Quintessential Support Ltd

Quintessential Support Brokers

Inspection report

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Tel: 07901660895

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Quintessential Support Brokers is a small domiciliary care agency registered to provide personal care to people living in their own homes. At the time of our inspection the service was providing care to six people following their discharge from hospital. The service also provided short term care for people at the end of their life. We undertook an announced inspection of the service on 20 April 2016 and 5 May 2016.

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

The provider was eager to develop and improve the service and had taken action when concerns had been raised by health and social care professionals and at our first visit. However, the registered manager had not always been pro-active in assuring themselves the service was safe and people received good quality care before concerns were reported. We found the provider did not meet the regulation in relation to good governance. Improvements were needed to ensure the provider would routinely review the service and make the required improvements when shortfalls were identified.

The provider had a staff recruitment process in place to identify applicants who were suitable to work with people. However, the registered manager had not always followed this process through to completion. The registered manager had not ensured all pre-employment information was available to support them to make safe recruitment decisions. At our second visit the registered manager provided us with the required information for all care staff, however sufficient time had not passed for the provider to demonstrate that safe recruitment processes had been sustained.

Relatives and care staff told us people's risks were understood by care workers and arrangements put in place to keep them safe. However, we found the provider had not systematically reviewed the care people received. Reviews are required to ensure the care provided continues to meet people's needs and keeps them safe.

People and relatives told us their preferences were met and care workers had a good understanding of people's care needs, their likes and dislikes. People's care records however did not always reflect their current needs and the support they required. New care workers would not have all the information they needed to know how to support people effectively.

People and their relatives knew how to complain if they had any concerns about the service. People had received a copy of the provider's complaints policy. The complaints policy however was not sufficiently comprehensive so people would know what to do if they were not satisfied with the way the provider had managed their complaint.

One person we spoke with and their relatives told us they felt they were safe, cared for and supported by care staff in their own home. They were treated with kindness and respect. They told us the service was reliable, there were sufficient care staff and visits were never missed. They were satisfied with the service they received.

Care staff had received induction training which gave them the basic skills to care for people safely. They told us they felt supported and received regular supervision.

People were supported to eat and drink from care staff who knew what their food preferences were. People and their relatives told us they were involved in decisions about any risks they may take. Systems were in place to protect people from abuse.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told 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.

All the information required to inform safe recruitment decisions was not readily available prior to some applicants starting in their role. The registered manager provided us with the information we needed for all care staff employed at our second visit. However, at the time of our second visit sufficient time had not passed for the provider to demonstrate that safe recruitment processes had been sustained.

Risks were identified but people's care, required to manage their risks, was not continuously evaluated and recorded to ensure staff had all the information they needed to keep people safe and manage their changing risks appropriately.

Although care staff knew how to apply people's topical medicines safely, this information was not included in people's care plans and the service's medicine policy. New staff that did not know people well would not be able to tell from people's care plans how to apply their topical medicines appropriately.

Care staff took action to protect people from abuse and were aware of the procedures to follow to report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff had received training and supervision in their work to discuss any learning needs. However, assessment of staff's competence had not been completed routinely to determine whether they had the skills to effectively meet people's needs.

People gave consent to be cared for. Care staff had an awareness of the Mental Capacity Act (2005) and knew when to report any changes.

People were supported to access health and social care professionals when needed.

People were supported to eat a balanced diet by care staff who knew their likes and dislikes.

Is the service caring?

Good

The service was caring.

People and relatives were happy with the care provided. They said care staff treated them with kindness and respect.

People had developed caring and meaningful relationships with care staff.

People felt they worked as a team with the care staff and were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs had not always been re-assessed to ensure people's care arrangements would reflect the care they needed and received.

People's care records were not up to date. They did not contain all the information necessary to guide care staff on how to meet people's needs in a consistent way

People and relatives told us people always received their care visits and care staff gave people sufficient time to complete tasks at their own pace.

People were aware of who to contact if they wished to make a complaint and were confident their concerns would be listened to. .However the provider did not ensure that people knew how to escalate their complaint externally if they were unsatisfied with the registered manager's response.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some quality assurance systems were in place. However, these were not sufficient to regularly monitor all aspects of the service to ensure good quality care was being provided.

Service audits had not always been completed effectively. The shortfalls we found had not been identified and addressed prior to our inspection. .

Care staff told us they felt valued and supported in their roles and they described the registered manager as a good leader.

Quintessential Support Brokers

Detailed findings

Background to this inspection

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

This inspection took place on 20 April 2016 and 5 May 2016 and was announced. We gave the service 48 hours' notice of the inspection because it was a small service and the manager was often out of the office supporting staff or providing care. We needed to be sure that they would be available. The inspection was completed by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law.

We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information on the day of our inspection.

During our inspection we spoke with one person using the service and relatives of four other people who received care from the service.

We reviewed a range of records about people's care and how the service was managed. These included four people's care records, six staff recruitment files, staff training records, minutes of meetings and a selection of policies and procedures relating to the management of the service. Following the inspection, we received feedback from five health and social care professionals and commissioners.

This was the first inspection of the service since they were registered and began delivering care in December 2015.

Requires Improvement

Is the service safe?

Our findings

During the assessment process staff identified risks to people's safety relating to the care they received and the risks associated with people's home environment. Relatives told us risks identified were discussed with people who had been involved in the development of their risk management plans.

Relatives felt people were safe when receiving care. One relative said, ''They are always careful when supporting [the person] to walk, making sure they go slowly and there is nothing in the way''. Care staff could describe how they supported people to move safely to minimise their risk of falls. However, health care professionals told us information in people's care plans did not always reflect people's mobility needs or the support care staff were providing.

Care staff told us one person occasionally used a hoist to transfer from their bed to a chair or bathroom. However, their care plan did not inform care staff when to use the hoist and how to protect this person from the risks associated with using this equipment. Another person had been assessed as requiring a slide sheet to move but care staff told us they did not need to use this anymore as they were able to reposition and move the person as needed to ensure good skin integrity. We could not see from people's care plans that their mobility needs and risks had changed and that their care arrangements had been reviewed as required. People's care plans had not been updated promptly to ensure they would receive safe and appropriate care. Information provided to care staff was not always accurate and current. Whilst regular care staff were aware of the changes in people's needs this had not been documented to ensure that in the event they were not able to deliver care new care staff or other agency staff instructed by the provider, would immediately know the support and care people required.

Relatives and care staff told us people's risks were understood by care staff and arrangements put in place to keep them safe. People using the service were frail and spent a significant time of the day in bed or sitting which put them at risk of developing pressure ulcers due to the increased pressure on their skin. One relative told us ''Staff check [the person's] skin every day. If they see any redness or bruising they let me know so I can contact the GP or district nurse. They also write it down on the notes so that the district nurse can see it when she comes''. Care staff told us they had informed the registered manager and the community nurse when they were concerned about a person's skin becoming red and sore.

However, health professionals told us they were concerned that the service did not have processes in place to be able to identify promptly when people's risk of developing pressure ulcers had increased. This would allow care staff to take the additional action needed to protect people's skin. People were prescribed topical creams to hydrate and protect their skin to minimise the risks of developing pressure ulcers but their care plans did not accurately reflect the preventative action to be taken. Care plans did not inform staff what type of topical cream people used, when and where it needed to be applied and the necessity to record that people had received their cream as prescribed. The information in people's care plans did not make it clear to care staff what type of skin observations would identify a potential area of concern and required reporting to the registered manager and health professionals. This would ensure timely and appropriate action was taken to minimise the risk of deterioration in people's skin integrity. The service did not have a skin

management protocol in place to provide guidance to care staff on how to manage people's risk of pressure ulcers at our first visit and had drawn one up by our second visit. The registered manager had not evaluated people's skin care to ensure that current practices kept people safe, especially when people had chosen to refuse some of their daily visits and therefore saw care workers less frequently. People's risks might be overlooked because the provider did not systematically review people's care to ensure it identified the potential risks to people's health and care staff had sufficient guidance to know how to keep people safe.

We looked at the arrangements in place to ensure people would receive their medicines safely when needed. At the time of our inspection people only required support to apply their topical cream and ointment medicines and care staff were not administering any other medicines. The registered manager told us additional medicine support would be provided if people required it. Care staff had received on-line medicine training. However, the registered manager had not formally assessed the competency of care staff to safely administer medicines. This is current good practice to ensure care staff have the skills to safely support people with their medicines. Relatives told us care staff had applied people's topical cream and ointment medicines correctly. However, new care staff and agency staff who did not know people well did not have sufficient information in people's care plans or the service's medicine policy to know how to apply their topical creams and ointments appropriately. The registered manager had drawn up a medicine policy by our second visit but further improvements were needed to ensure it reflected current best practice and gave care staff clear instructions in how to safely administer and record people's medicines if they were to administer other medicines in the future.

We found that some care staff recruitment information relating to pre-employment checks was not readily available. Care staff recruitment records showed that not all the required checks had been completed prior to an offer of employment being made to ensure staff were suitable for the role.

For example, references were available to evidence care staff had displayed appropriate conduct and good character in previous employment. However, adequate checks of previous employment had not always been completed for care staff. Four care staff had missing information regarding their full employment history which meant that unexplained periods of employment had not been unaccounted for which could identify reasons that would make applicants unsuitable. A Disclosure and Barring Service (DBS) check was not available for one of the six care workers employed by the provider. The DBS helps employers make safer recruitment decisions and helps prevent the employment of care staff who may be unsuitable to work with people who use care services. The registered manager provided us with the information we needed for all care staff employed at our second visit. However, at the time of our second visit sufficient time had not passed for the provider to demonstrate that safe recruitment processes had been sustained to ensure pre-employment checks would always be completed for all future care staff prior to an offer of employment being made.

Care staff took action to minimise the risks of avoidable harm to people from abuse. Care staff understood the importance of keeping people safe from abuse and harassment, and they could describe what was meant by abuse. Care staff had completed training in recognising and reporting abuse and a policy was available to inform care staff of the action they needed to take if they had any concerns about people's safety. Care staff said they would report any poor practice or abuse they suspected or witnessed, to the registered manager or the commissioners. Care staff told us they felt people were safe and had not needed to raise any safeguarding concerns.

There were sufficient care staff to provide support to the six people using the service. One person we spoke with and relatives told us care staff were seldom late, spent the required time and did not rush people. People were protected from the risk of large numbers of different care staff visiting their homes. People

received care from only two or three care staff which meant few care staff had access to people's homes and people received consistent care from care staff that knew them well. When care staff needed to use a key safe to access people's homes the code was only known to the registered manager and the regular care staff. One care staff member told us ''When I use the key safe I always check that it has been closed securely and the code is not displayed before I leave''. The registered manager told us in the event of staff sickness they would use other agency staff if required but this had not been needed in the past two months.

People told us care staff wore protective clothing such as gloves and aprons as needed when supporting people to minimise the risk of infection. One relative said care staff ensured there was sufficient stock of these at their home and always used gloves when applying the person's topical cream or supporting them to have a wash. Care staff told us they were able to call the registered manager when they ran low on stock and this was made available promptly. They were trained in infection control and could explain how they would reduce the risk of cross contamination for people. One care staff told us ''I always make sure my ID card is in my pocket and not hanging around my neck because it could get dirty. I need to make sure it does not become a source of cross contamination when I then support the next person''.

Requires Improvement

Is the service effective?

Our findings

One person we spoke with and people's relatives told us that they were confident in the knowledge and skills of the care staff who were caring for them. One relative said, ''The staff are really very confident in what they are doing''. Care staff told us the training they had received was good and had enabled them to support people effectively. Inexperienced care staff worked alongside more experienced care staff to observe and learn how people liked to have their care delivered.

People were supported by care staff who had undergone an induction programme which gave them the basic skills to care for people safely. Training records showed there was a programme of on-going training for all care staff covering health and safety related topics and also topics relevant to the support needs of the people living in the home. Care staff training included medicines management, moving and handling, death, dying and bereavement, dementia awareness and food hygiene.

Training was provided by a variety of methods including on-line computer based training, face to face training, staff meetings and shadowing. All the care staff were being supported to complete a relevant qualification such as Qualifications and Credit Framework (QCFs) in care. The QCF has replaced National Vocational Qualifications (NVQ's) and is a flexible work related qualification made up of units which can then be used to build up to a credited qualification.

The registered manager checked care staff's knowledge through the completion of online knowledge assessments after care staff completed each of the required online courses. They told us experienced care staff then observed new care staff when they worked together to check whether they completed the required care tasks appropriately. However, the service did not have a documented assessment format or records for these competency checks to ensure they were completed consistently and included all aspects of relevant care practice. Improvements were needed to ensure the registered manager continuously checked whether care staff were able to apply their training into practice and could manage confidently. For example, recorded checks had not been completed on care staff when administering people's medicine or providing assistance with people's moving and handling needs to ensure they had the support they needed to develop the skills and knowledge required to work with people unsupervised.

Care staff received regular one to one meetings and team supervision with the registered manager to support them to develop their skills and knowledge. They told us that they were in daily contact with the registered manager to discuss their care visits and were provided with support and guidance if they had any concerns.

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 looked at whether people had the mental capacity to make decisions about specific aspects of their care and how the provider would respond if it was considered that people did not have capacity. The registered manager, care staff and relatives told us people were able to make informed decisions about their care. The registered manager told us people were referred externally when their condition deteriorated and they were deemed to lack capacity to make specific decisions about their care. In that event the person would be referred to and assessed by the commissioning team to determine if their care was to be provided in their best interests.

Care staff were aware of their responsibilities in relation to the MCA and adhered to the MCA code of practice. Care staff had received training on the MCA and were aware that they were to assume people had capacity to make decisions unless they had any information that suggested otherwise. We saw from the information that was included in people's care records that people had been involved in decisions about their care and had consented to the support they received.

People at the time of our visit were supported by relatives to make their own decisions about the healthcare services they wished to access. Community nurses regularly visited people at home to provide on-going healthcare support. Relatives told us care staff would raise any concerns relating people's health with them and contact the community nurses if required. One care staff member told us ''I noticed one person's skin was getting red, I phoned the community nurse and wrote it in the person's notes. The community nurse then went the next day to have a look. I have also contacted them when people's catheters were leaking''.

Care staff had received training in basic emergency awareness and were able to describe how they would call for help during a care visit if someone became seriously ill or needed medical assistance.

The registered manager and care staff told us at the time of our visit only one person required regular support with mealtimes. Care staff could tell us how they supported this person and knew what they liked and where they liked to eat. The person told us ''I choose my meals and then they heat it for me. They know what I like to drink''. Staff were aware of supporting people to remain hydrated and told us they always checked that people had a drink in reach.

Good

Is the service caring?

Our findings

One person we spoke with and relatives told us they liked the care staff. They were complimentary about the service their family members received and the attitude of care staff. They described care workers as ''Kind'', ''Friendly and outgoing'', ''Respectful'' and ''Caring''.

Relatives told us interactions between people and care staff were good humoured and caring. One relative told us ''They are always chatting and laughing while they are supporting her''. Care staff spoke with kindness and affection when speaking about people. They were able to describe people to us in a very detailed way and knew people well. Their descriptions included details about people's care needs, as well their personal histories, why they were using Quintessential Support Brokers and specific details about their likes and dislikes.

Care staff told us they enjoyed their job and were enthusiastic about providing good quality care and celebrated people's achievements. Care staff were passionate about supporting people to maximise their abilities and to remain independent for as long as they can with some aspects of care such as washing and dressing. One care staff member told us ''One client can move themselves in bed and we are always encouraging them. As long as they can still do it we need to support them to keep that skill''.

Care staff told us how they were given time to build relationships with people and get to know their preferences. People's individuality was recognised by care staff and people were supported to make day to day decisions that reflected their preferences. One care staff told us ''One person likes to look nice and we always do their hair and nails like they tell us to.''

People were frail and at times found it difficult to communicate their needs. Care staff could describe how they would give people time to respond to their questions and use short sentences to aid people's decision making. Relatives told us care staff would also ask them what people would like if they were finding it difficult to tell care staff themselves.

One person who spoke with us and relatives told us people were treated with dignity and respect by care staff. Their comments included; ''Staff are always kind and respectful towards me and [my loved one]'' and ''They are always discreet''. Care staff described how they ensured people had privacy and how their modesty was protected when undertaking personal care tasks. Relatives told us that care staff closed curtains and doors before undertaking bathing tasks. Relatives said care staff would respect and be conscious of other people in the house, at the time of their visit. Care staff knew people's individual dignity needs and adjusted their approach to accommodate these. They gave examples of how they were aware some people become self-conscious when supported with personal care tasks ensuring were reassured and approached with sensitivity.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with and relatives told us the service was responsive to people's needs. Relatives told us they had agreed the times of the care visits with the registered manager and people received their care at the times agreed. The service was flexible and adjusted people's care times when requested. One relative told us ''I really can't complain, they are on time and if they are running late they will let me know''. Relative told us care staff always came and they were assured people would receive their care as needed.

Relatives told us care staff stayed for the allocated time agreed for the visit and people were not rushed but supported at their own pace when care tasks were completed. One care staff member told us ''People's energy and strength can go up and down, we always take our time so that people can do as much for themselves as possible''.

One person we spoke with and relatives told us they felt they had contributed to planning people's care. They told us people had received a visit from the registered manager to discuss their care and the service had used the referral assessment of the commissioning team as the basis of their assessment. One relative told us ''They always involve me and will always ask if there is anything that needs to be done differently''. The registered manager told us people's relatives' views about people's care were sought with the consent of the person receiving the care.

The registered manager had assessed people's care needs and agreed the frequency of care visits when people were still in hospital or had just been discharged from hospital. Care staff and relatives told us people's needs had at times changed quickly as people became stronger or their health deteriorated. At times people had also requested the service to reduce the number of agreed visits. However we found people's needs had not always been re-assessed promptly when their condition or preferences changed to ensure their care arrangements would continue to meet their needs. For example, three people's mobility needs had changed since they had started receiving care and relatives told us care staff had adjusted the support and number of care staff provided. However, people's care records did not evidence how the registered manager had reviewed people's care and considered how the adjustments in people's care arrangements would continue to meet people's assessed needs and risks. Improvements were needed to ensure people's needs would be re-assessed and their care reviewed continually to ensure people would always receive appropriate care that met their changing needs and preferences.

One person we spoke with and relatives told us their preferences were met and care staff had a good understanding of people's care needs, their likes and dislikes.' Whilst care staff had this understanding of people's individual needs people's care records had incomplete information about what was important to the person, their preferences and what they could do for themselves. This is important to ensure that in the event that a new care staff or another agency's staff were required to deliver care they would have detailed guidance available to be able to meet people's needs effectively. After our first visit the registered manager had reviewed the care plan format and re-written all care plans. Further improvement was needed to ensure people's care plans would accurately reflect their current needs and abilities so that care staff who did not know people well would have all the information they needed to support them appropriately.

People and their relatives we spoke with knew how to complain if they had any concerns about the service. They told us they had the contact details for the registered manager and would feel comfortable about complaining if something was not right. People and their relatives were confident that any concerns would be taken seriously. One relative told us ''There were some niggles in the beginning, but I spoke with the manager and it got sorted.'' People had received a copy of the provider's complaints policy however it did not fully detail how people could take matters further if they were not satisfied with the provider's response to their complaint. It did not include information for people about which external agencies to contact if they were not satisfied with the way the provider had managed their complaint such as the Local Government Ombudsman and the Care Quality Commission.

The registered manager told us they had not received any formal complaints in the past year. Health and social care professionals told us they had received four concerns from people receiving the service since January 2016. These concerns related to lateness, staff not wearing gloves, concerns about the support one person had received to manage their skin and poor recordkeeping. The registered manager could describe some of the action they had taken to address the concerns they had been informed of. For example, they discussed with care staff the importance of notifying her if they were running late and ensuring all care staff had sufficient aprons and gloves. However, the action taken in response to the recordkeeping and skin management concerns had not brought about improvement across the service as we received ongoing concerns relating to the quality of care plans and people's skin management when we spoke with health care professionals as part of our inspection. Improvements were needed in relation to how the provider investigated concerns so that shortfalls in the service could be identified and learning from these investigations could be used to improve the service for all people.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to have systems and processes in place to assure themselves that the service people receive meet the regulatory requirements, is safe and of a good quality. These systems should enable the registered manager to identify risks and shortfalls in the service promptly and take action to drive improvements when needed.

The registered manager told us that they checked the quality of the service regularly as they were in day to day control of the service. However, the registered manager did not have effective systems or processes to identify all the shortfalls we found during this inspection and had therefore not taken sufficient action to ensure the service would always be safe and of a good quality. For example, the registered manager had not reviewed the staff pre- employment checks to ensure all relevant information was recorded to evidence they had implemented safe recruitment practices.

The registered manager had not systematically reviewed and evaluated people's care and re-assessed people's needs to ensure they would promptly identify any changes or potential risks. This meant suitable adjustments could not always be made to people's care in a timely manner to ensure their needs would always be met. For example, when care staff reported that people's mobility needs had changed or people declined some of their care visits they had been assessed as requiring to remain safe and healthy, their care had not been re-evaluated and their care plans updated accordingly.

The registered manager had some systems in place to monitor care staff's knowledge and improve their understanding of their roles and responsibilities. However, effective systems were not in place to support them to pro-actively identify when staff's care practice were not meeting people's needs or putting people at risk. For example, whether care staff were competent to administer medicines and support people to move safely. When concerns had been raised about care staff's skills for example, to support people whose behaviour could challenge, the registered manager had taken action to develop care staff's knowledge but had not ensured that they could effectively apply this learning into their practice.

The registered manager was eager to improve the service however; they had not always used concerns raised about the service for example, in relation to care planning, to improve the service. Health care professionals also told us they had found people's care plans did not always accurately reflect their assessed needs. The registered manager had reviewed people's care plans after our first visit however, we found people's care records still required improvement to accurately reflect the support people required. For example, in relation to their mobility needs and medication support.

Although people's records were not always accurate and up to date, one person we spoke with and relatives told us care staff supported people appropriately. Care staff explained they managed people's risks through their knowledge of people and information had been passed on to them verbally by experiences colleagues, relatives and health professionals. However, new staff and other agency staff might not have all the information they needed to understand people's risks and know how to provide appropriate support if they had to rely on people's care plans.

People, relatives and care staff told us they had been asked for their feedback about the service and the provider had completed a satisfaction survey in April 2016. People, relatives and care staff's feedback was positive with no areas for improvement noted. The concerns we received about the service were raised by health and social care professionals. The provider told us feedback had been received from one professional as part of their quality assurance. They said that quality assurance forms were available but feedback had not been received at the time of the inspection. The provider's feedback process did not routinely ask or seek professionals and commissioners about their views of the service. As a result the health and social care professionals had to inform the registered manager when complaints had been made rather than the registered manager actively seeking their views and concerns. This would have allowed for early potentially preventative action to be taken specifically in regards to record keeping and skin care for example. Therefore the provider had missed opportunities to identify shortfalls in the service so that action could be taken to improve the quality of the service provided to people.

The provider did not operate effective quality assurance systems to assess, monitor and improve the quality and risks related to the service. The provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they checked people's daily records regularly and had identified that these required improvement. We saw they had addressed this with care staff at the last team meeting and had added prompts to the daily record sheet to support care staff to provide more detailed records of the care provided to people at each visit.

Care staff told us that the registered manager was a good leader and gave them direction and a sense of value. Their comments included ''She is always available and approachable'', ''If I have any concerns I just contact her and she tries to sort it out'' and ''We all meet regularly and she always asks us how we can improve things''. Care staff told us they had clearly defined roles and understood their responsibilities in ensuring the service met the desired outcomes for people. They felt encouraged to question decisions and share with the registered manager any concerns.

One person we spoke with and relatives told us they were satisfied with the service people received. They found the care staff and registered manager to be open and told us they had experienced the service's values of caring and respect when observing them supporting people.

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 did not take formal enforcement action at this stage. 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 did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the service. The provider had not always maintained an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to each person and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17(1)(2)(a)(b)(c)