Reliance Care Solutions Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 September 2018 and was announced.

The Care Quality Commission (CQC) received anonymous concerns in relation to staff using unsafe lifting techniques, issues related to supporting people with meals and language barriers. Because of these concerns we undertook this responsive comprehensive inspection.

At the last inspection in February 2016, we judged the service as Good overall with requires improvement in the key question of effective. We found procedures for protecting people's rights where they lacked capacity needed improvement.

Reliance care Solutions Limited is registered to provide the regulated activity of personal care. It provides personal care to people living in their own homes in the community. The service is provided to people who have a range of needs to include, Dementia, Learning disabilities or autistic spectrum disorder, physical disabilities, Mental Health, or eating disorders. At the time of inspection this was a small service providing care and support to 20 people. The Care Quality Commission (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 consider any wider social care provided.

At this inspection in in September 2018 we found the provider did not always identify, assess and mitigate risks to people to ensure they received consistent safe care. Staff were not using safe techniques to move a person. The support plan was not updated to provide information to staff to deliver care safely. The provider had not taken steps to reassess a person's care package to reduce known risks and assure themselves they could continue to meet the person's needs safely. The provider did not recognise or report the incident as a potential safeguarding concern.

Whilst people told us they were happy with the support they had from staff to take their medicines, we found medicines were not always administered in a safe way.

The providers systems and processes to audit and monitor the quality of care was not effective in ensuring good working practices amongst all staff. The providers checks and audits had not been effective at identifying matters that needed to improve. Previous inspections had shown the provider had a history of

not meeting regulations, and having previously made improvements we found that they had not sustained these.

You can see what action we told the provider to take at the back of the full version of the report.

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

People felt safe with staff in their home. Staff had completed safeguarding training but did not always recognise when people could be at risk of harm. The provider had systems in place to ensure staff were suitable to work with people in their own homes. People were happy they had regular staff and that staff stayed the duration and sometimes over as needed.

Staff had training to ensure they had the skills to support people. However, training and on-going support was not sufficiently informative to ensure best practice so that people were always supported in the right way. People told us that staff sought their permission before providing care and support. However, the provider needs to evidence people's consent was sought and recorded in line with the MCA legal framework.

People were supported with their meals and were happy with these arrangements. People were supported with their health and to access the doctor or other services when they needed. However the provider had not always followed professional's recommendations to ensure the best outcome for people.

People were consistently complimentary about staff and described them as kind, respectful and considerate. People told us they made decisions about how they wanted their care provided.

Staff were responsive to people's needs so that they received care and support at the times they needed. People were supported by staff who could communicate with them in their first language. People and relatives were confident in the service and felt any concerns or complaints had been managed to their satisfaction.

People and their relatives were happy with the service and described it as reliable and responsive to their needs. They felt it was well-led because they had positive relations with the provider and staff. They were happy the provider communicated with them on a regular basis and they always had a response when they called the office. People said the service had improved and it was a service they could work with.

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

Risks to people's safety were not consistently assessed and mitigated and risk management plans were not always in place. Where people's safety may be at risk this was not always shared with external organisations.

The arrangements for supporting people with their medicines was not consistently safe.

Safe recruitment checks were in place and people received regular support at the times they needed. People were happy that staff maintained hygiene and infection control standards in their home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Checks to monitor staff practice and ensure they applied their training had not been effective.

People's consent was sought but where people were unable to make decisions consent was not always sought and recorded in line with the MCA legal framework.

People were provided with support to maintain their nutrition and hydration needs. People had been supported to access health professionals. Recommendations from health professionals were not consistently followed.

Is the service caring?

Good

The service was caring.

People spoke highly about the staff and described them as kind, attentive and respectful.

People were supported by staff who could communicate with them and who respected their cultural and religious needs.

People were supported with their choices about their care.

Is the service responsive?

Good

The service was responsive.

People were supported in the manner they wished and happy that they had a regular group of staff who understood their needs and called on time.

Support plans reflected people's likes, dislikes and preferences.

People knew how to make a complaint and had their complaints addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of management oversight to ensure the quality and safety of the service. The provider's audits were not always effective in identifying shortfalls.

People found the service reliable, described good communication and had confidence in staff.

Reliance Care Solutions 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 announced comprehensive inspection of Reliance Care Solutions Limited took place on 13 September 2018. The inspection team comprised of two inspectors, an interpreter 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.

We gave the service 48 hours' notice of the inspection visit because it is a small service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. Inspection site visit activity started on 13 September 2018 and ended on 17 September 2018. We visited the office location on 13 September 2018 with our interpreter to see the manager and office staff, and to review care records and policies and procedures. Our Expert by Experience carried out telephone calls over a two-day period on 14 and 17 September 2018 and spoke with 5 people, and 6 relatives of people who were receiving a service.

In preparation for this inspection we considered the information supplied to us by the provider in their Provider Information Return (PIR). This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

We contacted local authorities who provided the funding for people to ask them for information. We also

considered information available from other sources which included complaints shared with us by people who used the service and a whistle blower. We were aware that aspects of this information were brought to the attention of the Local Authority. For example, manual handling techniques, issues related to supporting people with meals and language barriers. We used this information to explore aspects of current care and treatment during the inspection.

During our inspection, we spoke with the registered manager, the deputy manager and the providers quality manager. We used the services of an interpreter and spoke with twelve staff. We looked at the care records for four people who used the service, four people's medicine records, staff training records, three staff recruitment files, records of staff supervision and competency checks, provider surveys, complaint records, and records relating to the management and audit of the service.

Requires Improvement

Our findings

At our last inspection in February 2016, we rated this key question as 'Good'. At this inspection, we rated this key question 'Requires Improvement'.

Prior to the inspection we had received concerns from a whistle blower regarding the safety of a person using the service. This concern had been shared with partner agencies by CQC. We took into consideration the concern when conducting this inspection. This included reviewing current risks to people, identifying any impact on people using the service and whether the provider was in breach of their legal requirements. We also considered if any action was being taken by the provider to mitigate risks.

The information we had received indicated that the moving and transferring of a person was not safe. We had been told the person's condition had deteriorated and they were unable to transfer without equipment to support them. We were informed there was no hoist in the person's home and staff were said to be manually lifting the person. During this inspection our discussions with staff confirmed that they were not using appropriate equipment to support the person to move safely. When we asked why they were lifting this person without the use of a hoist we were told, "We have to lift [person] can't walk, and there's no hoist". Staff had not recognised this as unsafe and poor practice.

We spoke with the registered manager and quality manager who acknowledged manual lifting was taking place. They told us this was because the person did not have a hoist and they, "Wanted to help the family". The registered provider informed us they had attended a meeting and were aware of an assessment carried out by the occupational therapist [OT], which had identified the need for a hoist in June 2018. Therefore, they were aware the person's needs were deteriorating. The manually handling risk assessment and support plan had not been reviewed or updated to reflect the person's deterioration or to provide guidance for staff in how to deliver safe support to the person based on the OT assessment. This practice could have resulted in serious injury to the person.

Whilst some risks to people's safety such as the risk of choking, not eating enough or falling were identified and managed, action had not been consistently taken to mitigate some all risks to people's safety. For example, where people had health conditions such as epilepsy, their support plan described the condition but further information was needed about how staff should manage risks associated with this. Staff told us they hand tested water temperatures to ensure it was safe for people before they had a bath or a shower. However, there was no information in risk assessments about the use of thermometers to prevent people from injuries such as scalding. Whilst there were examples of home visits and changes to support plans to

reflect people's changing needs, this had not happened on all occasions. People's changing needs were not consistently updated to ensure they were safe. Risks to people's safety were not always assessed and managed to prevent avoidable harm.

Medicines were not consistently administered safely. For example, Staff we spoke with confirmed they assisted some people with the administration of their medicines. We also heard from staff that on occasion family members would prepare the medicines for staff to administer to the person. Administering medicines in this way is unsafe as the staff could not be sure what medicine they were giving to the person. People's support plans were not clear as to the level of support needed with medicines and or who was responsible for administering these which could have put people at risk of not receiving their medicines as prescribed.

People's Medication Administration Records (MARs) which staff complete when administering people their medicines showed gaps where staff had not signed to say they had given people their medicines. We looked at how the provider checked MARs and found that their audits had not picked up these gaps or explored if people had had their medicines. We discussed this with the registered manager as unsafe practice. They told us they would take action to review their medicines processes to include their audit of MARs and to clarify the level of support needed in people's support plans. This would help to ensure staff were only administering and recording medicines they were responsible for. People's medicines were not always administered safely.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment .

People told us they felt safe with the staff. One person described the provider as, "Very good and very nice to me, like my family. Staff are also nice to me - like my daughters". A relative told us, "Yes, we both feel safe. They're the best staff we've had". People told us because they had regular staff they felt safe with them and trusted them in their home. Staff had completed safeguarding training but did not always recognise potential harm. Whilst the provider understood their responsibility to refer any allegations of harm or abuse to the local authority safeguarding team they had not recognised staff practice as potentially harmful. This demonstrated that people were not always protected from the risk of harm as the provider had not taken appropriate action regarding the unsafe practice. The provider had a whistleblowing policy and staff were aware of this. Contact numbers for reporting safeguarding concerns outside of the organisation were available.

People and their relatives told us they received their calls on time and were happy that they had regular staff who they knew and trusted. People told us they were always informed if staff were running late or if different staff were attending them. People spoken with said they had not experienced any missed visits. Staff told us their calls were in close proximity which enabled them to arrive on time and complete the full duration of the call. The electronic rota showed some calls overlapped. We discussed this with the deputy manager who explained they were still learning about how to schedule the calls on the new system. They assured us staff had sufficient time to travel between each call. We heard examples from people using the service that staff often spent longer periods with them to ensure their comfort and safety.

The providers recruitment procedures continued to be good. Records we saw confirmed that the appropriate checks had been carried out to include obtaining references and DBS [Disclosure and Barring Service] checks. The DBS check would show if a prospective member of staff had a criminal record or had been barred from working with adults.

People told us they had no concerns regarding cleanliness and hygiene. They confirmed that staff wore

gloves and aprons and left their home clean and tidy. One relative said, "The main safety issue is the environment - [the person] living conditions. This company responds; it's cleaner now, and my relative's made a 3000% improvement in cleanliness definitely. All the staff follow the schedule attending to [the person]".

The provider told us that they had learned from events and were improving the service. For example, they had identified the need to match people to staff who shared the same language. This was to ensure staff could communicate with people.

Requires Improvement

Our findings

At our last inspection in February 2016, we rated the service as requires improvement under the key question is the service effective. This was because staff were not always trained in some aspects of the care they provided. Procedures for protecting people's rights were not fully understood. At this inspection we found the service had made some improvements but other areas were identified as needing improvement and the rating has remained 'requires improvement'.

Prior to our inspection we received information that staff did not always have the skills and training in relation to some aspects of their role. For example, in preparing food, undertaking cleaning tasks and language skills. We were also made aware that staff were moving a person in an unsafe way. Although records showed that the provider had provided training in manual handling, they had not ensured this training was effective. In addition, whilst staff had safe medicines training they were not always following correct procedures regarding supporting people with their medicines. Our discussions with staff showed that they did not recognise these practices as poor. There was also an element of confusion about their role when supporting people in their own home. For example, not recognising that without the correct equipment they should not be lifting people, or giving medicines on behalf of family members. These instances indicate the providers systems for training were ineffective in ensuring staff used their knowledge and understood the boundaries of delivering safe care.

Staff had an induction which included training in core areas. They told us they worked through their hand book and received practical sessions in the office for the use of equipment. They shadowed experienced staff and told us they felt prepared for their role. Whilst we saw examples of competency checks that had been carried out for some staff this system was not formalised to ensure all aspects of their role was checked systematically. The provider told us supervision and competency checks on staff were behind schedule due to management changes but that they had made a start. Staff told us they felt supported, could speak with managers and get advice.

Most people felt staff had the skills to meet their needs. They said staff understood their medical conditions such as a learning or physical disability and how best to support these. For example, one relative told us, "[Staff] is very efficient; they wait and work around [family member]". Some people told us they had discussed staff skills with the provider where they felt this needed to improve. They confirmed that the provider had taken steps to ensure staff delivered care effectively. For example, one person said, "There's room for improvement. I asked him [person who uses the service] and he said they could do better if they didn't rush so much. He can't stand that quickly and I told the manager who pointed this out to the staff - it's

a company I can work with". Another relative told us, "Our (relative) thinks so – [that staff have the skills]. It's all done really good I would say". The provider and quality manager acknowledged that some practice had identified that training was needed. For example, the quality manager told us, "We do recognise that not all staff have skills in some areas, for example realising they need to tidy up, put the laundry away, or even cooking skills. We are trying to address this and we do speak with people for feedback and give staff guidance".

People told us an assessment of their needs was completed before they received support from the service. They confirmed they were involved in this process which identified their personal care needs, medical history and dietary needs. People's needs in relation to any protected characteristics under the equality act such as disability, religion and culture were also identified. For example, staff had guidance for using a person's communication aid to ensure they could communicate effectively with the person.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff understood the principles of the MCA and told us how they obtained consent and provided people with choices around their care. One staff member said, "We always ask what they want and make sure they consent, we can explain things and give them choices but if they don't agree we don't do it". It was not always clear how decisions were made for such as administering medicines. Records had been signed by relatives when consenting to administering medicines but a capacity assessment had not been completed or best interest meeting documented to support how decisions were made. The management team they told us this was a cultural preference but acknowledged they needed to evidence people's consent was sought and recorded in line with the MCA legal framework.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection. The provider informed us no one was deprived of their liberty.

Information we had received prior to the inspection indicated people did not have support with their meals. We did not identify any concerns regarding people's support in this area. Several people confirmed that staff supported them with their meals and drinks. They were happy that staff understood their needs and ensured meals and drinks were prepared to their liking. They also told us staff made sure that food and drink was within reach before they left their home. Some people needed help with preparing their meal or encouragement with eating and drinking. The level of support people needed was identified in their support plan and staff were aware of this.

People told us that staff had called the GP and ambulance when emergencies occurred. Examples were also given where people were supported by staff to attend appointments. Staff were aware of emergency procedures to summon help. The provider had liaised with other health professionals involved with people's care, for example the occupational therapist.

Good

Our findings

At our last inspection in February 2016, we rated the registered provider as 'Good' in this key question. At this inspection we found that the service had sustained this rating.

Everybody we spoke with consistently described staff as caring, kind and friendly in their approach. People and relatives told us that staff were caring and considerate, a person told us, "Yes, [staff] shows attention to detail, asks how I am and what I've done". A relative said, "Yes, all of them are caring and kind, and nice people. They even phoned me now, just now, to see how she is in hospital and what's happening". Another relative described how staff made time to listen to and talk to people and make them happy and comfortable, they said, "[Staff] tells [person using the service], what's on TV, or tells them about something funny that happened".

We found staff knew people well and had formed positive relations with them and their family. One relative told us, "When staff walks in [name] lets out a big laugh; [name] likes them". People described how staff took the time to interact with them and listen to them. People said their regular staff knew and understood their needs and preferences and they liked them. A relative told us that staff were considerate and respectful of people's needs and said, "[Name] has same set of staff that know us very well. They phone if they're sending a new person to be trained and ask is it okay for them to shadow". People provided several examples where staff had gone over and above what was expected. One relative said, "They're the best staff we've had. They really do care. They even visited [name] in hospital".

People told us they made their own decisions and choices about their care. One person told us, "We've always had male staff for religious reasons". Staff described how they involved people in expressing their views and making decisions. One staff member said, "We speak to people all the time, they tell us what they want or don't want". We heard examples from people about decisions they had made about their care such as their religious, cultural and language preferences being respected. The registered manager had matched staff to people who shared the same language. Our discussions with people showed they were happy with the way in which the provider had taken account of their preferred language and matched staff to them. People and their relatives told us that staff spoke to them respectfully and in a way, that they could understand. One person said, "It's the same staff member and they speak Gujarati and English". Another relative told us, "My mum interacts more with them than with me. They [staff] are Indian and speak Hindi and talk about things back home in India". We concluded there were currently no communication barriers.

Staff told us and we saw that care plans provided guidance about people's routines and preferences and

how they wished to be supported. The registered manager showed us they were conducting home visits to speak with people about their care and support to ensure they were happy about how this was being delivered. People and their families told us staff respected their dignity when undertaking personal care tasks. One person said, "Staff creams my legs; he is polite and well-mannered". Staff provided examples of how they promoted privacy such as ensuring doors were closed. We also heard how people were encouraged to be independent such as taking part in aspects of their care such as washing and dressing. People's personal information was kept secure to ensure confidentiality.

Good

Our findings

At our last inspection in February 2016, we rated the service under the key question is the service responsive? as 'Good'. At this inspection we found the service had remained 'Good'.

People and their relatives confirmed their involvement in the planning and review of their care plan. One person told us, "The care plan is exactly what I need - my (relative) works together with them like a team to get what I want". A relative told us, "They do and they come out for reviews quite regularly with someone who speaks her language and they go over the package". Care plans were individualised and informed staff of people's likes, dislikes, routines and preferences and how people liked to be supported. A relative told us, "I would recommend Reliance - it's basically because they know what [name] wants and needs, and the consistency with which they turn up, and the little things they do like combing her hair and washing her the way she likes - she feels really safe and she smiles when they come in". People's cultural and religious needs were captured and staff were able to say how these were met. For example, one person had made gender specific decisions related to their religion and another person was supported to cover their head as per their religious custom. Staff were also well informed about how they responded to cultural or religious customs when in people's homes.

All the people we spoke with told us they received the care and support they needed at the times they had asked for. People were informed when calls were late and told us the service was responsive where this had happened in the past and was now resolved. They were happy that staff stayed for the duration of the call and several people commented that they stayed over the time to ensure people were comfortable and safe before they left.

People commented that the service was responsive and recognised the importance of regular staff attending to them. One relative told us, "We have a rota with several staff, they are all familiar; [name] doesn't like strangers touching him". We also heard from people that staff did not rush people and stayed over to complete people's care. One relative told us, "To be honest it is very difficult as her condition is getting worse. From 20 minutes it can take 40 minutes to have her tea in the morning - she has to sip it. They finish so late".

We looked at whether the service was compliant with the Accessible Information Standard. This 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. Records indicated whether people had disabilities or sensory impairments and there was guidance in how to communicate

with people in a manner they could understand. For example, a relative told us how staff used a specific communication aid to communicate with a person, they told us, "[Name] can't speak but they [staff] have got to understand how to use the board-they've learnt how to communicate using it. They all use the board". We heard examples of the importance of staff using the communication aid. For example, the person had been able to spell out that they had, "pain in my side" and on another occasion, "chest pain" which enabled staff to seek medical help quickly.

People told us they knew how to complain and their complaints had been addressed without delay. Where people had raised issues they had been responded to, discussed and resolved. For example, one person told us, "They ring me to say what's been done. There were two or three staff not to her satisfaction but they took time to learn and know now - and I'm not just saying this but they're the best staff we ever had". Records we looked at confirmed the provider had a system in place to respond to complaints and use complaints as an opportunity to improve the service.

No one was in receipt of end of life care. The provider had links with external health professionals where people had life limiting conditions but there was no impact for people at this time. Staff had knowledge about people's religious beliefs which they respected and understood would need to be taken into consideration.

Requires Improvement

Our findings

At our last inspection in February 2016, we rated the service under the key question is the service well-led? as 'Good'. Prior to that inspection in 2014 we identified several breaches of regulations which included ineffective quality assurance systems to monitor the delivery of the service. At this inspection we rated this key question 'Requires Improvement'. This was because the provider had not sustained improvements and we found other areas of the service that needed improvement.

The providers systems for identifying risks to the safety of people and reducing those risks were not effective. The provider was aware from attending external meetings that the moving and handling needs of a person using the service had changed. They were aware that an Occupational Therapist assessment had resulted in the need for a hoist to support the person in their own home. However, they had not taken steps to reassess the package of care to ensure that the delivery of care to the person continued to be safe in the absence of a hoist. The provider told us that they had 'chased up' the hoist, which further demonstrates they were aware there was a need to use a hoist to avoid risks to the person's safety and well-being.

The provider's quality monitoring systems had failed to ensure the service user was safely and competently supported, particularly when being moved or transferred. Whilst the provider did carry out some competency checks on staff undertaking care tasks, there was no record that this had happened in this instance. There was also no record of observations of the support being provided until prompted by us at which point the provider conducted a reassessment of the care package and instructed staff to cease manually lifting the person. In addition, the person's support plan had not been updated to provide an accurate record of how to deliver their care. This in turn meant that staff did not have accurate and up to date guidance in how to deliver safe care.

Providers have a duty to ensure that risks to people's safety and welfare are escalated within their service and to external bodies as appropriate. We found that the provider had not assessed, acted on or shared this risk. This indicates the provider did not fully understand their responsibilities in key areas of providing a registered service. For example, the provider had not considered this incident as a safeguarding concern in order to protect the person from experiencing harm. We found that the provider's oversight of risk within the service was compromised and they needed to look at ways to reduce the likelihood of re-occurrence. Without a system to monitor risks the provider would not be able to maintain oversight of such incidents.

The provider carried out quality checks but we found these were not fully effective. We looked at people's Medication Administration Records, [MARs]. We found gaps in signatures which meant we could not be

confident that people had always received their medicines as the GP prescribed. We looked at the providers own audits of MARs which did not identify the shortfalls we found. Quality checks carried out by the provider had not identified that staff were administering some people's medicines in an unsafe manner.

Whilst the provider had made improvements in relation to obtaining people's consent to care, their governance did not always reflect this. For example, some people's relatives were signing consent forms and consent to administer medicines. A capacity assessment had not been completed or best interest meeting documented to support how decisions were made. Whilst we noted the explanation from the provider in relation to cultural preference, further improvement was needed to ensure people's consent was sought and recorded in line with the MCA legal framework.

We identified that requirements of the Duty of Candour had not been considered with regards to the specific incident concerning unsafe lifting. The provider had not provided evidence that action had been taken in line with the expectations in place to comply with the regulations related to the Duty of Candour. This requires providers to be open and transparent with people who use their service and other relevant people. It sets out specific requirements that providers must follow when things go wrong with people's care or treatment. Whilst the provider acted on this after the incident, this demonstrated a lack of understanding of this requirement when the hoist was not in place.

Systems and processes had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

The provider informed us that recent management changes had impacted on the service. He had recruited a quality manager to assist them in developing the monitoring systems. People told us they had noticed improvements since his appointment. One person said, "I think is a personnel manager I spoke with, he's marvellous. He's recognising where there can be improvements and is working with the staff, and it's noticeable that he's made changes".

The registered manager was also the provider (owner) of the service. All the people we spoke with had positive things to say about the service. People had noted improvements and all of them said they would recommend the service. Their comments included; "Overall, I feel really happy about it (the service)." "They come and visit to get feedback and do ring me from time to time to see how it's going." "I know the manager for long time, very good and very nice to me, like my family. Staff are also nice to me - like my daughters." "Concerns get sorted out definitely, the office are easy to get hold of and they take action - I feel comfortable contacting them".

The registered provider had conducted competency spot checks on carers and provided supervision in which carers could discuss their practice. The provider told us these were behind schedule due to management changes but had a schedule to plan them in. These systems are necessary to ensure staff are competent to carry out tasks, such as moving and handling. However, we found staff were unsure of their role, for example in giving medicines prepared by family members. This indicates the providers systems to evaluate staff practice were not fully effective in identifying where improvement was needed.

The provider had sought and reviewed people's feedback on the service via completed surveys. We saw people were complimentary in their feedback, such as, "Keep up the good work", "Carers are brilliant", and "Very good service". Phone surveys and home visits had also been conducted and the provider had acted to reduce the language barriers between people and staff. One person told us, "Surveys they do and they come out for reviews quite regularly with someone who speaks her (family carer) language and they go over the

package". The provider had actively recruited staff with suitable levels of English language and had matched staff to people so that they shared the same language. People told us they were happy with these arrangements.

Staff told us they felt supported and could approach management at any time. They attended team meetings and felt communication was good. Staff presented as very committed to their role. One staff member said, "It is not just a job; my service users have a big place in my heart". Another staff member told us, "They check I am working well, very supportive".

The registered provider told us how they shared appropriate information with other health professionals for the benefit of people who use the service. We saw they had attending meetings but needed to ensure they could demonstrate they had implemented and acted on recommendations.

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 People were not protected from harm due to inadequate risk management processes within the service. Regulation 12 (2) (a) (h) People were not protected from harm by the safe management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17 (1) (2)(a)(b)