BMBC Services Limited

Barnsley Council Home Assessment and Re-ablement Team

Inspection report

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Date of inspection visit:
19 September 2017

Date of publication:
15 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Barnsley Council Home Assessment and Re-ablement Team took place on 19 September 2017. We previously inspected the service on 3 September 2013, the service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Barnsley Council Home Assessment and Re-ablement Team is registered to provide personal care for people who require support in their own homes following a period of illness so they may continue to live independently. The service provides support for people until they gain independence or for a maximum of six weeks, after which support may be needed from a more long term service. At the time of the inspection 55 people were receiving care and support from the service.

The service had a registered manager in place. 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.

People told us they felt safe. Staff had received training in safeguarding and were aware of the different types of abuse and their responsibility in reporting any concerns. Relevant risk assessments were completed when people began receiving the service.

The registered manager followed safe recruitment procedures. The staff worked in teams based on geographical location and both staff and people told us staff were on time and calls were not missed.

There were systems in place to reduce the risk of errors being made where staff were required to support a person with their medicines. However, we were not able to evidence all staff had received a recent assessment of their competency to administer medicines. We have made a recommendation about medicines management.

Although staff told us they felt supported and received regular training and supervision we identified that not all training was current and we saw in one team, only 13 of the 26 staff had received supervision during 2017.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice, however; not all staff understood the principles of the Mental Capacity Act 20015. We have made a recommendation regarding this.

People were able to access relevant healthcare professionals in a timely manner; this helped to ensure the re-ablement process was effective.

Staff were caring and kind. People told us staff offered them choices and respected their right to privacy. Staff were clear their role was to re-able people and not to complete all their tasks on the person's behalf. Staff supported people to regain a degree of independence for example to make drinks and simple meals.

People told us they had been involved in the development of their re-ablement plan. Referrals for the service were received from a variety of sources and there was a triage system in place to manage them. Re-ablement plans included a record of the goals people wanted to achieve and the progress they had made. A record was made by support staff when they attended people's calls, although these were not always returned to the service when the support package ended.

People we spoke with told us they were happy with the service they had received. There was a complaints procedure in place and the registered manager told us they were currently investigating one formal complaint.

Staff were clear about their roles and responsibilities. Regular staff meetings were held and feedback was gained from people who used the service. The current systems of governance were not sufficient to ensure all aspects of the service were safe and effective. We have made a recommendation about systems of governance.

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.

Not all staff had received a recent check on their competency to administer people's medicines.

Relevant risk assessments were in place.

People told us staff were on time and did not miss their calls.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff training and supervision was up to date.

Not all staff understood the principles of the Mental Capacity Act.

People were supported to access external health care professionals as required.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

People's privacy and dignity was respected.

Confidential information was not shared inappropriately.

Is the service responsive?

Good

The service was responsive.

The service had a system in place to enable them to prioritise referrals.

Re-ablement plans included a record of the goals people wished to achieve during the period they were receiving support.

There was a system in place to manage complaints.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

Systems of governance were not sufficiently robust.

Regular staff meetings were held.

There were systems in place to seek feedback from people who used the service and from staff.

Barnsley Council Home Assessment and Re-ablement Team

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 19 September 2017 and was announced. The inspection team consisted of two adult social care inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience on this occasion had experience in caring for a person who required support with health and social care.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our visit we spent time looking at seven people's care plans. We also looked at five records relating to

personnel management and various documents relating to the service's quality assurance systems. We spoke with the head of service, the registered manager, the performance manager, three re-ablement managers and a care co-ordinator. Following the inspection we spoke with five support workers on the telephone. We also spoke on the telephone with 33 people who used the service and five relatives of people who used the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "Oh yes, very much. They are like handpicked. They are such nice girls." Another person said, "I feel safe and comfortable with them. We have a chat and they make sure I'm safe. They're always on time."

All the staff we spoke with were able to identify different types of abuse, one member of staff said, "If I thought someone was being taken advantage of, for example, I would tell the office." Another support worker said, "If a family member was taking their money, mental cruelty or if I thought someone was taking advantage of them, or if they didn't have enough food in the house. I would report it straight away to a manager." The registered manager told us all staff had completed safeguarding training and any concerns would be referred to the local authority safeguarding team by one of the office based staff. This demonstrated staff were aware of their responsibilities in identifying potential harm or abuse and any concerns would be reported promptly.

Each of the re-ablement support plans we reviewed contained a generic risk assessment regarding aspects of the person's home. For example, parking, access to the home, gas and electrical safety, pets and trip hazards. The re-ablement support plans recorded the equipment people had in their homes and staff told us if further equipment was needed a referral would be made by a re-ablement manager for a review by a physiotherapist or occupational therapist.

One of the re-ablement plans we reviewed included a moving and handling risk assessment which recorded the equipment and the number of staff the person needed to enable them to mobilise. Having this level of detail recorded, helped to reduce the risk of injury to both staff and the person receiving care and support. Staff told us information regarding people's individual moving and handling needs was recorded within their re-ablement plans. They also told us they had all received training and had many years of experience. One of the staff told us if they were unsure about any aspect of safety regarding a person's moving and handling needs, they were able to contact the physiotherapist or occupational therapist who would visit the person's home to ensure staff were confident in completing this task. This demonstrated staff were provided with adequate information and support to reduce the risk of injury to themselves or the people they were supporting.

Staff we spoke with were clear about what they should do in the event they attended a call and the person had fallen. One staff said, "I would make sure they were safe, then if needed I would call 999, inform their family and report to the office." Staff were also clear about what to do if a person they visited did not answer their door. One of the staff said, "If they had a key safe, I would go into check if they were okay. I would also ring the office and inform them. I would stay initially until the office told me it was okay to go. There is usually a rational explanation for why someone isn't at home." This demonstrated staff knew what was expected of them in these situations.

There had been no new staff employed at the service for over twelve months, therefore we did not check the recruitment practices for new staff. However, we reviewed the process which had been followed when an

existing staff member had applied for an internal post. We saw they had completed an application form and references had been obtained. There was also evidence of a Disclosure and Barring Service check (DBS). The DBS is a national agency that holds information about criminal records. The performance manager told us all DBS checks were routinely renewed and the electronic management system they used would not allow staff to be allocated to calls if their DBS was out of date. This showed there was a system in place to reduce the risk of employing staff who may not be suitable to work with vulnerable people.

People told us staff were usually on time, rarely late and never missed their calls. One person said, "They're on time, when I'm expecting them. They might be five minutes late, but never as much as half an hour." Another person said, "I think they're really good. They're always on time. The carer said she'd come at one o'clock and she did. I've never been left without." A relative told us, "At most, five minutes late. Sometimes, on time."

We spoke to a care co-ordinator who said, "We make sure everyone is in the right place at the right time." They showed us the electronic management system which they used to allocate staff and people's calls. They also showed us how, using the information received throughout the day from staffs' hand held electronic devices, office based staff could easily see the calls which had been completed and those which staff were still to attend. They told us staff were split into teams of three and this was based on geographical location, to reduce travel time and improve efficiency. The care co-ordinator told us a re-ablement manager visited each person on a weekly basis for the timeframe in which they were receiving support. They explained that after each visit, the re-ablement manager notified them of any changes to the scheduled calls, for example a reduction or increase in the number of scheduled calls per day, and they adjusted staff rotas accordingly. All of the staff we spoke with felt the system worked well and told us no one had experienced a missed call.

The majority of people we spoke with told us they or their families were responsible for managing their medicines, although two people told us they took their medicines while the staff were present.

Re-ablement plans had a section where the level of medicines support needed could be recorded. Information recorded, included whether the person needed a reminder or assistance to take their medicines, when they needed this, where their medicines were stored, if they were kept in a secure location and the contact details for the dispensing pharmacist. We saw two completed medicine administration records (MARs), one of which had been handwritten and there was no record of the identity of the person who had transcribed it. The other persons MAR was completed and had been signed appropriately by staff.

The registered manager told us medicines were only administered by support staff when they had received up to date information from the persons dispensing pharmacist regarding the medicines the individual was prescribed. Each of the staff we spoke with told us they had completed medicines training. One of the staff told us, "We make sure everything is right, we log everything. There are safeguards in place to reduce errors, such as all the medication has to be dispensed from the chemist." Another member of staff said the district nursing service would support people with their medicines until the relevant documentation was in place for the re-ablement team to be able to provide this service to the person. We asked staff how they knew when and where to apply peoples creams. Staff told us they each had a list which recorded the names of the creams they were allowed to apply, they also said information would be included in people's re-ablement plan.

We saw from the registered manager's training matrix that all staff listed had completed medicines training within the last 18 months. The registered manager told us they aimed to ensure staff had an assessment of their competency to administer medicines completed annually; however, one of the re-ablement managers

we spoke with told us an assessment of their competency had never been completed. We asked to see evidence that all staff had received a recent competency assessment but we were told the re-ablement managers retained this information for their own team of staff. We reviewed the information for one team which listed 26 staff, of which only 17 had received a competency assessment in the previous 16 months. The registered manager told this because at the time of the assessment, they were not supporting anyone with their medicines, however; this meant we could not be assured that all staff were assessed as competent in the event they were required to support someone with medicines management.

The re-ablement service did not have their own medicine policy; they followed Barnsley's Clinical Commissioning Groups' (CCG) Medication Guidelines for Domiciliary Care. The document was dated 21 August 2014 and the review date was recorded as 21 August 2016 but there was no evidence the re-ablement service had received a more recent copy. We also noted the guidelines made no reference to the need for competency checks to be completed on staff. Current NICE (National Institute for clinical Excellence) guidelines, Managing medicines for adults receiving social care in the community, advises staff 'are assessed as competent to give the medicines support being asked of them, including assessment through direct observation' and 'have an annual review of their knowledge, skills and competencies'. We raised the concern regarding the date of the guidelines with the registered manager after the inspection, they assured us they were aware of this and they were currently working in partnership with the CCG to review the guidelines. We recommend the registered manager consider current guidance on administering medicines to people in their own home.

Requires Improvement

Is the service effective?

Our findings

There had been no new staff recently employed at the service. Therefore, we did not review in detail, the induction process. However, the registered manager told us new staff would attend the local authority corporate induction programme as well as complete a period of role specific induction with the re-ablement team. This showed there was a system in place to support new staff in their role.

We saw from the registered manager's training matrix that staff received training in a variety of topics including, moving and handling, food hygiene, emergency aid and infection control. Although the vast majority of training dates were recorded between 2015 and 2017, we did see some staff had not refreshed some training for a significant period of time. For example, of the 54 staff listed, ten staff had not refreshed their emergency aid training since 2013, one staff had not refreshed this since 2011. The matrix recorded three staff did not have moving and handling training and seven staff had not completed food hygiene training. Following the inspection we contacted the registered manager about this. They told us a number of planned training events had been cancelled by the training department, however, a number of staff had been re-booked on training planned for later in 2017. They also clarified that only one of the three staff we had identified on the training matrix did not have up to date moving and handling training. Ensuring staff receive thorough training and regular updates means staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

The registered provider's supervision policy stated that in a 12 month period, support workers should receive an observation and both an annual and six monthly performance review. The registered manager also told us there was a matrix in place to record when staff received their annual performance review (PDR), their supervisions; which were held approximately every three months, and field based observations of their practice. Each of the staff we spoke with told us they felt supported by the management team and they were regularly spot checked and attended office based PDR's. However, we found the records did not clearly evidence this process. When we reviewed the records of four staff we saw each staff member had received a field based spot check within the previous 12 months, but we did not see evidence of one to one management supervision. Following the inspection the registered manager emailed us a spread sheet for one of the staff teams; this listed 26 staff, of whom only 13 had received supervision during 2017. This demonstrated that systems in place were not robust in ensuring staff received ongoing formal supervision to monitor their performance and development needs and ensure they had the skills and competencies to meet people's needs.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. For this type of service any applications to deprive a person of their liberty must be made to the Court of Protection.

The registered manager told us people who used the service had the capacity to make day to day decisions. They said where there were doubts; an assessment of the person's capacity was made prior to the referral or prior to their acceptance of the referral. They explained this was because if a person lacked capacity to make day to day decisions this would impact upon their ability to benefit from the re-ablement programme.

We saw evidence from the training matrix of the 54 staff listed, only four staff had not completed MCA training. However, of the five staff we spoke with on the telephone after the inspection, one was unable to describe any aspect of the MCA and could not recall any relevant training in this subject. Another staff member told us the MCA was about a person's, "Ability to act for themselves", but when asked about 'best interests' decision making, they said, "I've not heard of that." This demonstrated the current training had not been sufficient to ensure staff understood their responsibilities under this legislation.

People told us staff always gained consent before providing any support. One person said, "Yes, they always said: 'Is it ok to do this?' I think they must have been trained very well." Another person told us when we asked if staff gained their consent, "Oh yes, they always do that." Staff also told us they asked people for consent prior to providing support. One staff member said, "I ask, if they say no, I try again but respect their right to say no." This demonstrated staff respected people's right to make their own choices and decisions.

We recommend the registered manager seeks relevant training from a reputable source to ensure all staff understand this legislation.

People told us they were happy with the support they received to enable them to eat and drink. One person told us, "They wash the pots and make me dinner. One makes my bed. They make me a drink. They always ask if I want a drink." Another person commented, "If I haven't done it (prepared a meal) by the time they arrive, they will do it for me."

The registered provider's PIR noted 'Protocols are in place with our partners within the Intermediate Care Pathways where we need to step service users up to other services. Where a service user requires support which is beyond that which can appropriately or safely be provided via the Re-ablement Service we have protocols in place to ensure a seamless transition to alternative more appropriate services'.

All the staff we spoke with told us the re-ablement service worked closely with other healthcare professionals. This included GP's, district nurses, physiotherapists and occupational therapists. We saw evidence of this in the records we reviewed. Staff told us one of the primary aims of the service was to help people regain independence following a period of ill health or after discharge from a hospital stay; the input of other healthcare professionals supported the re-ablement team to function effectively and for people who used the service to gain prompt access to other professionals who may be able to assist them to regain and retain key skills.

Good

Is the service caring?

Our findings

Everyone told us the staff were kind and caring. Comments included; "They are very nice and greet me 'Good morning. They all have been very good"; "They talk to me. We have a laugh. Cheer me up" and "They're nice, caring. They helped to get me back on my feet." A relative commented, "They do those little things, anything she wants, they will do."

People also told us staff routinely offered them choices, for example, what to eat and drink and what to wear. Staff comments included; "We get them involved, we show them what is in the fridge. We never take their independence away from them", "Everyone makes their own choices, they have their own preferences" and "Everything is around what they want. It's quality of life. What they want to do, how they want to do it. We don't judge." Offering people choice and control over their daily lives is a key aspect of maintaining a person's dignity and life skills.

People told us they had been involved in the development of their re-ablement plan. One person told us, "I was involved in my care plan. I said what I wanted." Another person said, "It's my choice to stop them coming every day. Now they just come at breakfast time. It's nice to know they're there if I need it. I've been surprised at how much care I've had. They're nice, caring people." This showed people were supported to express their views and were actively involved in making decisions about their support.

The key focus of the service was to re-able people with the necessary confidence and skills to retain a level of independence. People said, "I'm doing lots of jobs myself now. I have one in a morning. This morning she opened a can for me" and "They make suggestions on how it's easier to do things. It's a really good service. I'm grateful for it."

Staff were clear their role was about helping people to gain independence and not completing tasks for them. One of the staff said, "We have goals to achieve with them; it may be getting up or changing their own pad." The registered manager told us as when a person reached the end of the re-ablement process, which lasted a maximum of six weeks, a decision was made by as to whether the package ended as the person had regained a sufficient level of independence or whether they needed a referral for on-going support from a long term care provider.

People told us staff respected their privacy and dignity. One person said, "Yes, they stay outside when I have a shower. I am independent." Another person commented, "They have helped me with the bath and shower. I do feel that they have treated me with dignity." A relative said, "They asked if they needed to take off their shoes before coming in." Staff we spoke with understood the importance of maintaining people's privacy and dignity and gave examples of how they would implement this, for example, "When the service user has a bath, I close the door, I stand outside and they shout me when they are done. You use a towel to cover them up."

Staff understood the importance of ensuring records and information was stored confidentially. Staff each had a hand held electronic device to enable them to access specific information regarding the people they

were supporting. Staff told us the devices could not be accessed without the individual PIN code and each device 'timed out' after a specific period of inactivity. This helped to reduce the risk of unauthorised access to people's personal information.

Good

Is the service responsive?

Our findings

People told us they had a re-ablement plan in their home. One person said, "Yes, I have seen it. Well set out." Another person said, "I was involved in my care plan. The manager came. We discussed 'achievements'."

The registered manager told us the service took referrals from a variety of sources; these were then triaged using a priority matrix, with hospital discharges taking priority over other referrals. They explained that due to the nature of the support packages they offered, for example, providing urgent support to a person who was being discharged from hospital, sometimes the support staff made the initial calls to the person prior to the re-ablement managers having been out to complete their assessment. The care co-ordinator said when this occurred, the relevant staff would be contacted by telephone to ensure they were informed of all available information regarding the person's needs.

The registered provider's PIR detailed 'We have clear Referral Prioritisation protocols in place which are known and understood by referring agencies with whom we have good working relationships. In the case of Priority 1 referrals for Re-ablement service, we deploy a Re-ablement Manager to undertake assessments and complete a Support Plan within 48 hours of the Referral being accepted. Priority 2 referrals are within 3 to 4 days of receipt, or sooner if capacity allows; and Priority 3 within 3 to 9 days, or sooner if capacity allows'. This showed the service had clear guidelines to ensure referrals were dealt with appropriately.

Each of the re-ablement plans we reviewed contained a copy of the referral paperwork. A goals sheet recorded peoples individual goals, for example, washing, showering and dressing. Each goal included a section which indicated the level of support needed, ranging from being independent to needing the assistance of two staff. Individual's progress in meeting these goals was assessed and logged on a 're-ablement weekly progression report' which was completed by the re-ablement manager during their weekly visit to each person receiving support. A daily record was completed by the staff attending people's individual calls; this noted the date, start and end time and a brief description of the support provided. On one of the daily records we saw, each time a new member of staff completed the call, they recorded they had read the person's goals plan. A service user contact sheet was kept at the office and was used by office based staff to document their input into the care package, including meetings and discussions with the person and or their families.

The care co-ordinator told us, when a package of care ended, the member of staff who completed the final call would collect any relevant documentation form the persons home and return it to the office. A re-ablement officer said records were then checked and archived. Two of the plans we reviewed were for people whose package of care had recently ended. One person had been urgently admitted to hospital and the other person had begun receiving care and support from a long term care provider, but in both cases, no daily records had been returned to the office. The registered manager told us this was due to the nature of the termination of the service, therefore a member of staff had not been able to collect the relevant records form the person's home. However, this meant the service had no record of the support provided by staff on a daily basis, we brought this to the attention of the registered manager at the time of the inspection, they said they would consider how this matter could be addressed in the future.

Most people told us they knew how to complain but no-one raised any concerns or complaints about the service when we spoke with them. One person said, "I know how to complain alright." Another person said, "No, no need to complain, because they're good." Although another person said, "If I had a problem with the carers, I wouldn't know who to call." A relative said, "Yes, I ring the manager up."

There was a system in place to manage complaints. The registered manager told us information on how to complain was provided to people when they began to use the service. They said they were currently dealing with one complaint, but no other formal complaints had been received.

Requires Improvement

Is the service well-led?

Our findings

People said Barnsley Council Home Assessment and Re-ablement Team provided a good service. One person said, "Without it, I wouldn't have made progress." Another person said, "Excellent service." Some of the relatives we spoke with were concerned about the support package ending as they felt their relatives had improved as a consequence of having the support of this specific service on a regular basis.

Each of the support workers we spoke with told us they had been employed at the service for a number of years. They each told us they 'loved their job' and the registered provider was a 'good employer'. One member of staff said, "We have very few new staff, people stick to it, we don't want to leave. We are really well treated."

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

The registered manager told us the organisation had undergone a restructure earlier in 2017 and a new management structure was introduced. They said that since that time the re-ablement managers had been embedding into their changed roles and responsibilities. From our discussions with the re-ablement managers, performance manager, care co-ordinator and support workers, staff were clear about their roles and responsibilities within the organisation.

The performance manager gathered a variety of information about the service to enable the registered provider to monitor the service they provided. This included analysis of the source of referrals, the reason the support package ended, the length of the support package received and the final outcome, for example, package ended or transfer to a long term care provider. This enabled the registered provider to review the effectiveness of the service they provided to people.

We asked the head of service how they monitored the performance of the registered manager. They told us this was done through management meetings, reviews of the service performance statistics and service user feedback. Risk management and health and safety meetings were held monthly by senior managers and included the head of service and registered manager. The head of service told us topics covered included incidents and investigations and CQC inspections. We reviewed the meeting minutes dated 24 July 2017 which detailed the topics discussed and the staff responsible for implementing the required actions.

A record keeping audit had been completed in July 2017. This identified a number of areas where improvement was needed to the records made by the re-ablement managers, including recording allergies and dating alterations to records. We were unable to identify an action plan regarding the highlighted concerns. When we raised this with the registered manager they told us it was to be discussed at the next monthly re-ablement managers meeting. Following the inspection, they emailed us a copy of a re-ablement managers meeting dated 1 August 2017 which evidenced the findings of the audit had been shared.

The registered manager told us each Monday a meeting was held in the office to review the weekend activities and the on-call log. A case review meeting was also held each Wednesday involving the registered manager and the re-ablement managers. Support workers also told us monthly meetings were held where updates and information was shared amongst staff. Meetings are an important part of a registered manager's responsibility to ensure information is communicated to staff appropriately and to come to informed views about the service.

The registered manager told us each person who used the service received a quality assurance survey; they said they reviewed each returned survey. Due to the nature of the service provided, these were sent to people throughout the year and therefore no formal analysis had been completed, although all comments received were recorded on a spreadsheet for ease of reference. We reviewed 101 completed surveys dated between January and September 2017. All the comments were positive and there were no negative scores. Comments included; 'the support and care has been fantastic', 'made me feel comfortable and confident' and 'nothing too much trouble'.

We saw there was a range of policies in place which could be accessed via the registered provider's intranet service. The registered providers PIR noted 'The Service adheres to Barnsley MBC policies and procedures in all matters including, for example: Health and Safety, Employment, Codes of Conduct, Recruitment and Selection Information Security, Attendance and Disciplinary procedures, and Equality and Diversity'. However, as evidenced earlier in this report we found that not all polices had been reviewed within the timeframes specified by the registered provider. Having up to date policies provides staff with relevant guidance in line with current legislation and good practice.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents and changes to the service. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

During this inspection, as evidenced within this report there were a number of areas where improvements were needed, for example, medicines competency assessment, staff training and supervision. Although it was clear the registered provider had systems of governance in place, these had not been effective in highlighting these issues. We recommend the registered manager seeks guidance from a reputable source regarding effective systems of governance to ensure people consistently receive a high quality, safe and effective service.

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 18 HSCA RA Regulations 2014 Staffing Staff had not all received supervision and training.