Peoples Care Limited

Peoples Care Limited

Inspection report

65 New Road
London
London
E1 1HH

Tel: 02072477332
Website: www.peoples-care.co.uk

Date of inspection visit:
21 December 2016
22 December 2016

Date of publication:
24 February 2017

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 21 and 22 December 2016 and was announced. The provider was given 72 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. This was their first inspection under this registration with the Care Quality Commission.

Peoples Care Limited is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our visit the service was providing personal care and support to 14 people in the London Boroughs of Tower Hamlets, Southwark and Barking and Dagenham. All of the people who used the service and the care workers who supported them used Bengali to communicate with each other.

All of the people using the service were funded by the local authority and were able to choose their service provider with the use of direct payments. A direct payment is the amount of money that the local authority has to pay to meet the needs of people and is given to them to purchase services that will meet their needs (as assessed by the local authority).

There was a registered manager in post at the time of our inspection. 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had a medicines policy in place where care workers were only allowed to prompt people with their medicines. Staff had completed basic training in medicines and knew what to do if they had any concerns. However care records were not always clear about people's medicines and were not always recorded in people's daily logs.

People's risks were identified and care plans contained risk assessments to reduce the likelihood of people coming to harm, however guidance for care workers was not always accurately recorded and was given verbally during shadowing visits.

The provider had a robust staff recruitment process and staff had the necessary checks to ensure they were suitable to work with people using the service. People had regular care workers to ensure they received consistent levels of care.

People and their relatives told us they felt safe using the service and care workers understood how to protect people from abuse. Staff were confident that any concerns would be dealt with appropriately. All staff had received training in safeguarding adults and had a good understanding of how to identify and report any concerns.

Care workers received an induction training programme to support them in meeting people's needs

effectively and were always introduced to people before starting work with them. They shadowed more experienced staff before they started to deliver personal care independently and received regular supervision from management. They told us they felt supported and were happy with the supervision they received, although supervision records were not documented.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and were aware of the processes to follow if they had concerns about people's capacity. Care workers respected people's decisions and gained people's consent before they provided personal care.

Care workers were aware of people's dietary needs and food preferences and this was highlighted in people's care records. Care workers told us they notified the management team and people's relatives if they had any concerns about people's health. We also saw people were supported to maintain their health and well-being through access to health and social care professionals, such as occupational therapists, advocates and social services.

People told us that staff respected their privacy and dignity and promoted their independence. There was evidence that language and cultural requirements were considered when carrying out the assessments and allocating care workers to people using the service.

People and their relatives told us care workers were kind and caring and knew how to provide the care and support they required. Care workers understood the importance of getting to know the people they supported and were able to communicate with them in their own language.

People were involved in planning how they were cared for and supported. The registered manager or team of supervisors visited people in their own homes to carry out an initial needs assessment, from which care plans and risk assessments were developed. There was evidence that the provider listened to people about who they wanted to work with them.

People and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. There were quality monitoring visits, phone calls and regular satisfaction surveys in place to allow people and their relatives the opportunity to feedback about the care and treatment they received. Feedback could be given in people's own language.

The service promoted an open and honest culture. We received positive feedback about the management of the service and staff felt well supported and were confident they could raise any concerns or issues, knowing they would be listened to and acted upon.

Procedures were in place to check standards of care and the satisfaction of people who used the service, although not all records were being documented. Audits on daily logs did not always pick up the issues we found during the inspection. The registered manager acknowledged this and told us they were in the process of developing new translated forms to help their staff with recording information.

We identified one breach of the Regulations in relation to good governance and made one recommendation in relation to the safe management of people's medicines. You can see what action we told the provider to take at the end 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.

Medicines were prompted by staff who had received relevant medicines training however care records were not always clear about people's medicines and medicines were not always recorded in line with the provider's policy.

Risk assessments were in place to identify the areas of risk and to reduce the likelihood of people coming to harm. However guidance for care workers to carry out tasks safely was not always recorded in people's care plans.

The provider took appropriate steps to ensure robust staff recruitment procedures were followed and there were sufficient staff to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm. Staff were confident that any concerns they brought up would be dealt with appropriately.

Is the service effective?

Good

The service was effective.

Care workers received the training and supervision they needed to meet people's needs and felt supported in their role. The registered manager acknowledged that supervision records should be documented.

Staff were aware of people's needs related to their health and well-being and responded if their needs changed. People had access to health and social care professionals, such as social workers, advocates and occupational therapists.

Some people were supported to have a balanced diet, which took into account their preferences as well as medical and cultural needs.

The registered manager and staff understood the legal requirements of the Mental Capacity Act 2005 (MCA) and knew

the process to follow if concerns about people's capacity arose.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were happy with the care and support they received. Care workers knew the people they worked with, understood their cultural needs and treated people with respect and kindness.

People, including relatives and health and social care professionals, were informed about their health and well-being and were actively involved in decisions about their care and support, in accordance with people's own wishes.

Care workers promoted people's independence, respected their dignity and maintained their privacy.

Is the service responsive?

Good

The service was responsive.

Care records were discussed and designed to meet people's individual needs and staff knew how people liked to be supported. The information was able to be explained in people's own language so they could understand it.

There was an appropriate complaints procedure in place. People and their relatives knew how to make complaints and said they would feel comfortable doing so.

The service gave people using the service and their relatives the opportunity to give feedback about the care and treatment they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Procedures were in place to check standards of care and the satisfaction of people who used the service, although these were not always being documented. Audits on daily logs did not always pick up the issues we found during the inspection.

People told us that the service was well managed and spoke highly of the management team. Staff spoke positively of them and felt they were well supported to carry out their responsibilities.

The registered manager was in regular contact with people using the service, sought their views as to the quality of care and support provided and involved them in all aspects of their care.	

Peoples Care Limited

Detailed findings

Background to this inspection

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

The inspection took place on the 21 and 22 December 2016 and was announced. The provider was given 72 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of one inspector and a Bengali interpreter. A Bengali interpreter was required because all of the people using the service, their relatives and care workers could not communicate as effectively in English as it was not their first language.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC. The provider also submitted a provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

We spoke with three people using the service, two relatives and 10 staff members. This included the registered manager, three supervisors and six care workers. We looked at four people's care plans, four staff recruitment files, staff training files and records related to the management of the service.

Following the inspection we contacted one health and social care professional who worked with people using the service for their views.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe when receiving care. Comments included, "Yes, I do feel safe with them" and "I am safe. I don't have any problems with how they help me." Relatives were confident that their family members were well looked after and did not have any concerns.

There were procedures in place to identify and manage risks associated with people's care however they were not always fully detailed in people's care plans. Before people started using the service an initial assessment of their care needs was carried out by the registered manager or a supervisor. This identified any potential risks associated with providing their care and support. Some of the risk factors that were assessed related to people's mobility, support required with transfers, communication, infection control and physical health and well-being. They also assessed levels of risk in relation to the person's home environment, including an internal and external assessment. For example, the nearest bus routes were recorded in people's assessments so care workers could plan their route accordingly. We also saw records that showed a fire alarm was found to be faulty and relatives were contacted to arrange for it to be repaired.

Once completed, this information was then used to produce a personalised care plan and risk assessment around the person's health needs. The risk assessment contained information about the level of support that was required and details about any health conditions the person had. For one person who had reduced mobility, it highlighted it may take longer for the door to be answered but to call the office if it was longer than 10 minutes. It also included what mobility aids were to be used by the person to reduce the risk of them falling. For another person, there was information for care workers to wear personal protective equipment and how to dispose of continence pads.

However practical guidance for care workers about how to manage risks to people was not always recorded. For one person with reduced mobility and dexterity who was supported to have a bath, there was no guidance on how to carry out the task safely. The assessment said 'ensure proper personal care and detailed hygiene instructions given to care workers'. For another person who was supported to access the community, the risk assessment said 'when taken outside, see support plan', but there was no information recorded in the person's support plan for staff to follow. We spoke to the registered manager about this who confirmed that this guidance was only given to care workers verbally when they carried out shadowing visits and was not recorded. They added that it was easier to explain the tasks during a practical example, and in the care workers own language. Care workers we spoke with confirmed this and knew about the individual risks to people's health and well-being and how these were to be managed. The registered manager acknowledged that this should be included in people's care records and told us they would update them accordingly.

Some people were supported with their medicines and the registered manager explained to us that it was their policy to only prompt people with their medicines. Care workers did not assist or administer medicines and if people needed this support, it would be the responsibility of relatives or healthcare professionals. We saw records within care plans which highlighted who supported people with their medicines and also if people were able to self-administer their own medicines. Where appropriate, records also highlighted who

was responsible for collecting prescriptions and where they were stored. Care workers had received training in medicines awareness during their induction and records we saw confirmed this.

However, it was not always clear from the records we saw if people were being safely supported with their medicines. The providers wording for 'prompting' that was recorded in people's files was 'care workers to talk about medication whilst visiting'. In one person's care records, it stated they managed their own medicines and took full responsibility; however it was recorded in the tasks that they were to be prompted with their medicines. We looked through a sample of their daily logs which confirmed that care workers had prompted people to take their medicines. For another person who was being supported with their medicines, we saw that this was not being recorded in their daily logs. This meant from reading the care records we could not be assured how people's medicines were managed. We spoke to the registered manager about this who acknowledged this needed to be improved and told us they were in the process of implementing a new daily log form, which would be easier for care workers to complete when English was not their first language.

We also saw in the daily logs for one person that creams were being used but were not recorded in the care plan. The registered manager confirmed they were non-prescribed creams but would update the care plan accordingly. We recommend the provider seeks advice and guidance from a reputable source in relation to the management of people's medicines.

The four staff files that we looked through were consistent and showed that the provider had robust recruitment procedures in place. We saw evidence of Disclosure and Barring Service (DBS) checks and photographic proof of identity. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. The provider asked for two references and people could not start work until they had been verified. Referees were able to comment on areas such as experience, teamwork, punctuality and communication and we saw positive feedback in all the references we viewed.

Staff had received appropriate training in safeguarding and were able to explain what kinds of abuse people could be at risk of, potential signs of abuse and what they would do if they thought somebody was at risk. This topic was covered during the induction programme and the registered manager told us training would be refreshed on a yearly basis. He added, "We always instruct our care workers to observe everything and we remind them when we carry out regular visits." Comments from care workers included, "If I find any sign or symptom of abuse, I must report it to my office, the police or the CQC. I am always making sure my service user is safe" and "As a care worker, I need to ensure that my service users are free from abuse and neglect. Our agency has a policy that we need to follow and we must observe, report, record and take the necessary action."

There were sufficient care workers employed to meet people's needs. At the time of our inspection there were 14 care workers employed by the provider. People and their relatives confirmed that they had regular care workers and they arrived on time. A relative said, "She has never missed an appointment or been late." The four members of the management team were responsible for covering the out of hours service and were available 24 hours a day, seven days a week. The registered manager told us that all office staff were able to carry out personal care and were able to cover in emergencies.

Good

Is the service effective?

Our findings

People told us their care workers understood their needs and circumstances and received the care they wanted. One person said, "They know what they need to do and I get whatever I need." Another person told us about a specific health condition they had and that the care worker was aware of it and what action to take to support them with their healthcare need. One relative said, "The carer will always do whatever we ask them to do."

Staff had to complete a five day induction training programme when they first started employment with the service. This programme covered a range of policies and procedures to highlight the role of the care worker and mandatory training. The training programme covered 12 topic areas which included medicines awareness, moving and handling, fire safety, food hygiene, dementia care, person centred care and health and safety. New starters were also given a Care Certificate assessment tool which they had to read through and highlight areas of their understanding to the registered manager. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. The registered manager explained that this was a good way to get an understanding of their experience but would also be able to explain it in Bengali to ensure their understanding. One care worker said, "The quality of the training I had was really beneficial to me and it really boosted my confidence." All of the staff files we looked at had certificates that confirmed training had been completed and were up to date. However we did see that the induction forms had not always been completed or signed off.

Care workers were introduced to people first before they started work with them and were able to shadow senior care workers and supervisors before working independently. Records to show that care workers had completed shadowing were not recorded but care workers confirmed the training had taken place. One care worker told us how they were able to have 11 shadowing visits before starting work on their own. The registered manager added that staff would also be able to observe care tasks and have this explained to them in their own language.

Staff would then have supervision and spot checks every month. A supervisor told us that supervision was an opportunity to discuss the wellbeing of the care worker, along with any concerns they had about people they were working with. Care workers told us they received regular supervision and spoke positively about the support they received during these meetings. One care worker said, "We always follow our organisations rules and regulations and they always carry out regular meetings of supervision with me." We were unable to see copies of documents related to supervision records as the registered manager confirmed that they did not record them, but acknowledged that they should keep a record of them. Staff had not worked for the provider long enough to have received an end of year appraisal but the registered manager was aware of this and told us that they would meet with staff to discuss their employment after 12 months.

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.

The registered manager and staff had a good understanding of the principles of the MCA. We saw evidence of signed consent to care and treatment and staff understood consent and capacity issues and were aware of what to do and who to report to if people they were caring for became unable to make decisions for themselves. Where people had capacity to make their own decisions, care plans had been signed by the person who used the service to show their agreement with the information recorded. The registered manager told us that all the people they supported had capacity so we were unable to see any cases where people lacked the capacity to make decisions about their own care. The registered manager added, "Depending on the diagnosis, we know we would need to make contact with the relevant people in the social services departments and have authorisation documents in place highlighting this."

Some people required care workers to support them with meal preparation. This information was recorded in their care plan along with the level of staff support needed and if anybody had any specific dietary needs. It was highlighted if people were diabetic or had any food allergies. We saw information in one person's care plan that highlighted breakfast was important due to them being diabetic and snacks should be left out for the person before the care worker left. We saw records in their daily logs that this was taking place. For example, one recording showed that fruit was cut up and left in the person's room. One person said, "I need to take medicine, I am a diabetic, I have to watch my cholesterol. She knows about this and supports me to have a balanced diet." We saw throughout people's records that specific cultural food preferences had been recorded and daily logs confirmed people were supported to eat what they wanted. Staff had received training in food hygiene and infection control during their induction.

Care workers said they helped people manage their health and wellbeing and would always contact the office if they had any concerns about the person's healthcare needs during a visit. One care worker said, "If there is an emergency, I will call 999, the manager, family members and other relevant people. It is always reported to the office and they will take action." Another care worker said, "I am always making sure that the service user is safe and I must report any concern." We saw records and correspondence for one person that the registered manager had attended a meeting with a social worker, an occupational therapist and an advocate when concerns had been highlighted. We saw records for another person when care workers had reported a concern regarding the condition of the environment and this hindered the working space for providing personal care. The registered manager had informed the relevant health and social care professional highlighting the concern and asking for advice.

Good

Is the service caring?

Our findings

All the people we spoke with told us they were well supported by the provider and thought the staff were respectful and caring. Comments from people included, "They are kind and always show respect. They never answer back to me" and "Yes, my carer is very kind, she's very good." Relatives were also positive about the staff. One relative told us that they could see from the way staff talked to their family member and their interactions with them showed they had a caring attitude.

We saw records that showed people using the service were involved in making decisions about their care and their relatives were present during assessments and reviews where appropriate. The registered manager told us they carried out initial assessments in people's homes and always made sure, where appropriate, a relative or health and social care professional was present with the person to ensure they had the support they required during the assessment. Once the assessment of needs was complete they would discuss people's preferences and find out how they wanted their care to be carried out. The registered manager said that they always made sure people understood what service they would be providing and gave them a copy of the service user guide. The registered manager explained that they were able to explain how the service was delivered in people's language to ensure they could fully understand the care package. He added that all of the office staff were able to communicate in people's languages so they were always sure people had the information they needed.

At the time of the inspection the registered manager told us that they worked closely with an advocacy organisation who supported people managing their direct payments. Advocates are trained professionals who support, enable and empower people to speak up. This meant that where people did not have the capacity to express their choices and wishes or found it difficult to do so, they had access to independent support to assist them. The provider had their contact details within people's records and they were also available in the service user guide.

People were assigned a designated care worker but the registered manager told us that they always allocated more than one care worker for each person for continuity of care when regular care workers were not available. New care workers would always be introduced and have the opportunity to shadow more experienced care workers before working with people. One relative said, "We don't have any problems with this. If our regular carer cannot come they always send us another one." Care workers knew the people they were working with and were able to communicate with them in their own language. People using the service and their relatives told us how important this was as they did not use English as their first language. One care worker said, "I maintain a good relationship by respecting their choice, dignity, values and human rights. Our manager always tells us to put the service user first and respect them as an individual." One relative told us that there had been times when their care workers had stayed longer than their scheduled visit. They added, "If my [family member] starts talking about something, he will stay until he finishes talking."

Care workers had a good understanding of the need to ensure they respected people's privacy and dignity. One care worker said, "We respect their beliefs, culture and gender because this is what we need to do to

make them feel that we are there to help them and be supportive, respectful and kind." Another care worker said, "I always respect people's privacy when I do their personal care. I make sure nobody is there and respect their choice. I always make sure I have good manners." We saw records that showed privacy and dignity was covered during the staff induction and positive comments were seen in service user satisfaction surveys for all the files we looked at.

Good

Is the service responsive?

Our findings

People and their relatives told us they were happy with the care and support they received from staff and that they felt listened to. One person told us, "We told them what we wanted and they listened to us." Another person said, "They always ask how I want to be supported. For example, he will ask if I want a bath or a shower today." Relatives commented that they were always involved in the care and reviews of their family members and had good communication with the office. One relative said, "I was involved in the planning of their care and it was discussed with me." Another relative said, "They always keep in touch with the telephone and if needed will make a home visit. I don't have any complaints."

We spoke with the registered manager and the supervisors about the process for accepting new referrals. All of the people that received care from the provider were funded by the local authority and had personal budgets where they could choose their own care provider. When people made contact with the provider, they would schedule a home visit to discuss people's needs and explain with the person and their family what care and support they would be able to provide. They would then discuss their preferences for care workers and start to set up their care folder, with risk assessments being completed before delivering a service. The registered manager told us that they were able to provide a service that met people's cultural needs and could communicate with people in Bengali as people and their families could not communicate as easily in English. A service user guide was given to people to keep in their home which set out an overview of what people could expect and included a range of the provider's policies and procedures.

The registered manager told us that people and, where appropriate their next of kin were always involved in the development of their care plan. Care workers were introduced to people first to make sure they were comfortable with each other. They followed this up during the first two weeks of service with either telephone calls or home visits, and a satisfaction survey was completed. If care workers had any concerns about the person they would inform the office and the management team would make contact to see if people's needs were being met. The service was reviewed on a regular basis as this was tied in with a satisfaction survey every two months, but we saw some people had a review every month, depending upon their needs. The registered manager told us that if there were any significant changes to people's needs, this was brought forward.

Care plans were consistent and contained contact details for the person, their next of kin, their GP and other health and social care professionals involved in their welfare. It identified health issues and their level of communication, including languages spoken. They highlighted people's hobbies and interests, religion, culture and what were important things in their life. Tasks to be carried out were recorded and records showed the provider was flexible and made sure people's views were respected. One person who was supported with accessing the community, their care plan highlighted their interests and that the visit time was flexible and agreed with the person. Care plans also had other relevant information, such as people's assessments from the local authority, correspondence with health and social care professionals and quality assurance monitoring forms.

We saw a sample of some daily log records and found that people were receiving the care that they wanted,

however not all care tasks were always being recorded. We spoke to the registered manager about this who told us that they were in the process of developing new log sheets that would be translated, as this would help care workers with recording when English was not their first language.

There was evidence that the provider listened to people's preferences with regard to how they wanted staff to support them. People and relatives had highlighted, for cultural reasons, the need to have only a male or female care worker, or care workers who could speak their own language. One person said, "I got choices about how I received my care. I wanted a female care worker and they were able to give me a female care worker." People's care records highlighted that they wanted a Bengali speaking care worker and this was able to be accommodated. As people were responsible for purchasing their own care, we saw records that showed the provider listened to people regarding their preference of care workers and if people requested a person that they wanted to work with them, the provider would recruit them and put them through their staff induction and training programme. There were male and female office staff who were also able to cover calls in an emergency and meet people's cultural needs. One person's care plan highlighted the importance of their religion and that they wanted a Bengali speaking care worker to escort them to the mosque.

People and their relatives said they would feel very comfortable if they had to raise a concern and knew how to get in touch with the service. Comments included, "If it was required, I would feel comfortable making a complaint", "We try and resolve the issues ourselves but I know I can call the office and feel comfortable doing that" and "I'm happy with the service and know how to make a complaint but I have had no need." There was an accessible complaints procedure in place and a copy was included in the service user handbook and given to people when they started using the service. Staff were able to explain it to people in their own language to ensure they were able to understand it. Their complaints policy stated they would respond to any complaint within 24 hours and would aim to have a final outcome within 28 days. There had been no complaints in the past 12 months. The registered manager told us that they always encouraged people to let them know if they had any concerns. They added, "We encourage service users to comment on any matter, no matter how small it might be."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Care Quality Commission (CQC) since June 2015. He was present on both days we visited the office and assisted with the inspection.

The provider had internal auditing and monitoring processes in place to assess and monitor the quality of service provided but many of the systems the provider had in place did not always include documenting what had taken place and the outcome. For example, the registered manager told us they had monthly meetings where they were able to discuss issues relating to the service and supervisors confirmed this, however they were not documented. We were told that there were monthly spot checks, sometimes more depending on people's needs. Care workers confirmed this, one said, "Spot checks are monitored by the supervisors every month." However these were also not documented, along with supervision records, and the registered manager acknowledged that they should keep a record of them. The registered manager told us that they had monthly home visits to discuss the service and check the daily logs for recording. They said they checked the time, the tasks completed and whether the correct tasks were being carried out. The daily logs were returned every four weeks however we found that this was not always the case. One person's most recent daily logs were dated June 2016. Another person's logs did not have the recording of medicines being prompted, and this had not been picked up when they were returned to the office. We also found that people's risk assessments were not sufficiently detailed to provide guidance for staff about how to help keep people safe. The registered manager acknowledged this needed improvement.

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

Staff told us they were aware of the reporting process for any accidents or incidents that occurred. They told us they would record any incidents in people's daily log record and report the incident to the registered manager. One care worker said, "I have to report to my organisation about any changes to our service users, physical, emotional or any other unusual symptom. I am fully confident this will be followed up." The registered manager told us that they were in the process of drafting a separate accident and incident form to improve the service.

We received positive comments about how well managed the service was. One person said, "Yes, I feel I can talk to the manager. They make home visits and telephone calls." One relative said, "The manager comes for home visits and I can talk to him. The supervisors come quite a few times as well."

Care workers told us they felt well supported by the management team and all of them had positive comments about the management of the service. They said if they had any problems they were confident they could contact the office and speak to the management team who would deal with the situation. Comments included, "Peoples Care support me in my role and provide me with training, supervision, monitor my work and treat me well. I am happy with them", "They are providing a service to people with care workers of the same cultural background. They listen to me and support me to learn more. They are a

very good team" and "The staff are very friendly and helpful. We are always in contact with them and they let us know any information as well as understanding the carer's needs. They give us maximum support." Care workers felt that the service promoted a very open and honest culture and even though none of the care workers we spoke with had any concerns, they were aware of the providers whistle blowing policy and were all confident that concerns would be dealt with immediately.

We reviewed the satisfaction surveys of all the people's care files we looked at. The survey was made up of 28 questions which covered areas such as communication with the office, awareness of needs, privacy and dignity, quality monitoring, if people felt listened to, documentation and complaints. Positive comments and responses were seen in all the records we reviewed.

We had a discussion with the registered manager who showed he was aware of their registration requirements regarding statutory notifications and it had been highlighted in their safeguarding adults policy.

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 Systems or processes must be established and operated effectively to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity and the management of the regulated activity. Regulation 17(2)(d)(i),(ii)