Ashridge Home 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?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection started on 11 July and was concluded on 24 July 2018. It was an announced visit to the service. This was the first inspection since the service was registered to provide personal care. Ashridge Home Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. It focuses on providing live-in care workers, but it also provided hourly support. At the time of the inspection 16 people were supported by the service.

The service had 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.

Where people required support with managing and taking their prescribed medicine, processes and records did not always provide sufficient guidance for staff or followed national guidance and the provider's policy. We found where people required medicines for occasional use, no additional guidance was given to staff on when and how their medicines should be given. Medicine administration records were not routinely completed with all the required information. This had the potential for mistakes to occur.

Risks posed to people as a result of their medical conditions were not routinely assessed and considered. We have made a recommendation about this in the report.

Some records relating to people's care were not always updated in a timely manner, some records gave conflicting information and had not been signed or dated. We have made a recommendation about this in the report.

People were protected from the risk of abuse, staff had received training and were knowledgeable about what do to in the event of a safeguarding concern being raised.

People were supported by staff who had received appropriate support by their line manager.

People were supported to maintain good health and were referred to healthcare professionals when a change in their condition was noted.

People told us they were treated with kindness, respect and compassion. Comments from people included "Yes, they (Staff) are very respectful of my home," "I cannot complain, all very respectful" and "Absolutely, the house is hoovered every day."

Care workers understood how to promote people's choice and independence. Comments from care workers included, "To exercise anyone's choice and control I need to give them opportunity to make simple

day-to-day choices, for example discussing their likes and dislikes and asking them what they would prefer to eat or wear, if they'd like to go for a walk or prefer to stay at home."

People and their relatives told us they received a personalised service. One person told us. "I have someone who comes each week. We have a chat and decide what we are going to do, they have been this week and we had a nice lunch together and went to Marlow."

The service was aware of the Equality Act 2010. They supported a same sex couple with some respite care. To enable the staff to have a better understanding of the person's needs, the registered manager had attended a conference arranged by nationally recognised charity supporting same sex couples.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We found the registered manager and senior management team open and welcome to our feedback. Some quality assurance processes were in place; however, they did not always pick up areas of improvement.

You can see what action we told the provider to take 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.

People were supported by staff who did not routinely work within national guidelines for managing medicine safely.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures in place for staff to follow in the event of any abuse happening.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify areas of potential risk. However not all risks had been identified and assessed.

Is the service effective?

Good

The service was effective.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in accordance with the Mental Capacity Act 2005.

People were cared for by staff who were aware of their roles and responsibilities.

Is the service caring?

Good

The service was caring.

Staff were knowledgeable about the people they were supporting and aware of their personal preferences.

People were treated with dignity and respect.

Staff were aware of people's likes and dislikes.

Is the service responsive?

Good

The service was responsive.

People were able to identify someone they could speak with if they had any concerns. There were procedures for making compliments and complaints about the service.

People were supported to access a range of healthcare and appointments were made promptly when needed.

People received a personalised service, however their care plan was not always updated in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems did not routinely highlight areas of improvement required.

People could be certain any serious occurrences or incidents were reported to the Care Quality Commission. This meant we could see what action the service had taken in response to these events, to protect people from the risk of harm.

There was a strong positive working culture within the organisation.

Ashridge Home 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.

This was the first inspection of the service since it was registered to provide personal care. The inspection was carried out by one inspector.

We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the manager would be in.

Inspection site visit activity started on 11 July 2018 and ended on 24 July 2018. We visited the office location on 11 and 12 July 2018 to see the manager and office staff; to review care records, policies and procedures. Following the visit to the office, we contacted people and staff to seek feedback. We visited three people at their home and spoke with two live-in care workers.

Prior to the inspection we sent questionnaires to people, their relatives and staff. We received three back from people, two from relatives and five from staff. We have used their feedback in this inspection.

Before the inspection the provider completed a Provider Information Return (PIR). We used information the provider sent us in the 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. We reviewed notifications and any other information we had received. A notification is information about important events which the service is required to send us by law.

We also contacted healthcare professionals with knowledge of the service.

Requires Improvement

Is the service safe?

Our findings

Where people required support with managing and taking their prescribed medicine, this was detailed in their care plan. However, in one person's care plan we found conflicting information on who supported the person with their medicines. This was because the person had support from the district nursing team to administer one medicine. The care plan stated, "Medication is fully administered by Ashridge Home Care". However, in another document it stated the person was supported by the district nursing team. This meant it was not clear throughout the care records who provided support with medicine and was contradictory, which could have led to confusion. We fed this back to the registered manager, who confirmed with us after the inspection the care plan had been updated and clarified. Medicine administration records (MARs) were hand written by staff. It is nationally recognised safe practice for hand written medicine charts to be signed by two staff to ensure they reflected the dispensing label. We looked at MARs completed by staff, these did not always reflect an accurate record of how and when the medicine was required. The National Institute for Clinical Excellence (NICE) had issued guidance for services providing support with medicines for people who live in their own home. The records we looked at did not follow this guidance as they did not routinely record how many tablets were to be given or the route of administration. One person was prescribed a medicine to take daily. In a monthly medicine audit completed in February for the previous month it was noted the medicine was only to be given when the person was distressed. However, there was no written confirmation from the GP and the prescription had not been changed. We looked at the MAR's for March and noted the medicine had been given every day apart from eight days. Another person's MAR's recorded that a medicine had been discontinued, again we did not find any written evidence of this from the GP. The provider's policy stated that when changes were made a number of actions were required. This included, receiving written confirmation from the prescriber about the change or receiving an updated prescription. In both cases this was not the case. This meant the provider had failed to follow it's own policy.

Where people were prescribed as required medicine (PRN), we saw this was recorded on the MAR. However, this was often listed with other routine medicine. It is good practice for services to have additional information recorded for PRN medicine. Sometimes this is called a 'PRN protocol'. These documents would include specific information on when the medicine should be given. We checked a selection of records and found this was not the case. This information is important to ensure staff are aware of the circumstances under which these medicines should be given. In addition, we found staff did not always record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. The provider's medicine policy stated
"Where a client is prescribed "When Required" medication, a specific plan for administering this must be documented in the medication care records." We found no 'specific plan' and the provider and registered manager acknowledged these were not in place. Therefore the provider had not ensured it followed it's own policy. We acknowledge we received confirmation following the inspection that changes had been made to implement PRN plans.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service routinely assessed the environmental risks to people and staff, this included looking at lighting and floor coverings as examples. Risks posed to people as a result of their medical or mental health were not always routinely assessed. For instance, one person had a medical condition which had the potential to quickly change. There was no risk assessment in place, or additional guidance for staff on how they would identify any change in the person's health. We spoke with the registered manager about this. Following day one of the inspection the registered manager confirmed they had implemented a risk assessment. We noted specific risk assessments were not in place for other people who had medical condition which had the potential to change suddenly.

People who had been identified as high risk of falling had a risk assessment in place. However, we noted this had not been updated following a fall. This meant there was a potential for the person to be at higher risk than initially identified.

We recommend the service seeks guidance from a reputable source on the management of risks posed to people.

The service operated robust recruitment processes. Pre-employment checks were completed for staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. The service had just recruited another office based member of staff to take the lead in future recruitment. They had a history of working in health and social care and was aware of the all the required pre-employment checks. The registered manager advised that they had recently changed the interview questions to understand more about a potential member of staff, their personality and values. The registered manager told us this was used to ensure each live-in care workers were placed with likeminded people. The service had developed a worker profile, titled 'about me', this was not in place for all live-in care workers, we discussed this with the registered manager and they advised this was due to be completed in the near future for all live-in care workers. The service had a clear recruitment pathway which they used to ensure all appropriate checks were made.

Due to the nature of the service provided, we noted enough staff were employed and deployed to meet people's needs. The live-in carers breaks were covered by the service. A relative told us "They always cover the regular carer (Name of Care worker) when she's away." We received mixed feedback from people and their relatives about the care workers and how much information they had received about them before they started working. We received feedback from people and their relatives they were not always informed about the new live in care worker. One person told us "We did not know anything about her until she arrived." A relative told us "Better screening of carers is needed. We would like to meet them first to make sure they have the right skills and that there is chemistry for a good relationship with my mother. My mother had the chance to speak to someone on the phone before and we have face-timed another carer but it doesn't give you an accurate idea of them. There is no choice of carers with Ashridge." Other people told us "The carers are lovely, just what I needed" and "Very caring and warm. Carers know the care she needs, cooking and companionship. She gets on really well with her regular carer." We discussed this with the registered manager and they advised they did always offer people an overview of experience of the new care worker (Worker Profile) but some people stated they didn't want it.

People were protected from the risk of abuse. The service had a safeguarding procedure in place. Staff received training on safeguarding people. Staff had knowledge on recognising abuse and how to respond to safeguarding concerns. One member of staff told us "Signs to look out for concerning abuse would be physical signs appearing on the body - bruising, lesions, any bodily marks that look questionable." They went onto to say "If I had seen anything like this or anything in fact that I had a bad feeling about, I would immediately inform my care manager, ensure that it is all fully recorded, what the client may have said, what

I have observed and what I have reported and when. If I did not get a satisfactory response, I would then go to the relevant authority and "blow the whistle" so to speak." Another member of staff told us "If I became suspicious that a client was being abused I would contact a manager or superior person and advise them of my concerns and take their advice on what action I should take next."

People we spoke with stated they knew who to speak with if they had any concerns. Where concerns were raised about people's safety or potential abuse, the service was aware of the need to report concerns to the local authority and also their requirement to report this to the Care Quality Commission (CQC).

Staff had received training in infection prevention, health and safety. We noted staff had access to personal protective equipment, such as gloves and aprons. We observed staff asked the office staff to deliver more stock when supplies were running low.

The office staff worked together to resolve issues when the service felt short of expected levels. Following feedback from people and their relatives the service had implemented regular management meetings to discuss care workers placements, compatibility and areas of improvement required. Following an annual survey and feedback received about the cookery skills of the live-in care workers, the service had sought the help of a local home economist to produce a recipe book.

Good

Is the service effective?

Our findings

Prior to people receiving support from Ashridge Home Care Limited, a care needs assessment was completed by the registered manager. This included collecting information about the person's medical condition and what level of support they needed. Where the assessment identified a need for a specific piece of equipment, we noted the service arranged for this to be in place. Examples of this included personal alarms, and pressure relieving equipment.

Where people required support with nutrition and hydration this was detailed in their care plan. We received mixed responses about the support people received with their meals. Three out of the five people we spoke with told us they were unhappy about the cookery skills of the live-in care worker. Comments included "They just don't know how to cook, I am having to teach them," "The major problem is with the cookery skills, they are non-existent" and I have told them I do not want to be used as a training camp for new staff." This was supported by feedback from relatives and people's representatives. Comments included, "She (care worker) couldn't cook and didn't know how to prepare English food. Even sent me photos of food from the freezer asking what it was and how to cook it. The meals were inedible" and "She (family member) needs someone who can cook really well, like a shepherd's pie, as meals are so important to her." We fed this feedback to the registered manager who advised us that they were aware of the negative feedback from people about meal preparation. They told us the service was looking at how it could address the failing and was looking into further training for staff.

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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person who is supported in their own home need to be made to the Court of Protection (COP). At the time of the inspection one person had a court appointed attorney and the service worked in partnership with them to promote the individual's rights. The staff received training on the MCA and were able to communicate their understanding of the Act to us. One member of staff told us "The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment." Another member of staff told us "Giving provision for our clients to make decisions (as long as it's in their best interest), doesn't remove responsibility, control and dignity from the client and is there to protect the client." The service provided the live-in care workers with a reminder of the five core principles of the MCA. This was confirmed by one member of staff who told us "We have also been given a credit card size prompt card to remind us of the main points of the Mental Capacity 2005 Act."

People were supported by staff who had received training the provider deemed mandatory. Prior to a new member of staff being placed with a person, they underwent induction training with the registered manager.

The registered manager had a qualification to enable them to train others. We received positive feedback from staff about their induction. Comments included, "Information I received was clear and well explained. I met with my supervisor and manager before being matched to my client" and "My induction training with Ashridge Home Care was a one to one session with (Name of registered manager) where she went through all the relevant subjects one by one. I felt that this was more personal as it was then taken at my pace and I felt at ease to ask any questions I had on all the subjects. Another benefit was also that the induction was tailored towards the specific type of work and care I would be carrying out for Ashridge and therefore more specific than general training." A third member of staff told us the service responded to new training needs quickly "Recently I raised the fact that I felt as I was working more with clients with Alzheimer's and Dementia that I was lacking in some knowledge. This was taken on board immediately and within a week I had an on-line course to do to increase my knowledge and also a Dementia Friends session was organised specifically so I could attend on a break to also increase my knowledge and ways of learning."

Following the initial induction staff were supported with ongoing support and training. Staff received regular support from the office staff and management. This included one to one meetings, quality spot visits and telephone calls. All the staff we had contact with told us they felt supported by the service. One member of staff told us "My experience at Ashridge has been very positive, the training I received was excellent and the contact that I get from the office is very regular." The management had oversight of staff training and booked them on refresher training when required. Another member of staff told us "The training was very insightful, I learned a great deal and I am incorporating all newly found knowledge into my daily practice as a live-in carer."

Where concerns were noted about people's health, the live-in care workers made contact directly with healthcare professionals or reported the concern to the office. We noted one person was beginning to develop a pressure sore, due to the amount of time spent in bed. We spoke with the district nursing team who advised, "They phoned us as soon as they noted it." We spoke with the person and they told us they were very worried about developing a sore as an elderly relative had suffered with pressure sores. When we visited the person, we saw that pressure relieving equipment was in place and the live-in care worker was aware of how to monitor the condition. One person had severe swelling in her legs. The live-in care worker took advice from a healthcare professional on what they could do to support. The care worker massaged the persons legs every day and encouraged them to carry out some moderate exercises. The person had commented to the care worker their legs had not been that good since they were married. The service had also received positive feedback from the person's relatives on how well the legs looked.

The service worked with external organisations to ensure people received effective care when they moved between services. For instance, when people attended day services. The service ensured it communicated with them.

Good

Is the service caring?

Our findings

People told us they were treated with kindness, respect and compassion. Comments from people included "Yes, they (Staff) are very respectful of my home," "I cannot complain, all very respectful" and "Absolutely, the house is hoovered every day."

When we visited people in their homes and met their live-in care workers, it was clear the care workers had built up good working relationships with people. We observed people were relaxed with staff, we saw laughter and lots of smiles. One person told us "She would go to the end of the world for me, I cannot praise them (care worker) enough." Another person told us "The service is excellent, I am very happy with the arrangement."

People's preferences for how they wanted to be supported were respected. For instance, one person was in a same sex relationship and to minimise the distress caused their partner requested that the live-in care worker was the same sex. Staff were aware of how to provide a dignified service.

Care workers understood how to promote people's choice and independence. Comments from care workers included, "To exercise anyone's choice and control I need to give them opportunity to make simple day-to-day choices, for example discussing their likes and dislikes and asking them what they would prefer to eat or wear, if they'd like to go for a walk or prefer to stay at home," "Although she has mobility issues, my client wanted to go shopping so I took her in the car. We used her walking aid and adjusted the car so she could get in and out as best as possible. She got some items and when she had enough we returned home. She said it made her feel like the boss for the day" and "I believe that one of the most important parts of my role as a Live in Carer is to assist my client to live life as independent as possible and to remain as independent as possible for as long as possible. It is part of my role to make sure that my client is allowed to make choices for themselves wherever possible and these choices are respected by all. My current client was recently in hospital and I was supporting my client whilst there. Hospital staff tried to insist that my client needed to wear one of their gowns. This was for their convenience and to make their jobs easier and not for the benefit of my client. My client had made his preference known that he would prefer to wear his own pyjamas. I made sure that this preference was heard by all relevant staff and that his decision was carried out." Relative told us their family member was encouraged to be independent. One relative told us "The support for my mother is usually very much in line with our targets and goals and has helped to ensure that mum is able to remain as independent as possible in the earlier stages of her illness."

People were encouraged to be involved in decisions about their care. A member of staff from the office maintained close and regular contact with people. This was used as an opportunity to ensure people were happy with the care provided and check if they required any changes. Relatives told us changes were always accommodated by Ashridge Home Care. One relative told us "(Name of registered manager) has been able to accommodate any increases in care needs quickly." They went onto say "She is able to put additional care in place quickly, understands the need for the same carer where possible and any potential difficulties change can cause."

People told us the live-in care workers had been chosen well to suit their needs and personality. This was supported by what relatives told us, "In the last couple of years (Name of director) has come to our aid again, this time with my mother. She has handled her with great skill as my mother was exceptionally reluctant to accept help was required. (Name of director)'s colleague (Name of care worker) was selected as someone who would fit my mother's needs and get on with her. My mother is bowled over by (Name of care worker) and has increased her hours. A supreme achievement by (Name of director) and Ashridge."

The service provided information to people to support them live in their own home. This included information on equipment, day services and support groups.

Good

Is the service responsive?

Our findings

People and their relatives told us they received a personalised service. One person told us. "I have someone who comes each week. We have a chat and decide what we are going to do, they have been this week and we had a nice lunch together and went to Marlow."

Each person had a care needs assessment prior to the support commencing. The detail from that was used to formulate a personal care plan. We asked people who we visited if they had been involved in the care plan, and all confirmed they had been involved. We found the care plans and risk assessments did not always capture up to date information and provide clear guidance for staff. For instance, one person was a diabetic. No information was available for staff to guide them about signs of high or low blood sugars. We noted the staff had not received any diabetes training. Another person's care plan had been updated on the 18 April 2018 and referred to the person falling and dislocating their hip. However, the fall did not occur until the 20 April 2018. We spoke with the registered manager about this and they could not tell us what date the care plan had been updated.

One person had been supported by Ashridge Home Care since September 2017. We checked what records the service held about them. A care needs assessment was dated 1 September 2017, this stated the person "Self-administer" medicines. However, the care plan stated care workers were to provide support. The general risk assessment was dated 13 April 2018. We asked the registered manager if there was a previous version of the risk assessment. They were unable to confirm if one had been written. They told us "We shred previous versions, but keep a copy electronically." We asked if there was a previous version of the risk assessment. They checked the electronic records and no previous version was found.

Some of the care plan records were not dated or signed which made it difficult to determine if it was the latest version.

We recommend the service seeks guidance and support from a reputable source about record management.

Care plans did contain important information on how a person liked to be supported, for instance, when they woke and what they liked for breakfast. Topics covered in the care plans included, daily routine, overnight care, housekeeping and equipment used as examples.

Following the commencement of a person being supported a member of the office staff visited the person within two days to check they were happy with the care provided. This was used as an opportunity to resolve any possible previous miscommunications about care needs. Following that initial review each person was visited once a month by a member of the office to ensure the level of care was still appropriate.

The service was aware of the Equality Act 2010. They supported a same sex couple with some respite care. To enable the staff to have a better understanding of the person's needs, the registered manager contacted The Terrace Higgins Trust (A national charity supporting same sex couples) and attended a conference

facilitated by the trust on 'Caring for a Generation'.

The service facilitated dementia awareness sessions in the local community with support from a university lecturer. We saw family members had been invited to attend to increase their knowledge of the condition. We received positive feedback from relatives about how they had been supported as well as their family members. We had feedback from the lecturer who told us "These events are a great way to enhance people's understanding of dementia and also gives Ashridge the opportunity to invite their carers and client family members to an informal training session."

The service had supported people who required end of life care. One relative told us how well they had been supported at the time. "My family have a long-standing relationship with (Name of director) who looked after the care of my father over his final months some five years ago. Her attention to detail, kindness and understanding made my father's final months easier. She also provided great reassurance to my mother and my brothers during this period. The knowledge we were in very capable and caring hands helped all of us."

The service was aware of the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. At the time of the inspection nobody required information in a different format.

The service has a compliment and complaint process. It sought feedback from people and their relatives on a regular basis. This included monthly quality visits and an annual survey. Feedback was analysed and action plans were created to address any trends identified.

Requires Improvement

Is the service well-led?

Our findings

We received lots of positive comments from relatives about how the service was run. Comments included, "The lady we deal with in regard to mum's contract (Name of registered manager) is friendly, helpful and quick to reply to any query or issue", "From our first contact with (Name of registered manager) we were filled with confidence, everything was organised efficiently and in a thoroughly professional manner and the quality of carers provided has been exceptional" and "Our satisfaction can be judged by our recommendations to various friends , some of whom now have (Name of director) and her team looking after their parents. There's nothing better than a recommendation." A university lecturer who worked with the service on promoting dementia awareness told us "From my experience and knowledge…they are very committed to delivering quality services to their clients. The commitment that goes into organizing such events (dementia awareness sessions) demonstrates that they are a caring business who want to make sure they do the very best they can."

Staff told us they were happy with the management of the service and felt there was a commitment from management to provide a high-quality service. Comments included "Having worked for many different care providers in different places I have basis for an objective opinion, and must say that Ashridge Home Care is the first organisation I came across that really knows what care means," "If I have any problems at all I can call (Name of registered manager) or (Name of director) who are always happy to help me" and "I definitely feel supported by the current manager. I am very appreciating with all of her help and support." Staff told us the values of the service were clearly communicated with them. The company's values formed part of the induction training for staff.

The service provided regular support to staff and operated an on-call system to provide 24-hour support to people, their relatives and staff. One member of staff told us "In Ashridge Home Care clients and carers have the priority. I feel supported and listened to. I know I can call the care manager anytime asking for anything and she'd be there for me."

Systems were in place to seek regular feedback from people. Feedback was used by the service to drive improvements. People we spoke with told us they would not hesitate to contact the registered manager or director at any time.

One of the directors of Ashridge Home Care was one of the founding members of the Live-in care hub, which is non-profit organisation which raises awareness of live in care. The service is also a member of UKHCA (United Kingdom Homecare Association, which is a support organisation for home care providers) both organisations meet frequently and provide sessions on best practice and up-to-date news. The service had provided data to the live-in care hub in a recent research project on the levels of well-being for people receiving live-in care and support.

There is a legal requirement for providers to be open and transparent. We call this duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was

meeting the requirements of this regulation. At the time of the inspection there had not been any event which would have triggered DOC. However, the registered manager was aware of what to do if required.

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. At the time of the inspection there had not been any events which the service was required to tell us about. However, we discussed reportable events with the registered manager and they were fully aware what they needed to tell us about in the future.

The service worked in partnership with external agencies. For Instance, they worked with a university to deliver dementia awareness training. The company's director was a member of local support groups and charities.

The management did have some quality assurance processes in place, however, they had failed to pick up on the issues found by us. We found records were not always updated in a timely manner. The checks completed on the management of medicines did not highlight the areas of improvement required. Risks posed to people were not routinely assessed. However, once our findings were shared with the provider and registered manager, we found them to be responsive and open to our feedback.

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 The service did not routinely ensure peoples medicine management was safe.