observed staff washing their hands after supporting one person. Staff were also observed using and disposing of personal protective equipment (PPE) safely to reduce the risk of cross contamination. The provider ensured PPE was in place in people's homes by providing aprons and gloves at each review.

There was a plan in place to allow the service to continue in the event of an emergency. A business continuity plan was in place that planned for situations such as extreme weather, pandemic or fire that could affect people's care.

Requires Improvement

Is the service effective?

Our findings

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

People's legal rights were not protected because staff did not follow the correct legal process as outlined in the MCA. Whilst staff were able to tell us how the MCA worked and affected the people that they supported, we found evidence that the correct process was not being followed. Records showed that people's mental capacity to consent to their care had not always been assessed. There were also no records of best interest decisions being made for people who lacked the mental capacity to consent to their care. For example, we noted that one person's care plan had been signed by their relative. There was no evidence of a mental capacity assessment to assess this person's ability to consent to their care. There was also no evidence of documentation to show that their relative was legally able to provide consent on their behalf, such as a registered Power of Attorney document.

We also identified that the correct legal process had not been followed where one person had been administered covert medicines (without the person's knowledge or consent). The person's daily notes recorded two consecutive days in which staff recorded that they had given them their medicines within food, as the person had refused. The person had no mental capacity assessment regarding whether they could make decisions around their medicines. There was no record of a best interest decision or authorisation from the prescribing doctor and a pharmacist. The provider told us that this had been agreed with the community mental health team (CMHT) that had prescribed the medicines. However, there was no record of this and the provider was unable to obtain any documentation from the CMHT after our inspection. We saw a letter from the person's GP written after our visit that confirmed this person was to receive their medicines covertly. However, at the time the medicine was administered there was no evidence that the correct legal process had been followed. This demonstrated a significant lack of understanding of the MCA and an inappropriate use of restrictions that could place people at risk.

The failure to follow the correct legal process as outlined in the MCA was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014).

People told us that staff were competent in their roles. One person said, "I think the staff are very well trained, I have to have a hoist and I am always confident they know what they are doing with that." A relative said, "They [staff] need to use a Rotunda (moving and handling equipment) to move [person] and she was very nervous of it. They are very reassuring and talk to her all through what they are doing."

Records showed that staff had received training but this was not always kept up to date. Training courses staff had attended included person centred planning, moving and handling and safeguarding. We did note that a significant proportion of staff in one area had not attended training in health and safety, fire and

medicines. This demonstrated impact as we found numerous errors on medicines records. The majority of staff had not had training in the MCA for over two years and the staff member who had administered medicines covertly had not had MCA training since 2014. This showed that gaps in staff training were impacting negatively on the care that people received. The registered manager told us that staff supervision took place every three months. However, we found a number of staff had not had one to one supervision in the last six months. There was no system in place to track supervision and to ensure staff received these meetings regularly.

The failure to ensure staff training was up to date was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014).

Staff said that they received an induction when they started work and that training made them confident in their roles. Training was delivered in house by a trained member of staff which staff said they benefitted from. One staff member said, "I am very impressed with the training, [staff member] is trained to do it in the office so we can have discussions."

Staff worked alongside healthcare professionals to meet people's needs. People's records contained evidence of work with healthcare professionals. For example, one person was under the care of a community psychiatric nurse (CPN). Where staff had noted changes to the person's behaviour, they had contacted the CPN and the person's medicines were reviewed. We also saw that staff responded appropriately to changes in people's physical health. Where one person had developed a cough staff had contacted their GP who had visited and prescribed them antibiotics.

People's needs were assessed before they received a service. One person told us, "The manager came and talked to me when they set the care plan up. They checked and double checked that they had covered all the things I needed help with." People's care records contained evidence of initial assessments used to capture people's needs and preferences. This information was then added to people's care plans. Where people's homes contained adaptations or equipment to support them with care, this was documented in care plans. One person's records said they had a wet room and equipment to be used when supporting them with personal care. Another person had walking aides and fittings within their home. We noted these were in place when we visited and staff were observed using the equipment as outlined in the person's care plan.

People were prepared food in line with their preferences and dietary needs. One person said, "As a rule they don't do meals for me but when I've been a bit tired they've made me something up." People's care plans documented their preferences with food as well as their dietary needs. One person liked to eat fruit and enjoyed a glass of sherry in the evening. This was in their care plan and daily records recorded where the person had their fruit. Another person had difficulty swallowing and had been seen by a speech and language therapist. To reduce the risk of choking, the person was to have soft foods. This was in the person's care plan and records showed that staff followed this guidance.

Requires Improvement

Is the service caring?

Our findings

People told us that they were supported by caring staff. One person said, "We all know one another, the regulars are more like friends than paid employees." Another person said, "The staff are always very kind and attentive. They chat away to me while they are helping me and always have a smile for me when they come in." A relative told us, "The girls are very kind and caring and I feel their help is just right for me. They are patient and professional."

Despite this feedback, we identified shortfalls in the running of the service that impacted on staff capacity to spend time with people. Whilst some people told us staff stayed for the full call time and sometimes extended visits, this was not consistent across the service. One person told us, "Some of them don't do anything, no bed making, hoovering, washing nothing. They spend a lot of time writing in the book." As reported in Safe, the scheduling of calls in one area meant that if staff stayed for the full length of the call, they would not be on time for their next call. This heightened the risk of staff being hurried and not staying for the full call time. People told us that they felt staff were sometimes rushed or hurried on their calls. One person said, "Sometimes I feel they rush my care." Some people told us that staff were able to spend time and interact with them. However, we also received feedback that staff interaction with people was lacking. There was also no system in place to monitor that calls had taken place and check that staff were on time. People were asked feedback regularly on staff punctuality and call times, but this system was not suitable for people living with dementia who could not always provide feedback. Until this is addressed, we will not apply a 'Good' rating in this domain.

People were supported by kind staff. During the inspection, we visited people in their homes and observed pleasant interactions between people and staff. For example, one person was observed laughing with staff and sharing jokes during a visit. The person spoke highly of the staff that supported them and there was evidently a good rapport between them. Another person told us that the staff member who visited knew them very well and they felt comfortable with them. This staff member was able to tell us about this person's needs and also their background and family situation. One person told us, "They [staff] all have different ways of doing things but they are all always willing to do anything they can for me."

People were supported by staff that knew them well. One person told us, "They really try to get to know you so that they are delivering help that is just right for you." People's care plans contained information about their family background and previous occupations to allow staff to get to know them. One person's care plan detailed their busy professional working life and staff spoke with us about this when we met the person. Another person's care plan detailed that they had an interest in sailing and sports and staff knew this about them. During the inspection, staff working in the office were able to provide us with information on people's needs and backgrounds, which showed that they had regular contact with people and got to know them well.

Staff respected people's privacy and dignity. One person said, "They've never treated me with anything but the utmost respect and kindness." People told us that staff were respectful when entering their homes and always asked permission before providing care to them. Where one person required support with personal

care during our visit, staff did so discreetly and in private. Staff were able to tell us how they promoted people's privacy by ensuring curtains and doors were shut and people told us staff provided care in this manner.

People were involved in their care. One person told us, "From the outset they have been very kind. They came and talked everything through with me at the beginning. They asked what help I wanted and what I liked and didn't like." We did see instances where care plans were detailed and reflected people's backgrounds. For example, two people were married and both received care in their home. One person liked to get up earlier and have a cup of coffee before personal care. This information was in their care plan and daily notes showed this had been fulfilled. Another person had requested for a large glass of cold water each morning, this was also listed in their care plan. Staff recorded that they had provided this to the person each morning.

Staff supported people in a way that encouraged them to develop independence. People's care records contained information about their strengths and goals they wished to achieve. For example, one person liked to prepare their meals with staff. Their care plan detailed that staff should support them in a way that allows them to keep ownership over this task. In daily notes staff recorded that they had supported the person with this.

Requires Improvement

Is the service responsive?

Our findings

People told us that they received person-centred care. One person told us, "My care plan is enough for my current situation and was reviewed recently, within the last month I think." Another person said, "They will change things around for you if there's a particular reason why a visit isn't convenient at a particular time."

Care plans did not always contain person-centred information about people. Shortfalls in records meant that the level of detail in care plans was inconsistent. Whilst we found examples where care plans contained lots of detail on people's backgrounds and routines, others contained very limited information for staff. For example, one person had a diagnosis of depression and there was no person centred care plan to guide staff on how to promote the person's mental wellbeing. We also noted that the wording in care plans and risk assessments was generic. This showed that consideration had not always been given to people's individual need to ensure staff could deliver personalised care. For example, the wording in two people's care plans for nutrition and hydration were identical. We also found that the wording used in falls risk assessments were the same, with just names having been changed. This did not demonstrate a commitment to person-centred care planning.

We recommend that the provider ensures that care plans are personalised and reflect each individuals' needs and preferences.

In other cases, care plans did contain person centred information. Staff had gathered information about people's needs routines and preferences and this information was in their care plans. For example, one person was living with dementia and may not have always prepared for different temperatures. In their care plan, there was guidance for staff on how to support them to find appropriate clothing and how to use their heating system in cold weather. Another person had an interest in football and liked to talk about this with staff. This was in their care plan and recorded their favourite football team as well as their favourite snacks to enjoy with staff on companionship calls. Where people needed specific help with personal care tasks, care plans outlined these.

People's care was regularly reviewed. Care plans contained evidence of reviews taking place and these involved people. One person told us, "They review it at roughly every six months and in between times the office ring from time to time to check that everything is going on fine." People's care plans contained evidence of regular reviews and people told us that they were given regular opportunities to request changes to their care plans. For example, at a recent review, staff had noted one person had lost weight. In response, a food and fluid chart was put in place to monitor food intake to assist healthcare professionals in making decisions about the person's care. Reviews showed that people were asked for their feedback on their care, the staff that supported them and their punctuality. This showed that reviews were holistic and provided people with opportunities to make changes.

People's complaints were responded to appropriately. One person said, "I have no complaints and I don't think [person] does either." People told us that they knew how to complain if they needed to. People were given information on the procedure to follow to make a complaint and they were regularly asked at reviews

and surveys if they were satisfied with the care that they received. Records showed that where people had raised concerns, the provider had taken action to address them. For example, a relative had recently complained that staff did not have enough tasks to complete on care calls. In response, a review was carried out and it was found that the person had developed confidence and independence and needed help with less tasks. The person's care calls were shortened and their care plan was updated. Records also showed that where people did not get along with particular staff they were able to request changes. The provider's systems for scheduling ensured that where people made specific requests not to see certain staff, these requests were fulfilled.

Inadequate

Is the service well-led?

Our findings

People told us that they felt there had been some improvements to the running of the service. One person told us, "The admin side of things is getting better and the staff are always approachable and willing to do what they can." Another person said, "I know the manager vaguely, she has been here to talk things through with me." Another person said, "It's a very well-run company and they have a very good relationship with the district nurse so they liaise with her if I need to be seen." A relative told us, "I've always found the office staff very helpful and when I've needed help I was very pleased with the way they reacted."

At our inspection in December 2016, we found shortfalls in record keeping and audits that meant there was a lack of oversight at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some action had been taken in this area. The provider had introduced changes to audits and records and the examples seen showed more detail than at our previous inspection. However, we found that there was a continued lack of oversight at the service.

There were continued shortfalls in record keeping and governance. The provider had introduced analysis for accidents and incidents, however, we only saw examples of this that covered one geographical area. There was also no central analysis of complaints to enable the provider to monitor for patterns and trends. The examples seen showed appropriate response to complaints, but the provider's analysis and documenting of complaints did not allow for analysis. This showed a lack of systems to analyse risk and the quality of the care delivered. We will require further action from the provider to ensure accidents and incidents are analysed in a more timely manner.

Checks of records were not robust enough to identify significant risk. Where we identified a person being administered medicines covertly, an audit had not picked up on this. The person's daily notes had been signed as checked but staff had not followed up on the fact that covert medicines had been administered to the person. The registered manager did not check all records themselves, this task was delegated to team leaders. Immediately following our feedback, the provider made changes to their auditing tools to ensure that all records were signed off by the registered manager and the provider. However, the provider submitted an action plan to CQC after our last inspection where they said that they would make improvements to records and auditing. By the time of this inspection, improvements had not been made in line with the provider's action plan.

There was a lack of checks on people's care experience. We noted that surveys were completed and the most recent survey had not identified any concerns. Whilst we noted that people were also asked about staff punctuality and care at reviews, there was not a system in place to effectively monitor call times and punctuality. We identified one person who was living with dementia who may not be able to provide this information to staff. This also meant if someone suffered a fall and became unwell and staff missed the call, the provider would have no way of ensuring that this was flagged up. We noted that some spot checks had taken place, but there was no system in place to track which people had received spot checks and when. This meant that the provider was unable to show us when spot checks had been completed and when they

were due. This showed a lack of monitoring and oversight of care delivery.

The lack of improvement following our previous concerns and the lack of oversight of people's care was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014).

Staff felt supported by management. One staff member told us, "I get good support and can speak to the office." All staff told us they could call to the office whenever required and benefitted from on-call management when required. Staff told us that they had regular meetings where they could discuss people's needs and make suggestions to improve the way that they service was run. Records of meetings showed that these were used to discuss care, training and communicate information about people's needs.

The provider understood the responsibilities of their registration. Providers are required to notify CQC of important events such as injuries, deaths and allegations of abuse. We found that where required, the provider had submitted notifications to CQC.

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 Mental capacity assessments were not documented where people could not consent to their care. The correct legal process had not been applied where covert medicines were administered.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Analysis of incidents relating to people's safety was inconsistent. There was a lack of action taken in response to shortfalls in medicines records.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff training was not up to date and where we identified concerns with medicines and the Mental Capacity Act, staff training was lacking in these areas.