

HH Community Care Limited

# Helping Hands Community Care - Blyth

## Inspection report

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Date of inspection visit: 24, 25 and 26 March 2015  
Date of publication: 23/06/2015

### Ratings

#### Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires improvement 

Is the service well-led?

Good 

### Overall summary

This inspection took place on 24, 25 and 26 March 2015 and was announced. This was so we could be sure that somebody would be available in the office, as it is a domiciliary care service. We last inspected this service in August 2013 and found no breaches of regulations at that time.

Helping Hands Community Care – Blyth provides personal care and support to people either within their

own homes or the community in the Northumberland area. The organisation is large and at the time of our inspection the provider delivered care and support, in one form or another, to over 850 people. Over 500 staff were employed by the provider at this location. The majority of people using the service are older persons, although the provider also offers care and support to people with learning disabilities, brain acquired injuries and a respite service for parents of children with

# Summary of findings

disabilities. The support provided ranges from 24 hour care packages to supporting people with shopping, housework and companionship. The provider also facilitates a number of drop in centres across the region which people can attend if they would like social contact and activities to pursue.

At the time of our inspection a registered manager had been in post and registered with the Care Quality Commission since June 2013. A registered manager is a person who has registered with the Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People spoke highly of staff whom they said supported them well. They told us they felt safe and there were systems in place to protect people from abuse and channels through which staff could raise concerns. Records showed that safeguarding matters had been handled appropriately and referred on to either people's care managers or Northumberland local authority safeguarding team for investigation.

People's needs and risks that they were exposed to in their daily lives were assessed. Care records were reviewed and medicines managed and administered safely. Staff supported people to manage health and safety risks within their own homes and refer matters on to third parties if necessary. Recruitment processes were thorough and included checks to ensure that staff employed were of good character, appropriately skilled and physically and mentally fit. Staffing levels were determined by people's needs and the number of people using the service. There were no significant issues with staffing.

Staff records showed that they received training in key areas such as safeguarding, medication and moving and handling. Training was up to date but some records related to training needed to be updated to reflect the current position. Supervision and appraisal systems were in place. Staff meetings took place and staff confirmed that management were approachable and they could feedback their views at any time.

CQC monitors the application of the Mental Capacity Act (2005) and any applications to deprive people of their

liberty. People's ability to make informed decisions had been assessed, and the 'best interest' decision process was followed in practice. The organisation's involvement in any best interest decision making, was not clearly documented within people's care records. In addition, the provider had not explored with people's families if there were any court of protection orders or lasting power of attorney's in place. The provider gave his assurances that going forward, improvements in records would be made in this area.

People told us that they were supported to access healthcare services if they needed this help. Records showed that where staff were concerned about people's well-being during a visit, they contacted relevant healthcare professionals for assistance and advice, with the person's consent. People were given support with nutrition where necessary.

People said they enjoyed positive relationships with staff whom they found helpful, kind and caring. They commented that they were able to remain as independent as possible, they were given choices and they were treated with compassion, dignity and respect. People's relatives also spoke highly of the staff team and said they felt involved in their relation's care.

The provider told us that he monitored the business performance informally, but management information could easily be extracted from an electronic system. Records showed that where issues were identified, these were reported to management and resolved as soon as possible. People told us they knew how to complain and we saw a complaints policy and procedure was in place. We received positive feedback about the leadership and management of the service, from people, their relatives and staff.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and their corresponding regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was Regulation 20, Records, which corresponds to Regulation 17, Good governance, 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.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

People told us they felt safe when receiving care and support from staff.

Systems were in place and matters of a safeguarding nature were reported to management by staff and then referred on to external organisations if required.

Care delivery had been planned and risk assessed. Recruitment procedures were thorough and staff who worked at the service had been vetted before they started working with vulnerable people.

Medicines were managed safely and staffing levels ensured that people's needs were met.

Good



### Is the service effective?

The service was effective.

Staff told us they undertook training regularly and records showed that a wide variety of training was offered. People reported that staff met their needs and were knowledgeable.

The provider followed their legal responsibilities under the Mental Capacity Act 2005. People told us they felt communication within the organisation was good and they were supported if necessary to access healthcare services.

People were supported where necessary to consume food and drink of their own choice.

Good



### Is the service caring?

The service was caring.

People told us they were happy with the staff and the care and support they received whilst living in their own home. They spoke highly of staff and the positive relationships that they enjoyed.

They told us that staff respected their privacy and dignity and that they were free to make informed choices in their day to day life. People said they felt involved in their care and this was echoed by their relatives, who said they were kept fully informed.

Independence was promoted and people said they were encouraged to do what they could for themselves, in order to maintain their independent living skills as much as possible.

Good



### Is the service responsive?

The service was not always responsive.

Requires improvement



# Summary of findings

Care records were not detailed enough and they were not always well maintained. Some other records within the organisation were not up to date.

Complaints were handled appropriately and in line with the providers policy. People were made aware of their right to complain and said they were happy to approach staff with any concerns they may have.

Care was person centred and reviews of people's care took place. The provider had established a drop-in centre for people to access which promoted their involvement in the community and social interaction with others.

## Is the service well-led?

The service was well led.

The provider had management structures in place and plans to employ a further general manager in the business to oversee the standard of work.

Policies and procedures were in place to aid staff and give them the information that they needed to provide care of a good standard.

Management acted promptly to rectify matters and issues that were brought to their attention.

Good



# Helping Hands Community Care - Blyth

## 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 24, 25 and 26 March 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by one inspector and an expert by experience, with experience of older persons care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form which asks the

provider to give some key information about the service, highlighting what the service does well, and identifying where and how improvements are to be made. We reviewed the information returned to us by the provider in the PIR, alongside information held by the Commission (CQC) about the home. This included reviewing statutory notifications and any safeguarding information that the provider had sent us within the last 12 months. In addition, we contacted the commissioners of the service and the local authority safeguarding team based in Northumberland. Neither of these parties raised any concerns about the service.

As part of our inspection we visited five people in their own homes and spoke with a further 20 people, all of whom used the service. We spoke with seven people's relatives, two care staff, the registered manager and the nominated individual. We reviewed a range of records related to people's care and the management of the service. These included five people's care records, ten staff recruitment, training and induction records, medicine administration records (MARs) and records related to quality assurance.

# Is the service safe?

## Our findings

All of the people we spoke with said they felt safe in the presence of the staff who delivered their care, without exception. One lady described the care worker who visited her as “one of the family” and this was echoed by several people.

Staff told us they had received training in safeguarding which involved identifying signs of abuse and what action should be taken. Training records confirmed this. They were aware of their own personal responsibility to report matters of a safeguarding nature, in order to ensure that vulnerable people remained safe and were protected from abuse. Records showed that there had been occasions where staff had raised concerns with management and the local authority safeguarding team, where they were concerned people may have been taken advantage of by a third party. There were safeguarding and whistleblowing policies and procedures in place and safeguarding systems related to people’s finances which reduced the likelihood of financial abuse. The provider told us they would contact people’s care managers, or alternatively the local safeguarding team about any concerns or issues should they arise.

Procedures were in place to report accidents or incidents and these were recorded on an electronic system at the provider’s office. Records showed that the management team acted on concerns or matters raised in respect of people’s care, as a result of an accident or incident. For example, where necessary care staff referred matters to care managers for more support to be arranged to ensure that people remained safe following incidents that had occurred. Staff also attended the office to complete incident forms that were held within people’s care records. The provider told us that accidents and incidents could be reviewed and analysed by printing off the electronic entries for each individual or by area.

Risks that people were exposed to in their daily lives (such as being at risk of falling) and in respect of the care that was delivered to them had been assessed by the provider, although the documentation of these risks and how to manage them was limited.

Staff and people told us that they felt able to do their jobs in the time allocated to them for each home visit. People said that their needs were well supported and staff stayed

for the 30 minute time slots they had been allocated for each visit. People said that staff completed their designated tasks in this time. Some people reported some time delays in their visits, but all said that these delays were acceptable and were usually caused by traffic conditions or delays at the staff member’s previous appointment. The provider told us that all staff were issued with a mobile phone when they start working for the organisation and they were expected to call people in advance if they were delayed on a previous home visit. In addition, people are supplied with the ‘on-call’ and office telephone numbers, so that they can alert office staff if their care worker misses a call altogether. Staff were allocated home visits on a weekly rota by the administrative staff based at the provider’s office. Any issues or changes with rotas, calls and staffing were reviewed by the administrative staff covering each geographical area. This showed that there were systems in place to monitor any staffing issues. We had no concerns about staffing levels within the service.

Staff files showed that the provider’s recruitment procedures were robust. Staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks (or previously CRB checks) were obtained before staff began work. Staff also completed a health declaration questionnaire. This meant the registered provider had systems in place designed to ensure the person’s health and welfare needs were met by staff who were fit, appropriately qualified and physically and mentally able to do their job.

Where relevant, people were supported to take their medicines safely. Individual records related to the administration of medicines were maintained within people’s homes, where this was a duty performed by staff. These records detailed the type of medicine, date and time that it was taken and they were well maintained. Staff told us that they supported people to take their own medicines independently, assuming they were able to, once they had dispensed it from the relevant container. They were knowledgeable about their involvement in the management of people’s medicines, but this was not clearly defined within people’s care records. A detailed medication policy was in place which gave information and guidance to staff.

There was evidence that staff were mindful of health and safety risks within people’s own homes and supporting

## Is the service safe?

them to remain safe. For example, one person had a problem with their heating in the winter months and records showed that their care worker had supported them to contact a plumber to come out and service the gas

equipment within their home. In addition, environmental risk assessments were carried out by the provider at the point that the care package commenced, so that staff were aware of any potential health and safety risks.

# Is the service effective?

## Our findings

All of the people we spoke with were positive about the quality of the care and support they received. They commented on the skills of staff which they described as good. One person told us, “The carer I have is a young girl who is very good. I asked her why she did this job and she said she had always wanted to care for people”. Another person told us, “They know exactly what to do and how to do it!” Other comments included; “It’s a great service”; “We are happy with the care that we get” and “X (staff member) knows how I like things done”. Relatives also spoke highly of the service and said that it was “Spot on” and that staff “Finished the job properly”.

Electronic records and certificates showed that staff had completed training in a number of key areas such as safeguarding and medication. An extensive and thorough induction programme was in place which tested new staff member’s knowledge as they progressed in the early stages of their role. Most of the training within the organisation was delivered internally by the company’s training department, which was run by an experienced training manager. In addition, some external training had previously been delivered in more specialist areas such as epilepsy awareness, dementia and challenging behaviour. We noted that staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and discussed the benefit of this with the provider. Staff told us that they felt they received enough training in order to deliver care effectively, and people’s comments reflected that they did.

‘Support sessions’ took place between staff and their line managers. These were one to one meetings in which the staff member and their manager could discuss their performance, any issues that they may have and any training needs. Records showed that these sessions were interactive and each party had the opportunity to feedback their views. Some of the records related to supervisions and appraisals were not well maintained and copies of these had yet to be added to individual staff member’s files. An annual appraisal system was in place, although we found some staff had not received an annual appraisal for over 12 months. Despite this, staff told us they felt fully supported by management and equipped with the necessary skills to do their jobs. We discussed our

observations with the provider who gave his assurances that he would address this matter with the team leaders who held responsibility for this work in each of the different geographical areas.

The provider informed us that they offered a range of services to people and their families including respite for parents of children with behaviour that may be perceived as challenging, enablement and personal care. People told us that staff knew their needs and they were aware of “what needs doing”. There was evidence of continuity of care, which people said they thoroughly appreciated. Some people had been using the service for several years and spoke of how they enjoyed effective care and support from the same staff member(s), who knew them, and their needs, very well.

Staff told us communication between themselves and the management of the service was good and they felt informed. People and their relatives talked of good communication between themselves and staff, either face to face, or via the telephone.

People told us they were supported by staff to arrange healthcare appointments such as going to the doctors, if they wanted this input. Staff were proactive in ensuring that people got the medical support that they needed. For example, one person told us that a staff member who was concerned he was not well, encouraged him to ring the doctors but he refused and said he was fine. Later in the day the same staff member telephoned to check on the person again and confirm that he still did not need the doctor. Records showed that where staff had arrived at a person’s home and they were injured or not well, they had sought immediate medical attention or obtained advice from medical professionals in order to promote people’s well-being.

The service was involved in supporting people in the preparation of their meals and, where necessary, assisting people to consume their food. Records showed that some staff had received training in specialised areas such as Percutaneous Endoscopic Gastrostomy (PEG) feeding tubes, which are used for people who cannot take food by mouth. This showed that measures were in place to ensure that where people’s nutritional needs were high, the service had invested in their staff so that they could meet these needs.

## Is the service effective?

We discussed the MCA and Court of Protection orders to deprive people of their liberty in a domiciliary setting with the provider. They told us that people's care managers assessed their capacity and then informed the service of people's cognitive abilities at the point of commissioning the service and subsequently, if necessary. The provider and several team leaders working at the service told us that they did not routinely establish with people or their relatives, when they first started using the service or as time progressed, if any Court of Protection orders or lasting power of attorney's were in place. Consequently, there were no copies of these held within people's care records within the service. However, they told us that they were not aware of anyone using the service who lacked capacity to a level which would require these measures to be in place.

The provider told us that as part of future assessments of people's care records, they would build in clearer information about people's capacity levels and if relevant, obtain copies of Court of Protection orders or health and welfare lasting power of attorneys from the relevant parties.

There was evidence to show that the provider referred matters related to people's capacity and any decisions that needed to be made in their best interests, to either care managers within the local authority or other relevant healthcare professionals where people funded their care privately. Therefore, we were satisfied that the provider was aware of, and carried out their legal obligations under the MCA.

# Is the service caring?

## Our findings

People commented on the positive relations that they enjoyed with staff. Several people told us they had received care and support from the same member of staff over a number of years and this had led to them developing a close bond. These long term relationships had resulted in a more positive experience for both people, and the staff who supported them. One person described the staff member who supported them as “one of the family” and a second person said, “My carer is truly marvellous”. Another person spoke about a member of staff and said, “She is very helpful and very friendly. She comes with a smile and nothing is too much trouble”. One comment made was, “It’s good value for money because my lasses (staff members) are so kind. Nothing is too much trouble and they often stay an extra five minutes to do the little things that I sometimes miss”.

People described how staff were very friendly and engaged with them, for example, through talking about their family, whilst maintaining client confidentiality. They told us how staff shared day to day news with them. People who were more mobile told us that staff made every effort to enable them to go out. In one particular case the person in receipt of care was taken out for meals and to the cinema. People told us they felt involved in their care and arrangements to go out were made in discussion staff, and only if they wanted to. Relatives told us that they felt involved in their relatives care as appropriate. One relative said, “The carer will talk to us about what my wife wants or needs, and they keep us up to date”.

Those people who received support with food preparation described how they were supported in a way that ensured their independent living skills were maintained as much as possible. This showed that the service promoted people’s independence.

People described how staff members took great care to ensure their dignity and modesty was respected. One lady commented “They always ask if they are doing something which is sensitive”. Another person described how they were visited daily for personal care and how this was dealt with “sensitively” whilst their dignity was maintained. They said, “They take account of my modesty and treat me with great respect. It is a very hard job and they do it very well”. One man who had assistance with personal care told us, “I used to be embarrassed at first, but I am used to it now and the carers give me my privacy”.

People and their relatives confirmed they received enough information from the service and we saw that they had access to a service user guide which the provider had drafted. This guide gave people important information about the organisation, including a list of services that were on offer. There were also details about how to contact the office and to raise any concerns or complaints. People told us that their experiences of contacting the office had been positive and they had always found the staff to be very informative and helpful.

The provider had an equal opportunities statement in place and the induction programme for newly appointed members of staff incorporated a diversity questionnaire. This contained a number of scenarios involving people with very diverse needs, where staff had to comment on their proposed responses. This showed that the provider promoted equality and diversity within their organisation.

The provider told us they would support people to access advocacy services via their care manager or other professionals, if required.

# Is the service responsive?

## Our findings

We identified shortfalls in the quality of people's care records which we shared with the provider and registered manager. Although we established that people were safe and they received the appropriate care that they needed, care records maintained within people's homes about their care and support needs lacked detail. This meant that staff were not equipped with all of the relevant and necessary information related to people's care. For example, there were no medicine care plans or risk assessments in people's care records and no clear guidance on the role that staff should take in supporting people to take their medicines. Some of the instructions within people's care records were very brief and, for example, said 'support to bathroom and toilet'. However, there was no detail around how the person needed to be supported to the bathroom or toilet or what their moving and handling requirements would be. There was no written instruction or guidance around people's general capacity levels, where they were suffering from the early stages of dementia. In addition, where people had specific medical conditions, this was not clearly evident in their care records. There was no care plan or risk assessment in place for one person who suffered from skin integrity issues and pressure damage. In another case, there were sections in the care plan documentation about how to support a person which were left blank.

Although people's care records were individualised, they were written in a task based manner and they did not sufficiently describe people's conditions and needs. Where people's care was funded by the local authority, the provider told us that the handover information they received (from the local authority) was used to form the basis of each person's care plans and risk assessments. People told us that the provider carried out a pre-assessment of their needs, prior to them receiving care from the organisation, but this was not evident in their care records.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about the people they supported and their needs. Whilst records did not always reflect or document it accurately, there was evidence that

the provider assessed, planned and reviewed people's care and support needs. Team leaders within each of the different geographical areas told us that they carried out reviews of people's care at least every six-months. People confirmed that a care support worker visited them in their own home prior to the care package starting, in order to identify their needs, write their care plan and risk assessments and to introduce the company. One person said, "They have come back and checked the plan and my needs. As I get older things have changed".

There was evidence that staff responded to matters and issues brought to their attention, at both junior and senior level, in respect of people's care and well-being. For instance, records showed that staff had referred matters of a health and safety nature to external organisations and they had kept people's families informed where they had concerns about people's well-being. In addition, there were several examples of where staff had referred matters to the local safeguarding authority or people's care managers, where they had concerns that people were vulnerable and had been taken advantage of by a third party. This showed that the provider was responsive and proactive to changing circumstances.

People explained that they were always given a choice, be it about the clothes they wanted to wear, food they wanted to eat or drink. One person told us, "They ask me what I want to do, particularly things which are not on their list. They are so thoughtful". This showed that staff recognised people's individual right to make their own decisions, where they were capable of doing so.

The provider told us that he had also set up 'drop-in' centres across the regions and communities in which the service delivered care, where staff supervised activities and socialising within a safe environment, such as a community hall. One such drop in centre operated three times a week and the provider told us that a group of people, who attended, had set up their own charity to raise money for day trips and the purchase of a summerhouse, for an allotment facility that they also had access to. This showed that the provider sought to enhance people's lives by providing them with activities, encouraging social contact, supporting them to be involved in their own communities and giving them a sense of well being and achievement.

The provider told us that they did not utilise questionnaires or contact people directly to ascertain their views of the care that they received, but that people's opinions of the

## Is the service responsive?

service were gathered during six monthly review meetings. Any issues they raised were acted upon. The provider also told us that he would expect staff members to feedback any concerns or issues that people had raised with them during care delivery. Staff told us that they could feedback their views through staff meetings, which were held two or three times a year, or alternatively during their support supervision sessions.

The provider had a complaints policy in place and we saw that any complaints or compliments raised were recorded on the electronic system. The complaints policy provided

information for people about how to complain and the timescales within which they could expect a response. The complaints policy was also brought to people's attention in the service user guide issued to all people when they started using the service. We examined a file at the provider's head office which demonstrated how historic complaints had been handled by the organisation. This showed that complaints were responded to appropriately and any correspondence with the complainant had been maintained to demonstrate the outcome of each case.

# Is the service well-led?

## Our findings

People told us they believed the service to be relatively well organised, and well led. All of the people we spoke with relayed positive views about the management of the service. They described the managers and office staff within the organisation as “very helpful”. One person said, “They always answer my questions and always try and help”. Another person told us, “I like the way they work” and a third person said, “They are so helpful in the office; nothing is too much trouble for them. If I want to rearrange a visit time they go ahead and do it”.

The provider told us that his ethos was to remind staff about their role by reiterating what he called ‘Back to basics’. He told us that he believed that staff should be aware of their surroundings and do the little basic extras for people when caring for them in their homes. For example, he told us that he would expect a staff member to be observant within people’s home and if their bin was full empty it, or if their kitchen bench was dirty, wipe it clean. Staff told us this message had been passed down to them and they actively embedded this when supporting people in their own homes.

Staff told us that they found the provider supportive and they were kept informed of for example shift changes via email or by a phone call from their manager. The provider told us and staff confirmed that he sent out a monthly newsletter to all staff within the organisation, which included a blog and any messages that he wished to pass on. In addition, there were reminders within this newsletter about, for example, medication management and appearance. Staff said that they found these newsletters useful and they felt part of the wider organisation. All staff reported that they had managers that they could approach at any time and ask for guidance and support when needed.

Management reporting structures were in place and there were several different roles and seniority levels within the organisation. These included roles where staff had responsibility for scheduling care visits, assessing people’s needs and writing care records, dealing with issues raised and incidents, delivering training to staff, and conducting staff support and appraisal sessions.

The organisation was large and at the time of our inspection the provider delivered care and support, in one

form or another, to over 850 people. Over 500 staff were employed by the provider at this location. The geographical area in which the provider operated was extensive and the provider had divided the area into three distinct teams, with individual reporting structures that mirrored each other. There was another separate team which provided more specialised care to people who, for example, had suffered an acquired brain injury, or who had been diagnosed with a learning disability. This team worked across all geographical areas. We established that in some areas the management of records and supervisions and appraisals was better than in others. The provider and team leaders themselves told us that they checked people’s care records within their own homes, although the lack of detail, and in some cases incompleteness of these records, had not been identified.

We considered that the work carried out by the team leaders in each of the different teams was not always appropriately monitored, although people’s care and wellbeing had not been affected by this internal management issue. We discussed our concerns with the provider and gave him some examples of our findings. He acknowledged that there needed to be more of an overview of the work carried out by each of the individual team leaders. He told us that plans were already in place to recruit a general manager who would contribute to the operation of the business and support the registered manager and himself. The provider envisaged that the general manager would hold responsibility for ensuring that all staff reporting to them, carried out their roles effectively.

An electronic system was in place in which the organisation recorded accidents, incidents, complaints, safeguarding issues, matters that needed to be followed up and any referrals to be made to external parties. Whilst the provider said that managers and team leaders did not routinely run reports off the system in order to monitor this information overall, it could be easily obtained via people’s individual accounts, or by geographical or team area. The provider told us that each individual matter was dealt with at the time it was raised, and it was recorded on the system for future reference if necessary. The provider told us that he informally monitored where the business “was up to”. We discussed the benefit of producing, for example, quarterly

## Is the service well-led?

reports about the number of medication incidents or safeguarding issues dealt with, so that it was easier to gain an accurate overview of the service and address any themes that may arise.

Observations of staff to confirm their competency in care delivery and the administration of medication were not routinely carried out. However, we did see evidence that where there had been any issues related to a staff member's practice, a supervision support session had taken place. The provider told us that he would consider introducing these mechanisms in the future. We were satisfied that any identified issues were handled appropriately and measures taken to rectify them.

People were supported to remain safe in their own homes and staff and the provider told us that during their visits to

people's homes, staff carried out visual health and safety checks on the premises. Records showed that staff had referred any dangers to the office and action was taken to resolve these. For example, in one case a staff member had reported that a person had boxes and furniture stacked in their hallway and it was felt that this was a danger to them. The matter had been reported to office staff, who made arrangements to address this with the person and their family. This showed that the provider had systems in place to ensure people's health and welfare.

The provider had many detailed policies and procedures in place covering all aspects of care delivery and any other services that the organisation offered. These gave staff and people a point of reference, and guidance to follow.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements 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      | <p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met: People who use services and others were not protected against the risks associated with records as detailed records about their needs and care and treatment were not maintained. Regulation 17 (1)(2)(c).</p> |