Castlerock Recruitment Group Ltd

CRG Homecare - Lincolnshire

Inspection report

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20 December 2016

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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

We carried out an announced inspection at CRG Homecare – Lincolnshire on 12, 13, 14 15 and 20 December 2016.

CRG Homecare – Lincolnshire provides care for people who live in their own homes. Some people who receive care live in accommodation referred to as extra care housing. This means they have their own apartment in a communal complex where care and support is provided. CRG – Lincolnshire are one of a number of agencies who provide care within these settings.

The service can provide care for adults of all ages. They can care for people who experience mental health needs or live with dementia. They can also provide care for people who live with a learning disability, physical disability or special sensory needs.

In 2015 the registered provider won a large contract with the local authority to provide services within the Boston and Sleaford areas of Lincolnshire. This involved the provider assimilating the work programme and staff members from a number of smaller domiciliary care agencies into their organisation. At the time of our inspection the service was supporting 389 people.

There was a manager in post at the time of the inspection, however they were not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not always deployed sufficient numbers of staff to ensure people's care needs were reliably met. You can see what action we told the registered provider to take at the end of the full version of this report.

The registered provider had identified and begun to take action to improve many of the shortfalls noted in this report. This had led to a significant reduction in complaints and safety issues. However, systems were not always sufficiently robust to ensure consistent and timely monitoring. We have made a recommendation about monitoring the quality of the services they provide.

People were satisfied with the support they received with managing their medicines. However, shortfalls in the way medicine administration records were completed increased the risk that they may not receive their medicines in the right way.

Risks to people's health and safety had been assessed and planned for and staff were aware of how to help people avoid accidents. However, some of this information had not been regularly reviewed which

increased the risk that people may not always receive their care in a safe way.

Staff understood and followed the Mental Capacity Act 2005 (MCA). The MCA is intended to ensure that people are supported to make their own decisions. Where this is not possible the MCA requires that decisions are taken in people's best interest. However, care records did not always accurately describe the support people required.

People were treated with kindness and care when they received support in their home. Their privacy and dignity was maintained by staff who understood the importance of doing so. However, shortfalls in communication from the agency's main office had sometimes meant that people experienced issues with this aspect of their care.

Some people had been involved in developing and reviewing their care plans. However, care was not always planned and reviewed in a consistent way.

People knew how to make a complaint and they received information from the provider about how to do this. However, systems for contacting the agency had not always supported robust complaints management.

Staff were recruited in a safe way and had the knowledge and skills to care for people.

People felt safe when in the company of staff. Staff knew how to identify and report any situations in which people may be at risk of experiencing harm or abuse.

Staff helped people to access the healthcare services they required and supported them to eat and drink enough to stay healthy.

People were consulted about the development of the service and staff were able to speak out if they had any concerns about poor practice.

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 consistently safe.

Staff had not always been deployed at the right times and in the right numbers to meet people's care needs.

Medicines records had not always been completed correctly.

Staff knew how to keep people safe from harm and avoid the risk of accidents.

Background checks had been completed before new staff were employed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some staff had not received all of the training and support the provider said they needed.

People were supported to make decisions for themselves. However, there was a risk people's legal rights may not be protected due to shortfalls in care records.

Staff helped ensure that people received the healthcare they needed.

People where helped to eat and drink enough to stay well when they required such.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff provided direct care in way that was caring and maintained people's privacy and dignity.

However, people did not always experience dignified and caring responses from office staff or because of the way some systems to support new staff were implemented.

Personal information was maintained in a confidential manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not always been consulted about how they wanted their care to be provided.

Care plans did not always support the consistent delivery of care that people needed.

Although some people had not received their care in a timely manner they had been provided with the basic assistance they needed.

Verbal complaints were not always managed effectively.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Managers monitored the quality of the service. However, the assurance systems were not always robust enough to accurately identify shortfalls in a timely manner.

People had been invited to provide feedback to guide the development of the service.

Staff had been encouraged to speak out if they had any concerns.

CRG Homecare - Lincolnshire

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 was 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.

Before the inspection, we asked the registered provider to complete 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. The registered provider returned the PIR and we took this into account when we made our judgements in this report. We also reviewed all of the information we held about the service. This included any notifications of incidents that the registered persons had sent us. We also contacted local health and social care agencies to gain their views about how well the service was meeting people's needs.

This inspection took place on 12, 13, 14 15 and 20 December 2016 and was announced. The area manager and the location manager were given 48 hours' notice of our visit to the main office. We did this because they were sometimes out of the office and we needed to be sure they would be available to contribute to the inspection.

The inspection team consisted of two inspectors and an expert 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.

During the inspection we spoke with 11 people who used the service and five relatives. We visited some of those people at their home and spoke with others by telephone. When we visited four people at their home we were able to examine documents relating to the planning and delivery of care. We spoke with two team co-ordinators, a senior care worker and five care workers. We also spoke with the provider's area manager and the agency manager. Throughout this report we refer to these people as "the managers."

During our visit to the main office, we looked at a further six people's care records and the personnel files for eight staff members. These files contained information about staff training and support. We also looked at staff duty rotas and records and arrangements for managing complaints and monitoring and assessing the quality of the service provided within the home.

Requires Improvement

Is the service safe?

Our findings

We spoke with people and their relatives about their experience of receiving their care calls in a timely and co-ordinated manner. We received mixed views about this subject. Most people told us they were currently satisfied with the timeliness of their calls although they acknowledged that there had been issues in the past. One person told us timekeeping, "Wasn't too bad." However some of the people we spoke with raised their concerns about calls being missed, being earlier or later than expected or only one staff member arriving when two were required to carry out the person's care. We were given examples of this such as staff arriving one and a half hours earlier than expected and staff arriving in the afternoon to carry out a morning care routine. Three people noted that they were not given information about the times they would be receiving calls, only how many calls they would receive each day.

We noted from care records that some people required two staff to assist with their mobility. This may be because they needed to use a hoist or be repositioned in bed. One person described a recent situation in which one staff member arrived to support them instead of two. Their care plan showed the need for two staff to attend the call. The person told us that since May 2016 there had been 15 occasions when this had happened. This situation had increased the risk that the person would not safely and promptly receive the care and support they needed. However, the person's care records showed, and the person acknowledged that this situation had improved during December 2016. Other people we spoke with and the care records we looked at also reflected a recent improvement.

The managers acknowledged that there were issues in relation to the timeliness and consistency of care calls. An example we saw in the records we examined showed that in the Boston area during October 2016 there were 17 missed calls and 476 calls were earlier or later than planned. In the Sleaford area during October 2016 there were 38 missed calls and 454 calls were earlier or later than planned. The managers also acknowledged occasions when two staff had not been provided when required. They told us that these situations had arisen mainly from a shortage of staff in a particular geographical area and they had also identified issues with the quality of communication between staff. We saw that managers had reviewed the systems for planning and delivering consistently timed care calls and had made improvements to the way in which the systems operated. They gave us examples such as refining recruitment processes to include incentives for existing staff to introduce potential new workers. They had increased pay scales. They had also introduced a team of staff in the Boston area to manage the care and support for people who were new to the service until they could be provided with a consistent staff team.

Each member of staff had a work sheet which gave them details of the care calls they were required to make each day. The work sheets showed what times people were to receive their calls and how long the call would take. On the six work sheets we reviewed for December 2016 we saw that a travel time of between five and ten minutes was allocated between calls. Most of the staff we spoke with told us that this was usually enough time to get to their next call. However, some staff told us that traffic conditions and the geographical locations contributed to the lateness of some calls. We were also told that when there were staff shortages extra calls were added to planned worksheets which meant that staff would have to rearrange their travel routes and priorities. This increased the likelihood of people receiving unreliably timed care calls.

In the care records we examined there was evidence to show that the timeliness and consistency of care calls and the provision of two staff where required had improved during November and December 2016. People and their relatives acknowledged that some improvements had been made. However, in four of the care records and other service records we saw that in December 2016 some people continued to receive a number of late calls. One person told us, "I want to tell CRG to get their act together. It's not fair that I should be worried about staff turning up late and having to be uncomfortable." Managers told us that a new system to record the arrival and departure times of staff was currently being implemented to enable them to monitor the issue more effectively. This system was not sufficiently embedded for us to judge the impact for people who used the service.

We concluded that although there had been improvements, some people who used the service still did not reliably receive all of the care calls they needed. This was because of shortfalls in the numbers of staff and organisation of the staff team.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that the managers had undertaken a range of background checks to ensure that any new staff employed directly by them were suitable to work for the service. These checks included obtaining references from previous employers and establishing the person's identity. They also carried out checks with the Disclosure and Barring Service to establish people's previous good conduct. Other members of staff had been transferred from their employment with previous care providers under legal agreement. The managers had taken action to review those recruitment records to ensure they met the recruitment policy and procedures for CRG Homecare – Lincolnshire.

All of the people and relatives we spoke with told us they were satisfied with the way staff supported them with their medicines. They told us the assistance they received from staff worked well for them. We checked people's care notes and found that staff had recorded when people had been assisted with their medicines and this reflected what people had told us. However, the quality of medicines administration record (MAR) completion did not always reflect that people had received their prescribed medicines at the right time or in a consistent manner. An example of this was in one person's MAR for September 2016; a total of six out of 16 possible entries were left blank. The MAR for October 2016 showed that out of a total of 64 possible entries only 10 had been completed. In another person records, MAR's for November and December 2016 were completed correctly, however there were numerous gaps in the MAR for September 2016. Although we could not establish any direct impact on people's health and welfare, poor record keeping increased the risk that people may not receive their medicines in the right way. We could also not determine from records the impact that missed or late calls had upon people receiving their medicines in a timely manner.

People's care records contained a range of risk assessments that had been carried out so that actions could be taken to reduce the risk of accidents occurring. These assessments included the identification of potential risks such as tripping hazards, the use of hoisting equipment and unauthorised access to a person's home. Staff we spoke with demonstrated their knowledge of people's risk assessments and how to identify risks to people's health, safety and welfare.

The managers had identified that some of the risk assessments had not been regularly reviewed and we saw this when we looked at care records. They told us that staff from another part of the provider's organisation was currently visiting everyone who used the service to ensure that risk assessments and other care records were reviewed and updated.

People we spoke with told us that they felt safe in the company of staff. Those relatives we spoke with also told us they were confident that staff provided care in a safe way. One person told us, "Yes I do [feel safe], particularly with my regular carer." Another person said, "They are very good and I can trust them." A relative told us, "Yes, [my loved one] is happy with them."

All of the staff we spoke with demonstrated their understanding of how to identify and report any situations where they thought people may be at risk of experiencing abuse. This included making contact with external agencies such as the local authority and the Care Quality Commission. We saw from records that most staff had received training about how to keep people safe.

Since the service was first registered we know that the managers had responded to a significant number of safety concerns raised by people who used the service, their relatives and health and social care professionals. Records showed that the managers had worked together with external partners such as the local authority to investigate and resolve the identified issues and ensure people's safety in the future. We noted a decrease in the frequency and number of concerns recorded since October 2016. The managers told us this reflected improvements in staffing levels and training arrangements.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they felt staff who provided care understood their needs and provided care and support in the right way. They told us they thought staff had received training to carry out their roles. One person told us, for example, "Yes I think so; they know what they're doing." Another person told us they were, "Very happy with the actual care." A relative said, "Yes I do [think they are well trained] just by the way they treat [my loved one]."

The managers told us they had reviewed the level of training undertaken by those staff who had transferred from previous employers. We noted that some of those staff had undertaken update training in subjects such as medicines management, infection control, managing epilepsy and keeping people safe. However, some staff had yet to do so. The training matrix we saw during the inspection was not up to date which meant the managers did not have accurate information to rely on when monitoring the progress of the training programme.

The managers told us that all staff recruited directly by CRG Homecare – Lincolnshire had undergone a four day induction programme followed by a period of supervised work with more experienced colleagues. Staff we spoke with and training records confirmed this. Staff told us they felt their induction programme prepared them for their job role. The managers also told us they had introduced the Care Certificate training programme to ensure all staff were trained to the same level in subjects they said were essential. The Care Certificate is a nationally recognised training programme which is designed to equip staff to care for people in the right way. We saw that some staff had completed this training and plans were in place for all other staff to commence.

We found that the staff we spoke with had the knowledge and skills to provide people with the care they needed. Examples of this were staff describing how they cared for people who experienced mobility issues, problems with their skin and how they promoted the principles of infection control. One person raised an issue with us about some staff not using aprons when they carried out close personal care. We spoke to the managers about this and they took appropriate action to deal with the issue.

The managers had identified that formal supervision sessions and 'spot checks' were not consistently carried out with all staff in line with the provider's policies and procedures. They told us this was because there was a shortage of field work supervisors at present. They showed us the plans they had implemented to increase the numbers of field work supervisors and improve staff support systems. Staff we spoke with told us they felt supported in their roles. They said senior staff and the managers were helpful and always willing to discuss issues. Some of the staff told us they had received formal supervision with their immediate work supervisors and some told us that they had received 'spot checks' from their supervisors when they carried out care calls. They said that this helped them to develop and improve their skills.

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 interest and as least restrictive as possible. A person remarked to us that staff, "Ask me the questions and always ask if there is anything else I need." Another person commented on how staff enable them to make their own decisions by saying, "My regular carer is fantastic." On the same subject a relative said, "Yes, they are very good about that." The managers and staff demonstrated their understanding of the provisions set out in the MCA which protected people's rights.

In some people's daily notes we could see that actions had been taken to include those within the person's circle of support when there was a need to agree care that was in the person's best interest. However, the care files we looked at did not clearly demonstrate that assessments of people's capacity had been carried out; nor did they contain clear information to guide staff about how to support people to make their own decisions. In one care plan it was recorded that "Mother gives consent." However there was no information to show that this relative had the legal authority to make decisions on behalf of the person. When we spoke with the person it was clear that their regular care staff did support them to make their own decisions. This meant that care records did not always accurately describe people's capacity to make decisions and there was a risk that their legal rights may not be protected if they were supported by staff who did not know them. The managers acknowledged that care records needed to be reviewed and updated in regard to the issues of mental capacity. They explained to us the actions which were in place to enable this to happen.

Where people required support with their nutrition this was recorded in their care files. People we spoke with told us they were happy with the support they received in regard to this. We also spoke with people who were not assessed as needing this support and they told us staff still always checked they were eating and drinking enough to stay well. One person told us, 'If my [relative] isn't around [when they come], they'll make me a sandwich for lunch." Another person told us that staff always ensured they had access to drinks.

People told us and records showed that staff supported people to engage with healthcare services when they had a need. Staff demonstrated that they knew how to identify if a person needed healthcare support and gave us examples of how they monitored issues such as continence needs and skin integrity to help them with this. We saw examples in which staff had consulted with community nurses or GP's when they had concerns about a person's health. One person told us how staff had "got an appointment for them with the doctors." However, most people we spoke with told us that this was not a required part of their care from the agency and that friends and relations helped them in this respect.

Requires Improvement

Is the service caring?

Our findings

Most people told us they were satisfied with how they were treated by care staff. For example, a person said, "They're all caring and very good." Another person said, "All the girls are very good." A further person said, "They're excellent, I feel cared about." However, in relation to contact with the agency's main office one person told us they "don't bother" contacting the main office anymore because "no one gets back to you." A relative told us, "The service is quite poor really and needs a lot of improvement. If they don't get back to you it makes you feel that they don't really care."

Most people and their relatives told us that staff maintained people's dignity and privacy when carrying out care in their home. They gave us examples such as staff making sure doors and curtains were closed and speaking with them privately about personal issues. However, one person gave us an example of not being asked in advance if new staff members could shadow their regular care staff and they felt obliged to allow them into their home. They told us this did not promote their dignity or privacy.

Most people and their relatives told us that they usually knew which staff would be coming to support them. However, others were concerned that unfamiliar carers arrived at their home without prior communication from the main office. Some of the staff we spoke with also mentioned arriving at people's home to find people had not been informed that their regular care staff would not be attending. They also told us they sometimes found that the main office had not contacted people to inform them staff would be running late for calls. In respect of this a person told us, "I don't think that the office staff quite understand what it's like to be stuck in bed [waiting] and no one turns up and no one contacts you to tell you what's happening. It's very stressful and unsettling."

We spoke with the managers about people's differing views and they acknowledged that there had been issues with communication systems. They explained they had introduced a new system to ensure calls were responded to and followed up in a timely and appropriate manner and that people were provided with accurate and timely information. They said the new system had helped to reduce the number of issues people had raised with them in regard to this. They also confirmed that they would address the issue of seeking consent in advance from people to accommodate new staff who were shadowing regular staff to gain experience.

People and relatives we spoke with told us that staff enabled people to maintain as much independence as they were able to. In regard to this one person said, "Yes they do, they help me with what I can't do but not what I can." Staff demonstrated they understood how important it was to enable people to maintain as much independence as they were able to. They told us this in turn helped people to maintain other aspects of their life such as their dignity and their mental wellbeing.

Staff told us they understood and had received guidance about how to correctly manage confidential information. They were aware that this included both verbal and written information. None of the people or their relatives we spoke with expressed any concerns regarding this issue. We saw that staff in the agency's main office spoke about people's care in lowered voice tones or in a private area so that only those people

who needed to know about such could hear them. We also saw that in the agency's main office people's personal information was stored within locked cabinets and information stored on computer systems was password protected.

Requires Improvement

Is the service responsive?

Our findings

The registered provider told us in their PIR that "comprehensive, person centred care plans" were in place for people who used the service. However, in the records we looked at we found variations in the quality of care planning and in some cases we could not find a care plan completed by CRG Homecare – Lincolnshire. In those cases local authority care plans were in place but they showed only what care the person should receive, not how staff should carry out the intended care.

Some care plans we looked at contained only brief descriptions of the care to be provided which increased the risk that people would receive an inconsistent approach to their care, particularly where they did not have consistency of staff members. We knew that one person had requested not to be supported by male staff and this was implemented but it was not contained in their care plan. One person and their relative told us that their care plan was in place to help develop independence and socialisation. They said that after a "good start" with CRG Homecare – Lincolnshire the support had become repetitive and unimaginative and did not achieve the intended outcome. This description was confirmed when we looked at the notes in the person's home which staff completed after their visits in December 2016. The person told us, "I would like to do more but we usually do the same thing and I would like to be helped to do other things."

We noted that it was not always possible to ascertain from people's records that they had been consulted about or that they had agreed to the care plans that were in place. Some care plans were not signed or dated by the person, their legally appointed representative or the staff member who had compiled them. There was also limited documentation to demonstrate that people had been involved in reviewing and updating their care plans. Only three of the care plans we looked at clearly showed that review meetings had taken place in 2016. We were told that those people who lived in 'extra care housing' who received care from the agency had recently been involved in reviewing and updating their care plans. A sample of those care plans confirmed this.

The managers demonstrated that they had identified issues with care planning through their quality assurance systems. They explained to us the actions they had taken to address the issues. We saw that they had identified staff from another part of the provider's organisation to visit with each of the people they supported. Their role was to carry out a comprehensive review of the support people received which included improving the detail of and updating care plans where necessary. We viewed some of the records of visits that had already taken place to confirm that this was happening.

Where detailed care plans were already completed they showed the intended outcomes for the person. They included guidance about how staff should promote a person's independence, how they should maintain a person's dignity and how they should provide close personal care.

Despite the issues we have described above and some people's views about the timeliness and reliability of care calls detailed earlier in this report, people we spoke with told us that they had usually received the basic care they required. This included support with continence, personal hygiene, keeping their skin healthy and taking their medicines.

People and their relatives told us they knew how to make a complaint if they needed to and would be comfortable to do so. They told us that they had received information about how to do this from the registered provider. However, we received mixed views about how people's complaints were responded to. Most people told us their concerns and complaints had been acknowledged and addressed in a timely manner and that they were happy with the outcomes. One person told us how they had raised a concern about the timing of their care calls. They said they were happy with how the matter had been dealt with and the outcome. However, another person said that they had contacted the agency early in December 2016 to raise a complaint verbally but had yet heard "absolutely nothing back." A relative told us that they had complained about not getting information for the timing of their relation's care calls. They said they did not get this information until they "insisted" it being provided. We knew from information we had received prior to the inspection that other people had raised this issue directly with the service through their complaint systems. We also saw that the service's complaint records identified missed and poorly timed calls as a recurring theme. A relative told us, "All we want is for visits to be completed on time and for the right amount of time. That shouldn't be too much to ask for but in the past CRG simply hasn't been able to manage it." We spoke with the managers about this and they agreed to review their system for recording and responding to verbal concerns and complaints.

We knew from the information in the provider's PIR and from information we held about the agency, they had received 33 formal complaints between October 2015 and August 2016. During the inspection the managers demonstrated a significant reduction in the numbers of complaints received since that time. Records showed that only five complaints had been received in the last four months, all of which had been resolved in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Many of the people and their relatives we spoke with were happy with the way CRG Homecare – Lincolnshire was managed. In regard to the organisation of the services, one person said "Yes I think it is. It's not too bad at all." Another person said, "Yes it is. The people at the end of the phone are always very polite." However, some people expressed different views about the management and organisation of the service. These comments were mainly related to their experiences of late and/or missed calls as described earlier in this report.

We noted during the inspection that people had been invited to share their views by way of quality questionnaires. We saw some of the responses people had returned to the agency in June 2016 and December 2016. These responses ranged from ratings of 'average' through to 'excellent.' We saw where people had raised issues in their responses action had been taken to resolve them. An example of this was a person who was concerned that staff did not follow instructions about how to enter their home. The managers described how they had spoken with staff and reiterated the entry instructions. People also recently had the opportunity to provide feedback during visits which were taking place to carry out comprehensive reviews of the support they received, as described earlier in this report.

Staff we spoke with noted that there had been issues with the organisation of services in the past, and they mentioned issues related to shortages of staff and record keeping. However, they said that they now felt there had been significant improvements in the way they were supported to carry out their work. They told us that communication with the managers and senior staff had improved and they were able to attend staff meetings so as to keep up to date with practice issues. They also told us there were reliable systems for contacting senior staff outside of normal working hours if they needed support or advice.

Staff said they would be comfortable to raise any practice issues or concerns with the managers and were confident these would be dealt with. One staff member commented that when they had raised issues with the managers "they jumped on it straight away and sorted it." Another member of staff said, "[Agency manager] is the best manager we've had." All of the staff we spoke with said that they were aware of how to raise any concerns outside of the agency if they felt issues had not been dealt with in the right way. The procedures for doing this are referred to as 'whistle blowing.'

There was no registered manager in place. This is a condition of the provider's registration with the Care Quality Commission (CQC). The agency manager had been employed at the service since August 2016 and informed us during the inspection that they had recently begun the process to register with CQC.

The managers described to us how they monitored the quality of the services provided for people. This included reviewing any trends in complaints and concerns, monitoring staffing levels, monitoring training and support for staff and reviewing the quality care records. We also saw records to demonstrate that representatives of the registered provider's organisation had carried out a visit to the main office in September 2016. This was to check the systems in place for areas such as staff training and support, recruitment and the quality of care planning. This approach to monitoring the quality of the services had

identified many of the shortfalls we have noted in this report, and the managers had taken action to address them. However, this approach was not robust in that it did not provide a framework for regular audit activity or set benchmarks for the expected standards of performance. It also did not consistently take account of the shortfalls in the systems that would be relied upon for accurate quality monitoring. We noted an example of this earlier in this report with regard to the completion of the staff training matrix. These issues meant there was a risk that some shortfalls in the quality of services may be not be identified in a timely and accurate manner.

We recommend that the service considers advice and guidance from a reputable source about robust approaches to monitoring the quality of their services.

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 The registered provider had not ensured that sufficient numbers of staff were deployed to reliably meet people's care needs.