Efficiency-For Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced inspection of Efficiency-For Care Limited on 9 October 2017. Efficiency-For Care Limited is registered to provide personal care to people in their own homes. At the time of our inspection, the service provided personal care to eight people in their homes.

This was the first inspection of the service since the service moved to a new location in September 2017. During this inspection, we found breaches of regulation that may put people at risk of harm. Therefore the service has been rated Inadequate under Safe.

The service had a registered manager. However, we were informed the registered manager had left the service. A new manager had been recruited who was present during the inspection. The provider informed us that an application would be submitted to register the new manager and de-register the previous 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 were not always robustly managed. We found 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.

People and relatives told us that medicines were given on time. Records confirmed this. However, we were not assured that people's medicines were appropriately reconciled and there were inconsistencies with people's risk assessments for medicines.

Staff had not received specialist training, such as ventilator awareness, which they needed to do their jobs effectively. Some staff had not received formal training from the service prior to delivering personal care to people.

Care plans were inconsistent. Some care plans did not include the support people would require in relation to their current circumstances. Pre-assessments forms had not been completed in full to assess people's needs and their background.

Not all people or their representatives had been involved with decision making of the support people would require.

Quality assurance systems were in place but were not always effective. For example, the audits had not identified the shortfalls we found during the inspection to ensure people were safe at all times.

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

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 to ensure staff were suitable to provide care and support to people safely.

There were arrangements in place to ensure staff attended care visits. Staff told us they had time to provide person centred care and the service had enough staff to support people. There had been no missed visits.

Supervisions had been carried out regularly. People were being cared for by staff who felt supported.

Staff knew the principles of the Mental Capacity Act 2005. People had capacity to make their own choices and were independent.

People had the level of support needed to eat and drink enough and were supported with cooking meals when required.

People had access to a range of health care professionals, which included booking appointments on people's behalf and supporting people to access healthcare services.

People's privacy and dignity were respected by staff.

Complaints and concerns were investigated and staff were aware on how to manage complaints. People and relatives knew who to raise complaints and concerns with.

Staff told us the culture within the service was like being part a family and were positive about the management. People's feedback was sought from telephone surveys.

We identified breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to risk assessments, training 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?

Inadequate

The service was not safe.

Risks assessments had not been completed for people with identified risks. This is to ensure people were kept safe at all times.

People were receiving their medicines. There were discrepancies between what was recorded on people Medicine Administration Records and what was recorded in the care plan.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

There were appropriate staffing arrangements to ensure staff attended care visits.

Pre-employment checks had been carried out to ensure staff were suitable to care for people safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received essential training needed to care for people effectively.

Staff received regular supervision and support to carry out their roles.

People were supported with making meals when required and were given choices.

People had access to healthcare services when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all people or their representatives had been involved in decision making on people's support.

Staff had a good relationship with people.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were inconsistent and some pre-assessment forms did not include people's care and support needs.

Staff had a good understanding of people's needs and preferences.

Staff knew how to manage complaints and people were confident with raising concerns if required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems in place to monitor and improve the quality of service provided were not robust. Shortfalls in the service were not always identified by the provider and the management team. Therefore necessary action was not always taken to rectify them.

Accurate and complete records had not been kept.

Staff were positive about the management. Regular staff meetings were being held.

People's feedback about the service was obtained from telephone surveys.

Efficiency-For Care Limited

Detailed findings

Background to this inspection

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

The inspection was carried out on 9 October 2017 and was announced. We announced our inspection because we wanted to be certain that someone would be available to support us. The inspection was undertaken by one inspector.

Before the inspection, we reviewed relevant information that we had about the provider including 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 used this information to decide which areas to focus on during our inspection.

During the inspection, we spoke with one person's representative, the operations director, the operations manager, the manager, a compliance officer, the care coordinator and one member of care staff.

We reviewed documents and records that related to people's care and the management of the home. We reviewed four people's care plans, which included risk assessments and five staff files which included pre-employment checks. We looked at other documents held at the service such as medicine, training, supervision and quality assurance records.

After the inspection, we spoke to three relatives and one person who used the service. We also spoke to four care staff.

Inadequate

Is the service safe?

Our findings

Prior to the inspection, we received reports that there had been six incidents from August 2017 to September 2017, which a person using the service sustained harm when receiving support from staff. These incidents are currently being investigated by the local authority.

We found risk assessments had not been completed in full for four people with identified risks. We looked at the records for a person who required oxygen through a Non-Invasive Ventilation (NIV) mask and found that risk assessments had been completed on moving and handling and how to transfer the person, using a hoist. However, information had not been included on how to ensure the NIV mask was kept on when staff supported the person with moving and handling and personal care. Furthermore, a risk assessment was not in place to ensure the oxygen tank still had battery power when the plug was required to be taken off. The reserve battery power lasted for 30 minutes, after which, staff had to make sure that the oxygen mask was plugged in thereafter. The consequences of not assessing the risk in this area could be very serious. It could be either fatal or could cause irreversible damage to the person's health, if staff did not know how to ensure the NIV mask was kept on or ensure the oxygen tank had power when supporting the person.

One relative told us that their family member was not safe. They told us, "The [staff] roll [person] and [person] head falls from the bed causing pain in [person] neck. They do not know how to use a rolling sheet. I have to show them how it is done." We were informed that a rolling sheet was also used to re-position the person when they were in bed; however, this had not been included on the moving and handling risk assessments. We were informed after the inspection that there had been an incident, whereby the person had not been moved appropriately causing harm to them. Another person required hoisting, although there were no moving and handling risk assessments in their care plan. This meant that people were at risk of harm when being supported by staff during moving and handling.

We were informed that a person had weakened muscles on their neck and leg area. This had not been included in their care plan. A risk assessment had not been developed on how to support the person safely. Staff we spoke to were aware of the risk. However, without this information any unfamiliar, new or agency staff may not be aware of this risk. Therefore, there was a risk that staff may not know what part of the body to avoid when supporting the person to ensure they were not in pain.

One person had a number of health conditions that could affect their well-being. The person also had poor mobility, was prone to anxiety attacks and had lower back pain. There were no risk assessments in place to identify if the person posed a risk when being supported by staff with personal care. Another person had type 2 diabetes, Chronic Obstructive Pulmonary Disease (COPD) and a brain injury. They were at risk of choking due to the build-up of mucus on their airways. Records from the local NHS Clinical Commissioning Group (CCG) showed the person may be at risk of having seizures. Risk assessments had not been completed in these areas. There was no information regarding what action staff should take if the person choked, had a seizure or how to prevent hyperglycaemia or hypoglycaemia. These failings could put people at risk of harm.

Assessments were not being carried out to identify the level of risks with skin integrity for people at high risk of skin complications. Records showed that three people were at high risk of skin complications and there were no management plans in place to ensure people's skin did not deteriorate. This meant that the service would not be able to monitor the level of risks to people's skin integrity and take appropriate action if required to minimise the risks of skin complications.

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. Although some staff were aware of people's conditions, any unfamiliar, new or agency staff would not have this information, which placed people at risk of not being supported in a safe way at all times.

The service supported people requiring help with taking their medicines in their own home. We checked three people's medicines and MAR charts. Guidance on the level of care and support to be provided to people that needed support with medicines, including administration of medicines, were all documented in their care plan. We looked at medicines administration charts (MAR), care plans, audits and training records in relations to medicines management. The majority of people required complex medicine administration procedures, for example via a percutaneous endoscopic gastrostomy (PEG) tube. PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding, when oral intake is not adequate. Staff that looked after people with a PEG tube had received additional training for this.

Medicines reconciliation is the process of obtaining an accurate list of a person's current medicines. It was not clear whether the provider had a system for carrying out medicines reconciliation for people when they were initially referred to the service. We did not see any gaps on the MAR charts provided; although there were discrepancies between what was recorded on people's MAR chart and what was recorded in the care plan. We noted that the medicines risk assessments, most of which were reviewed and updated 10 days before the inspection, did not accurately reflect the medicines people were taking, as listed on the MAR charts. We asked the operations director where and how these risk assessments were carried out and were informed that these were done in people's homes, where the stocks of medicines were kept. Therefore, we were not assured that people's medicines were appropriately reconciled. The inconsistencies we noted with the medicines risk assessments could potentially put people at risk. This meant inaccurate information could be shared with other healthcare professionals if people were transferred to other healthcare settings.

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

We saw evidence that consent for the provider to complete medicines tasks were always obtained from people or their representatives. People and relatives told us that they did not have any concerns when staff managed people's medicines. One relative told us, "I have not had any concerns with their handling of medicines." We saw evidence that staff had undergone medicine administration training; however this did not include competency based assessments. The provider confirmed competency checks were not carried out following medicines training but supervisors conducted random spot checks in people's homes to ensure that medicines were being managed safely by care workers. Records confirmed this.

Most people and relatives told us they were safe. A relative told us, "If it was not for them [service], my [family member] would still be in hospital. They are excellent." Another relative told us, "[Relative] does feel safe." A person told us, "I am very safe."

Staff were aware of their responsibilities in relation to safeguarding people. A relative told us, "We have been

very happy with the care. [Relative] is very happy." A staff member told us, "Safeguarding is making sure people are not in any danger. You have to be able to identify if they are being harmed such as they may be fearful, have a change of behaviour or have bruises on them." Another staff member told us, "It is protecting vulnerable adults. There are different types of abuse, physical, emotional and physiological. They could become fearful or withdrawn. If they do, I will find out what happened and then let my manager know. If they do not do anything, I will contact the CQC." Staff were able to explain what abuse is and who to report abuse to. They also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission (CQC) and the police. There was a safeguarding and whistleblowing policy available, which had been displayed on the provider's office and staff had been trained in safeguarding.

Pre-employment checks had been carried out to ensure staff that were recruited were suitable to provide care and support to people safely. One staff member told us, "After all my checks [pre-employment], I started working here." We checked five staff records. Relevant pre-employment checks such as criminal record checks, references and proof of the person's identity had been carried out as part of the recruitment process.

None of the staff we spoke with had concerns with staffing levels. They told us that they were not rushed in their duties and had time to provide person centred care and support to people when needed. A staff member told us, "We have enough time to go to appointments. There is a driver there to take us to every appointment." Staff told us that the service had a dedicated driver to take staff for care visits. The operations director confirmed this and told us that there had been no missed visits. The management team also reviewed call logs to review staff attendance and time keeping.

Most people had no concerns with attendance and time keeping. A relative told us, "They come on time." However, one relative told us that there had been a number of times that staff had been late, which impacted on the care and support their relative should have been receiving. The relative told us, "They have been late more times in the last month than when they came on time." We fed this back to the operations manager who sent us an action plan after the inspection evidencing what arrangements would be in place to ensure lateness is minimised. During the inspection, the operations manager showed us that in future, staff would have to electronically log in and out by telephone. We saw systems that showed management would be able to monitor if staff had attended an appointment and at what time. The system also alerted management if staff had not attended an appointment, was late, or did not log in, so the management team could then contact the staff member.

Requires Improvement

Is the service effective?

Our findings

We received reports that some staff members had not been trained when going out to support people. A relative told us, "The girl [care staff] is fantastic. She is knowledgeable and very bright. But the others that come to help are not good, I do not think they have been trained properly." A training matrix showed that three staff had started employment with the service and were provided with formal training approximately after two months from when their induction finished. The operations director told us that formal training had not been provided to these staff after the induction period had finished because the staff members had been trained in mandatory areas in their previous jobs, prior to commencing employment with the service. These training certificates were not available at the time of the inspection and were not provided to us after the inspection when requested. This meant that there was a risk that people may have been receiving care and support from staff that had not received formal training required to perform their roles effectively.

Specialist training had been provided on PEG feeding to staff that supported people with this. However, we found that the service provided support and care to people with diabetes and people who used an oxygen machine. Training in these areas was not provided. We fed this back to the provider who informed us that training in these areas would be completed. This meant that staff had not received all the training required to perform their roles effectively, which may put people at risk of harm.

The above issues related to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

One staff member told us, "During induction, I did moving and handling. I shadowed a senior carer, which enabled me to meet people and read their care plans to get to know them." Another staff member told us, "They let me know what work entailed. They took me to meet each client to see what their needs are and gave me opportunity to shadow." Records showed new staff that had started employment had received an induction. Induction involved looking at care plans and shadowing experienced members of staff. Furthermore, the induction programme also covered safeguarding, infection control, roles and responsibilities of a care staff, health and safety and moving and handling.

During the inspection, records showed that staff participated in formal training when their induction finished on moving and handling, safeguarding, health and safety, infection control, medicines and food hygiene prior to supporting people unsupervised. A staff member told us, "I got training in moving and handling, health and safety, medicines and safeguarding. Without these training, I would not be able to do a lot of things." Staff told us that training was helpful and they were able to approach the management team with any additional training requests if needed.

People told us staff were skilled, knowledgeable and able to provide care and support. A relative told us, "They are so good." A person told us, "Yes" when we asked if staff knew how to help them.

Records showed that regular supervision had been carried out. Staff told us that they were supported in their role. Comments from staff included, "I am supported; I know I can turn to [provider] if I need to", "[Care

coordinator] is very accessible. Any problems we have, we call them and they respond immediately. Anything we need, they support us", "They support me with everything they can, if I need anything they help me." As staff had not been employed with the service for over 12 months, an appraisal had not been carried out. Supervision meetings took place regularly. They included discussions on staff performance, team work and training needs.

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 provider and staff were able to tell us the principles of the MCA and the best interest decision process and how this should be applied for people living in their homes. Training had not been provided to staff on the MCA. Staff that knew the principles of the MCA told us that they had received this training in their previous role. Care plans provided information about people's memory/cognition and recorded whether people might struggle to make decisions. Where people struggled to make a decision, records showed that people should be supported or prompted to be able to do so. A staff member told us, "When I communicate, I come to their level and help them make a decision as much as I can." Records showed that people had capacity to make decisions.

Staff we spoke to told us that they always requested consent before doing anything. A staff member told us, "When I give them a bath, I tell them what I am doing stage by stage to make sure if they are ok. I have to be sensitive." People and relatives we spoke to confirmed this. A relative told us, "They do ask for permission, they do not just do things." Records showed inconsistencies with obtaining consent from people using the service or their representative to give their consent to the care and support provided. We found two care plans that evidenced people or their relatives had signed a consent form to receive care and support. However, in two other care plans, records did not show if consent had been obtained. The provider told us that they had attempted to obtain consent from people or their representative without success and would try again.

Much of the food preparation at mealtimes had been completed by family members and staff were required to reheat and ensure meals were accessible to people who used the service. People who required assistance at meals times had a care plan for this. Records showed that people were supported with meals via a PEG. One relative told us, "[Relative] is pump fed. They know more than the hospital staff." The plans described the support people needed. For example with the preparation of meals, when they preferred to have their meals and the support required with eating and drinking. A staff member told us, "If someone does not like something, you give them a choice. It is their house." Another staff member told us, "They tell us what they want." People and their relatives told us that people were supported at mealtimes to access food and drink of their choice. A relative told us, "They always give [person] the choice with meals."

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 than they called for health professional to support the person and support their healthcare needs. One staff member told us, "They can be moody and not cheerful. If they do not feel well, we will call nurse but we will need to ask them first." A relative told us, "My [person] had issues with blocked catheter twice and they called the district nurse and on another occasion they called 111. It is very good that things can get sorted without me."

Requires Improvement

Is the service caring?

Our findings

Most people and relatives we spoke to told us that care plans were reviewed with them and they were involved with decision making. A staff member told us, "When we review their care plans, we go and speak to them about it to make sure they are happy." However, one relative told us, "They came to me with [person] care plan and it was dated June expecting me to sign it. We are in October now, so I refused to sign this." Another relative told us, "We did have an initial meeting at first but I was not told about signing anything or agreeing to anything." Records showed that for two out of the four care plans we viewed, people or their family members had signed their care plans to indicate that they were involved with the care plans and had agreed with the contents of the support and care. However, the remaining two care plans had not been signed by people or their family members. The provider told us that attempts were made to obtain the signature of the people or their family members but a response had not been received. This meant that not all people or their family members had been included in the development of people's care plan.

People and relatives told us that staff were caring. One relative told us, "They are very caring and kind." Another relative told us, "They are very caring and friendly, not just to my [person] but to me and my children." A person told us, "They treat me very well." The operations director told us that people were supported by the same staff team as long as possible to ensure that positive relationships were maintained and people received continuity of care. Staff we spoke to confirmed this.

Staff told us how they built positive relationship with people. A staff member told us, "You just talk to them, find out about their background and take an interest in them." Another staff member told us, "Before I start, I familiarise myself with their care plan so I can get to know them better." People and relatives we spoke to did not have any concerns on the relationship with staff. A relative told us, "[Person] has built a good relationship with them." Another relative told us, "They do make the effort with [person]. They always sit down and chat with [person]. They chat about all sorts of things."

Independence was promoted and records showed that staff should encourage people to support themselves where possible. Staff told us they supported people to make choices in their day-to-day lives with personal hygiene and care. A staff member told us, "I will try to encourage them to do as much as possible but sometimes it can be difficult as people need our help to look after them but we do try our best." A relative told us, "They do try [independence] but [person] is very dependent so it can be difficult."

Staff ensured people's privacy and dignity were respected. They told us that when providing particular support or treatment, it was done in private. A staff member told us, "For example, when we give someone a shower, we ask them if they are ok and make sure they are covered and it is being done in private." Another staff member told us, "We make sure we cover them up and do not expose them when we give sensitive support." People and relatives confirmed this. A relative told us, "As far as I know, [person] privacy and dignity is respected." Another relative told us, "They do try to cover [person] up, they do not just leave [person] lying there."

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 the way staff approached them.

Care plans included how people communicated. A relative told us, "They give [person] a lot of time. They give [person] the time to express [person]. [Person] does not have good speech but they laugh and joke with [person]." Records showed how staff should communicate with people. For one person, information included that although the person could speak fluently, they may struggle to express themselves and speak slowly, therefore staff should be patient.

Requires Improvement

Is the service responsive?

Our findings

Pre-admission assessments had been completed prior to people receiving support and care from the service. Records showed that information was obtained on people's health conditions and support needs for two people, prior to delivering support and care. However, for two people this information had not been obtained. The service relied on the NHS CCG referral form to obtain this information. This meant that staff may not know if people's needs had changed and therefore would be unable to deliver a personalised service. In addition, the social history section on the pre-assessment forms had not been completed such as social networks, current and former lifestyles and life history. This meant that background information had not been sought in order to deliver person-centred care.

Each person had an individual care plan which contained information about the support they needed from staff. One staff member told us, "Care plans are useful." Another staff member told us, "Care plans are helpful. We would not know what to do without them." Care plans detailed the support people would require, timetable of care visits and included a daily routine and personal care section, that described the tasks that staff would need to complete during care visits. In one person's care plan, information included the time a person liked to wake up and that they preferred to watch TV first, before a full body wash and bath. Care plans also included people's sensory abilities, nutritional information, mobility needs, and details of their next of kin, health professionals and whether people preferred male or female carers. There was a personal profile section that included people's ethnicity, religion, sexual orientation and marital status. People were provided with guides about the service and the type of support offered with contact numbers of the service's management team.

However, there were some inconsistencies in the care plan for two people. One relative told us, "Most of the staff that come do not know what to do. I have to tell them how to help [person]." For one person, information included that they did not have a cognitive impairment but records from NHS showed they did. For another person, information included that staff would need to apply cream to the person to ensure their skin was intact. However, the delivery of support section that provided information on the specific support the person would require, did not include the application of creams. In another care plan, records showed that a person lived with two family members. However, we were informed that this was incorrect, as the person lived alone. This meant that people may not be getting personalised care needed to ensure they were in the best of health.

Staff we spoke to were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. A staff member told us, "We know them very well, we know their abilities." Most of the people and relatives we spoke with confirmed that staff were responsive. One relative told us, "We have a new carer, she is very confident and knows [person] well."

There was a complaints policy in place. People and relatives knew how to make complaints. The registered manager and staff were aware of how to manage complaints. A staff member told us, "If I receive a complaint, I will report to my manager straight away to investigate." Records showed that complaints that

had been received had been investigated and a response sent to the complainant by a member of the management team.

Requires Improvement

Is the service well-led?

Our findings

The provider had failed to ensure that adequate quality assurance and systems were in place. The provider carried out yearly staff file audits and a monthly medicine audit, visit log in sheets and care plan audits. However, the audits had not identified the shortfalls we found during the inspection, specifically with risk assessments, medicines and training. The audits, which included reviewing risk assessments, showed that three out of the four care plans we looked at had been audited and shortfalls had not been identified. The audits with medicines did not identify the shortfalls we found with inconsistencies with medicine record keeping and risk assessments. The review of staff files had not been completed, as staff had been employed for under a year. This meant that the quality assurance systems were not robust enough to identify shortfalls to take immediate action. This was required to ensure high quality care was being delivered at all times and there was a culture of continuous improvement.

The registered person (provider or manager) must send notifications about incidents that affect people who use services to CQC without delay. This includes safeguarding issues. We found that there had been incidents within the service that may affect people's safety and that the management team had not sent notifications of these incidents to CQC as required. The operations director was aware that CQC should be notified of such incidences but told us that notifications had not been sent as a result of the person's representative's not providing consent to do so. Since the inspection we have received relevant notifications.

The provider had failed to ensure that identified risks had been assessed and mitigated to ensure people were safe at all times. There had been a number of incidents with one person the service supported. Records showed that staff that were involved when these incidents took place had received spot checks and did not support the person anymore. However, there had been no records of lessons learnt or a risk assessment implemented to ensure these risks were reduced, so the provider can be assured the person received safe care.

The provider had failed to ensure that all staff had mandatory training required to perform their roles upon employment and before delivering personal care to people. We received reports that staff had not been trained before being sent to deliver personal care. We found no records that showed staff had received adequate training prior to receiving personal care. The operations manager told us that staff had received training in their previous roles and would send us evidence to support this. This had not been sent to us, therefore we cannot be sure that staff had been adequately trained before delivering personal care to people prior to our inspection. This meant that staff had not been trained to perform their roles effectively, ensuring people received high quality care and were safe when receiving support from staff.

Records were not always kept up to date. We found the care plan records such as the pre-assessment sheet had not been completed in full and there were some discrepancies within people's care plan as covered under Responsive. We also found that the medicines risk assessments did not accurately reflect the medicines people were taking as listed on the MAR charts we reviewed. Furthermore, risk assessments had not been completed in full in order to ensure staff had the relevant information to provide high quality care

at all times.

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

After the inspection, we sent a letter of intent to the provider requesting an urgent action plan on how they would address the breaches we identified at the inspection, to keep people safe. The provider sent an action plan in response to this, which provided information on how they will address the breaches to keep people safe and mitigate known risks.

Staff told us that they were supported in their role, the service was well-led and there was an open culture, where they could raise concerns and felt this would be addressed promptly. We observed the relationship between staff and the management team to be professional and respectful. One staff member told us about the operations director, "[Operations director] is a good manager." Another staff member told us, "[Care coordinator] is a very good team leader." There were reporting structures in place to ensure the management team always had oversight of the service and the management structure with lines of responsibility had been placed in the provider's office.

Staff told us that they enjoyed working at the service. Comments from staff included, "I enjoy working here. I like the staff and clients", "I enjoy working for them; staff here have a good rapport. I enjoy working for the people I work for and they enjoy my service as well" and "I really enjoy working with them, I enjoy working with elderly people."

Most people and relatives we spoke with had no concerns about the management of the service. A person told us, "[Care coordinator] is very helpful." Another relative told us, "[Operations director] has always been responsive and friendly. I am trying to get my [family member] to use the service." However, one relative we spoke to told us that the management of the service was poor and not responsive when they requested assistance.

People's and relatives' feedback were sought through telephone surveys. Records showed that three surveys had been completed recently. This was generally positive. A comment from one of the surveys included, '[Person] and family are very happy with the carers [person] has.' The provider had introduced this system recently and told us the telephone survey had not been completed yet but once completed, the information would be analysed and used to make improvements where required.

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 staffing, recruitment, complaints, supervisions, roles and responsibilities, safeguarding and spot checks. A staff member told us, "We do meet up regularly as a team to discuss what is going on, it helps us to improve the service." 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 service 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 18 HSCA RA Regulations 2014 Staffing The service provider had not ensured that all staff received appropriate training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(1)(2)(a).

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was not doing all that was reasonably practicable to mitigate risks to service users to ensure people were safe at all times. Regulation 12(2)(b).

The enforcement action we took:

Urgent Imposing Condition

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered 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 user's 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).

The enforcement action we took:

Urgent Imposing Condition