

EcoClean Community Care Limited

EcoClean Community Care

Inspection report

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Date of inspection visit:
17 August 2018
18 August 2018

Date of publication:
11 September 2018

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This was an announced inspection which took place on 17 and 18 August 2018. We gave the provider 24 hours' notice to ensure someone would be available at the office.

EcoClean Community Care is a domiciliary care agency. It provides personal care to older people living in their own houses and flats.

At the time of inspection 17 people were using the service.

At the last inspection in August 2017 the service was not meeting all of the legal requirements with regard to regulation 17, good governance.

Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions needed for governance to at least good.

At this inspection we found some improvements had been made with regard to the breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the service was still in breach of this regulation 17 as other improvements with regard to governance were required. Breaches of regulation 9, person-centred care and regulation 18 staffing were also made at this inspection.

You can see what action we told the provider to take at the back of the full version of the report.

This is the first time the service has been rated Requires Improvement.

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

Improvements had been made and the provider undertook some audits to check on the quality of care provided. However, more frequent audits were required.

People and their relatives told us they felt safe using the service and they trusted the workers who supported them. However, some aspects of service delivery required strengthening to ensure people were kept safe.

People mostly received their medicines in a safe way. However, we identified more frequent audits of medicines management was required to ensure all people received their prescribed medicines.

Improvements were required to staffing capacity to ensure sufficient staff were employed to provide safe, consistent and flexible care to people. Improvements were required to the provider's recruitment process to

minimise the risk of unsuitable staff being employed.

There was communication between people, relatives and the service to try to ensure relevant people were kept up-to-date about people's care and support needs. However, improvements were required to ensure people's care was co-ordinated effectively by the agency.

Initial assessments of people's needs took place when people started to use the agency but a system of review was required to ensure they continued to identify any current risk to people. Care plans were in place for some needs but they did not provide guidance for how people were to be supported to ensure consistency of care. Care plans did not show evidence of regular review or review as people's needs changed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible, the policies and systems in the service were not available to support this practice. Staff had some understanding of best interest decision making, when people were unable to make decisions themselves. People were not kept involved in decisions about their care. Staff had not all received training about the Mental Capacity Act 2005.

People did not have the opportunity to give their views about the service. There was consultation with staff, family members and friends and their views were used to improve the service.

People did not receive an accessible information pack when they started to use the service that gave them information about the service and informed them about their rights.

Staff had received training about safe working practices. Staff received limited opportunities for training to give them more insight into people's care needs. Informal supervisions took place with staff to support them in their role, a formal system was not in place.

Staff were aware of people's nutritional needs and made sure they were supported with eating and drinking where necessary. People were supported to attend medical appointments if necessary to ensure their health needs were met.

People, relatives and staff said the registered manager and management team were supportive and approachable.

A complaints procedure was available and people we spoke with said they knew how to complain if they needed to or bring any concerns to the registered manager's attention.

People and relatives told us staff were kind and caring as they carried out their role. People's privacy and dignity were respected.

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 not always safe.

Staffing capacity was not currently flexible and responsive to meet people's needs and providing consistency of care. Vetting procedures needed to be more robust to protect people from possible abuse.

Improvements were required to medicines management to ensure more frequent auditing of medicines records to ensure people received their prescribed medicines.

Staff said they would be able to identify any instances of possible abuse and would report any that occurred.

Requires Improvement



Is the service effective?

The service was not always effective.

Staff did not all receive training appropriate to their role and a record was not available to show that supervisions took place to support staff in their role.

People received food and drink to meet their needs.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

Staff liaised with General Practitioners and other health care professionals to make sure people's care and treatment needs were met.

Requires Improvement



Is the service caring?

The service was not always caring.

Regular staff were aware of people's individual needs, backgrounds and personalities. Records were not available for staff who did not know the person to provide person-centred

Requires Improvement



care.

Accessible information was not available for people to inform them of how the service operated and to inform them of their rights.

People and their relatives said the staff team were compassionate, kind and cheerful. Good relationships existed and staff met people's needs in a sensitive way that respected people's privacy and dignity.

Is the service responsive?

The service was not always responsive.

Care records were in place but some improvements were required to ensure they reflected the care provided by staff.

End-of-life care arrangements and people's spiritual wishes, if any were required at this time, were not recorded.

People were supported to access the community and follow their interests and hobbies.

People had information to help them complain. A complaints procedure was available that detailed how complaints would be dealt with.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Efforts had been made by the provider to work towards achieving compliance with the regulations since the last inspection. However, we considered further improvements were required with regard to governance to ensure people received safe, effective and person-centred care.

People and relatives told us the provider was supportive and could be approached for advice and information.

Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

Requires Improvement ●

EcoClean Community Care

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 17 and 18 August 2018 and was announced.

We gave the provider 24 hours' notice to ensure someone would be available at the office.

We carried out a site visit on the first day of inspection and carried out telephone interviews with people who used the service, relatives and staff on the second day.

The inspection was carried out by one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the Local Authorities who contracted people's care and the local authority safeguarding team.

During the inspection, we spoke with the provider and two senior care workers. We reviewed a range of records about people's care and how the service was managed. We looked at care records for five people, recruitment, training and induction records for five staff, staffing rosters, staff meeting minutes and quality assurance audits that had been completed. After the site visit we telephoned five people who used the service, four relatives and three staff.

Is the service safe?

Our findings

People told us they were safe with staff support. One person commented, "Yes, I feel safe with the staff." One relative commented, "I do think [Name] is safe, the manager carried out a safety inspection before the service started" and "I was very impressed when there was heavy snow the manager went themselves to calls to ensure people were alright."

Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed in the handling and administration of medicines. One staff member told us, "I did medicines training and was then observed by the registered manager and other staff to make sure I was competent." Staff had access to a set of policies and procedures to guide their practice. We discussed the frequency of medicines audits as deficits in the recording of people's medicines had been identified by recent safeguarding investigations. We were informed that the three-monthly spot check that took place in people's houses checked the medicines management and Medicine Administration Records(MAR)s. A more regular audit of MAR charts should take place to ensure people received their medicines safely and to identify any gaps or errors in staff recording when administering medicines. We were informed by the provider that this would be addressed and the new electronic 'nurse buddy' system could be used to audit medicines more frequently.

A robust system to recruit people safely was not in place. There were areas that required improvement. Checks were carried out of applicants for most roles. Photographs and proof of identity, criminal history checks, and references from prior employers, job histories and health declarations were available for most staff. We discussed the need for a criminal history check for the person who carried out some maintenance on behalf of the service in people's houses as this had not been done. The provider informed us this had already been identified by safeguarding and was being addressed. References provided for staff were telephone references and written references were not available except information that had been transcribed from telephone references. We discussed the need to ensure that written references were obtained from referees. Interview notes showed the provider interviewed prospective workers. At least two members of staff should be involved in face-to-face interviews to ensure a fair process was followed. The provider told us that this would be addressed as a member of staff responsible for human resources and carrying out audits had been employed and they would be involved in interviewing in the future.

People and relatives told us the staff were usually on time and they were informed if a visit may be delayed. People said staff stayed for the appropriate and expected length of time each time they visited. The service used a computer-based system for monitoring visits and to ensure no calls were missed. Staff had mobile telephones with an application they used to report when they arrived at and left people's homes.

People and relatives commented the person did not always receive the same staff members to provide consistency and continuity of care to people. One person told us, "Staff keep changing. You get to know one person and then they are changed." Relative's comments included, "It would be so helpful if [Name] had regular care workers for consistency" and "[Name] misses the continuity of staff." One staff member told us, "I have been supporting the same people at all my calls today. We try to keep the same carer to provide

consistency of care for people who live with dementia." However, we considered this consistency should be available for all people, wherever possible.

Improvements were required to staffing capacity to ensure flexible, reliable and responsive care was provided to meet people's needs. The service provided support to 17 people and at the time of inspection five care workers were employed, three senior office based care workers and the registered manager. The registered manager told us they and office staff also provided direct care and support when the service was busy. The service currently provides care until 6:00pm. Comments from some relatives expressed some disquiet that the service only provided support until this time as a later call was not available. The provider told us later calls were planned and two additional care workers had been recruited and they were being vetted, more staff would therefore be available to provide some flexibility.

Cover for absence was provided by existing staff and the management team and external agencies were not used. There were on-call arrangements outside of office hours to provide telephone advice to staff if required.

Staff had undertaken some safeguarding training about how to recognise and respond to any concerns. This training did not include the local authority multi-agency training to make staff aware of the role of the different stakeholders. The registered manager told us this was being addressed and liaison was taking place with the local authority safe guarding team. Staff were able to describe the appropriate steps they would take if they were worried about people's safety or wellbeing. One staff member said, "I would report any concerns to the registered manager or the office staff." Safeguarding records showed referrals had been made to the local authority safeguarding team, and investigations had been undertaken where necessary. At the time of inspection four safeguarding's were being investigated.

Assessments were undertaken to assess any risks to people who received a service and to the workers who supported them when the person started to use the service. This included environmental risks and any risks due to the health and support needs of the person. Risk assessments included information about action to be taken to minimise the chance of harm occurring. However, there was not a formalised system of re-assessment by the agency to check people were still being supported safely.

Staff confirmed they had the equipment they needed to do their job safely. They were provided with protective clothing and had completed training in infection control, having access to gloves and aprons.

On-site supervisions checked that staff referred to risk assessments. They also checked staff prevented infection through good hand hygiene and use of disposable gloves.

Staff had guidance to follow about adhering to professional boundaries, gifts and the handling of people's money. Any support people needed with their finances was assessed. Transactions by staff, mainly shopping on people's behalf, were recorded and backed by receipts. Checks of the records were carried out by management.

Regular analysis of incidents and accidents took place. The provider told us accidents and incidents were monitored. Individual incidents were analysed and a monthly analysis was carried out to look for any trends. They told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring.

Is the service effective?

Our findings

Staff had received training about safe working practices when they began working with the service. A programme of training was not in place to ensure all staff received training to give them more awareness of the needs of some people whom they may support.

The staff training matrix did not show that staff had received training in areas of care such as dementia care, positive behaviour support and mental capacity and best interests decision making.

Staff and the provider told us staff were supported to carry out their role with informal supervisions. However, they were not documented and information about how often they took place was not available. Evidence was not available to show that staff had the opportunity to discuss training, development and their work performance on an individual basis. A record was not available that recorded areas discussed. A schedule of supervisions was not available to show that they had taken place or that they were planned to take place. One staff member told us, "I am very interested in the social side of care to try to reduce the isolation of people who live on their own. When we talked about it the provider asked me to do some research about day centre provision."

Staff did not receive appropriate training and support to assist them in their role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff told us when they began working at the service they completed an induction and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member commented, "I spent time shadowing the registered manager and other staff in people's homes when I started." Staff told us induction included information about the agency and training for their role. The provider told us staff were to study for the Care Certificate as part of staff induction to increase their skills and knowledge in how to support people with their care needs. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.)

A staff member commented, "I did all the required training as part of my induction." Another staff member said, "We do get quite a lot of training to help you with the job. I want to do a course about dementia care. There are plans for staff to specialise in different areas of interest." Another staff member told us they had received training about mental capacity. However, not all staff had received training to ensure they were aware of the different care and support needs of people.

A system for annual appraisals of staff performance and development was in place. One staff member told us, "I have recently had an appraisal with [Name]." Staff did tell us they could approach the manager and co-ordinators in the service at any time to discuss any issues.

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.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The provider was aware of where relatives were lawfully acting on behalf of people using the service. Such as where they had a deputy appointed by the Court of Protection to be responsible for decisions with regard to their care and welfare and finances when the person no longer had mental capacity.

Records showed that people signed their contract for care with the agency. For people who did not have the mental capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. People told us care workers always asked their permission before acting and checked they were happy with the care that was provided.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

Staff assisted people with their dietary requirements and, where needed, helped with food shopping and preparing meals, snacks and drinks. The registered manager told us of plans to promote healthy eating with all people. Staff cooked a meal for people rather than using ready meals, where people consented. One staff member told us, "I have time at the call to make the meal and while it is cooking I can spend time talking to the person."

People were supported to access other healthcare services in order to maintain good health. Health care needs were met through people's GP and the district nurses if any treatment was required. One relative told us, "Staff will take [Name] to the GP." Another relative commented, "They are very good at keeping us informed about [Name]'s health." Another relative said, "They keep us informed."

People told us they could contact the office if they needed to. They said communication from the office was organised. One relative told us, "We have put pre-programmed telephone numbers in [Name]'s telephone so they can contact the office." A staff member commented, "Now we have office staff communication is better." Another staff member described the electronic system that staff and relatives had access to that recorded information about people's needs. The staff member said, "Communication is effective. With the electronic system we can use 'pin it' notes and leave messages for each other. For example, a person needed some more apple juice and I left a pin note for the next support worker to take some in on their next call."

Relatives had access to the electronic records and the provider planned that relatives would be able to use the 'Pin it' note system to communicate with the agency.

Is the service caring?

Our findings

We had concerns systems were not all in place for people to receive person-centred care and to ensure that they were at the centre of service delivery with their views all being taken into account.

The culture of the service did not promote person-centred care, for each individual to receive care in the way they wanted. Information was not always available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. Improvements were required to evidence that all people were encouraged to retain control in their life and be involved in daily decision making, whatever the level of need. This was also corroborated in the analysis of the last provider survey responses which showed that some people and relative's did not feel involved or listened to. One relative commented, "Staff talk over [Name] as if they aren't in the room."

The service had policies on data protection, confidentiality and obtained people's consent for sharing their personal information. Paper records were held in the person's home, currently readily available to the person and relevant staff, and were kept up-to-date. However, they were being transferred to an electronic system and would not be accessible to the person. We discussed this with the provider in terms of the need to balance confidentiality with the rights of people to view their own records.

People were not provided with an informative welcome pack about the service that was available in larger print, in audio form or translated into different languages, if required. People were given contact details for the service. Immediately after the inspection we received a written service user-guide that was to be made available for people at the start of the service.

People's individual communication needs were assessed taking account of any sensory loss. However, these needs were not care planned. We discussed this with the provider who told us it would be addressed.

Information was not available in sufficient detail to provide person-centred care to people. People's care records did not all contain information about people's likes, dislikes and preferred routines. They did not provide information of how the person wanted to be supported, if they were not able to fully inform staff of their preferences. For some people we noted relatives had provided a very detailed account of the person's daily routine and their dietary preferences to ensure care was provided in the way the person wanted. However, the service did not routinely collect detailed information for people to ensure person-centred care was provided unless the relative volunteered it. Regular carers knew people's care and support needs but there had been concerns expressed about lack of continuity of carers and detailed records were not available to ensure people received consistent and individualised care.

People were encouraged to make some choices about their day-to-day lives and they were involved in some aspects of decision making about their care. However, evidence was not available to show that people were involved in developing their care and support plan and identifying the support they required from the service and how this was to be carried out. It was also of concern that people who used the service were not included and surveyed about their views about care provision in the last provider survey carried out in 2017.

Information was collected from relatives, friends and staff about the quality of service provision.

Records provided some guidance for staff about people's choices in daily living such as rising and retiring routine and what to eat. For example, "I will prepare a sandwich in the morning and cook tea in the evening", "I usually get up early in the morning" and "[Name] often reads two newspapers a day." However, information was not available for all people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People and relative's were complimentary about the kind and caring nature of the staff team. Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. People and their relatives told us the staff and management were supportive and spent time engaging with them.

One person told us, "The staff are very good. They are kind." Other people's comments included, "The staff are fine, I am well-looked after", "I get different care workers to visit me but they are very good", "Staff are introduced before they provide support to me" and "The registered manager is very caring." One relative commented, "[Name] gets a team of about four regular care workers, that they know."

Staff were given training in equality and diversity to help them recognise the importance of treating people as unique individuals with different and diverse needs. Staff we spoke with had a good knowledge of the people they supported.

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the service any issues or concerns. This sometimes led to a more formal advocacy arrangement being put in place with external advocacy services. Advocates can present the views for people who are not able to express their wishes.

Is the service responsive?

Our findings

Records did not all reflect people's care and support needs. Limited information was available for staff to ensure staff provided consistent care to people. A system of regular care reviews and meetings with people and relatives did not take place to ensure the care being delivered met people's needs and included their preferences.

People who were using the service were known to the provider as they received a cleaning service from the provider's cleaning company. When they required support with care the provider's care organisation provided this support as the provider maintained it provided continuity and staff and people knew each other. The registered manager told us, "Cleaners look for signs to see if any care support is needed."

Before people started to use the care service a care needs assessment was carried out by the provider or senior care worker. From the information outlined in these assessments individual care plans were put in place. However, there was a reliance on 'pin it' notes and information passed verbally between staff to ensure people were receiving appropriate care. This was in the absence of information being available for staff in people's care plans that detailed how they wanted to be supported.

Improvements were needed in the co-ordination of service provision. The detailed information that was available about some people's care requirements and needs had been supplied by relatives, this information was not available for all people. There was a reliance on relatives being pro-active and them trying to ensure the most up-to-date information was available. This was in place of the service seeking and obtaining this information through regular re-evaluations of assessments and care plans and carrying out a re-assessment of a person after a change in circumstances.

Some care plans were in place that covered a range of areas including, diet and nutrition, personal care and managing medicines. One medicine's care plan documented, "Collect new supplies of medicines from the pharmacist and inform them not to post through the door." However, information in care plans was vague and did not provide staff with guidance of how the care was to be delivered to the person in the way they wanted and that promoted their independence. Care plans were not person-centred and detailed to guide staff's care practice. For example, one care plan stated, "[Name] may need help with washing clothes."

The provider and some relatives told us some people became distressed and agitated and refused some support with aspects of their care. Care plans were not in place to provide guidance for staff to recognise triggers when people may become agitated or how to de-escalate a situation when a person may become distressed, reducing their anxiety. Care plans also did not detail instructions of how the person may like their care delivered in a way that may reduce their anxiety and ensured all staff provided consistent care.

Records showed that care plans and risk assessments did not show they were all regularly evaluated to ensure they accurately reflected people's current care and support needs. The provider told us they were to be evaluated monthly or as people's needs changed. People and relatives told us their care could be changed if they needed it to be. They told us they were involved in discussions about their care and support

needs. One relative said, "The manager came to meet with us when [Name] came from hospital and we discussed the need to increase the support for [Name] so we have increased the number of care calls each day." A system of regular review and meetings involving relevant people was not in place for all people to check the service was still meeting people's care and support needs. One relative commented, "I have not been involved in care reviews." Another relative told us, "I have not been asked to a care meeting to review [Name]'s care needs."

Information had been gathered for some people to inform staff about people's social interests. For example, one record stated, "[Name] loves reading but due to their limited mobility they have been unable to buy books and would need support to maintain this hobby." However, a care plan was not in place to document how they could be supported to buy books.

The provider told us the service at times provided care at the end of people's lives. More time and greater flexibility with staffing was arranged to make sure the person was comfortable and their family was given support. Staff usually worked with community nurses. We advised it would be beneficial to capture the person's wishes about their end-of-life care whilst they were still able. Where applicable, people's instructions not to be resuscitated were in place.

Records did not provide guidance and were not up-to-date to ensure that people received care that met all of their needs. We had received some comments from people and relatives that staff did not always deliver care in line with their preferences.

This was a breach of Regulations 9 and 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff supported people to access the community as part of their care and support. One relative told us, "Care workers will take [Name] out for meals." The care worker for the person also stated the person used to enjoy attending a local drop in centre, where the service was based. They told us, "I hope to support [Name] to come with me to the drop in centre, if their confidence increases." Other people were supported by staff to shop and visit places of interest to the person. One relative told us, "Staff take [Name] for a short walk every day."

People and relatives we spoke with did not express any concerns or complaints to us. Any concerns that were mentioned by people and relatives had been raised with the provider. Everyone felt listened to and said the provider was receptive and responsive to any concerns. We looked at the provider's complaints over the last 12 months and found that no complaints had been received. One person commented, "I'm quite happy with the service, I have no problems with EcoClean." Another person said, "They [the service] do alright for me, I have no complaints." Other people's comments included, "I have no complaints. I can telephone the office if I needed to."

Is the service well-led?

Our findings

Some improvements had been made to service provision and aspects of governance since the last inspection. However, further improvements were required in governance as the auditing processes were not robust. The provider had not identified areas highlighted throughout the report such as deficits in staff training, staffing capacity, staff supervision, care records, information for people who used the service, co-ordination of care, system of regular review of people's care and support needs, vetting procedures and the frequency of audits and consultation with people who used the service.

We discussed with the provider the need for other audits to take place. For example, medicines records (MAR)s and daily accountability records, needed more regular checking to ensure records had been completed, that records were professionally recorded and provided an accurate account of care provided to people. Audits to check on staff training, personnel records, care records, infection control, nutrition, falls and mobility, health and safety and accidents and incidents also needed to be in place.

Care records needed to be audited more frequently to ensure the quality of recording and to ensure they were up-to-date. Staff training also required more regular auditing to ensure staff were completing the required training and other training that was provided. A system of formal supervision needed to be introduced.

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

The provider had been responsive since the last inspection and made some improvements. They had employed three senior staff to be responsible for different aspects of service delivery. An electronic system had been introduced to help ensure compliance and paper records were being transferred to this system. A human resource, employment company had been hired to advise about aspects of employment and to review all the policies and procedures to ensure they provided guidance for staff.

Some auditing and governance processes were now in place to check the quality of care provided and to keep people safe. A three-monthly spot check visit to people was carried out to check care records that were kept in people's houses. Staff were also observed as part of the spot check as they supported people, feedback was obtained from people and a form was completed that showed results and if any areas were identified for improvement. Identified areas were followed up.

The provider now monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to relatives, friends and staff. However, crucially people who used the service were not surveyed and asked for their views. Results were available from a survey carried out in November 2017 that had been analysed and showed that the provider wanted to make improvements to the survey to encourage more responses. There were positive comments from the majority of respondents and an action plan had been put in place where any issues required addressing.

The registered manager and senior support workers assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and was open to working with us in a co-operative and transparent way.

The atmosphere in the service was friendly. Staff and people we spoke with were positive about their management and had respect for them. Staff said they felt well-supported and they told us they worked as a team. One relative told us, "The manager is very approachable." Another relative commented, "The manager turns up from time-to-time to chat with [Name], they do get on with the manager."

Some relatives commented the service was very caring but organisationally things could be improved. Staff said now staff with specific responsibilities had been employed in the office organisationally improvements were being made. One staff member commented, "It is easier now there are office staff. "

Staff told us and minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. One staff member commented, "Staff meetings happen in the evening so more people can attend." Another staff member told us, "Meetings do take place quite often."

Most people and relatives stated improvements had been made in communication now the electronic system was in place for staff to leave 'pin it' notes in people's care records.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The culture of the service did not promote person-centred care, for each individual to receive care in the way they wanted. Information was not always available to help staff provide care the way the person may want, if they could not verbally tell staff themselves.</p> <p>Regulation 9(1)(3)(a)(b)(c)(f)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>People were not protected from the risk of inappropriate and person-centred care due to a lack of information or failure to maintain accurate records. Robust systems were not in place to monitor the quality of care provided.</p> <p>Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>Staff did not all receive appropriate training and supervision to give them more insight into people's care and support needs and to ensure their competence was maintained.</p> <p>Regulation 18(1)(2)(a)</p>

