RSM Topjobs Ltd

RSM Care Services

Inspection report

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Date of inspection visit:
01 May 2018

Date of publication:
07 June 2018

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

We carried out an announced inspection of RSM Care Services on 1 May 2018. RSM Care Services is registered to provide personal care to people in their own homes.

The CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of our inspection, the service provided personal care to 44 people in their homes. This was the first inspection of the service since it registered with the CQC.

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

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

People and relatives told us that medicines were given on time. However, there were discrepancies in people's medicine records as records had not been kept of topical cream administration.

Pre-employment checks had not been carried out in full to ensure staff were suitable to provide care and support to people safely. We found the provider did not follow their recruitment policy in some instances, which detailed that two references should be requested before employing staff.

Staff had been trained to perform their roles by the provider's in-house trainer. However, the qualification held by the trainer was not recent. Therefore, important updates on certain areas may not have been covered when training was delivered.

Some staff had not received Mental Capacity Act 2005 (MCA) training. Most staff we spoke to were unable to tell us what this was. Records showed that one person did not have capacity to make decisions and an assessment of their capacity using the MCA principles had not been carried out.

Effective quality assurance systems were not in place. The audits carried out by the service had not identified some of the shortfalls we found during the inspection.

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-assessment forms had been completed in full to assess people's needs and their background before they started using the service. Reviews were held regularly to identify people's current preferences and support needs.

There were arrangements in place to ensure staff attended care visits on time. Staff told us they had time to provide person centred care and the service had enough staff to support people.

People were being cared for by staff who felt supported by the management team.

People had access to healthcare if needed.

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

Staff, relatives and people were positive about the management team. People's feedback was sought from surveys.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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

Accurate records had not been kept of topical medicine administration.

Pre-employment checks had not been carried out in full to ensure staff were suitable to care for people safely.

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.

Appropriate infection control arrangements were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

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

Assessments had not been carried out using the MCA principles to determine if people had capacity to make certain decisions.

People's needs and choices were being assessed effectively to achieve effective outcomes.

Staff were supported to carry out their roles.

People had access to healthcare services when required.

Is the service caring?

Good

The service was caring.

Staff had positive relationships with people.

People told us that they were involved in decision making.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive

Care plans were person centred and included people's support needs.

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

People's ability to communicate was recorded in their care plans.

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 management team.

Accurate and complete records had not been kept.

Staff, people and relatives were positive about the management team. Regular staff meetings were held.

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

RSM Care Services

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 1 May 2018 and was announced. We gave the provider 24 hour notice. 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 and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We also received a Provider Information Return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make. We sought feedback from health and social professionals.

During the inspection we reviewed documents and records that related to people's care and the management of the service. We reviewed five 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 and supervision records. We spoke with the director, registered manager and deputy manager.

After the inspection, we spoke to five people who used the service, five relatives and five staff.

Requires Improvement

Is the service safe?

Our findings

Assessments were carried out with people to identify risks before they started to use the service. Most risk assessments that had been completed provided information and guidance for staff on how to keep people safe and were regularly reviewed and updated. However, we found that some risk assessments were inconsistent.

We found that some risk assessments had not been completed for people with identified risks. Records showed that some people had specific health conditions such as diabetes, history of strokes and multiple sclerosis. Risk assessments had not been completed in these areas. Although there was some information on diabetes and multiple sclerosis with regards to what these conditions were and the symptoms people may display, there was no information regarding what action staff should take if people found it difficult to move. For example, if they were displaying signs of a stroke or how to prevent hyperglycaemia (high blood sugar levels) or hypoglycaemia (low blood sugar levels).

Records showed that one person had sustained multiple falls and on one occasion had sustained an injury from falling prior to receiving care from the service. However, a falls risk assessment had not been completed on what staff should do to minimise the risk of falls.

For one person, records showed that they could demonstrate behaviours that may challenge the service. Although information listed potential triggers there was no de-escalation techniques listed on how to calm the person, to ensure the person and staff were safe at all times.

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. This placed people at risk of not being supported in a safe way at all times.

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

There were risk assessments associated with skin integrity, urinary tract infection (UTI), the home environment, self-neglect, drugs and alcohol. Some risks had been identified and assessments included the risk and strategies to mitigate the risks. Risk assessments for skin integrity included how staff should be aware of bruises or redness on people's skin when supporting them or repositioning people that were unable to move. This would minimise the risk of skin complications. A staff member told us, "Risk is when something or someone in danger. I am working with a person and she is exposed to danger. If I come in and see equipment in the middle of the room that can cause hazard, I would make sure it is put where it is supposed to be. If she has bed sore I use the necessary cream."

People and relatives told us that people were safe. A person told us, "No problem with staff." Another person commented, "Oh yes, the staff are nice." One relative told us, "They are very good." A relative told us, "I am

very happy with the carer. I don't want to say too much as she is really good. She is lovely." A social care professional told us, "We have had no complaints from service users about the service they are giving over the last few months."

Staff were aware of their responsibilities in relation to safeguarding people. A staff member told us, "Abuse is when someone is being treated badly, for example, they are sexually abused or financially, like taking something from a vulnerable person or emotional. I speak to the person and I tell them what they are doing is wrong and I tell management straight away. I try to protect the person by stopping the other person from doing what they are doing." Staff were able to explain what abuse is and who to report abuse to. Staff also understood how to whistle blow and knew they could report to outside organisations, such as the Care Quality Commission (CQC) and the police.

We checked five staff records to check if pre-employment checks had been carried out to ensure staff were suitable and were of good character before supporting people. A staff member told us, "They asked me for my DBS, birth certificate, update training certificates and two references and make sure I have a right to work. I didn't start until all that had come back." The Disclosure and Barring Service [DBS] is a criminal record check that helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people. Pre-employment checks such as criminal record checks and proof of the person's identity had been carried out as part of the recruitment process. However, there were some discrepancies. Out of five staff files we checked, we found that for three staff, two references, had not been sought in accordance with the provider's recruitment policy. This meant the provider may not be fully aware if staff were suitable to support people. We fed this back to the registered manager and director, who told us that this was for long serving staff that had been recruited previously and that two references were now being requested for staff that were employed recently. The registered manager told us that no concerns had been received about staff and this was evidenced through spot checks and feedback from people and relatives. Spot checks are when members of the management team carry out random checks on staff when supporting people. After the inspection, the registered manager informed that two references had been obtained for the three staff but was not kept in the staff file and this issue has been rectified.

Medicines were completed accurately on people's Medicines Administration Records (MAR). Staff had received medicines training and told us that they were confident with managing medicines. Medicines were audited by the registered manager as part of spot checks and audits. Assessments were carried out on the level of support people would require with medicines. For a person that received their medicine via Percutaneous Endoscopic Gastrostomy [PEG], there were records that evidenced when the medicine was administered. PEG is a tube, which is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

However, for one person medicine assessments records showed that the person did not require cream applied to their body. However, the skin integrity risk assessment evidenced that staff applied creams to the person's body to minimise the risk of skin complication. The registered manager confirmed a prescribed cream was applied. However, there was no Topical Medicine Administration Records (TMAR), to record that the creams had been applied and at what time, in order to minimise the risk of skin complications. The registered manager sent us evidence after the inspection on the forms that would be used to record topical cream application.

People and relatives had mixed responses about staff time-keeping. Most people and relatives told us that staff turned up on time and carried out the required tasks. One person told us, "The two I have I am quite happy with, I have no complaints." Another person told us, "They come on time. One comes a little bit earlier, the other about 15 minutes later." A relative told us, "They are generally on time and stay the whole

time." However, one person and two relatives raised concerns with staff attendance. A person told us, "They don't turn up at weekends or come late." A relative told us, "Two weeks ago no one turned up, there was a misunderstanding. I spoke to the manager to make sure it would not happen again." Staff told us that they were not rushed in their duties and had time to provide person centred care and support to people when needed.

The registered manager told us that staff were always on standby if staff could not attend appointments. Where there were missed visits, records showed this was investigated and action was taken to minimise the risk of re-occurrence. The service had recently purchased a digital monitoring system, which would enable them to monitor staff attendance and time keeping. The service would be alerted if staff did not check in on a visit after a certain time, which allowed them to investigate lateness or missed visits and arrange a cover if needed. The deputy manager told us that this would ensure missed visits were minimised and the service could take immediate action if staff were late or did not attend a care appointment.

Records had been kept of accidents and incidents. This detailed the incident and the action that had been taken. The registered manager told us that they always analysed incidents to ensure lessons were learnt and to minimise the risk of re-occurrence, which was why there was not many incidents. The registered manager told us that a person behaviour escalated when staff used to support them and through analysing and learning they were able to identify that this was because the colour of clothing some staff used to wear that triggered the behaviour as a result staff were informed not to wear a certain colour when supporting the person.

There were systems in place to reduce the risk and spread of infection. Staff had been trained on infection control. We asked staff how they minimised the risk of infection and cross contamination. They told us they washed their hands thoroughly when providing personal care. Staff were supplied with personal protective equipment (PPE) such as gloves, aprons and sanitisers when supporting a person. Staff told us they disposed of PPE in a separate bag when completing personal care. A staff member told us, "I do infection control all the time. If I don't know what to do, I will ask the manager."

Requires Improvement

Is the service effective?

Our findings

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.

Although training records showed that most staff had received training on the MCA, most staff were not 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. The registered manager told us that most people had capacity and there was consent forms that had been signed by people agreeing to the support provide by the service.

There was also a decision-making section in people's care plans that evidenced if people could make decisions. However, on one record we found a person who had dementia was not able to make decisions. We did not find evidence on how the person's capacity had been assessed and if a best interest decision had been carried out to make a decision on the person's behalf. Th decision-making form did not cover the elements of capacity, namely can the person understand, retain, and weigh the information, and make a decision on the information they received. This meant that the person's legal rights were not being adhered to.

The above issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staff we spoke with told us that they always requested consent before doing anything. A staff member told us, "Of course, I will always ask for consent before helping. People and relatives confirmed that staff asked for consent. A relative told us, "Yes, they ask [for consent]."

Some people and relatives told us staff were not skilled, knowledgeable and able to provide care and support. A person told us, "No, I don't, she [care staff] doesn't understand how to give me a shower. That I can only walk on my tip toes. I have brittle bones, people don't understand." A relative told us, "Some are, some are not. I would give them seven out of 10." Another relative told us, "Some are very good. The new [staff], I don't think are trained or knowledgeable. They don't have any idea." A staff member told us, "I need some new training; as soon as they are ready I am ready."

Records showed that staff received some training, which was delivered by the registered manager, who was also the in-house trainer. The training covered safeguarding, health and safety, moving and handling and infection control. We checked their training qualification and found that the training that they delivered, such as safeguarding, health and safety and infection control, did not correspond with their qualifications. The registered manager told us that as they were a nurse, they had previous nursing training. However, this training did not include qualifications to train other staff in specific areas and refresher training had not been sought to ensure they were up to date. This meant that staff may have missed important updates on

areas required to perform their roles. We were informed that this would be arranged as soon as possible after the inspection. In addition, records showed a number of staff had not completed first aid training, which may be required when supporting vulnerable people especially if they were not well or in an emergency. The registered manager told us they had recently completed their first aid train the trainer training and planned to schedule this training as soon as possible.

Records showed that the service provided specialist care with catheter care and PEG Feeding. Although specialist training had been provided in PEG Feeding, training had not been provided in supporting people with catheter care.

This meant that staff had not received training to be able to perform their roles effectively. This would ensure people received high quality care and were kept safe at all times when being supported by staff.

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

Records showed that staff had received an induction. The induction involved looking at care plans, their roles and responsibilities, confidentiality, personal care and shadowing experienced members of staff. A staff member told us, "Yes, [induction] from the branch manager. I came 40 minutes early to meet staff who had been covering and the manager spent nearly the whole day with me. It was very helpful." Whilst staff were receiving an induction, they also received training to ensure they were able to support people. The training was in accordance with the Care Certificate. The Care Certificate is a set of standards that health and social care workers comply with in their daily working life such as safeguarding, infection control and health and safety. A staff member told us, "They are very strict on training. They will tell you when you need to do training, you have to do the training."

Supervision meetings were held between staff and their line managers to discuss staff progress, identify developments and provide support if required. The provider's policy showed that supervision should be carried out as determined by the registered manager. We found for three staff that there were no records of supervision being held. The registered manager told us that this had been completed but was unable to find where the records were kept. Staff confirmed that they received regular supervision. A staff member told us, "Last supervision was in February. Very helpful. They help me if I want to do any training or what my outstanding training is and on medication too." Another staff member told us, "Yes, the last one [supervision meeting] was around 2 weeks ago. We talk about everything, from if I have any issues to what is the purpose of supervision, if I need support in any area." Another staff member told us, "[Registered manager] is very, very supportive."

Appraisals are important to ensure staff performance for the year is reviewed and objectives are set to ensure staff felt supported and were able to develop. For staff that had been working for more than 12 months, records showed that an appraisal had been held.

Pre-admission assessments had been completed prior to people receiving support and care from the service. These enabled the service to identify people's daily living activities and the support that people required, which allowed the service to determine if they could support people effectively. Using this information, care plans were developed. The service assessed people's needs and choices through regular reviews. Records showed that changes in people's circumstances had been recorded and used to update people's care plans. This meant that people's needs and choices were being assessed effectively to achieve effective outcomes.

Care plans included the level of support people would require with meals, such as with feeding and included people's likes and dislikes one care plan, information included that staff should give small amount of food to a person and feed them slowly as they had swallowing difficulties. People were given choices by staff and this was also recorded in people's care plans. On one care plan, information included that staff should always prepare a menu with the person they supported with meals based on their preference. A person told us, "Yes, [care staff] helps me with breakfast, I choose what I want. She heats up my supper for me in the oven." A staff member told us, "You tell the client what is available and they have a choice." Another staff member told us, "They don't want the same things every day and we give them a choice."

Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health. Where staff had more immediate concerns about a person's health, they called for a health professional to support the person and support their healthcare needs. Staff were able to tell us the signs people would display if they did not feel well. This meant that the service worked with health professionals to ensure people were in the best of health.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. A person told us, "Absolutely. No issues. All very good." Another person commented, "Yes, [Care staff] is kind and caring and helps me." A relative commented, "[Care staff] treats them like family, she is really good."

Staff told us how they built positive relationships with people. A staff member told us, "You have to have good communication with them, treat them equally and always respect them." People and relatives told us that they had a good relationship with staff. One relative told us, "They are all very understanding." Another relative told us, "Very good. She [care staff] is able to get [person] to shave, before he refused to and I had to do it."

People and relatives confirmed that they had been involved in decision making on the care people received. There was a section where people and relatives could sign to evidence that they agreed with the contents of their care plan. A person told us, "Yes, I am very heavily involved." Another person told us, "My daughter was involved in everything." People's independence was promoted. Care plans included information on where people could support themselves and area's they would need support with. On one person's care plan, information included that they were able to wash their body, face and arms themselves. 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, "We encourage them to do things for themselves, don't just do it for them. Sometimes they say they can't, but you are positive and tell them they can do it themselves. I prompt them to wash themselves and with support and encouragement and gradually they can do it themselves."

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, "If the client finishes having a bath or getting dressed in their bedroom we shut the door and keep it private." Another staff member told us, "When you are assisting a client with personal care you make sure they are covered up, you keep the door locked, you knock on the door, you never just barge in. If they can do their own private areas, we let them do that." People and relatives confirmed this. A person told us, "They do", when we asked if their privacy and dignity was respected by staff that supported them.

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

People were protected from discrimination within the service. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. A staff member told us, "This is where you make sure that you treat everyone equal, so everybody has to be equal. You don't treat one person one way and another a different way, treat everyone equal." People and their relatives we

spoke with confirmed that they were treated equally and had no concerns about discrimination.

Good

Is the service responsive?

Our findings

Staff we spoke with 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, "All we do is communicate because [person] is disabled. Sometimes we help her lift a cup, very light exercise. We talk to her if she is not watching TV." Another staff member told us, "Basically, it is putting the person at the centre of everything you do, you give them your undivided attention and they are at a stage where they might live at home alone and you give them the attention they need. Today I did shopping for this [person]. I made sure everything was in place and a lot of running around for bank holiday Monday; shopping, phone credit and money for him." People and relative's we spoke with told us that staff were responsive and knowledgeable. One person told us, "They do, they know me." A relative told us, "[Person] is happy with his carer."

Each person had an individual care plan which contained information about the support they needed from staff. One staff member told us, "They [care plans] explain everything, very helpful. They explain what we need to do to help her [person] improve." Another staff member told us, "They [care plan] are good, they are informative, you get to know everything you need about the client. They are very good." Care plans detailed the support people would require and described the tasks that staff would need to complete during care visits throughout the day. They also contained people's family contact details. Plans included people's personal information such as their preferred name, religion, any health conditions and date of birth. Care plans were personalised based on people's preferences and support needs. In one person's care plan, information included that the person feels cold and therefore staff should always ask if the person wanted to wear a jumper. On another person's care plan, information included that a person was unable to raise their arm and staff should perform light exercise such as raising their arms slowly. The registered manager told us that as a result of this, the person was now able to move their arm independently.

There were daily records, which recorded information about people's daily routines and the support provided by staff. Staff told us that the information was used to communicate with each other between shifts on the overall care people received and if a particular person should be closely monitored. A staff member told us, "Either we meet at the main manager's office, or things are handed over to me beforehand. If anything important needs to be handed over it is always done at the office. We have to record each day, as there is a document sheet in the persons house. We read and see if anything concerning has been documented. We call the line manager and try to discuss this. Everything is recorded." This meant that staff could summarise the care needs of the people on each shift and respond to any changing or immediate needs.

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information would tell them how to keep themselves safe and how to report any issues of concern or raise a complaint. There was information that had been translated in other languages. The registered manager told us this was because the service supported some people that could not read or understand English. We also saw evidence that some staff supported some

people who were from the same background and therefore, were able to communicate with people in their first language. Care plans included how people communicated. Staff we spoke to did not know what the AIS was in full but told us they looked at people's care plans on how to communicate with people and how to make information accessible. For example, one person, who had communication difficulties, had a care plan which described the signs they would make when communicating and how staff should respond to that. A staff member told us, "I work according to their needs. If someone wants to get up from their seat, I help them. If they can't talk I would use sign language."

There was a complaints policy in place. There was a complaint register that included the complaints received and the action taken, which ensured the management team were able to track complaints and have oversight of complaints investigations. People and relatives knew how to make complaints. A person told us, "I phone RSM and will tell them." Staff were aware on how to manage complaints. A staff member told us, "No complaints. If they do, I will let my manager know."

Records showed that the service had received compliments from people and their relatives. Comments included, "[Person] is receiving excellent care from your agency and I would highly recommend your services to others" and "[Person] carers are always punctual and extremely kind to her and always make sure they do all they can for her comfort."

Requires Improvement

Is the service well-led?

Our findings

There were systems in place for quality assurance. Audits were carried out on people's care plans, risk assessments and medicine records, However, the systems in place were not robust to identify the shortfalls we found during the inspection with risk assessments, MCA assessments and medicine records, which may impact on people's safety and the care they received. In addition, audits were not carried out on staff files, which may have enabled the management team to identify the shortfalls we found with training and pre-employment checks.

Records were not always kept up to date. We found some risk assessments, Topical Medicine Administration Records had not been completed in full in order to ensure staff had the relevant information to provide high quality care at all times. The registered manager was also unable to locate some staff supervision notes when this was requested, which meant there was a lack of good organisation to ensure staff were fully supported. Keeping accurate records is important to ensure the service had oversight of the support people required and if support had been delivered effectively.

This meant that robust governance systems were not in place to ensure shortfalls in relation to staff training, safer recruitment check and record keeping could be identified and action taken to ensure people always received safe and effective care at all times.

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

Spot checks of staff supporting people had been carried out and this had been recorded. They focused on infection control, time-keeping, medicines and hygiene. This was then communicated to staff and formed part of their supervision. A staff member told us, "She [registered manager] will check everything you are doing such as medicines and the support you give to clients. She is very good like that." This meant that the service was able to identify what areas staff were doing well in and identify if further development was required, to ensure people received effective care and support.

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. They felt concerns would be addressed promptly. One staff member told us, "Yes, she [registered manager] is okay, helpful." Another staff member commented, "I have been with the company for 2-3 years and I think they are quite good, whatever you need you get and they will try to support you as much as they can. Based on experience with them, I think they are good. For example, if I have concerns with a client and they remind me to put the client first and reassure me to help me do the right thing. Sometimes you can't get to the location easily so they help you out. I appreciate the little things." A third member of staff told us, "She [registered manager] is fantastic."

People and relatives were positive about the management and the service. One person told us, "I like [registered manager]." A relative commented, "We had contact initially. They are very efficient, no cause to complain." A relative told us, "[Registered manager] is very good. If no one turns up she will come herself to

do the job." A third relative told us, "I am happy with them."

People's and relatives' feedback were sought through surveys. The service also carried out telephone surveys. The survey focused on staff support, attitude, relationships, time-keeping, privacy and dignity and areas for improvement. The results of the survey were generally positive. A comment from a survey included, "We are happy with carers" and "I am happy with the service given."

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, time keeping and updates on service users. A staff member told us, "I think we do, the last one was in January. We talked about how the work can be improved and what the staff needs and we shouldn't let things run out before we ask for me." 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 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person as the registered provider was not always acting in accordance with the Mental Capacity Act 2005. Regulation 11(1)(3).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Personal care	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 users who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b).

	The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c).
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received effective training to be able to perform their roles effectively. Regulation 18(1).