Nestor Primecare Services Limited

Allied Healthcare - Middlesbrough

Inspection report

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Date of inspection visit:
28 January 2016
18 February 2016
29 February 2016

Date of publication:
27 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 January 2016 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 to assist us. Further visits took place on 18 February and 29 February 2016, and these were announced.

Allied Healthcare Middlesbrough is a domiciliary care service which provides personal care to people in their own homes. The service supports people in the Middlesbrough area. At the time of the inspection 260 people were using the service.

The service had a registered manager. 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.

Risk assessments and care plans were not always regularly reviewed to ensure they met people's current needs.
People's consent to care was not always recorded on their care plan.

Procedures were in place to reduce the risk of safeguarding incidents occurring, and staff could discuss the types of abuses that can occur and how they would respond if they had concerns.

Staff told us there were enough staff to support people safely. People said their care teams were stable which meant they were supported by staff they knew.

A number of checks were carried out before staff were employed to ensure they were suitable to work with vulnerable people.

People were supported to safely manage their medicines. People were responsible for ordering their own medicines, but staff assisted some people with administration. Where this was done, staff understood how to gain people's consent and accurately record administration.

Staff received training in a number of areas that they thought helped them to support people effectively. Staff felt confident to request any additional or specialist training.

Staff were supported in regular supervisions and appraisals, and felt they could raise any issues or support needs they had.

Some people received support with food and nutrition, and where this was done they said they always had a choice of what they wanted to eat. People's meals were recorded so that, if necessary, their food intake could be monitored.

People were supported to maintain and promote their health and wellbeing by accessing external professionals. The registered manager and staff were able to describe how people could be supported to access specialist services if required.

People and their relatives said staff maintained their dignity and treated them with respect. They said staff delivered support in a kind and caring way, and talked about the positive impact this had on their lives. People said staff helped them to maintain their independence.

No one at the service was using an advocate, but the registered manager was able to describe how this would be arranged if needed.

People and their relatives were involved in planning their own care, and felt they had a say in how care was delivered.

Some people received support with social activities, and where this was the case care plans contained details on how this could best be carried out.

There was a complaints policy in place, and where issues had been raised they had been investigated and outcomes sent to the people involved.

Quality assurance checks were carried out, though these did not always take place as regularly as staff told us they should.

People and staff said they were asked for feedback on the service, though we did not see any records in relation to this.

Staff felt supported by the registered manager, who they described as approachable and helpful. Staff and the registered manager understood their role and responsibilities.

There were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and good governance. You can see what action we took at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were assessed but not regularly reviewed.

People were supported by staff who had been appropriately recruited and inducted.

People were supported to manage their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent to care was not always properly recorded in their care plans.

Staff received training to ensure that they could appropriately support people.

Staff felt supported through supervisions and appraisals.

The service supported people to access external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People and their relatives said staff maintained their dignity and treated them with respect.

People and their relatives said staff were kind and caring.

Procedures were in place to support people to access advocacy services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were involved in planning their own

care, and felt they had a say in how care was delivered. However, reviews of care plans did not always take place.

Some people received support with social activities, and where this was the case care plans contained details on how this could best be carried out.

There was a complaints policy in place. Issues raised had been investigated and outcomes sent to those involved.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance checks were carried out, though these did not always take place as regularly as staff told us they should.

People and staff said they were asked for feedback on the service, though we did not see any records in relation to this.

Staff felt supported by the registered manager. Staff and the registered manager understood their role and responsibilities.

Allied Healthcare - Middlesbrough

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 28 January 2016 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 to assist us. Further visits took place on 18 February and 29 February 2016, and these were announced.

The inspection team consisted of one adult social care inspector and one specialist professional advisor. A specialist professional advisor is someone who has a specialism in the service being inspected, such as a nurse.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the commissioners of the relevant local authorities and clinical commissioning group, and the local authority safeguarding team to gain their views of the service provided by Allied Healthcare Middlesbrough.

During the inspection we spoke with 11 people who used the service. We spoke with four relatives of people who use the service. We looked at 11 care plans, medicine administration records (MARs) and handover sheers. We spoke with 10 members of staff including the registered manager, a care co-ordinator, a senior carer, the training manager and care staff. We looked at five staff files, which included recruitment records.

Requires Improvement

Is the service safe?

Our findings

Risks to people arising out of their environment or personal circumstances were reviewed and care plans were put in place to minimise them. Assessments were undertaken in areas including pressure area risk, health and hygiene, food hygiene, manual handling, financial safeguarding and internal and external risk. Where risks were identified, a care plan was put in place to minimise them. For example, one person was identified as being risk of falls. This led to a plan of care that included using support and mobility equipment.

However, risk assessments were not regularly reviewed. Most of the risk assessments we looked at took place in 2014, and some in 2013. There was no record of whether the risks to people using the service had changed. We asked the registered manager how often care plans were reviewed. They said, "if there's a change need the senior [carer] would go out. There's no maximum or minimum period, just as and when." The registered manager also said that the service was moving care plans onto the registered provider's electronic system, and there were plans to renew all risk assessments as this was being done. There was no time frame for doing this. This meant that risks to people using the service were not regularly assessed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff how they kept people safe in their own homes. One said, "If I saw a problem or a risk like a trip hazard, I would ask the person if they were aware of it and log it. I would involve the person's family." Another told us how they helped to support people to take risks and maintain their independence in a safe way. They said, "If someone wanted to do something that was risky I would highlight the problems and ask if they really wanted to do it. I know the people I support really well. I would advise them." Another member of staff said, "We let people take risks. It's about them. If I thought it was a bad risk I would report it to the office, but it's their choice."

People said that care staff kept them safe. One said, "I certainly feel safe." Another said, "I am safe around them." Another person said, "I feel safe. They stop me having accidents. I am a bit clumsy sometimes."

Staff told us that they had access to any personal protective equipment (PPE) they needed to support people safely, which helped to promote infection control. Stocks of this were available in the service's office, and staff had easy access to it whenever they attended.

Safeguarding procedures were in place to reduce the risk of abuse occurring. The service had a safeguarding policy, which contained guidance on the types of abuse that can occur, indicative signs to look out for and procedures to follow if concerns arose. Where issues had been raised, investigations had taken place and people informed of the outcome. Staff were able to describe the types of abuse that could arise and said they would be confident to raise any concerns. One staff member said, "If I had any concerns I would contact my line manager, [the registered manager] or higher up." Another said, "I look for changes in mood, see if there are any changes. I work with the same people every day and know if something is wrong."

There were no recorded accidents at the service. The registered manager said that if an accident occurred, a record would be entered on the registered provider's electronic record system and an investigation would take place. If numerous accidents occurred, the registered manager said they would monitor them for trends and take any necessary remedial action.

Some people received support with their medicines as part of their care. There was a medicines policy in place, which contained comprehensive guidance to staff on how support should be delivered. People were responsible for ordering their own medicines, and these were delivered to them at home. Where the staff assisted people in administering their medicines a medicine administration record (MAR) was used. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. MARs were kept in people's homes, but when they were completed they were returned to the service for storage. We reviewed some of these MARs, and saw that most were fully completed and recorded when medicines had been administered. We did see one MAR with some gaps in administration, and on another it was not clear what one entry said. We asked a senior carer about this, and they said they would investigate.

Staff were able to describe how they supported people with medicines. One said, "I do give medicines, with consent. If people are supported with medicines I [take the medicine from the packet], put it in a glass and provide a glass of water. I then fill in the MAR and document it in the daily log. I also check the MAR to make sure people get the right medicines." Another said, "Medicines are in a pack. We check what the medicine is and what time it is needed. We give the person water but ask if they want it before taking it out of the pack as we can't take it out of they don't. We then record it if it is taken. If people don't want it, we record it. We never force people to take medicines." On the first day of our inspection some staff were present in the office receiving medicines training. During this, we observed that they had knowledge of medicine administration and medicine record keeping. One person who used the service told us that staff were always on time as, "I am on strict medication. They know what they're doing with medicines. They've got proper charts and when I take it they properly record it. It reassures me as I'd normally forget to take them."

Recruitment procedures were in place to minimise the risk of unsuitable staff being employed. Applicants completed an application form requiring them to give details of their educational and employment history, and to explain why they wanted to work in the care profession. References were sought, including from past employers where possible. Disclosure and barring service checks were carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. One member of staff told us, "When I joined everything was done, like references and DBS."

The registered manager monitored staffing levels to ensure they were sufficient to support people. They told us, "We're recruiting all the time. We will get a call from the council saying there is [a person needing the service]. The care co-ordinator whose area it is will know whether we have [enough] staff to [accept the person]." Recruitment was organised centrally by the registered provider, and during the first day of our inspection we saw that two applicants were being interviewed for positions. Staff told us there were enough staff to support people. One said, "I think there are enough staff in my area. If someone is off sick we get a phone call asking if we can cover other calls and it usually gets covered." Another said, "We have enough staff in my area."

People told us their care teams were stable and that they were supported by staff they knew. One said, "They regularly send the same staff. I have one main carer, and the others are very good." Another said, "It's the same [staff] that come in." A relative of a person using the service said, "About six carers go in, the same

[staff]." Another relative said, "They went out of their way to always have the same faces. If someone was off sick, [the replacement] was always someone [my relative] knew." People told us that staff arrived on time, or that if they were running late they called to let them know. One person said, "Sometimes they are a bit late if one is off but if they are late they always let me know." Another said, "They're always on time."

There was a business contingency plan in place to help the service provide a continuity of care in emergency situations that disrupted the office. This contained relevant contact details and information on alternative sites the service could operate from. The registered manager was able to discuss how the service would relocate without disrupting people's care.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. The registered manager said that no one who used the service was subject to any Court of Protection orders. Some people had Lasting Powers of Attorney in place as the local authority managed their finances, and the registered manager said the local authority arranged those orders. Staff had a working knowledge of the principles of the MCA, and were able to describe how it was used to support people who may lack capacity to make decisions. They also said that they did not make assumptions about people's capacity.

None of the people we spoke with said that staff delivered care without their permission. Staff were able to describe how they obtained people's consent. One said, "I ask people for permission and they tell me." Another said, "I always ask for consent."

However, people's consent to care was not always recorded on their care plans. Most of the care plans we looked at were signed, 'UTS, which we were told meant, "unable to sign." However, there was no evidence on the files that the person lacked capacity to sign the care plans themselves. In addition, on one care plan, the person was recorded as understanding the plan and consenting to it but was recorded as being 'unable to sign'. There was no evidence of why the person was unable to sign.

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

Staff received mandatory training in food hygiene, moving and handling, safeguarding, first aid, medicine management, end of life care, behaviours that challenge, fire prevention, health and safety, infection control and hypothermia. Mandatory training is training that the provider thinks is necessary to support people safely. Staff received refresher training in these areas annually. An electronic 'training scheduler' was used to monitor staff training and the registered manager said they checked this to see when refresher training was required. Staff files contained training certificates, which were issued when training was completed.

The registered provider had a training manager and a training team leader, and they arranged training across several of the registered provider's services. The training manager said, "If staff need specialist training, or if people's needs are assessed and extra training would be useful the registered manager would contact my team and raise it. We would then contact other branches and get a [class] together." During the course of the inspection we saw staff receiving training in medicine management, safeguarding and end of life care. The registered manager said they would like to implement the Care Certificate at some stage, though there were no plans in place to do this. The Care Certificate is an identified set of standards that

health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected.

Staff said they received the training they needed to support people effectively. One member of staff said, "I keep up to date with training and we bring own expertise into training as everybody is different. I have done specialist training in PEG as I [supported a person who used it]." PEG is a method of eating that people use when oral intake of food is not possible. Another member of staff said, "We do training in moving and handling, medicines, dementia care and first aid. We come in every three months and speak with [a care co-ordinator]. We can talk about what we want and if we need more training." Another said, "We can't work without the training."

New members of staff completed an induction process before they were allowed to provide care and support to people. This consisted of classroom based training in 'core care skills', medicines, safeguarding, first and nutrition and dementia awareness. Staff then shadowed experienced members of staff before being supervised delivering care themselves. The registered manager said, "They do shadowing for as long as they need it. I wouldn't be happy with them going out if they weren't confident. We get feedback from care co-ordinators. We recently had feedback on [a new member of staff] that we weren't happy about so they didn't start with us."

People who used the service thought that staff had the skills they needed to support them effectively. One said, "They know what they're doing." A relative of a person using the service said, "I think [staff] had enough training. [My relative has] specialist needs, and they totally understood everything needed."

Staff were supported through supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Supervisions took place every three months, and involved staff meeting with a care co-ordinator or the registered manager to discuss the service and any support needs they had. Records confirmed that staff could raise issues at supervisions. For example, in their supervision one member of staff requested specialist training and a plan was put in place to arrange this. Appraisals took place annually. Additionally, spot checks were undertaken to monitor staff competencies when delivering care. These were done randomly, and involved staff being supervised when delivering care. Staff said they could raise any issues of concern at supervisions and appraisals. One said, "We get called in for supervisions and appraisals. If you have any concerns you can speak about it, and they see how things are going." Another said, "I get supervisions and appraisals. It's a one to one with [the registered manager] or the care co-ordinator. You're always asked if you want to raise anything or if you have any issues or concerns."

Some people received support with food and nutrition as part of their care. Where they did, they told us that they received a choice over their meals. One person said, "It's completely up to me what food I want. [Staff] are always happy to cook what I want." Another said, "I get to choose what I eat and drink." Staff explained how they supported people with food and nutrition. One said, "I support people with meals. People decide what they want. Time can be tight but we give people a choice. We used to have a [person] who was on a specialist diet and we recorded what they ate." Daily care notes contained references to the meals people had been supported with. The registered manager said that there was no one using the service who was subject to any specialist dietary needs such as soft or pureed foods, or receiving support from the nutritionist.

The service supported people to access external professionals to maintain and promote their health and wellbeing. Care records contained references to referrals to GPs and district nurses, and the registered manager said the service would work with social services if more complex support was needed such as

interventions from the falls or speech and language therapy team (SALT). A member of staff said, "I make appointments for people with the GP. I always ask if people want me to do it. We also have contact with the district nurse."

Good

Is the service caring?

Our findings

People said that staff maintained their dignity and treated them with respect. One person said, "There's no problem with dignity and respect." Another said, "[Staff] are always polite and pleasant." Another person said, "I don't feel undignified when getting care. They're very professional." Another said, "They're always very polite and always respectful." Another said, "They're all very pleasant and good on respect. They always cover me up and ask for permission to do things, and ask if I need anything. We're on first name terms but they don't take advantage."
A relative told us, "[Staff] are always polite and friendly when they come in." Another relative said, "[Staff] are always respectful when helping [the person] with things like showering."

Staff described how they supported people with dignity and respect. One said, "We close doors and keep [care] private." Another said, "I treat them as if they were part of my family."

People said staff supported them to do things for themselves, which helped them to maintain their independence. One person said they were encouraged to make their own meals, with staff supervising and helping if needed. The person told us, "They sometimes supervise me doing it to get me going. They encourage me to do a lot, which is good." Another person said, "I do things for myself, and they do things if I want them to."

Staff told us how they encouraged people to remain independent. One member of staff said, "You have got to encourage people to do things for themselves. If you do everything you take people's independence away. I always try to encourage people to do things, like helping with personal care and meals." Another said, "I support people's independence by making my presence known and letting people know I am there to help them do things."

People and their relatives said staff delivered support with kindness and care, and spoke positively about the impact this had on their lives. One person said, "They have been brilliant. They keep my life moving." Another said, "I find them excellent. Very, very good. The staff are friendly. We chat about our families. They've got to know my family. They're friendly and professional and I'm happy with them." Another person said, "The carers are very nice, all very nice." Another said, "I am very happy with them. Very pleasant staff." A relative of a person using the service said, "Staff are very nice and helpful. They also have a chat [with the person], which I think is as important as the care."

Relatives of people who could not always communicate said staff found ways of interacting with people, and that this had a positive impact on their care. One said, "[My relative] can't talk but they would have banter with [my relative]. They would howl with laughter with each other, and were really happy. 10 out of 10. Really good." Another relative described how staff communicated with a person who could not always talk. They said, "[A carer] comes in and is very good. They talk with [the person] about what they have been up to, and [the person] likes that. There's banter, joking, and the carer really seems to understand [the person]. [The carer] helps with personal care and [the person] is comfortable as [the carer] talks while doing it."

Written compliments from people and their relatives were displayed in the service office. One relative wrote, 'I would like you to thank [named member of staff] for the way they have cared for [named person]. They have gone beyond the call of duty and given their own time on many occasions, going in early or staying back a bit later to give [the person] support and care.' Another relative wrote, 'We would just like to take the time to let you know how pleased we have been with the work of [named carer]…[they] have an excellent relationship with [my relative]…and genuinely loves and is good at their job."

At the time of the inspection no one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager was able to describe how people would be supported to access advocacy services should the need arise. At the time of the inspection no one was receiving end of life care.

Requires Improvement

Is the service responsive?

Our findings

People's care was planned to reflect their individual needs and preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. People and their relatives said they were involved in planning their own care. One person said, "I wrote the care plan entirely. It reflects what I want." Another person said, "The care plan has what I want." Another said, "I have a care plan and I tell them what I want doing. They do ask." A relative told us, "The care plan reflects [the person's] preferences." Another relative said, "Carers came and asked what us questions to see what we wanted. We were greatly involved in care planning."

Care plans began with people's contact details, the details of the GP and any other external agency that was supporting them. Health conditions were then recorded, along with a summary of people's communication and personal needs. Care plans also contained information on people's activities and hobbies, which would allow staff who had not supported them before to know something about them before support was delivered.

Care plans then detailed information on how the person wanted to be supported in a number of different areas, including mobility, personal hygiene, medicine management and nutrition. Though plans were written from the perspective of staff and not the person they did contain details of people's personal preferences. For example, one person's plan stated, 'Carer to provide assistance with bathing using own choice of toiletries. [Person] requires assistance both in and out of bath due to left side weakness.' In other care plans, we saw details of the social activities that people enjoyed and how they would be supported to access them.

People told us that they were asked for feedback on their care plans to see if their needs had changed. One person said, "Periodically they come and do a survey, once or twice a year to see if things are okay and we would ask if anything needed changing." Another said, "Sometimes [named staff] come out and do a questionnaire."

However, not all care plans were regularly reviewed to ensure they always reflected people's current needs. There was no regular review date set for care plans, and it was not always clear when they had last been reviewed. Staff told us that care plans were not always up to date. One said, "They could be updated a bit more often. It's supposed to be every 12 months or if there is a change but it can sometimes be a lot longer." Another member of staff said, "I think care plans could be better. Not a lot of them are up to date. Sometimes you find out that people have more health issues than are on the care plan. Co-ordinators are supposed to do them." A third member of staff said, "Some care plans need updating. For example, one [person] we [support with medicines]. The office has been told [that the care plan needs updating] but it has not been done. If I saw a change in a person I would phone the office and ask for guidance, but it is not updated in the care plan."

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

Some people received social and activity time as part of their care. One person told us, "[Staff] do activities with me." A member of staff said, "I do social calls, for example shopping calls and trips to Teesside Park. I took [a person] swimming before, and also walking." Where people received support with social activities their care plans contained information on their interests.

There were procedures in place to investigate and respond to complaints. Six complaints were received in 2015, and records confirmed that these had been investigated and people informed of the outcomes. People received a copy of the service's terms of business when they started using the service, and this referred to the complaints policy. People told us they would be confident to complain if any issues arose. One said, "If I had a complaint I would go straight to the [registered] manager, and if not satisfied the head office."

Requires Improvement

Is the service well-led?

Our findings

Some quality assurance checks were carried out to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. A care co-ordinator said care plan reviews took place annually or if people's support needs changed. However, staff told us that care plan reviews were often overdue. Audits of medicine administration records (MARs) took place, though it was not clear how often this should happen. A senior carer we spoke with said the audits were being transferred onto the registered provider's electronic system. There was no time frame for doing this.
The registered manager had not identified that the care plans and risk assessment had not been regularly reviewed. They had also not identified that the records failed to record how consent for the care had been obtained when people lack the capacity to make decisions. We found that the systems in place for monitoring the service were not effective.

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

People who used the service were sent a welcome pack and service user guide when they started. This included the service's mission statement, which read, 'Our mission statement is: Dedicated to making every interaction with our customers a positive defining experience.' We asked staff about the culture and values of the service. One said, "To deliver care to people who want to remain as independent as possible and stay in their own home and to treat people as individuals." Another member of staff said, "Everyone is accepted here. The team is so supportive. If you need help with anything, you get it." Another said, "Everyone works as a team and everyone works to provide the best care."

We asked the registered manager how feedback was sought from people who used the service and staff. They told us that the registered provider contacted a random sample of staff and people who used the service for feedback. If any issues arose, the registered provider sent the results back to the service with an action plan for remedial action. The registered manager said, "We do a sample call to staff. Every year, head office takes a sample. There is no minimum percentage, and head office is responsible. I don't think it's that effective. Also, a sample [call] for clients, too. [That is] also from head office. If [people] weren't happy they would phone us." The registered manager said that no issues had been raised in the 2015 survey.

We asked to see the results of the latest survey but these were not available during the inspection. We asked for these to be sent to us after the inspection, and did not receive them.

People and relatives told us they received questionnaires asking for their feedback. One person said, "I have had a couple of review questionnaires that I have filled in and sent back." A relative said, "[The person] has done about three questionnaires, I think."

Staff said they felt supported by the registered manager, and included in the running of the service. One

said, "Allied is a good company. I get on with the [registered manager] and I've always been supported. I would be comfortable to go to the [registered manager with any issues]." Another member of staff said, "The [registered manager] is absolutely lovely. If you have any problems you can go straight to [them]. They've always been very accommodating with child care, appointments, things like that. You can always contact if you need help." Another said, "I feel supported by [registered manager]. I have never had to raise any issues." Another member of staff said, "Allied back you up. You're out and about but feel involved. I had a problem once and the office was on it straight away. I have no problems and would be confident to go to the manager."

Staff meetings were supposed to take place every three months, though the last one occurred in August 2015. Agendas for meetings were set by the registered provider, and staff were expected to attend at least one meeting per year. The registered manager said that if staff did not attend they were sent minutes of the meeting to read and sign to confirm they had. One member of staff said, "We have staff meetings and get information."

Staff and the registered manager understood their role and responsibilities. The registered manager was able to discuss the notifications they would make to the Commission.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not regularly reviewed which meant that risks to people using the service were not regularly assessed. Regulation 12(1).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans were not always regularly reviewed to ensure they met people's up to date support needs, and people's consent to care was not always recorded. Regulation 17(2)(c).