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WrightChoiceCare

Inspection report

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Ratings

Overall rating for this service	Inadequate ●

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

Summary of findings

Overall summary

This inspection took place on 7 January 2016 and was announced. At the last inspection in April 2014, the service provided support to one person and was meeting all of the regulations we assessed.

WrightChoiceCare provides care and support to people living in their own home. They provide support to children and young people with learning and physical disabilities and autism. They also offer support to older people some of whom live with dementia. The service is a family run business, the provider manages the service. They employ an assessment officer and a staff coordinator who form part of the management team. The management team also deliver care and support. The service operates in Wistow and the surrounding villages.

The service does not have a registered manager. This is because the service is run by a sole provider who is in day to day control of the service and therefore, it is not a legal requirement to appoint a separate registered manager.

At the time of our inspection the service supported 17 older people and six younger people. Care staff worked across the service user groups.

The overall rating for this provider is 'Inadequate'. The means the service has been placed into 'Special Measures.' The purpose of special measures is to:
1. Ensure that providers found to be providing inadequate care significantly improve.
2. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
3. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

People's medicines were not safely managed; we found medicine administration records contained errors. There were no audits of people's medicines which meant there were no effective safeguards for identifying these errors. For people who required 'as required' medicines there were no protocols in place about when these should be administered. Risk assessments and risk management plans were basic. They did not provide staff with the guidance and direction they needed to keep people safe. Staff were provided with plastic gloves but did not have access to aprons, this meant there was a risk infections could be spread. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have systems in place to ensure staff were safely recruited. Although they completed DBS checks there was no evidence the provider sought employer reference checks. (DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people). This was a breach of Regulation 19 (2)(a)(3)(a) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were significant gaps in the training records we reviewed and we could see that staff had not been given training about the Mental Capacity Act 2005 (MCA) or deprivation of liberty safeguards (DoLs). In addition staff were not provided with supervision. This meant they did not have the opportunity to discuss their development needs or any concerns they may have. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not working in line with the principles of the Mental Capacity Act (2005).The provider identified people they said could not make an informed decision with regard to their care and treatment. We did not see mental capacity assessments or best interest decisions recorded in there care plans. Staff demonstrated a lack of understanding with regard to the providers responsibilities in relation to MCA 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have systems in place to audit the care people received. This meant that issues could not be identified in a timely manner and rectified. Record keeping was poor. This was a breach of Regulation 17 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.

The provider sought support from health care professionals in a timely manner. People told us they received care from staff who were kind and compassionate and their dignity was maintained.

People told us they were involved in the development of their care plan at the initial stage. However, there was a lack of person centred information in people's care plans. We have made a recommendation about this.

People said although they did not have formal reviews they were kept informed of any changes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

People told us their care team was consistent. Most people who used the service and their relatives told us they felt the care was safe. Although this was people's experience of the service we found significant concerns in relation to people's safety.

Medicines were not managed safely

Risk assessments and risk management plans contained limited information and meant people were not appropriately protected from the risk of harm.

The provider did not have robust systems in place to safely recruit staff. None of the staff files we looked at contained reference checks from previous employers.

Is the service effective?

Inadequate ●

The service was not consistently effective.

The provider was not working within the principles of the Mental Capacity Act (2005). They were able to identify people who may be unable to make informed decisions, but they had not completed mental capacity assessments or made best interest decisions.

Staff were not provided with the support they needed to ensure effective care was delivered. There were significant gaps in staff training and no formal systems in place to supervise staff.

Relatives told us the service was proactive in seeking input from healthcare professionals when this was required.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

People gave positive feedback about the support they received from care staff. They described staff who were kind and compassionate.

However, people were not protected from harm. Care plans were basic and staff were not supported to provide a good standard of care.

One relative raised a concern about confidentiality within the service.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

People told us they were involved in the initial assessment of their care, and were provided with information about the service to help them make an informed choice.

Care plans were basic and did not contain sufficient detail to support staff to deliver person centred care. Reviews did not take place on a regular basis, however relatives told us they were kept informed about any changes as required.

The service had a complaints policy. We did not see a record of formal complaints, the provider told us these were dealt with at an informal stage. However, the lack of records in relation to this meant the service could not demonstrate how they had learnt from feedback.

Is the service well-led?

Inadequate ●

The service was not well-led.

Staff understood their role and responsibilities and told us they were supported by the provider but they did not have effective systems in place to ensure staff received the support they needed to deliver safe care.

The provider did not keep records of important information about people's care needs such as contact with doctors and nurses. This placed people at risk of receiving unsafe care.

There were no systems in place to monitor the effectiveness of the service and drive service improvement. A lack of audits meant issues were not identified and addressed in a timely manner. This meant risks to people were not identified and measures to improve the service were not put into place.

WrightChoiceCare

Detailed findings

Background to this inspection

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

This inspection took place on 6 January 2016. The provider was given 72 hours' notice because the location provides a domiciliary care service and we needed to be sure that the staff would be available to speak with us.

Before the inspection we reviewed all of the information we held about the service. We contacted the local authority commissioning team and Healthwatch. Healthwatch represents the views of local people in how their health and social care services are provided. Neither provided feedback regarding the service. We reviewed all of the notifications we had received from the service since our last inspection. Notifications are incidents the provider has a legal duty to inform CQC about.

The inspection team consisted of one inspector and an expert by experience. The expert had experience of using this type of care service. The expert by experience spoke with eight older people who used the service and nine relatives. We also spoke with three relatives of younger people and one young person.

During the inspection we spoke with the provider, training coordinator and assessment officer. We looked at four people's care plans; two for younger people and two for older people. We reviewed medicine administration records for two people. We looked at five staff files.

We also spoke with a social worker and a community nurse to gather their feedback about the service.

Inadequate ●

Is the service safe?

Our findings

People and their relatives told us they felt they received safe care. A young person who used the service told us, "I feel safe when they [care staff] visit." A relative of a young person told us, "We trust the staff and [name] feels safe." A relative of an older person who used the service said, "I'm very happy with the people they have working for them, the girls [care staff] are very nice, I don't have to worry about [relative]." An older person who used the service told us, "They are gentle, [when showering] never hurt me and don't rush." In contrast to this one relative of a young person said, "I do not feel confident that staff know how to keep my [relative] safe."

People told us they had a small team of care staff and care was delivered reliably and punctually. They said they never had to wait too long for staff to arrive, although occasionally emergencies meant they could be unavoidably delayed.

Although we received positive feedback from the majority of people, we were concerned about the systems the service had in place to deliver safe care and we found the service did not consistently provide safe care and treatment.

Medicines were not safely managed. We reviewed two people's medicine administration records (MAR's) which had been archived in the office. We found medicine administration was not recorded accurately. One person had been prescribed a morphine pain relief patch (morphine is a controlled drug), their care plan had not been updated and stated this was administered by the community nursing service. We were told care staff had taken this role on from the district nurses, however the care plan had not been updated to reflect this change. There was no clear record of the date the service had taken on this role from the community nursing team.

We checked the MAR chart for September and October 2015 and found a number of recording errors. The daily records contained a record of the patch being changed on 15 September, this would have been the correct day for the patch to be changed based on the last recorded entry on the MAR chart. However, the MAR chart was blank for the 15 September and then there was a record of the patch being changed again on 17 September. This meant the patch was changed after two days instead of the prescribed seven days. Following this the patch was then changed on 22 September 2015. This meant the patch was changed after five days. These recorded errors were documented as being administered by the provider and the assessment officer responsible for the medicines training.

In October 2015 there were two records on the MAR charts which indicated the medicine had been incorrectly administered in line with the original prescribing instructions. This was because the patch should have been changed every seven days, but on one occasion the gap before it was changed was only six days and on the other occasion it was eight days.

We raised these concerns to the provider who told us at this time the person's medicines were being adjusted by the doctor on a regular basis and they were following the doctor's advice. However, there was no record of these conversations having taken place. Nor was the MAR chart amended to reflect the change in prescribing instructions. We asked the provider to make a retrospective safeguarding referral to the local authority for further investigation.

Prescribing instructions for morphine patches refer to the need for this to be applied to alternative sites on the body to prevent skin irritation. For example if this is applied to the left shoulder one week it should be applied to the right shoulder the following week. There was no body map within the care plan, the daily notes or on the MAR chart to say where the patch had been applied so it was not possible to determine that prescribing instructions had been followed.

MAR charts were difficult to follow and contained some handwritten records. It is good practice to get a second member of staff to cross check and counter sign hand written MAR charts, however the service was not doing this.

For another person we saw missing signatures on the MAR charts which meant we could not be sure whether their medicines had been administered in line with the prescribing instructions.

The provider told us the assessment officer took responsibility for ensuring medicines were safely managed. They completed the MAR charts for staff to fill in and checked the competency of care staff. We asked for evidence of recent medicines training the assessment officer had attended, we were told they completed a course run by Lloyds pharmacy, however, they said this was eight years ago. They told us they had completed on line medicines training more recently but there was no record of this within their staff file. Following the inspection we were provided with a training certificate for the assessment officer which showed the required training was completed on 6 January 2015.

Some people received 'as required' medicines. However we could not see any protocols in place to support staff to know when and why the medicine should be administered. This meant people were at risk of not receiving pain relief because staff were not provided with guidance about how to know if it was required. Not everyone who used the service would be able to tell staff if they needed their medicines.

We asked the assessment officer and the provider whether they completed any routine audits to check people were receiving their medicines safely. They told us no audits took place. This meant there was no system in place to detect errors in a timely manner and actions had not been taken to remedy any problems.

The service did not have adequate risk assessments and risk management plans in place which meant people were at risk of receiving unsafe care and treatment. The service supported a young person who had complex support needs and was at risk of harming themselves or others. The risk assessment was very basic and the risk management plan did not contain adequate guidance for staff. The person's relative expressed concern about their care plan and said, "It's basic. I thought care staff would have more detailed information about [name's] needs." There had been an incident involving a member of staff who had been harmed whilst supporting the young person.

Following the inspection we shared our concerns with the young person's social worker, we expressed concern about staff training in relation to supporting people with complex behaviour which posed a risk to themselves or those around them. The social worker reviewed the care planning documentation within the person's home and afterwards they contacted us to say, "It (the care plan and associated risk assessments) is not adequate." They assured us they would work with the family and provider to address the issues.

Staff told us about an older person they supported who was living with dementia. They explained to us the person's behaviour and it was evident this could place the person at risk. However, there was no risk management plan in place which provided staff with guidance about how to support the person to remain safe. We asked staff how they would know how to manage risk and they told us, "[Name of assessment officer] would tell us."

Staff told us they had access to gloves which were kept in people's own home. However, staff were not provided with plastic aprons or other personal protective equipment. This meant staff were at risk of spreading infection.

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

The provider did not have safe systems for staff recruitment. None of the staff files contained reference checks and we were not provided with evidence these had been sought.

The provider told us, as a small family business, staff were recruited via word of mouth and were known to the provider before they started work. Despite this we saw evidence that a member of staff had been dismissed in December 2015. This was due to concerns being raised regarding professional boundaries. The provider told us this person had provided personal character references and the provider had not sought a reference from their previous employer. This meant the provider was not completing a robust reference check and this meant the service did not have safe recruitment procedures in place.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider was not carrying out reference checks all of the staff we spoke with told us they had a DBS check before they started work, and this was confirmed in the five staff files we reviewed. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with certain groups of people.

The service had not made any safeguarding referrals since our last inspection. When we spoke with staff they were able to identify types of abuse. They told us if they did have any concerns about people they would contact one of the management team and were confident this would be dealt with. The service had a safeguarding and whistleblowing policy which provided staff with guidance about how to raise concerns.

The provider employed nine members of staff, this included themselves. There were sufficient staff employed to deliver care and people told us the care was consistent and they knew staff well. However, this involved the provider and management team delivering a significant number of hours of 'hand on' care (up to 50 hours). This meant the management team did not have the time to carry out the tasks required of them to ensure the service was well-led. The management team explained they were recruiting new staff with the aim of reducing this contribution so that they could focus on management of the service in future.

People told me they get a copy of the rota each week so they know who will be coming and that it was usually the same carers who attended them. The clients knew the carers by name and some seemed familiar with most of the tea. One person said, "I know them all and they know me."

One member of staff told us the on-call arrangements were not effective. They said it often took the provider some time to get back to them and because it was a small, family run business the management team often took time off together so there were delays in getting advice and support. The provider told us, and we saw records which confirmed this, that another member of staff provided on call cover if the family were away together. Following the inspection they told us they had bought a mobile phone which would be used as a dedicated 'on-call' phone.

Inadequate ●

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. One person said, "I know them all [care staff] and they know me well." However, two relatives expressed concern about the level of training staff had received.

There were a lack of formal systems in place to ensure staff received up to date training and regular supervision. Supervision and training should be in place to ensure staff have the skills and knowledge to deliver effective care to the people.

All of the staff we spoke with said they shadowed more experienced members of staff when they first joined the service. They explained their induction involved observing the practice of the management team and staff told us this lasted for approximately one month. One member of staff said, "We've had 'on the job' training." Although staff told us this was helpful, we did not see evidence of formal training taking place. This meant staff were not provided with training which was based on up to date good practice.

The staff coordinator told us they were responsible for ensuring staff received up to date training which was required to ensure they had the skills and knowledge to provide care. They explained staff had access to 'social care TV' which is an on line training provider and completed mandatory training, "within the first few weeks". In addition to this they told us all new starters would be expected to shadow more experienced staff, which would include the management team. They advised us staff shadowed medicines being administered and were then observed to make sure they were competent. However, these checks were not recorded.

We looked at five staff files and could not see any evidence of up to date medicines training. Out of the five staff we spoke with one member of staff told us, "I've done medication training in the past," but they told us they did not have to undertake any formal medicines training since they had worked for the service. They also told us they had not had their competency checked by senior staff within the service.

One person told us about their relative, who had behaviour which could pose a risk to themselves and others. There had been an incident involving their relative. They said, "I didn't feel the staff member was properly trained." This had left them lacking confidence in the provider. They explained since this incident their relative's social worker had arranged some specific training for staff. When we reviewed staff files we saw evidence of this training. However we were not provided with evidence of training staff had undertaken in relation to supporting people when they became distressed before the incident. We have discussed this with the person's social worker because we wanted to highlight to them our concerns in relation to the providers ability to support people experiencing distress which in this incident had resulted in them harming themselves.

From the five staff files we looked at we found; two people had a record of safeguarding training from 2014, one person last attended safeguarding training in 2012 and two people did not have any record of attending safeguarding training. We looked at dementia training and found that only two people had up to date training.

Staff told us they did not have formal supervision. However they said they could contact the manager if they needed support. One member of staff said, "I come into the office a lot and discuss issues with [name] the manager. Although I do not have formal supervision I feel well supported."

The staff files we reviewed did not contain records of supervision meetings or discussions. Supervision is an opportunity for staff to discuss any training and development needs, any concerns they have about the people they support, and for their manager to give feedback on their practice. This meant the provider could not be assured staff were providing effective care.

The lack of recorded supervision and training meant the provider did not ensure staff had the support they required to deliver effective care based on up to date good practice. This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 checked whether the service was working within the principles of the MCA. The manager, staff coordinator and assessment officer were able to identify to us people who lacked the capacity to consent to their care and support. However, we did not see mental capacity assessments or best interest decisions recorded within people's care plans. We asked the assessment officer about this and they said, "Best interest decisions would be made by someone else, the social worker or NOK representative." This demonstrated a lack of understanding of the legislation because if someone is unable to consent to care and support a member of care staff is making a best interest decision on their behalf when they provide care. The lack of best interest decision making meant people may be at risk of receiving care and support which was not based on their previous wishes as we saw no evidence of relevant people being consulted in the decision making.

When we looked at staff training none of the five staff files we reviewed contained up to date MCA training; however the assessment officer had completed training on Deprivation of Liberty Safeguards (this is part of the MCA) in 2014.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us the service was proactive in noting concerns about people's health. One person told us a member of staff contacted them to say their relative appeared more confused, they suggested a doctor was called to check whether they had a urinary infection. Another person relative said, "They [care staff] are very proactive and are ready to jump in if there is any concern." They went on to tell us a member of care staff had escorted their relative to doctors' appointments. A community nurse told us the provider contacted them for advice appropriately and followed the guidance they provided.

Requires Improvement ●

Is the service caring?

Our findings

People we spoke with were complimentary about the care and support they received. They told us staff were caring. Comments included; "I think they [care staff] are lovely, I can't say any more," "Wonderful, not one negative thing," "Just first class" and "Brilliant, go out of their way to do what you need. Do anything if it's possible."

People told us care staff knew them well and provided good care. One relative said, "They have got to know my [relative] well in just a few months I think they are tremendous they keep [relative] well. [Relative] has improved considerably and is more cheerful now."

We were told care staff were kind and caring. One person relative said, "The staff are kind and courteous, 'old school'. They make an effort to talk to my [relative] and have a laugh."

A relative whose family member was living with dementia told us they had experience of other care service providers and said, "I rate these highly in comparison. It's a well-managed company, good staff who are very knowledgeable if you have any queries." They told us unbeknown to the care staff they had been in another room and had heard them talking with their relative "kindly and courteously". This person went on to say they would definitely recommend the service to other people.

There was evidence that the service had provided support for wider family members. One person told us their family had been struggling to cope before the care service had been started and said the carers had helped the whole family, providing personal care and practical support. They also told us the provider had helped the family to get additional funding from the local authority for extra hours to give the family the level of care they needed. They told us the service had made a significant difference to the whole family.

We were given examples of where staff showed they were prepared to go the extra mile. This included taking one man out for a game of snooker so his wife could have a break, shopping, tidying up changing light bulbs and in one case helped a lady put a gazebo up so her husband could sit in the sun. All of the care staff we spoke with said they would be happy for their relative to be supported by the service if they needed this kind of care.

People told us they were treated with dignity and respect. We saw people were asked about whether they preferred a male or female member of care staff. A relative said, "I'm very happy with the people they have working for them, the girls [care staff] are very nice, I don't have to worry about [relative]."

Although the feedback we received from people indicated to us that care staff were compassionate, kind and caring. We found shortfalls across the service which demonstrated a lack of consistent care. These included examples related to people's safety in relation to management of medicines and staff lacked the skills and direction to protect people from harm in relation to managing people's distress. Care plans did not contain detailed person centred information. This meant people were at risk of receiving support which was not based on their preferences. One person told us they had complained about confidentially. They believed their relative had been discussed with other people who used the service. They told us this had been dealt with by the management and they were satisfied the issue had been resolved.

We concluded that the positive approach of individual staff was not linked to key principles in training and support from management and there was a lack of robust systems to enable them to ensure the maintenance of the overall quality of the caring experience for people using the service. In these circumstances, notwithstanding the positive personal relationships people using the service and their relatives which we have noted, we take the view that the provider needs to ensure that these informal positive relationships are better supported.

Requires Improvement ●

Is the service responsive?

Our findings

The provider explained they visited people to discuss the service WrightChoiceCare could offer, they left information for the person and their family to consider and then if they want to proceed they returned to complete an assessment. This meant people were provided with the information they needed to make an informed decision about whether they wanted support from the service.

The assessment officer explained an individual care package was developed, this included care plans and risk assessments. People and their relatives told us they had been involved in the initial assessments. One person said, "[Name of assessment officer] did the assessment. He discussed how I wanted things and that's how it's done."

We looked at four care plans and found they contained very basic information and guidance for staff about how care should be delivered. The care plans were not dated so it was difficult to establish when they had been written. We saw one person had a detailed social care assessment which had been completed by their social worker. This was in the care plan file but the information on the assessment was not reflected in the care assessment and plan which had been developed by the provider. This meant people may receive support which was not reflective of their needs.
However, all of the care staff we spoke knew people well. They were able to tell us about people's likes and dislikes and their previous life experiences this reduced the risk of people receiving inappropriate care or treatment but the quality of the care planning does need to be improved.

We recommend the provider reviews their care planning documentation to ensure they follow good practice guidance on person centred care planning.

Although we did not see evidence of formal reviews taking place people told us they were kept informed about any changes to their relative's needs. One person said, "If there are any concerns about my mother they are on the phone straight away." Another relative told us the provider communicated with them via emails or notes were left for them at their relative's home. They said, "They [care staff] ring me if there is a problem." While this informal approach to reviewing people's needs was currently mitigating any risk of people receiving inappropriate care or treatment, a more formal system of review of needs should be put in place and properly recorded.

We recommend the provider adopts a formal system to review people's care needs which is based on good practice guidance.

People told us the care delivered by the service was flexible and responsive. One relative said, "It's good to know I can call on them if I can't get there and need help at the last minute".

The provider told us the service had not received any formal complaints. They said they were proactive in addressing issues as soon as they were raised. Two of the relatives we spoke with explained they had needed to raise concerns with the provider, and that these had been resolved. Other people we spoke with told us they had not had cause to complain. They said staff were open and approachable and they would feel comfortable raising a concern if they needed to. One person who used the service told us, "They seem really keen to get things sorted and make things right." The provider had received numerous compliments including thank you cards.

Inadequate ●

Is the service well-led?

Our findings

As a family run business, the provider/owner employed two members of their family who worked as the assessment officer and the staff coordinator. In addition to this, at the time of our inspection, they employed seven members of care staff.

We were told by the staff coordinator and the assessment officer that the management team had each, up until the last month, been providing 50 hours of care per week. They told us the aim was to reduce this to enable them to have more time to manage the service.

People who used the service told us they knew the provider and they would raise any concerns they had with them directly. One relative told us the provider had been proactive in arranging additional support, "My [relative] was getting more confused. [Providers name] liaised with the council to get the hours increased so they come twice a day now."

Staff meetings did not take place on a regular basis due to the small size of the staff team and the commitments of providing care in people's own home. However, care staff told us the management team were approachable and they were confident issues they raised would be addressed in a timely manner. Staff were clear about their role and responsibilities. They gave us examples of when they needed to seek advice from the management team or healthcare professionals.

Despite this we found there were no formal systems in place to audit the care provided by the service. We asked the provider to tell us about the systems they had in place to assure themselves people were receiving a good standard of care which was safe and of a high quality. The provider explained across the management team they supported most people and so they had oversight of their needs and the care which was provided. They said as a small business they would know about any issues within the service or problems for individual people who used the service.

The provider explained they did not carry out audits on any element of the care people received. This meant there was no system to identify any potential shortfalls within the service to enable the provider to address them in a timely manner. For example the issues we identified during the inspection with regard to the unsafe practice of administering medicines may have been identified sooner if the provider audited medicines on a regular basis.

During our office visit the provider dealt with a number of telephone calls from health care professionals about people and their care. They told us they had constant contact with the district nursing team and local doctor's. We asked to review the records of discussions with health care professionals for two people. The provider explained these discussions were not recorded, they told us they had not realised they needed to be. This meant we could not see what advice had been provided in relation to people's care. A lack of contemporaneous record keeping means the management team have to remember important information about a number of people over a period of time. This meant information could be missed or passed on incorrectly and placed people at risk of receiving inappropriate care and treatment. It also meant that if health and social care professionals needed to review the care and support people had received they would not have all of the information they needed to support them in making effective assessments or clinical decision. This was particularly important for people living with dementia who may be unable to provide people with an accurate picture of their own needs.

However, the provider told us they had recently installed an electronic care planner and this would enable them to record all of the conversations which took place about people's care. They said they would ensure this happened from now on.

Although we were told complaints were resolved the provider had not kept a record of these. This meant we could not review the action which had been taken to resolve the complaint or look at how the provider learnt from complaints.

The provider did not demonstrate any systems they had in place to learn from incidents or change and develop practice. The lack of management oversight of staff training meant that, despite having a small team of staff they had not ensured their staff team were kept up to date and could not be assured they delivered care based on good practice guidance. The lack of recorded competency checks meant 'on the job' training which had been provided had not been validated. This left people at risk of receiving unsafe care.

One staff member raised concerns about not being able to get hold of the management team in a timely manner; this along with the lack of detailed guidance for staff in the care plans meant the provider had not taken steps to support staff to keep people safe.

The provider did not have systems in place to monitor or drive improvement within the service and record keeping was poor. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not following the principles of the Mental Capacity Act (2005), staff had not received up to date training. We did not see evidence of mental capacity assessments or best interest decision making when the provider had identified concerns about a person's ability to make an informed decision.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have safe systems for staff recruitment. None of the staff files contained reference checks and we were not provided with evidence these had been sought.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provided did not ensure people received safe care and treatment. We found medicines were not safely managed. Risk assessments were basic and did not contain adequate risk management plans to support staff to keep people safe. Staff were not provided with PPE.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have quality assurance systems in place to monitor and drive forward service improvement. Record keeping was poor and meant it was difficult to establish if people were receiving safe care and treatment.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff received effective support to deliver good care. There was evidence of significant gaps in training records across the staff team and we did not see evidence of supervision taking place.

The enforcement action we took:

Warning Notice