Chenai Holistic Home Care Agency Ltd

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an announced inspection of Chenai Holistic Homecare Agency on 27 November 2018. The inspection was partly prompted by concerns received from a local authority. Chenai Holistic Homecare Agency is registered to provide personal care to people in their own homes. The 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. At the time of our inspection, the service provided personal care to 78 people in their homes.

At our last inspection on 5 April 2017, we rated the service 'Good'. At this inspection, we found concerns with care plans, risk assessments, medicine management and quality assurance systems therefore the service has been rated 'Requires Improvement'.

The service had a registered manager. 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 legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is run.

Risks to people were not always robustly managed. We found some care plans did not contain suitable and sufficient risk assessments to effectively manage risks. This placed people at risk of not being supported in a safe way at all times.

Staff had been trained to manage medicines safely. However, we found gaps in some people's medicine records. We also found that staff were administering medicines without recording this on people's MAR.

Effective quality assurance systems were not in place. Audits had not identified the shortfalls we found during the inspection.

Accurate and complete records had not been kept to ensure people received high quality care and support.

Care plans were inconsistent as some care plans did not include accurate information and to ensure people received person centred care. People's ability to communicate were recorded in their care plans.

Although staff had received mandatory training to perform their roles, specialist training in area's such as catheter care had not been delivered by a qualified person. We made a recommendation in this area.

Staff time-keeping and attendance was being monitored. We noted where staff were late, this was not being pursued by office staff to minimise risk of late calls or missed visits. Staff also raised concerns on the lack of travel time to get to care appointments. We made a recommendation in this area.

We received mixed feedback from staff, relatives and people about the management team. People's

feedback was sought from surveys. However, the surveys were not being analysed to ascertain what the service was doing well in and what area's required improvement. We made a recommendation in this area.

Staff had been trained on safeguarding. However, not all staff were aware of how to identify abuse and knew who to report abuse to, both within the organisation and externally.

Pre-employment checks had been carried out, which ensured staff were suitable and of good character to support people in a safe way.

Pre-assessment forms had been completed to assess people's needs and their background before they started using the service. However, were there were issues, this had not been followed up during the referral stage.

Regular supervisions were being carried out.

People's privacy and dignity were respected by staff. People and relatives told us that staff were caring and they had a good relationship with them.

Complaints received had been investigated and relevant action had been taken. Staff were aware of how to manage complaints.

Spot checks of staff supporting people had been carried out to observe staff performance.

We identified two breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to risk management, medicine management and good governance. You can see what action we have asked the provider to take at the back of the full version of this 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.

Some risk assessments had not been completed for people with identified risks.

Medicines were not being managed safely.

Follow up action was not being taken where staff were late and some staff raised concerns with lack of travel time to go to appointments.

Not all staff were aware of safeguarding procedures and knew how to identify and report abuse.

Pre-employment checks had been carried out.

Appropriate infection control arrangements were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received mandatory training. However, some staff were not aware of the contents of the training and specialist training in area's such as catheter care had not been delivered by qualified person.

Although staff had received MCA training, some staff were not aware of the MCA principles. Consent had been sought from people to provide support to them.

Issues at pre-assessment stage had not been followed up to identify if this posed a risk to people and care plans were accurate.

Staff received regular supervisions.

People had access to healthcare services when required.

Is the service caring?

Good

The service was caring.

Staff had positive relationships with people and were caring.

People and their relatives were involved in decision making on the support people received.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were inconsistent as they did not detail the person-centred support people would require in full.

People's ability to communicate was recorded.

Staff knew how to manage complaints. People and relatives had access to complaint forms should they need to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality systems in place had not identified the shortfalls we found during the inspection.

Accurate records had not been kept to ensure people received high quality care at all times.

People's feedback about the service was obtained from surveys. However, this was not analysed in full to ensure there was culture of continuous improvements.

Staff, people and relatives had mixed reviews about the service.

Chenai Holistic Home Care Agency Ltd

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 was carried out on 27 November 2018 and was announced. We gave the service 24 hours' notice because we wanted to be certain that someone would be available to support us. The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed relevant information that we had about the provider including the last inspection report and any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We also sought feedback from social professionals.

During the inspection we reviewed documents and records that related to people's care and the management of the service. We reviewed eight people's care plans, which included risk assessments and eight staff files which included pre-employment checks. We looked at other documents held at the service such as medicine, training and supervision records. We spoke with the registered manager, deputy manager, two care coordinators and a recruitment officer.

After the inspection, we spoke to six people who used the service, six relatives and 10 staff by telephone.

Requires Improvement

Is the service safe?

Our findings

Assessments were carried out with people to identify risks. There were assessments that had been completed such as on moving and handling and potential hazards around people's homes. However, when some risks had been identified, there was no detailed information on what actions staff should take to minimise risks.

Risk assessments had not been created in relation to people's medical condition such as for people with arthritis, risk of aspiration and stroke. For example, some people had a stroke previously. This had not been risk assessed, particularly the signs that may lead to a stroke and what actions staff may take to ensure the person was in the best of health. In other care plans, some people had diabetes. Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications. For example, for people with diabetes, there was no information on the signs and symptoms of hyperglycaemia (high blood sugar levels) or hypoglycaemia (low blood sugar levels) particularly when supporting people with meals.

For another person, the placing authority referral form showed that the person may be at risk of malnutrition and dehydration. However, there was no risk assessment in place to mitigate this risk such as the signs and symptoms of malnutrition and dehydration and who staff should report to. The registered manager told us that food was offered to the person but the person refused to eat them. This had not been included on the person's care plan particularly if the person continuously refused food, which may place them at risk of malnutrition.

The above concerns meant that risk assessments were not completed to demonstrate the appropriate management of risks and to ensure support and care was always delivered in a safe way. A staff member told us, "Risk assessments could be more detailed. New carers do not know what they are doing." Some staff we spoke to were not aware of the signs and symptoms of diabetes and the actions to take and some staff members did not know what pressure sore was. Without this information, there was also a risk any unfamiliar, new or agency staff may not be able to support people in a safe way. This placed people at risk of not being supported in a safe way at all times.

People's medicines were not always well managed by the service. Care plans included the type of medicine people were prescribed. The service supported some people with medicines. We looked at Medicine Administration Records (MAR) for some of the people the service supported with medicines. MAR charts included the medicine people were given with the dosage and when this should be administered during the day. Staff had received medicines training and told us that they were confident with managing medicines. Staff were also aware on what to do if an error was made such as missing a medicine. They told us they would report this to the office and depending on the type of medicine then contact the GP for advice. The registered manager told us that medicines were audited as part of spot checks and audits. A spot check is a member of the management team observing care staff when they support people to check their performance.

However, we found records that showed a number of gaps on people's MAR. We fed this back to the registered manager and went through the daily records to identify if these medicines were administered. Records showed the medicines had been administered on the daily records or people were in hospitals but this had not been recorded on the MAR. In one person's MAR, we found a number of gaps, however we could not find the daily records to evidence if these medicines had been administered. The registered manager told us that staff had initially completed the incorrect MAR chart, this was identified as part of spot check audits and a correct MAR had to be completed afterwards, which was the reason for the gaps. The registered manager, showed as a photo of the incorrect MAR, which also showed some gaps therefore we could not be assured if the person had received their medicines.

For two people, we found MAR charts had not been completed after staff administered medicines. Daily records for one person showed that staff administered eye drops. There was no MAR chart in place and the registered manager told us that staff should not be administering these eye drops. This had not been identified as part of daily record audits. For another person, staff were applying prescribed creams without completing a topical MAR chart. This meant that by not recording the administering of medicines, the service may not be assured that medicine was being administered as prescribed.

The above issues meant that the service was failing to take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by not ensuring medicines were being managed safely.

The above issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We had mixed reviews on staff time-keeping. A person told us, "They come and go when they are supposed." A relative commented, "Yes, they are pretty regular, and we do give them a bit of grace. Most of them use buses." However, a relative told us, "The night carer comes at 6pm and that's it for the night, they are supposed to be at 7.30pm and that works better for us." One relative commented, "On Monday they were supposed to come at 8am but they came at 8.40am. Once, they came at 10:40." The service used an online call monitoring system to monitor staff timekeeping and attendance. Staff logged in and out of visits electronically or by using a phone. This showed they had attended and left their visit after carrying out personal care.

There were mixed responses regarding the time to travel to attend calls from staff. A relative told us, "The agency puts too much pressure on the carers and they don't have time to travel, which means they don't give the best service because they are always in a rush." A staff member told us, "I am given enough time to travel." However, another staff member commented, "We do not get anytime to travel." Another staff member commented, "Rota not being given enough time to travel in between appointments." Records showed that staff were given a short amount of time to travel in between care visits because they were allocated specific postcode areas to work in to minimise travel time. The care coordinator said staff did not usually have to travel more than 10 minutes between visits as rotas were organised according to close proximity where people lived. We looked at staff rotas and saw staff were generally given 5-10 minutes time to travel in between appointments. Rotas showed the days and times care was to be provided to people.

Records showed staff had been late by over an hour. We asked about this and the deputy manager told us that staff were late as an agreement had been made with people on the time staff should attend. However, there was no records to show that agreements had been made when we asked office staff to check records and if any action had been taken by office staff on why staff were late. We spoke to one of the placing authorities about this after the inspection who informed that the service should be letting the placing

authority know when such agreement took place but this was not being done.

We recommend the provider reviews procedures for late calls and rotas to ensure the risk of missed visits or late calls are minimised.

People and relatives we spoke to told us that people were safe. A person told us, "[Care staff member] makes me feel very safe." A relative told us, "They listen to [person] and give [person] general feeling of being safe." Another relative commented, "Now they listen and they don't have to be constantly told what to do, so we all feel safer."

We checked eight staff records to see if pre-employment checks had been completed. Pre-employment checks such as DBS and immigration checks, employment history, references and proof of the person's identity had been carried out as part of the recruitment process. This ensured staff were suitable and of good character before supporting people. The Disclosure and Barring Service (DBS) is a criminal record check that helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people.

Most staff were aware of their responsibilities in relation to safeguarding people. Some staff were able to explain what abuse is and who to report abuse to and understood how to whistle blow and knew they could report to outside organisations, such as the Care Quality Commission (CQC) and the police. Although staff had received training on safeguarding, four out of the ten staff spoken to did not know the types of abuse and one staff member did not know who they could whistle blow to. This meant that staff may not know how to identify abuse and who they can report this to.

Records had been kept of incidents. This detailed the incident and the action that had been taken. The registered manager told us that they always analysed incidents to ensure lessons were learnt and to minimise the risk of re-occurrence. The registered manager told us that they had a number of incident in a moment of time due to staff lateness and missed visits and gave us examples of the learning took place to ensure the risk of re-occurrence was minimised. Examples included providing staff with cars to ensure late calls were minimised.

There were systems in place to reduce the risk and spread of infection. A person told us, "[Care staff member] wears an apron, wears a glove and disposable footwear." Staff had been trained on infection control. Staff were supplied with personal protective equipment (PPE) such as gloves, aprons and sanitisers when supporting a person. Staff told us they disposed of PPE separately when completing personal care.

Requires Improvement

Is the service effective?

Our findings

Most people and relatives told us staff were skilled, knowledgeable and able to provide care and support effectively. A person commented, "[Care staff member] knows about my needs, exactly what I need and don't need." Another relative told us, "I call them the A team, they are so good." However, a third relative commented, "The regular carers are on the ball, some don't know what they are doing and I wonder how they got this job. I do give them time to settle in." A fourth relative told us, "They have a lot of good carers and a floating tank of not so good carers. Sometimes I feel like some of the carers are like a fish out of water, some of them don't have the caring quality and you have to be extremely hygienic."

Most staff told us that they found training helpful. A staff member told us, "Training is helpful." Another staff member commented, "I have had good training." However, some staff expressed concerns with training and told us they would benefit from practical training rather than theory based training. A staff member told us, "Training could have been better. We got shown videos. Needs to be more practical."

Records showed that new staff members that had started employment with the service had received an induction. There was a shadowing checklist that recorded area of shadowing that was covered by staff. Following induction, staff received mandatory training. This included Care Certificate standards. The Care Certificate is a set of standards that health and social care workers comply with in their daily working life such as safeguarding, infection control, first aid and health and safety.

We looked at the training matrix. The matrix was up to date and showed staff had received mandatory training. The registered manager delivered training to staff. We saw that they had a training qualification to deliver training to staff. Training topics included nutrition, food hygiene, infection control, moving and handling and safeguarding. Tests had been carried out after training to check staff understanding in area's they received training in. However, out of the ten staff we spoke to that had received training, six staff did not know the principles of the Mental Capacity Act 2005 [more information on this act can be found on the next page of this report], two staff did not know what pressure sore was or how to respond to it, four staff did not know the types of abuse and one staff member did not know who to whistle blow to.

Specialist training had also been delivered on dementia care and pressure ulcers. Records showed that the service provided specialist care with catheter care. The registered manager told us that she provided training on catheter care, however had not received training in this area to deliver this type of training to staff. In addition, we were informed for one person that the service supported required a blood monitoring machine to be attached to send reading to the person's GP. There were no records that training had been delivered in this area.

We recommend that the service seeks best practice guidance on delivering training this includes specialist training and ensuring staff understand the contents of the training.

Most staff told us they were supported in their role. A staff member told us, "[Registered manager] does support. If I need anything, I call the office and she supports." However, some staff members raised concerns

with the lack of support from the service. A staff member told us, "[Registered manager] does not engage with us. If you raise anything, she dismisses it." Records showed that staff received regular supervision. Supervision included discussions on uniforms, timekeeping, attendance, professional development and any concerns that staff may have. Where staff had been working for more than 12 months, records showed an appraisal had been completed that reviewed the performance for the previous year and if further training and development was needed.

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.

Records showed that staff had received training on the MCA, however some staff did not know the principles of the MCA when we spoke to them. Where possible, people had signed a consent to care forms agreeing to receive support and care from the service. Staff we spoke with told us that they always requested consent before doing anything. Another staff member commented, "I always ask before doing anything." A person told us, "In the morning before doing anything [care staff member] will ask me how I am and ask me before doing everything, not presume."

Pre-assessments had been completed before people started receiving support and care from the service. These enabled the service to identify people's daily living activities and the support that people required. Using this information, care plans were developed.

However, for one person, assessments had not been carried out effectively to ensure they received person centred support. The placing authority referral showed that the person was on Warfarin, which is a blood thinning medicine. This placed the person at risk of harm as they would be at risk of bruising or bleeding easily. Records also showed that they should be on a soft food diet and were at risk of aspiration. Daily records showed staff supporting the person to eat solid foods. We fed this back to the registered manager who told us, she thought that the referral forms were from past history and was certain from observation and knowing the person that the person was not on blood thinning medicine and on a soft food diet. The registered manager informed she would follow this up. However, this should have been identified at pre-assessment stage and followed up to identify if this was a risk as there were no records that showed this had been identified. We spoke to the relative of the person, who confirmed the person was on a soft food diet but informed that they prepared all the meals and staff only supported the person to eat. This had not been included on the person's care plan.

The service supported people with meals, which included preparing meals and making meals from scratch. Care plans included the support people would require with food. For example, on one person's care plan, information included, 'I will tell you what I need for breakfast and drink of my choice.' People were given choices by staff when supporting them with meals. A staff member told us, "We give them choices on what they would like to eat." A person told us, "[Care staff member] will ask if I want something. She will ask me before I want anything."

Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health. Where staff had more immediate concerns about a person's health, they called for a health professional to support the person and support their healthcare needs. Staff were able to tell us the signs people would display if they did not feel well. A relative told us, "Yes, it's happened a number of times [person not well] and they know just what to do." This meant the service supported people to access health

services to ensure people were in the best of health.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring and treated people well. A person told us, "[Care staff member] is very caring, very friendly." Another person told us, "They are like my mates, we have a laugh." A relative commented, "Very well, [person] is a very fussy lady." Another relative commented, "Very well, always cheerful and polite."

Staff told us how they built positive relationships with people. A staff member told us, "I do this by talking to [people using the service] and finding out about them first. I listen to what they need always." A person told us, "I have a very good relationship with [care staff member]." Another relative told us, "Yes, [person] has a good relationship with the ones [person] likes."

People and relatives confirmed that they had been involved in decision making on the care people received. There was a section where people and relatives could sign to evidence that they agreed with the contents of their care plan. A relative told us, "Yes, we make decisions as a family." A person commented, "They come round to my house and we review [care plans] together." A staff member told us, "I tell them what I will be doing. Like, I will bring their clothes and they choose, it is their right."

People's independence was promoted. Care plans included information on where people could support themselves and area's they would need support with. On one person's care plan, information included, 'I am able to wash my face and my upper body. My bottom half I would like carer to do.' A person told us, "[Care staff member] will say, try and do it yourself, if not, I will help you." A staff member told us, "When I am there, I guide them. I will first encourage them to do things and I will help them if they cannot." A relative told us, "Yes, they do, when [person] having a good day they ask [person to do [person] own buttons and go for a walk."

Staff ensured people's privacy and dignity were respected. They told us that when providing particular support or treatment, it was done in private. People and relatives, we spoke to confirmed this. A person told us, "[Care staff member] close door even though no one is in the house just to be safe, if anyone does come in. [Care staff member] would close curtains and windows."

Staff gave us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity. We saw that confidential information such as people's care plans and medicines records were stored securely in the office.

People were protected from discrimination within the service. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. People and their relatives we spoke with confirmed that they were treated equally and had no concerns about discrimination.

Requires Improvement

Is the service responsive?

Our findings

We received mixed reviews about care plans from staff. One staff member told us, "Care plan says what care person needs." Another staff member told us, "No details for staff on what to do."

Each person had an individual care plan, which contained information about the support they needed from staff. Letters were sent to people before they received support from the service that outlined the support the service would be supporting them and the previous Care Quality Commission inspection report was attached in addition to surveys. There was a 'About Me' section that included information on people's family background and housing. Care plans were divided into sections and included information on people's mobility requirements, religion, medical condition, continence and social support. Care plans included the times staff supported people and the support people required. In one person's care plan, information included that staff should ensure a person that used a wheelchair was strapped to minimise the risk of the person falling. In another person's care plan, information included that staff should ensure the person wore pendant alarm before they left so the person can raise an alarm in the event of an emergency. Daily records confirmed this was being done.

However, we found inconsistencies with some care plans. On one care plan, information included that a person's blood should be monitored and staff to use Wifi to send this to the person's GP. There was no information on how the person's blood to be monitored. The registered manager told us that staff had to use a blood monitoring machine and place this around the person's arm sending the reading automatically through Wifi. This level of information had not been included on the person's care plan. In another care plan, records showed that when supporting a person with drinks, thickener be used. We checked the daily records and found there was no thickener being used on drinks. The registered manager told us that the person may not need thickeners on their drinks and would check this and then update the care plan. We spoke to the relative who confirmed that thickener was needed when providing the person with drinks. In a third care plan, there was information that indicated that a person used an oxygen machine to help with their breathing. However, the registered manager told us that this had been completed incorrectly and the person did not use an oxygen machine. This meant that without accurate information staff would not be able to care for people in a person-centred way.

The registered manager told us that they were in the process of changing care plans that may have resulted with inconsistencies and would ensure all the information was captured in the new care plans.

There were daily records, which staff should record about people's daily routines and the support provided by staff. However, we were unable to find daily records for one person for a certain period of time to evidence if they had received their medicines. In another care plan, staff were required to put an apparatus on a person when transferring them. There was no information on the daily records that evidenced staff used the apparatus when transferring the person. We spoke to the relative of the person, who confirmed that apparatus was worn. They told us, "The personal care is very gentle they transfer [person] safely, [person] wears a [apparatus] and they are very careful with him." However, it is important to record each time staff put the apparatus on the person during transfers so the service could be assured care was being

provided in a safe way.

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information would tell them how to keep themselves safe and how to report any issues of concern or raise a complaint. Staff were able to tell us how they communicated with people. Care plans included people's ability to communicate and recorded how staff should communicate with people. Information on one care plan included, 'My hearing can be bad sometimes. Care workers to shout a little.' A relative told us, "They understand [person] and will give [person] time because [person] speech isn't great but they are very patient with [person].

There was a complaints policy in place. Complaints had been recorded with records of the actions taken as part of the investigation. Staff were aware on how to manage complaints. People and relatives knew how to make complaints. A person told us, "I do not need to report anything, if I need to, I would do it. I did so with my previous care company."

Requires Improvement

Is the service well-led?

Our findings

Most staff told us that they were supported in their role and the service was well-led. One staff member told us, "[Registered manager] has been wonderful, she is nice." Another staff member commented, "[Registered manager] is very nice. We work like a family." A third member of staff told us, "I never had any problems with them, they are good to me." However, some staff members had concerns about the service. One staff member told us, "They are not professional about the quality of care. Another staff member commented, "They can't provide care for clients." A relative told us, "My big concern is that during the seven months we have had some excellent people but they don't stay. When I ask them what the problem is they say it's the management, they don't know how to treat the staff. The result is that we get a good carer and then boom they're gone."

People and relatives had mixed response about the management and the service. A person told us, "If I ring [registered manager], she will get to the root of issues and get back to me." A relative told us, "I've met them a couple of times and if I do have a problem she [management] will try to sort it." Another relative told us, "The manager was great when we first started, very hands on but as soon as they took on more areas, the care dwindled, but now she has [deputy manager] as a deputy we are not ignored anymore." However, some relatives raised concerns. A relative commented, "I don't think I've had much to do with the manager, I have called a few time's but no one has gotten back to me." Another relative told us, "I've had some disagreements with [registered manager] but generally speaking she's ok. I think a lot of the problems start with the co-ordinating, which is down to the manager."

Audits were carried out on care plans, daily records and medicine management by care coordinators. The registered manager told us that they did visual audits on care plans. However, the findings and the areas that had been covered for the audits had not been recorded by the registered manager. Recording audits is important to make sure that any identified actions could be monitored and if any actions had been implemented. The audits carried out by office staff had not identified the shortfalls we found at the inspection with care plans, risk assessments, daily records and medicine records.

Records were not always kept up to date. We found in some care plans, risk assessments and medicine records had not been completed in full to ensure staff had the relevant information to provide high quality care at all times. In addition, we found a section of daily records for one person could not be found. Keeping accurate records is important to ensure the service had oversight of the support people required and if support had been delivered effectively.

This meant that robust governance systems were not in place to ensure shortfalls in relation to care plans, daily records, risk assessments and medicine management could be identified and action taken to ensure people always received safe and effective care at all times.

These issues were was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Spot checks of staff supporting people had been carried out and these had been recorded. They focused on time keeping, care plans, medicine management and care practice. This was then communicated to staff. This meant that the service was able to identify what areas staff were doing well in and identify if further development was required, to ensure people received effective care and support.

People's feedback was sought through surveys. The survey focused on performance, professionalism, expertise of staff, reliability and time keeping. Where there had been negative comments, records showed that the management took action to ensure improvements were made. However, we found the surveys had not been analysed to identify trends or patterns and the areas the service was doing well in and areas that required improvement on a regular basis. The registered manager told us that this was usually done on a yearly basis. However, if there were number of feedback that required improvement on a monthly basis, this may not be captured and used to make improvements to systems in order to ensure there was a cycle of continuous improvement.

We recommend the service analyses the results of surveys regularly to ensure there is a culture of continuous improvement.

Staff meetings were held regularly. The meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff held discussions on time keeping, training and sharing any concerns or ideas. Office meetings were also held. Minutes showed that staff discussed compliance, communication, infection control and service users. This meant that staff were able to discuss any ideas or areas of improvements as a team, to ensure people received high quality support and care.

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 provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. Regulation 12(1)(2)(a)(b). The provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines. Regulation 12(1)(2)(g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not robustly assessing, monitoring, improving the quality and safety of the service users and mitigating the risks relating to the health, safety and welfare of service users who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b). The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c).