APT Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 12 and 13 July 2018. The inspection was announced.

APT Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. Not everyone using APT Care 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. APT Care provides a service to older adults and younger adults with a disability. At the time of our inspection, 44 people were receiving personal care as part of their care package.

At the previous inspection in December 2016 we identified some improvements were required in four key areas we inspected; 'Safe', 'Effective', 'Responsive' and 'Well-led'. This resulted in the service having an overall rating of 'Requires Improvement'. We identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. This was because the provider had ineffective systems and processes in place to monitor quality and safety. 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 question Well-led to at least good. The provider sent us an action plan and told us they would make the improvements by 14 July 2017.

At this inspection, we found Regulation 17 remained in continued breach because the provider had failed to comply with their action plan. Additional shortfalls identified during this inspection had not been picked up on by internal audits and checks, meaning the governance of the service remained ineffective.

There was a registered manager at 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.

People experienced frequent late calls and there were insufficient staff employed to deliver the hours of care required. Agency staff were used and the registered manager and care coordinator also covered staff shortfalls.

The provider's staff recruitment procedure was not always fully completed, to ensure people were protected from unsuitable staff. Staff interviews were not routinely recorded. Staff had not received appropriate first aid training to support them to care for people safely and effectively.

Shortfalls were identified with medicines management. This included staff training and competency, how medicines administration records were completed and how some medicines were administered.

Staff were aware of their responsibilities to protect people from avoidable harm and abuse. Accidents and incidents were recorded, reviewed and monitored and action was taken to share any learning.

Shortfalls were identified in the induction, training and support staff received. The Mental Capacity Act 2005 had not been adhered to when people lacked mental capacity to consent to their care.

People's needs had been assessed to ensure they were known and understood by staff and did not expose people to any form of discrimination.

People received support with nutritional and hydration needs where required, and choices were promoted and respected. People's healthcare needs were monitored and action was taken when changes occurred, such as informing the person's relatives and representatives or health and social care professionals.

People did not always receive a consistent caring service because staff were regularly rushed and this impacted on the quality of care received. Independent advocacy service information had been made available to people. Independence was encouraged and people had been involved in the assessment stage before their care package commenced.

End of life care plans were not sufficiently detailed or person centred. Staff had not received training in end of life care. People did not know in advance what staff were expected and if staff were running late, they were not always informed of this. Improvements had been made in the detail of general care plans but these were not reviewed at the intervals the provider expected. People knew how to make a complaint but the system used to record concerns and complaints was ineffective in monitoring where improvements were required.

During this inspection, we found two breaches of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 consistently safe. People had experienced late calls that impacted on their health, welfare and safety. Safe staff recruitment processes were not always followed. There were insufficient staff employed. We found shortfalls in record keeping and staff training and competency in relation to medicines management. Staff were aware of how to protect people from abuse and avoidable harm. Risks associated with infection and cross contamination were managed. Accidents and incidents were acted upon and monitored.	**Requires Improvement**
Is the service effective? The service was not consistently effective. Shortfalls were identified in the induction, training and support staff received. The principles of the Mental Capacity Act 2005 were not fully understood and had not been adhered to when required. People had an assessment that considered their diverse needs to ensure there was no discrimination in relation to the protected characteristics under the Equality Act. Where required, people received support with their nutritional and hydration needs. Staff took effective action when changes to people's health conditions were identified.	**Requires Improvement**
Is the service caring? The service was not consistently caring.	**Requires Improvement**

Staff were often rushed and this impacted on the quality of care people received. Not all staff had a positive attitude and approach to their work.

People's independence was encouraged, advocacy information was available should people have required this support.

People were involved in the initial assessment before receiving a care package.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

End of life care plans lacked person centred information and staff had not received end of life care training.

Care plan reviews were not being completed as the intervals expected by the provider.

Complaints and concerns received were not effectively managed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's action plan following the previous inspection was found to have not been fully met. Additional shortfalls identified in this inspection had not been picked up by internal governance processes.

People and staff had been invited to give feedback about the service, but there was no evidence to show how feedback had been listened to and acted on to improve the service.

APT Care 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.

The inspection site visit activity was completed on 12 and 13 July 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered provider and their staff would be available.

The inspection team consisted of one inspector and one assistant inspector.

To assist us in the planning of the inspection we reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We also reviewed the last inspection report. We contacted commissioners and received information from Nottingham City Council, informing us of their audit completed in June 2018 which found some shortfalls.

Before the inspection, we spoke with 11 people who used the service via telephone. We did this to gain people's views about their care and to check that standards of care were being met. We also spoke with six care staff.

At the provider's office, we looked at all or part of the care records for ten people to see if information was up to date and provided staff with sufficient guidance. We spoke with the registered manager, provider's representative, the care coordinator and one care staff member. We also reviewed records relating to the management of the service. This included support provided with medicines, complaints and safeguarding and the provider's checks of quality, safety and their related service improvement plan. We looked at four staff files to review the recruitment, induction, training and support provided to staff.

Requires Improvement

Is the service safe?

Our findings

People had frequently experienced late calls that impacted on their health, welfare and safety. People told us staff call times impacted on some people's timing of medicines. If people's calls were late they were waiting for breakfast or if people received two calls close together, they did not feel hungry when staff returned to support them with meals. Some people thought their calls were at a set time but experienced much later call times. One person said, "They (staff) come when they feel like it, my times were changed, we didn't have a meeting, they just said we've had to alter the times." A second person said, "They don't turn up on time, when you're sat in your own mess for three or four hours it upsets me." A third person said, "They say we've got a lot of customers so we can't be on time." This meant there was a risk that people may not receive the support they required to ensure their safety.

From reviewing people's care records we found people had experienced late calls from the expected call time. In some instances, calls were late by up to two hours and one person had experienced a missed call. The electronic system used to monitor staff arrival and departure times from visits was not working. Whilst the current system was being replaced, staff were forwarding their call times daily. This meant there was no system to monitor late or missed calls until after they had occurred. During our inspection we heard people frequently telephone the office reporting staff had not arrived, they were assured staff would be visiting but were running late.

Some people required assistance with their medicines. We identified concerns with the training and competency checks staff had received in the management and administration of medicines. For example, the local clinical commissioning group (CCG) medicines management team had visited the service in 2017. They had advised best practice was for staff to receive yearly accredited medicines training and an annual competency assessment, to include an observed practice. We found the management team had not followed these recommendations. There were no records of observed staff practice. While 13 out of 24 staff had completed competency workbooks that showed the registered manager had signed staff off as competent, there was no evidence of how their competency had been assessed. This meant we were not sufficiently assured staff were fully trained and competent with the management of medicines.

Medicine administration records had not always been signed by two staff to ensure accuracy of transcription. This is best practice guidance to ensure there are no errors made. Some people had medicines prescribed to be administered as and when required. There were no protocols in place to provide staff with guidance of how these medicines should be administered. This was identified by CCG in their audit in 2017. This meant this potential risk of miss management of these medicines had not been addressed.

All of the above information shows a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From viewing staff files, we found some concerns with the process used for recruiting staff. The registered manager told us they had interviewed staff, but three out of four staff files did not contain staff interview records to confirm what we were told. This is an important process to support the provider to make safe staff recruitment decisions. The provider requested two staff references as part of their checks, but a staff member's file showed only one reference had been received. Whilst the registered manager told us they had followed this request up, there was no record to confirm this. Several staff told us they had a staff uniform but no identification badge. The registered manager confirmed six staff had not got an identification badge and were providing care, even though the service user guide informed people staff should wear an identification badge at every visit. This meant staff visiting people's homes were unable to provide evidence that they were employed by the provider and this was a risk to people's personal security and safety.

Staff had not received training in first aid but were provided with first aid handouts. We found this was insufficient and ineffective in providing people with safe care and support. We discussed this with the management team and they agreed to arrange appropriate first aid training as a matter of priority.

There were insufficient numbers of staff employed to deliver care. The registered manager told us staffing levels had reduced recently and this had impacted on how care packages were being met. Whilst new staff were being recruited, agency staff, the registered manager and care coordinator were meeting shortfalls in staffing. The provider had also agreed they would not take on any new care packages until additional staff had been recruited.

The risk assessment tool used to assess potential risks people were exposed to was found to provide staff with inadequate information in some places of how to manage the risk. For example, people who had a urinary catheter, their risk assessment did not include the signs and symptoms of an infection and what action was required of staff if they identified concerns. In addition, where people had a particular health condition such as diabetes, the risk assessment did not advise staff of the risks associated with this. Such as the signs and symptoms of high or low blood sugars and what action to take if a person was unwell. We discussed this with the registered manager and on the second day of our inspection, they showed how they had started to review and amend the information provided to staff. From the examples given this guidance was more detailed. Staff we spoke with were knowledgeable about how to manage these needs.

People reported they felt safe with the staff that supported them. A person said, "I do feel safe, yes, they're very good." Another person said, "They know when I've been out, they bring my keys in to the house, they make it safe, they will lock the door of a night time."

The provider had safeguarding systems and processes in place to support and instruct staff of their responsibilities to protect people from abuse, avoidable harm and discrimination. Staff were found to be knowledgeable and gave examples of when they had reported concerns to the registered manager. Records showed that when a safeguarding concern had been identified this had been appropriately acted upon and in line with the local multi-agency safeguarding procedures.

People were protected from the risk of cross contamination because staff were aware of the prevention measures and good practice in the management of infection control. People told us staff wore personal protective equipment when providing personal care, such as aprons and gloves, to prevent the spread of infection.

The provider had a process for staff to report any accidents and incidents. The registered manager told us they reviewed this information to assess if any action was required to reduce further reoccurrence. We saw an example of a staff alert that had been sent to staff in response to a medicines error.

Requires Improvement

Is the service effective?

Our findings

Whilst people told us they felt staff had received some training they were not aware of what this was and felt staff did not always understand their health conditions. Several people had diabetes and some concerns were raised about staff's understanding and competency in how to support them. A person said, "They're (staff) pretty decent, one or two are ignorant and don't seem to know what they're doing. It makes me angry. I don't think they've had enough training."

Shortfalls were identified in the training and support provided to staff. Three staff were positive about the training they received whilst three others raised concerns. A staff member said, "The training is good, if you ask the manager they support you, I'm doing an NVQ (this qualification is now known as a diploma in health and social care)." Two other staff felt satisfied with the training they received. In contrast, another staff member said, "The training could be much better, the manager talks to you and asks questions and we have a practice session in moving and handling." A fifth staff member said, "Training used to be much better, the manager delivers the training, we have some work sheets and DVD's, I'm okay because I'm experienced but I don't think it's enough for new staff with no experience." A sixth staff member said, "I had no induction and no shadowing and the training is very basic."

The registered manager told us about the staff induction process, training staff received and the opportunities to discuss their work and development needs. Three out of four staff files did not include the provider's induction. Staff supervision, appraisals and spot checks to review staff practice when supporting people, were found to have not been completed at the frequency expected by the provider. The registered manager told us they were aware of these shortfalls and explained due to them having to cover care calls, this had impacted on them in completing some administrative and management tasks.

The staff training record showed staff had received training, but we were not assured that this record was an accurate reflection of what training staff had completed. One staff member told us they had completed training in moving and handling and medicines. However, the training plan recorded they had completed training in all the areas the provider had identified as required. The registered manager was under the impression the person had completed this training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found no one had had an assessment completed to determine if they had mental capacity to consent to their care and support. The registered manager told us they thought this was the responsibility of external professionals and not theirs. When this was discussed further with the registered manager, they identified two people who they said lacked mental capacity to consent to their care. We noted from these people's care records there were no significant restrictions placed upon these people. However, this meant people's rights had not been fully protected because decisions had been made on behalf of people without consideration of the MCA.

The provider had no procedures to share information with external professionals in the ongoing care of the person, such as ambulance and hospital staff if a person was admitted to hospital. This meant there was a risk people may not receive person centred care when using different services. Since our last inspection the registered manager told us improvements had been made to the assessment process and care plans used to instruct staff of people's needs. The assessment considered people's diverse needs to ensure there was no discrimination in relation to the protected characteristics under the Equality Act such as their age, disability, race, religion or belief. Feedback we received from people who used the service did not raise any issues or concerns about experiencing any discrimination. For example, where people had specific mobility needs they were supported by staff effectively with any equipment they used. People's life style choices were respected.

Where people required support with meal preparation and drinks, people were positive about the support from staff when calls were on time. A person said, "Staff always give a choice about what to eat and drink." Another person said, "They help me with food preparation, they ask me what I want and prepare food from scratch."

Staff told us how they provided support with people's nutritional needs and hydration. A staff member said, "I always ask people what they would like, make sure I leave drinks and snacks close by when I leave and check use by dates of food kept." Some people had swallowing difficulties, staff were aware of how their food needed to be presented, and the support required.

People were confident staff acted an concerns relating to any changes in their health. A person said, "Staff will ring the GP to arrange an appointment, they check and ask 'what did they (GP) say?'" Another person said, "Staff report when they are concerned. If they find anything out of the ordinary, if they find any soreness they tell me about it, they leave a message in the book for other staff to read."

Staff gave examples of the action they had taken if they found a person was unwell; this included calling relatives or paramedics for assistance. Concerns were also reported the registered manager or care coordinator, who alerted health and social care professionals of any concerns or changes in a person's health that required action being taken. On the second day of our inspection, a staff member called the registered manager about a person who was unwell and distressed. The care coordinator went to the staff member and assisted them, they also liaised with the family and the local authority and requested an emergency assessment.

Requires Improvement

Is the service caring?

Our findings

People did not receive care and support that was consistently caring and respectful. Some people told us they found staff were caring and were positive about the support of staff. A person said, "They are very polite and friendly, I couldn't wish for better, they're more like friends than staff." Another person said, "Most of the staff that come are very nice."

However, some people were less positive and told us felt staff rushed and spoke over them when providing care. A person said, "They talk amongst themselves. Sometimes it's funny but other times I think shut up. Sometimes they fall out amongst themselves." Some staff were named for being caring individuals, two staff were named for being rude, and thoughtless in the way they behaved, we shared this information with the registered manager who agreed to follow it up.

Staff told us when they had to cover staff shortfalls they felt rushed and this impacted on them providing good, person centred care. A staff member said, "When we have the same people, it works better, we have time, people get to know you, but when you have to cover other calls that's when you can feel rushed and that's not fair on the person." Another staff member said, "Sometimes you are rushing from one to another person. My rota can say I need to be with two people at the same time, how can that be? It makes it impossible. There's not enough staff to deliver the care."

All staff told us there had recently been a high turnover of staff and this had been unsettling for people and had impacted on the quality of the service provided. During our second inspection day, we heard a staff member called the registered manager to tell them they could not get to a person's morning call because of the distance. However, they had also failed to arrive at two other people who were in walking distance from their home address. This meant another staff member had to cover these calls resulting in people receiving a later call than expected. This behaviour demonstrated a lack of commitment to people. Staff had mixed opinions about each other, some staff described others as having a bad attitude towards work and that care practice needed to be improved. A common theme was that some staff refused to work at the times they were available, putting pressure on other staff and causing resentment and ill feeling. This was a concern because there was a risk this negative attitude could impact the quality of care provided.

People were supported to be independent and to remain in their own homes. Staff told us how they encouraged people to maintain as much independence as they could. One person used assisted technology to support them with their independence.

Not all people could recall being involved in the planning of their care. A person told us changes had been made to their care package without them being consulted. People's care records showed an assessment of their needs had been completed prior to them receiving the service and this had included a meeting with the person and in many instances with a family member.

The provider's statement of purpose provided people with information about the service, including information about independent advocacy services. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Staff respected people's right to privacy. People told us overall staff treated them with dignity and respect. A person said, "They cover me up with towel. Always shut the door and make sure the heating's on." Additional comments included how staff reassured people and provided choice and explanation when providing care. A person said they valued having the company and conversation that staff provided during visits.

Requires Improvement

Is the service responsive?

Our findings

End of life care plans lacked detail and staff had not received training in end of life care. The registered manager told us that staff were expected to provide support to a person at the end stage of their life and showed us an example of a persons' end of life care plan. This did not demonstrate the principles of caring for a person at the end stage of their life, such as the person's wishes about how they received their care, spiritual support, needs associated with food, drinks, and pain management. Neither did it include information of how care was coordinated and delivered with external healthcare professionals. The training record did not show staff had received end of life care training and staff spoken with told us they had not received this training. The registered manager gave us a copy of an end of life care questionnaire training paper that consisted of 20 true or false questions. However, we did not see any completed training sheets. This meant people's end of life care may have been compromised due to a lack of assessment, planning and staff training.

People told us they did not receive a staff rota advising them in advance, of the staff expected to visit them and most commented that they would like this information. Not all people had met staff before they provided care. The registered manger told us they tried to ensure new staff shadowed experienced staff, to support them to become familiar with people's needs, but this had been difficult in recent times due to staff leaving and a delay in recruiting new staff.

Most people told us they had been given a choice of a male or female staff. However, one person told us they had two male staff providing personal care, which they complained about, and action was taken to change this to female staff.

Some people told us they had regular care staff and were positive about this, demonstrating they had developed good relationships with staff familiar to them. A person told us of regular staff that supported them, "They look after me very well. They come in and get me up, put me to bed, give me something to eat, they help me to have a shower because I'm nervous, they're good, they do a marvellous job."

Some people told us they had been informed if staff were running late whilst others told us they were not informed and this was a concern and frustration to them. The registered manager told us they tried to inform people if they were running late, but this was difficult because they and the care coordinator were also at times out of the office providing care.

People told us staff overall stayed for the duration of the call, but from viewing people's care records, when staff arrived late, people had mostly completed tasks or said they had. For example, that they had had their breakfast. This meant people's level of care was compromised at times.

We received a mixed response from people about their care plans. These documents provide staff with written guidance of how to meet people's needs. Whilst some people told us their care plans reflected their needs and had been reviewed, others could not recall seeing them. A person said, "I haven't got one of those I don't think." Another person said, "Its been modified (care plan) as times gone by, they've (staff) always been careful to ring about risk assessments, they consult us [family] before." A third person said their care plan had been reviewed and updated over the telephone. People told us that staff always recorded what they had done and this information was kept by them for other staff to read.

We found care plans, with the exception of end of life care plans as described above, had been improved since our last inspection. Staff were provided with information of people's health conditions and their routines and how they wished to be supported was recorded for staff to follow. Staff were knowledgeable about people's needs and preferences. Whilst people's communication and sensory needs had been recorded for staff, information was not provided in any other format for people such as large print, easy read, audio or braille. However, the registered manager told us they would provide information in alterative formats if required. The registered manager told us they planned to review people's care plans at three and six months and annually thereafter. However, they told us they were not achieving this, but had completed annual reviews and the review schedule confirmed this. This meant the provider's review process was not being completed as expected.

People told us they were aware of how to make a complaint; however, people could not be assured effective action would be taken to address concerns and complaints. Where people had complained they told us this had been around times of care calls. A theme raised by people in this inspection as a concern continued to be call times.

The provider's compliant log showed there was one recorded complaint received in January 2017. Whilst the registered manager told us of the action they had taken this was not recorded. The registered manager also told us and showed us how they logged concerns received from staff and people who used the service or relatives. They told us this was then discussed in supervision meetings with staff. We saw no examples to confirm what we were told. It was also not clear if this information was reviewed for themes and patterns. We concluded the systems and process to respond and record concerns and complaints lacked clarity and effectiveness.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection in December 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the governance of the service. At this inspection, we found a continued breach of this regulation. The provider had not met their action plan following the last inspection and we found additional shortfalls in the systems and processes to check on quality and safety.

Following the last inspection the provider told us how they would make improvements this included; reviewing and amending risk assessments to ensure staff had the required information and guidance. However, we found risk assessments continued to provide insufficient information to inform staff of how to manage risks associated with people's needs. Staff were to be provided with additional training in person centred care and dignity in care, but there was no evidence this had been provided. Monthly telephone calls to people who use the service were to be introduced to as a method to gain feedback from people about the service. This had not been introduced. Staff were to receive regular supervision meetings to ensure they were sufficiently skilled and to identify areas of improvement. This included the introduction of group supervisions. This had not been achieved; staff had not received regular meetings to discuss their work. This failure to implement actions following our last inspection had a negative impact on the quality and safety of the service provided.

Due to the registered manager and care coordinator having to provide care to cover shortfalls in staffing, this had impacted on them managing the service effectively. The provider's representative visited the service weekly, they made themselves available to staff and told us they were aware of some concerns about the service. This included a shortage of staff and how some staff were dissatisfied with the leadership of the service. Some staff felt there was favouritism shown by the registered manager and work was not fairly shared across the workforce. This situation had led to a discontentment amongst the staff team and we were concerned that this had impacted on the quality of care people received.

The provider told us that they had not completed formal audits and checks to review how the service was progressing and meeting the shortfalls identified at the last inspection. On reflection, they said they were aware they needed to improve on this. They told us the provider had a quality assurance manager who would support the registered manager to make the required improvements.

This inspection identified additional shortfalls in how the service was managed, which the internal governance systems and processes had not picked up. This meant the systems in place were ineffective. For example, staff recruitment, training and support had not been monitored effectively or managed in line with the provider's policies and procedures. This included how staff were interviewed, how staff were inducted and the training they received. Staff had not received training in some areas that were required to safely and effectively support people such as first aid and diabetes awareness. Staff supervisions, appraisals and spot checks to review their practice were infrequent and were not effective in supporting and developing staff. This meant there was a risk people may not have received safe and effective care and support.

Systems to ensure the quality and safety of the home were not effective. Consequently, we found multiple concerns about the service which had not been addressed by the provider prior to our inspection. This placed people at risk of receiving unsafe support that did not meet their needs or respect their rights.

The registered manager told us during 2017 staff meetings had been monthly, but they had not managed to continue with this frequency and the last staff meeting had been in March 2018. This meant that opportunities to support staff and monitor performance may have been missed.

The system and processes to record and investigate complaints and concerns had not been effectively managed. From reviewing these records, it was not clear what action had been taken to make improvements and resolve issues. This meant the provider could not demonstrate that feedback from people was used to evaluate and improve the service.

In November 2017, a survey was sent to people who used the service and staff, inviting them to give feedback about the service. The survey results from people who used the service showed some positive feedback. However, where people had rated the service to certain questions as average or below average there was no information to show what action had been taken to respond to this feedback. The staff survey showed a low response, four staff had responded and their feedback to questions in relation to working with colleagues and staff training and professionalism scored low. There was no evidence that action had been taken as a result of the staff survey. These results were reflective of what we were told and identified during this inspection. This meant feedback from staff and people who use services was not used to drive improvement.

All of the above information shows a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a current website but the ratings of the last inspection were displayed in the provider's office. The registered manager had submitted statutory notifications to inform us of events they are required to do so.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not sufficiently managed to protect people's health, welfare and safety. Shortfalls were identified Medicines management practice. 12 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service were not effective. Feedback about the service had not been effectively responded to. 17 (1)

The enforcement action we took:

Warning notice