Royal Mencap Society

Mencap East Hampshire Domiciliary Care Agency

Inspection report

Admiral House
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Fareham
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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 1st and 8th November 2017 and was announced. The last inspection of the service was in May 2016 and we found the service was compliant with the regulations at that time.

This service is a domiciliary care agency and is registered to provide personal care to people in their own homes. It provides a service to adults who have a learning disability. Not everyone using Mencap East Hampshire Domiciliary Care Agency received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There were seven people receiving personal care at the time of the inspection.

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

The registered manager oversaw the running of the full service and was supported by two service managers who were allocated a geographical area to manage. Service managers were responsible for individual parts of the service, for example support to people in a supported living home or support to people living in their own home. The service employed 19 care workers, 2 service managers and an assistant service manager.

Risks associated with the environment people lived in were not always managed well and medicines management was not always safe.

People told us they were always asked for their permission before personal care was provided, however their ability to make decisions was not always assessed in line with the Mental Capacity Act, 2005 (MCA). Staff's understanding of the MCA was limited.

Some people knew how to complain, however complaints were not always dealt with according to the provider's policy.

Although the management team had regular contact with the people using the service, there was no system in place to ensure feedback was acted on.

People's records in relation to their care plans and medicines were not always accurate and up- to- date. Daily notes about individuals' care were maintained but these were not regularly overseen by the management team.

The quality assurance process was not robust so the service was not able to effectively monitor, review and adapt the service.

The provider had not always notified CQC of significant events that happened in the service.

People mostly felt safe and staff demonstrated an understanding of safe practice. Procedures for safeguarding people were in place.

Risk assessments identified risks for each person, although records were not always updated on a regular basis.

Recruitment procedures ensured staff were vetted and their suitability to work with vulnerable people was checked. Staffing levels were supportive of people's needs.

Staff had opportunities to update their skills and professional development and staff said the training they received was very good.

People told us kind and caring staff supported them and relatives said staff were professional in their approach.

Staff worked well together and felt supported by managers and the organisation.

We identified 4 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The administration of people's medicines was not always safe.

Risks associated with the environment people lived in were not always managed well.

People were protected from abuse and avoidable harm.

There were enough staff to meet people's needs and the provider had effective recruitment procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not protect the rights of people using the service in line with the Mental Capacity Act 2005.

Staff supervision and training were in place which were effective in ensuring staff were supported, suitably skilled and competent in their roles.

People were supported to maintain a balanced diet. People were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

People were treated with kindness, sensitivity and compassion from staff.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints procedure in place but this was not always used effectively.

Risk assessments were not always updated when people's needs changed.

People received care that was responsive to their needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have effective systems for ensuring the quality and safety of the service and for making improvement.

People's care records were not always accurate or up to date.

People had been asked their opinion on the service they received but there was no system in place to ensure feedback had been acted on.

The provider had not always notified CQC of significant events.

People and staff felt they were well supported by the management team and they were approachable

Mencap East Hampshire Domiciliary Care Agency

Detailed findings

Background to this inspection

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

This inspection took place on 1st and 8th November 2017 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is a domiciliary service and we needed to ensure people would be available to talk to us. The inspection team included two inspectors.

Before an inspection we review information that we have about a service to inform and plan the inspection. This includes information we have received and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We had not received any information or notifications about this service.

We spoke with three people who used the service and two relatives of other people who used the service. We spoke with the registered manager, one service manager, one deputy service manager, the administrator and three care staff. We received information from two health care professionals who knew the service.

We looked at care records of three people and four staff files which included information on recruitment, induction, and training. We also looked at other records in relation to running the service. These included accident and incident records, complaints, meeting minutes, policies and procedures and quality audits.

Requires Improvement

Our findings

Most people and their relatives told us they felt safe. One person who we spoke to said "Yes, I'm safe here, the staff help us, they are brilliant".
Some people were supported to take their medication. Medicines records were not always accurately completed and contained gaps where a signature should be recorded to show they had been given. The registered manager said this would be classed as a medication error. Although we found these were recording errors no explanation had been documented. The registered manager was not aware of these and there was no evidence to show the gaps had been identified and investigated. Not everyone who was prescribed medicines to be given 'as required' had protocols in place which provided information to guide staff about when they would administer these. When we asked a staff member about one medicine, they told us that they knew this person had not taken the medicine for a long time and it wasn't needed at the moment. This information was not recorded on people's care plans. This meant it was not clear why and when people would need to take these medicines. Labels on some of the medicines were difficult to read. When people wished to take their medication out of the home, there was not always a clear audit trail in place. This meant that it was difficult to see that people had taken their prescribed medicines when they were out of the home.

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

Appropriate arrangements were in place for the ordering, administration and disposal of medicines. Some people's medication was stored in a medication trolley which was found in the hallway of the house. The provider's medication policy stated that 'medication should be stored in the least restrictive location – the risk will need to be assessed on an individual basis'. We could not find the relevant risk assessments. The registered manager told us that this was people's choice from a long time ago but there was no evidence that this had been reviewed when new people had moved into the house.
We saw that staff had received medicines training and had their competency to administer medicines regularly checked.

People's home environments had been assessed to make sure they were safe for the people who lived there, and for staff when carrying out support. In addition, 'run and grab' information sheets about each person were available, these documents highlighted the support the person required during an emergency. The registered manager told us that if there were any hazards identified the staff would report these to the office. We saw records that showed issues had been identified and relevant action had been taken.

However, in one instance we saw that one issue had been reported on 3/10/17 and was still not resolved on the date of the inspection. Regular checks of the environment took place to ensure risks were identified and acted upon including; legionella checks; first aid; health and safety and fire.

We found the fire procedure at night was not reflective of the current situation in one house. The fire procedure stated "If a fire is located in an occupied room, sleep in person should remove person we support". We were told by the registered manager that the people living in the house did not receive support at night as the sleep in member of staff had recently been removed, therefore this document did not reflect the staffing arrangements. The registered manager also told us the procedure related to a 'sleep in' staff member in a nearby location who provided support to another person. They said this member of staff would come over to this house in the event of a fire which would then leave the person they were required to support alone. A contingency plan was explained to us by the registered manager who told us the 'on call' staff member would attend to the person if such a situation arose. The evacuation procedure that was practised was not in line with the service's current fire procedure as people practised leaving the building on their own without a staff member. Additionally, entering a room with fire could pose a risk of harm to the staff member and cause the fire to spread. Staff had received fire training but were not always clear on what action should be taken.

We recommend that the provider updates their fire procedures in order to reflect the current situation, and that they refresh fire training for staff members so they are clear about the action they would need to take if a fire occurred.

People received support for the number of hours the local authority assessed that they required support for to meet their needs. Records showed the service delivered packages of care with a wide variety of hours. We were told by the registered manager that recently people's care hours had been reduced following a needs assessment by the local authority. The registered manager told us they had involved people and staff in how best to utilise the hours given. The registered manager told us they had undertaken different trials to see what worked best for people. However, people and relatives told us they were unhappy that a staff member who worked a sleep in shift at night had been removed in a supported living house. Some people in the supported living house had alarms to use if they needed help instead. One person told us they didn't feel safe with this arrangement. There was a staff member in a nearby location that was allocated to work a sleep in duty for a person who required one to one 'sleep in' care at night. In the event of an emergency they would attend to people living in the supported house. This would leave the person who was assessed as needing one to one 'sleep in' care at night alone. The registered manger told us that there were staff members on call who would go and help if this situation arose. The registered manager acknowledged that this was not an ideal situation and they were working with the local authority to address this issue.

During the day staffing levels met the needs of people and had been based on an individual assessment which accounted for their activity preferences. For example, one person's care records showed they liked to go out to social activities and appointments and would need the support of staff to do so. The person and members of staff confirmed staffing levels always enabled this to take place. They told us that they were currently recruiting for bank staff to cover staff absence. People's needs were matched to relevant staff where possible and care was taken to ensure the balance of male and female staff to support as required. Risks to people's health and well-being had been assessed and action was taken to reduce any risks for people. For one person, risks had been assessed to ensure staff were aware of how to keep them safe when travelling and also with daily living tasks that they required staff support with. Some people had a risk assessment in place so they were able to safely enjoy a holiday. Where some people could display behaviours which posed risks to themselves and others, staff were aware of techniques to use to de-escalate these situations and to report any incidents to their managers as required. Staff we spoke with said positive

techniques were used in routine situations to reduce the likelihood of people displaying these behaviours. This information was held in people's care records.
Training records showed that staff had received positive behaviour support training.
There was a system in place to monitor accident and incidents. Records showed action was taken to address concerns as these occurred and the registered manager had oversight of these.

Safeguarding and whistleblowing policies and procedures were in place and known by staff. Staff understood the possible signs of abuse and were confident to report any concerns to the service managers, registered manager and to the local safeguarding authority where necessary. One staff member said "If I had concerns I would speak to my line manager". Staff said they were confident that their line managers would investigate any concerns thoroughly if any suspicions of abuse were reported to them. One staff member said "If I thought there was a safeguarding issue, I would tell (name) and they would deal with it". New staff were given information about the organisation's safeguarding policies and procedures and training records showed that staff had completed training in safeguarding vulnerable adults.
The registered manager told us that when they received safety alerts, they forwarded them on to the service managers who shared them with care staff and acted on the information if necessary. A safety alert is issued by the Health and Safety Authority when there is a specific safety concern that could cause harm to people.

People told us that they were treated fairly. When questioned, a service manager was able to explain what equality meant and how to put this into practice in their day to day work. They said that all staff were treated the same and had the same opportunities regardless of any protected characteristics. They went on to say that what really mattered was that staff members held Mencap values.
Staff recruitment procedures were robust to ensure all those working with vulnerable people were suitably vetted. We looked at four staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed from two referees and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

People's homes were clean and tidy. People were supported by staff to carry out domestic chores such as cleaning, tidying and laundry.

Requires Improvement

Our findings

People told us they received effective care from staff. One relative told us they "Could not fault the care that was given" and praised the staff for how they managed situations that were complex. Another person told us "They (staff) are all absolutely brilliant and do their jobs so well"

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

We did not see mental capacity assessments in place for the care people were receiving from Mencap East Hampshire Domiciliary Care Agency. In one person's care plan it stated that they could make small decisions but were not able to make big decisions, however there was no clarity about what a small or big decision was. This meant staff did not have the guidance needed to know what decisions the person could make for themselves. In this person's records, the person had signed two consent forms which gave staff permission to manage their finances and medicines. However, a staff member told us they did not think this person really understood what they were signing for. The person's capacity to provide consent to staff undertaking these roles had not been assessed and there were no records to demonstrate that best interests decision making had been applied. This meant there was a risk that two significant issues within the person's life were being managed by others without the person's consent or in a way that ensured their best interests.

These failings amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a basic understanding of the MCA and had received training, although one told us they could not remember all of this. Staff were able to tell us that they would always ask for consent before they supported people with their personal care, one member of staff said that if a person didn't want to get up they would respect their wishes.

Staff told us they received training and support to help them carry out their work role. Comments from staff included; "The training is great – it's the best I've ever had".

Staff who were new to the service received an induction which consisted of time with the registered

manager and reading relevant policies and procedures, they also spent time with people who used the service by shadowing more experienced staff members. Newly appointed staff were enrolled on the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Staff all reported teamwork being very good and said they felt valued as a member of the team.

The registered manager told us they monitored staff training requirements regularly. They said an on line system alerted the registered manager and service managers three months in advance of when a staff member needed to do refresher training in any given subject area. Staff training records showed staff had undertaken all mandatory training such as health and safety, manual handling, food hygiene, medicines administration and safeguarding of adults. Some specific training relevant to the people they supported was also provided such as autism and positive behaviour strategies training. A service manager told us they were undertaking training on sexual relationships and learning disabilities. They said they would then roll this out to the rest of the team. They felt it was important to know how to support people in this area of their lives.
A document called 'shape your future' which was a performance supervision record was used throughout the year. This was used to keep an ongoing record of staff performance, review conversations and for them to set objectives to enhance their knowledge and skills.
Although most staff said they had received regular supervisions sessions, they were unsure how frequently these should take place.

Records showed staff received supervision and training although one staff member's records demonstrated that this was infrequent. There were individual staff records kept for the registered manager and service managers to keep a track of when supervisions had happened but these were confusing for the managers as they already had dates on for the future. If the planned supervision had not taken place it would appear on the record that the supervision had happened. This would mean the staff member would not receive supervision. This was acknowledged by the registered manager who said they would discontinue this practice.

Staff meetings took place, staff told us that they were able to discuss particular issues and felt confident to make suggestions to improve the service. It was acknowledged by one member of staff that staff meetings didn't happen as regularly as they could as it was difficult to get staff together. Staff used communication books, phone calls, and emails and received a monthly magazine to keep up to date with each other and the service. Staff said that this worked well and they were able to provide consistent and person-centred care to people.
The registered manager told us that the organisation had a practice leader who supported staff to work in line with best practice. The practice leader was currently helping staff to update care plans.

The service undertook a comprehensive needs assessment before people began to use the service. People's support needs, likes and lifestyle preferences had been considered and were reflected in the care plans.

People's care plans showed their health was being monitored and where necessary referrals had been made to other professionals with specialist knowledge. For example, one person required dental treatment that had been arranged. Where people's healthcare needs changed staff had helped them attend appointments with relevant healthcare professionals. We saw that care plans contained contact details of people's relatives, GP's or other involved health professionals so that staff were able to contact them in the event of an emergency. We were informed by a healthcare professional that "Mencap make an effort to have the patient's keyworker attending their appointments for support and continuity which is helpful from ours and the patients perspective". A keyworker is someone who is assigned to the person who works most closely

with them.

The registered manager told us that risk assessments were reviewed annually and we saw this in records. However, we were concerned that incidents which occurred may not be used to inform a reassessment of the risks and ensure the management strategies remained effective. For example, a staff member told us that a person got agitated regarding certain issues due to sharing a house with others. Not all of this information was in the person's risk assessment, this meant staff may not always use effective strategies to minimise the person's behaviour.

In a supported living house we saw that staff supported people to eat and drink. We saw that people could eat where they wanted to and it was a social occasion with people being unhurried. People could choose what they wanted to eat and staff supported them to maintain a healthy, well balanced diet. Some people were attending a slimming group which they enjoyed telling us about. People were encouraged to cook for each other and it was evident that this was an activity that people liked doing.

People lived in accommodation that was warm and comfortable. In one house people enjoyed using the lounge and dining room to socialise and eat their meals together. People could spend time alone in their bedrooms if they wished and it was acknowledged it was their own private space. People were encouraged to personalise their bedrooms and we saw posters on people's bedroom walls of things that interested them. We also saw people had many personal belongings that they were able to enjoy. For example, one person had an array of stuffed animals that brought them happiness. People had access to a garden and one person had a ramp in place so they were easily able to access their home. We saw in a house that there was an office that had been created by staff. We were told by the registered manager that this used to be the sleep in room and should not be used as an office. They told us they would look into this.

Good

Our findings

People were supported by staff that were kind and caring. One person told us that the best thing about the support they received was "the staff", another person said "the staff are brilliant". Relatives agreed with this, comments included "all the staff are so caring" and "the care staff provide wonderful care and support". One relative told us how impressed they were with the care that was given, particularly as the person's needs were complex. People told us they had the same regular staff. One staff member told us, "I work with the same people regularly. It helps to build up a relationship with them."

There was a long standing and stable staff team in the service and a staff member told us they thought it was because they enjoyed working with the people they supported. They said staff thought the job was fun and they liked helping people reach their goals. The consistent staff team enabled people to build relationships with staff.

Staff were able to talk knowledgeably about the people they cared for. They were aware of people's likes and dislikes and how to communicate with each person. People and their relatives told us communication with the staff was on the whole good although one relative told us that they would like it if the service kept in touch a bit more with them so they could be kept up to date with the person's changing needs.

Staff understood the need for people to maintain their independence; one staff member told us "One of our main aims is to improve people's independence and not to de-skill them". A person told us that they did their own laundry and cooked their own meals.

Staff knew how to protect people's privacy and dignity. One staff member told us they ensured they gave people the time they needed to be cared for. We observed a staff member knocking on a person's bedroom door and waiting for an answer before opening the door. Information about people was kept securely and treated confidentially. The staff team spoke positively about each other and the people they supported, they clearly understood and promoted compassion and respect.

We observed positive interactions between staff and people. We saw that people were treated with kindness and compassion; they were asked their opinion about how they wanted to spend the afternoon and were listened to, this resulted in card games being played. People were also asked their view about their meal arrangements in light of the fact that they were going out that evening, again their opinion was acted on. This helped to ensure people felt that they mattered.

We were told by people and staff that the service gave the staff enough time, training and support to provide care and support in a compassionate and personal way. People were able to make choices about who supported them and a member of staff told us that staff were matched with people who shared similar interests as much as possible.

The registered manager told us that they worked with families of the people that were supported and ensured that people had the choice and flexibility about the amount of family involvement to ensure their privacy was protected.

Requires Improvement

Our findings

People's care plans were not in a sequential order and out of date information was not always extracted. For example, out of date information from 2015 was in two people's care plans. A care record for one person was also found in the Health and Safety file. This could lead to confusion for care staff when accessing care plans and providing care for people because the records were not always up to date and based on the person's current needs. One member of staff told us that care plans could be out of date so they asked people what support they wanted. However, other staff members said they would look in the care plan. We were told by some staff that a new service manager was working hard to improve care records. This was confirmed by the registered manager.

A failure to ensure accurate, up to date and contemporaneous records placed people at risk of not receiving the appropriate care and support. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure in place and there was an easy read version given to people. We were told by the management team that there had been no complaints in the last year.
Not everyone knew how to make a complaint. A relative told us that they had raised a concern and despite chasing they had not received a response. The registered manager said they hadn't treated this as a formal complaint because the word complaint had not been used. Therefore they had not discussed the issue with the relative. At the time of inspection, the issue remained unresolved. One staff member told us "There have been small complaints recently but they weren't big enough to be logged, I think they were dealt with at the time the concerns were raised". Mencap East Hampshire's complaints procedure states "If it is possible to resolve the matter immediately, there is no need to engage the complaints policy but all comments must be recorded on a representations/ feedback sheet which will be kept in the complaints log book. There were no records of this in the complaints book.

A failure to ensure all complaints were acted upon was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said that people were involved in developing and reviewing their care plans; they said they would sit down together with people and look at what was working well and if anything needed changing. We saw in a person's personal development plan they had chosen to make plans to go out in the community more and have a holiday. Staff had helped them achieve this. We also saw that another person had expressed a desire to get better at cooking. The service had utilised a volunteer to help the person with this.

Care records contained a needs assessment and care plans were developed from this. These included information on a person's healthcare, personal care, food and drink, social interests, communication, money, behaviour and relationships. There was individualised information in the records and this was clearly centred around the person.

People were supported to participate in a wide range of activities, however a relative told us that due to a lack of staff that could drive their loved one was not always able to go out. Care records showed people engaged in outings, shopping and social clubs. Staff had recently helped some people hold a Halloween party which was enjoyed and there were plans in place for a pantomime at Christmas. The provider held different events to help people socialise and ensure they did not become isolated. On the 2nd day of inspection, there was a coffee morning happening which was well attended. A 'hub in the pub' event was also held fortnightly which enabled people who used the service to get together. Staff recorded the activities people undertook and those they indicated they wanted to do. Some people had wanted to go to go on holiday and this had been organised, the trips were hugely successful. Another person had needed a ramp to access some places where their mobility had deteriorated and the service had organised this. In these cases support was responsive to the individually expressed needs of people.

Requires Improvement

Our findings

There was not an effective system to monitor the quality of people's records and ensure the service held current and accurate records about people. The registered manager told us that they carried out annual audits for areas such as finances and care plans for the service. They said that the service managers kept an eye on things monthly. The registered manager told us that medicines were also looked at by the service manager every month but a formal audit of medicines was only done once a year. This meant the errors in recording we had found had not been identified because the systems in place were not effective. Because issues were not being reported or picked up, the service could not identify themes and patterns when things went wrong or learn lessons from these incidents.
The registered manager told us that they completed checks on daily records when they went into the service. However, these records were stored at people's homes and we found that there was no record of the checks being completed. We found that people's records were not always current and accurate. There was also a failure to identify recording errors and to analyse concerns. We saw records that were undated and incorrect.

The failure to ensure systems in place to assess, monitor and improve the quality of the service were effective was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked for a variety of records and documents during our inspection, including audits with actions plans, safeguarding records, staff supervisions, policies and procedures, meetings and training information. We found these were not always easily accessible. On the first day of the inspection the registered manager was absent and the staff who were in the office could not always locate information that was asked for. There was an electronic quality monitoring system in place which the majority of staff members found difficult to use and draw information from. In the absence of the registered manager appropriate staff should be able to access information in order to guide them in decision making and to monitor the service effectively.

The absence of a robust governance system to ensure records were accurate, up to date and stored appropriately was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and service managers were required to complete the provider's electronic quality assurance system. This included information about people such as money, friendships, happiness, moving and handling and social inclusion. Incidents, accidents and safeguarding matters were also recorded on

this system. We were told that these would be checked by senior managers for the provider who would then alert them locally if there was something that needed clarity or acting upon. We were told that because it was a new system, staff were still familiarising themselves with this.

Services that provide health and social care to people are required to inform CQC of important events that happen at their location in the form of a notification. Important events include accidents, incidents or allegations of abuse. We use this information to monitor the service and to check how events have been handled. We saw an incident recorded where one person had been shouting at another person and thrown something at them which had resulted in a person locking themselves in their room for safety. We were told that this person's behaviour used to be more challenging and the service felt that it had got better. We had not received a statutory notification in relation to this although it had been reported to the local safeguarding team. This meant that the Commission had been unable to monitor the concerns and consider any follow up action that may have been required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People told us that they were satisfied with the service provided and the way that it was managed. One person told us, "I know who the service manager is, they come in often, they're good"
A relative said "the whole set up is great, it's a great success and I hope (name) can continue with them".
Another relative told us they weren't sure who the manager was but they were happy with the service provided.

Staff spoke positively about the management team, comments included "My service manager is nice and friendly, I couldn't say a bad word about them", "I don't see the registered manager much but I'm well supported by the service manager", and "The registered manager is really supportive".
Staff told us they felt they worked as a team and all helped each other. They said the service managers were approachable and listened to their concerns and ideas for improvement. They felt they could raise issues in meetings and individually.

The registered manager told us that they knew what was happening with the people and staff in the service because they visited people on a regular basis. This was difficult to evidence as the computer system overrode historical dates and there were no records of what was found when they visited. Furthermore, when we told the registered manager about some issues such as delayed visits and medicines errors they were not always aware. We saw evidence that the registered manager met with the service managers on a monthly basis to discuss performance of the service. When issues were identified it was written in a book for example that 'service manager would speak to the staff member'. This was not recorded on an action plan and it was not easily evident that these actions had been taken or what the outcome was.

The registered manager told us that they listened to and acted on people's feedback when anything came up. They also told us they held an annual group meeting called 'What Matters Most'. This was a chance for people and their representatives to get together and discuss areas of their life that they wanted to change. The registered manager told us they used these meetings to make improvements for people. No records of these meetings were kept and no action plan was developed following the meeting, this meant there was no structured system to ensure people's feedback was acted upon. People were not encouraged to provide feedback in an anonymous way. The registered manager told us this was because the provider was working on surveys that would usually be given out. This meant that people and relatives could not give feedback in a confidential way. Furthermore, the results of any feedback could not be shared or acted on.

The provider worked in partnership with other organisations to make sure they were providing appropriate

care for people. These included social services, healthcare professionals such as G.P's, dentists and opticians.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to make appropriate statutory notifications. Regulation 18 (1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to ensure people only receive care and treatment with the consent of the relevant person. Regulation 11 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to fully protect people from the risks associated with the unsafe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

	Complaints were not always acted on. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A failure to have effective systems and processes in place to drive continuous improvements, and the failure to maintain an accurate, complete record in respect of each service user. Regulation 17 (1) (2) (a)(b)(c)(f)