Help Where You Are Limited

Help In Newham Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 January and 12 February 2018. The inspection was announced as the service is a small domiciliary care agency where the manager is often out delivering care; we needed to be sure someone would be in.

In November 2016 we identified breaches of five of our regulations relating to the need for consent, safe care and treatment, staff training and support, recruitment and governance. We asked the provider to complete an action plan to show what they would do and by when to improve the rating of the service to at least good. The provider had improved their risk assessments, medicines management, staff support and supervision and recruitment practice. People were now clearly consenting to their care. However, there remained issues with the governance of the service and there were not enough staff deployed to meet people's needs.

Help in Newham is a domiciliary care service. It provides personal care to people living in their own homes in the community. It provides a service to older adults. At the time of our inspection they were providing personal care to approximately 20 people. Not everyone using Help In Newham's services receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks relating to personal hygiene and eating.

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

People and staff told us they did not think there were sufficient staff to ensure people's needs were met. People told us they sometimes missed visits of care, and records showed people sometimes received care from one care worker when two were needed. Records of recruitment had not been appropriately maintained and the provider had not always checked whether or not staff had criminal records.

Staff were knowledgeable about how to support people with their medicines and described safe practice. However, records of medicines administration had not been completed. On the second day of the inspection record keeping had improved.

During the inspection the provider took action to update people's care plans and risk assessments to ensure they were clear, up to date and reflected people's needs and preferences. Once updated, they showed that people's needs had been holistically assessed and care was planned in a personalised and holistic way. They contained clear information about people's health and care needs and what staff needed to do to ensure their needs were met. Where staff supported people to prepare and eat their meals their preferences were clearly captured. People told us they were confident their regular care workers knew how to support them in a safe way, but did not feel that all care workers read their care plans.

Staff were provided with personal protective equipment to ensure people were protected by the prevention and control of infection.

Staff knew about safeguarding adults processes and were confident about their role in safeguarding adults from harm and abuse. The provider had robust systems in place to respond to incidents and allegations of abuse.

Staff told us, and records confirmed they received the training and supervision they needed to perform their roles.

People's consent to care was clearly recorded in their care plans. Records showed people's care was regularly reviewed and they were given the opportunity to provide feedback about their experience of care.

Staff spoke about the people they supported with kindness and compassion. People told us they had established positive relationships with their regular care workers, although they also told us the quality of their experience was affected when they had new care workers. Care plans contained information about people's pasts and ensured their religious beliefs and cultural backgrounds were taken into account.

The provider had a clear policy regarding equality and human rights. The registered manager demonstrated they understood the impact that people's sexual and gender identity could have on their experience of care.

People and staff told us the registered manager was approachable and kept them informed of any information they needed to know. The registered manager and care manager completed regular checks on the quality and safety of the service. However, they were not utilising all the resources available to them to ensure the smooth running of the service and not all records had been appropriately maintained.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding staffing and governance. You can see what action we told the provider to take at the back of the full version of this report.

This is the second consecutive time the service has been rated requires improvement.

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. There were not enough staff to ensure people's needs were met consistently.

Staff knew how to support people with their medicines in a safe way, but records were not always appropriately maintained.

The provider took action during the inspection to ensure risk assessments were clear and up to date.

People felt safe with their regular care workers. Staff were knowledgeable about safeguarding adults from harm and abuse.

Staff were provided with personal protective equipment to ensure people were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. Staff received the training and support they needed to perform their roles.

People's needs were assessed and care planned in a person-centred way.

People were supported to eat and drink in line with their needs and preferences.

Care files contained clear information about people's healthcare needs and the support they needed to access healthcare services.

People consented to their care and the service worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. Where people were supported by regular care workers they had established positive, compassionate and caring relationships.

People were supported to maintain their relationships and the

service was aware of the impact people's sexual and gender identity could have on their experience of care.

Staff supported people with respect and promoted their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans had to be updated during the inspection to become personalised.

People were confident the staff who read their care plans would know how to support them, although they felt not all staff read the care plans first.

People knew how to make complaints and the provider had a robust policy about responding to complaints.

The service did not support anyone who was at the end of their life, however, there were clear procedures in place to ensure people received appropriate end of life care if this was needed.

Is the service well-led?

Requires Improvement

The service was not always well led. The provider had not maintained records as required as files were not complete and not stored appropriately.

People and staff spoke highly of the registered manager.

The registered manager had plans in place to strengthen the governance and staffing levels in the service.

The management team completed checks of the quality and safety of the service and sought feedback from people and staff.

Help In Newham 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 took place on 30 January and 12 February 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. There was a delay in completing the inspection due to unforeseen circumstances for the provider.

During the inspection we reviewed four people's care files including assessments, care plans, risk assessments and records of care. We looked at five staff files including recruitment, training and supervision records. We looked at various documents, audits, policies and procedures as well as meeting records relevant to the management of the service. During the inspection we spoke with the registered manager and the care manager. After the inspection visit we spoke with three people who used the service and three care workers by telephone. The inspection was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the local authority contracts team and the local Healthwatch.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in November 2016 we identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because recruitment records did not demonstrate robust recruitment processes had been followed, interviews were not recorded and checks on staff member's criminal records had not been completed. The provider had addressed the concerns we had regarding references, with all the care files checked now containing two references. The registered manager did not have copies of staff interview records or criminal records checks available. After the inspection the registered manager emailed copies of staff interview records and the criminal records checks. However, they confirmed they had not completed a criminal records check on one member of staff as they had worked with them previously at a different organisation and felt confident their character was suitable. The registered manager showed us they submitted an application for a criminal records check after the inspection.

Following the last inspection the provider had sent us an action plan. In the action plan they had stated they would recruit an administrative assistant to support with recruitment, and that the registered manager would sign off all recruitment files to ensure they were complete. Although the checklists were in place indicating the registered manager was sure the files were complete, the records were not easily accessible within the service. This meant that good practice in terms of recruitment had not been embedded as files had not been appropriately maintained.

People told us their experience of care was affected by staff shortages. One person told us, "Sometimes they tell me when they are running late. When they are short of staff they come late. I think they need more staff." Other people told us the manager covered shifts when staff were not available, or that there were occasions when they went without care due to staff shortages. One person said, "I had a rough weekend a while back where I had no carers turn up." They continued to tell us this had been resolved after they had spoken with the registered manager. Staff told us they thought the provider needed to have more care workers to meet people's needs. One care worker said, "Sometimes we are short of staff. The clients don't like it if we swap around. [Registered manager] tries to get it covered, we have a message group which means she can immediately ask for cover and that works fairly well. The carers know if they are nearby and can fit it in." Another care worker said, "We could do with a couple more [care workers]. I get asked to cover about twice a week."

Records showed people were allocated a pool of care workers who were scheduled to attend their visits of care. The provider used an electronic scheduling and monitoring system which allowed the managers to monitor whether staff had attended visits in real time. The care manager told us they had established contacts with another local provider to provide additional support if they did not have sufficient staff to complete people's scheduled care. Records showed there were occasions when people received care from one care worker when two were scheduled. One person's records showed that between 1 January and 31 January 2018 there were 19 occasions where only one care worker attended when two were scheduled. The care manager told us the care worker would not attempt any moving or handling during these visits and the person would be cared for in bed. This meant the person was not always receiving care as planned and staff

had not been deployed in line with the person's assessed needs.

The above issue regarding staff deployment is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was insufficient information to ensure medicines and other risks were managed to keep people safe. The provider took action to ensure there was sufficient information to manage medicines and other risks safely.

The provider used an electronic system to capture information about people's medicines and for staff to record when they supported people to take their medicines. On the first day of the inspection we found staff had not been using the system consistently to record when they had supported people with medicines and there were multiple gaps in records. The care manager spoke to the care workers concerned and established they had administered medicines but not recorded it using the electronic system. We looked at medicines records again on the second day and found care workers had clearly recorded when they had supported people with their medicines. This included occasions when people had refused medicines.

Care records contained information about the medicines people had been prescribed, including their appearance, purpose, possible side effects and dosage information. There was information for care workers regarding the level of support people needed to take their medicines. This included where risk assessments were in place to store medicines in specific locations to mitigate the risk that people accidentally over-dosed. For example, one person's medicines risk assessment described where medicines were stored, but also advised care workers that if the person located medicines they should be relocated and how this information should be shared with the supporting team.

Staff were able to tell us how they ensured medicines were administered safely. They described safe medicines administration techniques including checking the records before supporting people with medicines. Staff told us the electronic medication administration records were helpful in terms of ensuring that temporary prescriptions, such as a short course of antibiotics, were included in the records. Staff told us they had the information they needed to identify the specific medicines people were taking and would report any errors or concerns to their line manager who would seek advice from a doctor or pharmacist. One care worker said, "If there was a mistake, or a dropped medicine we'd contact [Registered Manager]. She would call the doctor up and we'd pick up a replacement from the chemist. As the carer I am confident to phone the GP and explain. They will tell us what to do."

On the first day of the inspection we found risk assessments lacked detail of the steps care workers needed to take to support people with their moving and handling needs in a safe way. This was discussed with the care manager who was able to describe the support in place in a clear and detailed way. For example, for one person she described the equipment in place, and the specific details of how the person needed to be positioned within the equipment. On the second day of the inspection the risk assessments had been updated to reflect the detail known by staff. However, this had not been established before we inspected.

Staff told us and records confirmed they received training in safeguarding adults from harm and abuse. Care workers were able to identify the different types of abuse people may be vulnerable to and were confident in the actions they would take if they suspected abuse. One care worker told us, "If I noticed something, like a bruise or them behaving differently I'd have a gentle chat with the person, make sure they were OK. I'd make a note and call my manager. I'd expect her to find out what's been going on and make the person safe."

The provider had a clear policy regarding safeguarding adults from harm. This included the contact details of the local safeguarding authority and instructions about how to escalate concerns. Records showed the service had not raised any safeguarding concerns for people who received personal care. However, they had raised concerns about people who did not receive personal care. Records showed care workers had raised concerns about a person's circumstances and vulnerability and the provider had escalated these through the safeguarding framework. This meant the provider had effective systems in place to ensure people were safeguarded from abuse.

People told us staff wore gloves and aprons when supporting them with personal care tasks. Staff told us they were supplied with personal protective equipment such as gloves, aprons and shoe covers to ensure people were protected by the prevention and control of infection. Care plans contained details of how to support people to maintain their physical environment to reduce risks of contamination and infection. This meant people were protected by the prevention and control of infection.

The provider had a clear policy and procedure to inform staff how to raise incidents. The registered manager told us there had been no untoward incidents since our last inspection in November 2016. Records showed staff were reminded about how to record and report incidents during staff meetings and one-to-one supervisions.

Good

Is the service effective?

Our findings

In November 2016 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations as staff were not receiving supervision to enable them to carry out their roles. The provider had addressed this and staff files contained records showing staff received supervision from either the registered manager or care manager approximately every three months. Records showed staff were given the opportunity to talk about the people they supported, training and any issues with their colleagues. Staff told us they found supervision useful and supportive. One care worker said, "Supervision is our time. They [managers] always check if we have anything going on that we need support with. They would be very supportive if I needed anything changed or adjustments made."

In November 2016 we also made a recommendation about ensuring staff received an induction and ongoing observational assessments. Staff told us they received an induction where they completed training courses and worked with colleagues until they were confident to work alone. One care worker explained, "I had double up training, I worked with colleagues, quite a few different colleagues to get my confidence up." Staff files contained observations of their work completed by the care manager. These were completed approximately every three months and included feedback about their performance and guidance to support them to improve. Staff told us the provider had recently introduced a new way of sharing training via a messaging app on their phones. They told us they found this useful as it made training materials easily accessible to them. Records showed staff had received training in areas relevant to their roles, including various aspects of health and safety, moving and handling, medicines and first aid.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. Domiciliary care services must apply to the Court of Protection for legal authorisation to deprive a person of their liberty.

In November 2016 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations as consent to care was not clearly captured and it was not clear that best interests decision making processes had been followed for people who lacked capacity. The provider had taken action to address this concern and was no longer in breach.

Care files contained signed consent forms and care plans reflected people's choices regarding their care preferences. Where people lacked capacity to consent to their care the service worked with social services and people's families to ensure care was in their best interests. One care file contained a record confirming a relative was authorised by the Court of Protection as an attorney for financial affairs. Staff told us they had received training on the MCA. One care worker said, "The MCA is for clients who can't make their own decisions. Some people can, some can't so they need help to make decisions. We go via our manager, we can't make decisions for them." Staff described how they offered people choices on a day-to-day basis. One

care worker said, "Some people like their routine to be the same every day, exact and precise. We still check. Then there are other people who like to do things differently, maybe today they want their breakfast first, or they just want domestic support because they've got a visitor coming. We have to ask and follow their wishes."

Before people started to receive a service the provider completed a comprehensive assessment of their needs. This considered people's needs in relation to various aspects of care including washing, dressing, grooming, continence care, eating and drinking. People's support needs in terms of mobility, moving and handling, pain management and sleep were also considered which led to the creation of a care plan. Records showed people, and their relatives where this was appropriate, were involved in the needs assessment. Care plans reflected people's preferences and choices for their care. For example, one person's care plan described how they should be encouraged to use equipment but included clear instructions if the person decided they did not wish to use the equipment. This meant people's needs were assessed and personalised care plans created as a result.

People were supported to prepare and eat their meals. Care plans contained details of people's dietary preferences and instructed staff of likely choices. For example, one person's care file reminded staff to defrost pre-prepared meals at the morning visit so lunchtime staff could support the person to eat them. People's cultural preferences for their meals were captured. Records showed people were supported to eat in line with their preferences. Where people were at risk of not eating enough staff were instructed to keep clear records of what the person ate so their family members could escalate any concerns. Records showed that through gentle encouragement one person's nutritional intake had improved.

Care files contained information about people's health conditions and the support they needed to maintain their health and access healthcare services. People's GP contact details were included in care files and were easily accessible to staff. Where people received regular support from healthcare professionals, such as district nurses, this was clearly recorded. For example, one person's care file contained information that district nurses visited to support them with their healthcare conditions. Records showed care workers shared any concerns they had about people's health with each other and the managers of the service. People were supported to access healthcare services when this was necessary. Records showed the service worked with other agencies involved in people's care, including social services and healthcare professionals.

Good

Is the service caring?

Our findings

Staff spoke about the people they supported with kindness and affection. In conversation they demonstrated they knew people well and communicated with them in a sensitive manner. For example, one care worker told us how they would respond if a person they supported appeared sad or upset. They said, "Everyone can have a bad day. It's a different way of working with them. I'd start off by trying to calm them down, ask what the problem is. If it's something I can't deal with maybe we get in touch with the family or the manager. If we are calm and make sure they are comfortable with us. You give them time to talk about their problems if they aren't feeling well."

People told us they had established positive relationships where they had regular care workers visiting them. One person said, "[Regular care worker] is my angel. She makes sure I am alright. She's really lovely." However, people also told us where they had unfamiliar care workers visiting them they did not always display a caring attitude. One person said, "Some of them don't have any manners." This meant people's experience of the attitude of staff varied depending on whether or not they had established a long term relationship.

Care files contained information about people's pasts and how to communicate with them. Care workers told us they had time to build relationships with people. One care worker told us, "The main thing is to talk to them, you greet them, you're polite and make sure you say please and thank you. Some clients can be very quiet and cautious and won't speak to you until you manage to draw them out a bit."

Care files contained clear information for staff about how to ensure people's dignity and privacy were maintained. For example, care workers were instructed to ensure people were covered during personal care. Another care plan told care workers to open specific curtains to increase light, but not other ones as they would expose the person.

The provider had a policy regarding equality and human rights. This emphasised the importance of ensuring all people were treated equally and ensuring people were not discriminated against due to their race, religion, gender, sexuality or age. We noted the assessments considered people's ethnicity, and religious beliefs but did not explore people's sexuality or the impact it might have on people's experience of care. The registered manager told us they did support someone who identified as lesbian, gay, bisexual or transgender and the person had felt comfortable and confident to disclose this information. The registered manager described how they had had to address communications issues with a specific care worker who had not been able to separate their personal beliefs from their support. The registered manager told us they had spoken to that care worker and then had wider discussions with other care staff to ensure the person's experience of care was not negatively affected. The registered manager told us, "It's their home. They are free to do as they want and it's not for us to judge them. In terms of the staff, it boils down to the need to separate their personal beliefs from their work. If they cannot do that they cannot provide the care I need them to."

Information about people's religious beliefs and cultural backgrounds were included in care files. Staff told

us they ensured people's cultural needs and religious beliefs were respected. One care worker explained they had very specific instructions not to support one person with an aspect of their personal care due to the person's religious beliefs. Another care worker told us, "One person I work with has strong religious beliefs. She listens to the radio all day which plays songs from her faith and has pictures and writings all over the walls. When I know the songs playing I'll sing along. She'll hum with me and I can see she likes it, she relaxes." This meant the service worked to ensure people's choices and preferences were known and respected by staff.

Requires Improvement

Is the service responsive?

Our findings

People told us they met with the registered manager or care manager to talk about their care. One person said, "It used to be [registered manager] who would come and have a chat with me and now it's [care manager]. I can tell them if I want things changed."

Staff told us they looked at people's care plans to find out what support they needed. They confirmed they were able to access this information via their phones using the provider's IT app system. Initially when the inspector looked at the care plans, they did not reflect the knowledge and detail the care manager and registered manager told us about how to provide people with support. The provider updated care plans during the inspection to reflect their knowledge of people's preferences. Updated care plans provided staff with clear details about people's preferences for their support. For example, one person's care plan described the order in which they liked to complete their personal care, and ensured care workers offered choices throughout the routine. However, feedback from people suggested that not all staff accessed the support plans before providing support to people. One person explained, "I had two different ladies come in yesterday and they were useless. They didn't know what to do or where things were." Another person said, "When it's new ones you have to explain all the while."

Care workers told us they would report any changes in people's needs to the care manager or registered manager who would complete reviews and update care plans if required. One care worker said, "There have been times when people aren't very well and they need more time so we have been given more time. We don't like to rush before we leave so we'll ask for more time. The management get on it and will get us the extra time."

Records showed the care manager or registered manager reviewed people's care plans and risk assessments approximately every three months. When people's needs had changed, or they were more confident in expressing their preferences, care plans were updated. Records showed the provider used a combination of their IT system and secure messaging groups to ensure staff were kept up to date with changes in people's needs. However, it was not until we provided feedback during the inspection that care plans were updated to reflect people's preferences.

People told us they knew how to make complaints and raise concerns. One person said, "I've got the number written down on a sheet here. If things aren't right I call the office." The provider had a robust policy regarding complaints which included information about expected timescales for response and how to escalate complaints if people were not satisfied with the provider's response. The registered manager told us they had not received any complaints since their last inspection in November 2016.

Records showed people and their relatives were given the opportunity to provide feedback about their experience of care in their review meetings. Where people and their relatives had praised specific care workers this was passed onto the relevant staff through supervision. This meant the provider was listening and responding to people's feedback.

At the point of inspection in February 2017 the provider was not providing support to anyone who was identified as being at the end of their life. The provider had a comprehensive policy and procedure about supporting people at the end of their lives. This was based on the best practice guidance identified by the National End of Life Programme and provided clear guidance and structure for staff on how to explore people's preferences and ensure they were supported to live their last stages of life as they wished to. Care workers told us they were confident the provider would provide compassionate care if people progressed to needing end of life care. One care worker said, "Help in Newham would definitely be good at supporting people at the end of their lives. I've seen clients deteriorate and they take action to make sure they get good care, we have to be very gentle and make sure they get all the support. This meant the provider had systems in place to ensure people received appropriate support at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

In November 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records had not been appropriately maintained to enable the provider to assess and monitor the quality of the service. The provider had not adequately addressed this issue and the breach of regulations remained.

The provider had an online system which allowed for care plans, reviews and assessments, as well as staff records to be stored securely in their online system. The provider chose this system as this allowed the care manager to work remotely and meant care workers could access records easily through an app on their phones. However, the provider was not making full use of this system and record keeping was not appropriately maintained. For example, one person's needs assessment had been uploaded to another person's profile on the system, quality checks on records were paper based and had not been uploaded to the system. This meant the management team were not easily able to share information through the secure system. In addition, staffing records had not been appropriately maintained. The registered manager did not have copies of interview records or criminal records checks as these were held remotely by the care manager. Despite the system having the facility to upload these documents this had not been done and documents had to be submitted to us after the inspection as the registered manager was unable to access them. This meant the provider had not appropriately maintained the records required of them.

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

People told us it was easy to contact the registered manager. One person said, "If I think anything is wrong I'll pick up the phone and call the office. She'll listen to you, she's very good." Another person described how the registered manager and care manager sought feedback from them regularly. They said, "[Registered manager] pops in sometimes. I'll speak to her then."

Care workers spoke highly of the registered manager and the care manager and told us they worked well together to ensure care workers were supported to provide good quality care. One care worker said, "The leadership is quite good. [Care Manager] is quite good and she steps in if [registered manager] is not available. It's not a problem. We're always alerted if there's anything that's an emergency. We're told about these things and we're prepared. We get appreciated." Another care worker said, "I feel supported by management. I've seen that she [registered manager] really does care about us, first thing is that she checks we're alright at home, is there anything we need help with? She's very helpful and lets us all know beforehand if she's off so we know."

The registered manager told us she worked with another small local provider, particularly with regard to covering work when there were staff shortages. However, feedback from people and staff confirmed staffing capacity was still an issue for the service. The registered manager was aware of the local registered manager's network hosted by Skills For Care. Skills for Care is a workforce development organisation that supports care organisations to ensure they have the skills and expertise required. However, the registered

manager had not attended the local network as she found she did not have capacity to attend.

The registered manager had self-identified the risk to the organisation that she was both registered manager and registered provider; should anything happen to her the organisation may struggle with leadership. The registered manager and care manager told us there was a plan for the care manager to complete a relevant management qualification and apply to become registered manager. This would ensure responsibility was shared and there was an additional layer of oversight. This meant there were plans in place to ensure the management of the service were more robust and to help the service work more collaboratively with other providers in the local area.

The care manager and registered manager jointly completed routine checks regarding the quality of the service, including checks on the records of care and performance of care workers. Records showed that where there were issues with the quality and completeness of daily notes made by care workers these were addressed and did not recur.

The registered manager told us they had not completed any surveys of people and relatives since our last inspection in November 2016. She informed us the surveys were about to be distributed to people to seek their feedback and ideas for the development of the service.

Records showed there were regular staff meetings for care workers. These were used to introduce staff to each other, and as a place to discuss specific topics or issues. For example, in the January 2018 meeting there had been a group discussion around safeguarding and whistleblowing and discussion around the technology staff used in their roles as well as discussions of any issues regarding care delivery. The meeting records showed staff raised any issues that were concerning them and management provided information and guidance about how to respond. This meant staff were provided with opportunities to be involved with the development of the organisation.

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 17 HSCA RA Regulations 2014 Good governance The provider had not maintained appropriate records of staff recruitment or the management of the service. Regulation 17(2)(d)(i)(ii)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient staff were deployed to meet people's needs. Regulation 18(1)