Safe Hands Home Care Limited

# Safe Hands Home Care Limited

## Inspection report

Unit 5, Planet Business Centre
Killingworth
Newcastle Upon Tyne
Tyne and Wear
NE12 6RD

Tel: 01912681818

Date of inspection visit:
07 June 2016
09 June 2016

Date of publication:
08 August 2016

## Ratings

| Overall rating for this service | Requires Improvement |
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|---|---|
| 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

The announced inspection took place on 7 and 9 June 2016. We last inspected the service in August 2014. At that inspection we found the service was meeting all the regulations that we inspected.

Safe Hands Home Care Limited provided home care and housing support to 18 adults living in their own homes living in the Northumberland, Newcastle and North Tyneside areas. People were provided with a variety of support times depending on their care package and needs, with some receiving 24 hour care. It should be noted that the numbers of people being supported and the number of hours they receive will fluctuate due to the nature of the service.

The service had a registered manager in post. 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.

We found shortfalls in the management of medicines. The terminology used in recordings by staff was not in line with best practice guidance and the process adopted when administering people's medicines process needed to be improved. Full details about needs related to 'as required' medicines, were not always available to staff.

Record keeping within the service was not always maintained to suitable standards. Care planning, medicines records, risk assessments, best interest decisions and quality assurance checks were not always documented thoroughly or not at all in some cases.

Quality assurance checks were completed in some areas of the service, for example finances and staff confirmed this. However, we saw very little documented evidence that either the registered manager or the provider had a full and clear oversight of the service to ensure people received good quality care and support. People, and their relatives confirmed, however, that they received good care from the staff team. Accidents and incidents were recorded but not fully monitored for emerging trends by the registered manager or provider.

People told us they felt safe with the staff team that supported them and their relatives confirmed those thoughts. Staff were confident and had been trained in safeguarding procedures. They confirmed they would have no doubts about reporting any issues to management or other appropriate bodies if the need arose.

Risk assessments in place needed to be tailored to individual need and not completed as a blanket approach. The provider had contingency plans in place and staff knew what to do in the event of an emergency.

Staffing levels were maintained by timely and safe recruitment procedures. The registered manager told us they tried to ensure people were visited by the same care staff but that was not always possible due to sickness or holidays.

Staff had received an induction into the service and completed appropriate training. Staff said they felt supported by management and supervisions and appraisals were completed, although these were behind schedule and the registered manager was in the process of bringing them up to date.

Some people received support with mealtimes as part of their care package. People were supported to prepare meals and eat meals they had chosen. Staff ensured drinks were left between visits for people if they required them.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. Although best interest decisions were made, these were not always documented fully.

Staff promoted people's independence and treated people with warmth and kindness in a respectful and dignified manner. People were involved in the care planning process, although this was not always fully documented.

People had choice and could decide how they wanted to receive care and support. There was a complaints procedure in place and people and their relatives knew how to access and use it.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance.

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

People were not fully protected against the risks associated with medicines because supporting documentation was not always in place to safely administer all medicines including those that were 'as required'.

Risk assessments were not individualised or fully completed and in some cases not in place.

Safeguarding policies and procedures were in place and staff were aware of what actions they should take if abuse was suspected. Staffing levels were maintained and safe recruitment procedures were followed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The registered manager was aware of the Mental Capacity Act 2005, particularly in relation to the court of protection and lasting power of attorney, although best interests' decisions were not always fully documented or the details of people acting on behalf of an individual.

Staff were trained to meet the needs of the people in their care and the registered manager was working to bring supervision and appraisals up to date.

People received food and drink which met their nutritional needs. Staff supported people with any additional healthcare needs, including attending appointments with their GP or going to hospital.

### Is the service caring?

**Good**

The service was caring.

Staff were kind and caring. They treated people with dignity and respect and supported them to maintain their independence.

Staff had built a good rapport with people and appeared to know them well.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's needs had been assessed and care plans put in place, however these needed to be more detailed and more person centred. People told us that staff were responsive to their needs but documents were lacking.

People were encouraged and supported to socialise with visits to shops and relatives and friends, when this was part of their care package. They were able to choose how their care was delivered.

Complaints procedures were in place and people and their relatives knew who to contact to complain when they needed to.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

There was a nominated individual in place as part of the registration process, however they had left in 2014 and a change of name had not taken place until we followed this up. There was however, a registered manager in place.

There was not a robust system of monitoring quality assurance at the service by either the registered manager or the provider, and records were not well maintained.

People had taken part in surveys to give their views on the service they received and this was analysed by the registered manager.

# Safe Hands Home Care Limited

**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 7 and 9 June 2016 and was announced. We gave 24 hours' notice of the inspection because we needed to seek permission of people who used the service and to let them know that we would be calling them by telephone or visiting them in their own homes. We needed to be sure people would be in to access records. The inspection was carried out by one inspector.

We did not ask the provider to submit a Provider Information Return (PIR) prior to this inspection. 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.

Prior to the inspection we reviewed all the information we held about the service, including the notifications we had received from the provider about serious injuries. We contacted the local authority commissioning and safeguarding teams for the service and the local Healthwatch. We used their comments to support our planning of the inspection.

During the inspection we contacted two district nurses, a member of the community learning disability team and two care managers. Where we received a response, we used their comments to support our judgement.

We visited and spoke with five people in their own homes who used the service and spoke with three family members/carers either in person or on the telephone. We also spoke with the registered manager and four other members of care staff. We observed how staff interacted with people and looked at a range of records which included the care and medicine records for eight of the people who used the service, four staff

personnel files, health and safety information and other documents related to the management of the service.

During the inspection process we asked the provider to send us additional pieces of information, which they did so within agreed timescales.

Requires Improvement

# Is the service safe?

## Our findings

The service used a medicine administration record (MAR) to record medicines that had been given to people from a monitored dosage systems (blister packs) and also from individual packets or boxes. Monitored dosage systems (MDS) are a system used by pharmacists to dispense medicine's so that people can keep track of what to take at particular times of day. They are usually in some form of tray with medicines boxed into individual pods which are labelled by day and time. We saw that staff were signing once to indicate that the whole blister pack had been administered, rather than itemising the different medicines and dosages that had been administered from the pack. We asked one staff member how they checked what they were giving people was correct. They told us they emptied the blister pack directly into a medicines pot and after checking that all the medicines had been deposited into the pot, they then gave that to the person. Staff were aware that there was a description of the medicines on the blister pack, however, we were told that no one checked the medicines to confirm that what staff were administering agreed with the blister packs and that they relied on the pre-packaging of the MDS by the pharmacist for this. This meant the provider did not have a fully detailed and accurate record of the medicines that staff were supporting people to take and they were not checking that medicines were correct before administering them.

People received their 'as required' medicines from the staff who supported them, however we noted that records did not always show the full details of how many, when, how and why these medicines were/had been administered. 'As required' medicines are medicines used by people when the need arises; for example tablets for pain relief used for headaches. This meant there was a risk people may not have received these medicines when they needed them and in the correct way.

There were differences in the way staff recorded people's medicines. Staff told us they prompted people to take their medicines, when in fact they administered them. Prompting of medication is reminding a person of the time and asking if they have or are going to take their medicines. Administration of medicines is when staff give or offer a person their medicines at a particular time and in a particular way. Daily care notes of three people recorded that staff had prompted people to take their medicines, however we watched one member of care staff administer the person their medicines in a medicine pot after they had emptied it out of the blister pack. Two members of staff confirmed that they had administered medicines to people but recorded it as prompted as was usual practice. This meant that records indicated people had taken their own medicines after being reminded by staff, when in fact staff had administered them to people.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled safe care and treatment.

People we visited told us that staff helped them to take their medicines. The people we spoke with told us this had worked well and they had been happy with the way they had been supported to take their medicines. One person said, "They [staff] have helped me for a while and I have had no problems [with administration of medicines]. They helped me get my medicines sorted when they were not delivered properly." One relative told us how the care staff kept records relating to medicines so that the family could always see what had been taken when they visited.

The staff we spoke with told us they had completed training in relation to the safe administration of medicines and that observational checks had been carried out by senior staff. When we asked one member of care staff about the medicines that one person was allergic to, they said, "If people are allergic to anything it is marked there [and they showed us where the information was detailed in the person's records]."

People told us they felt safe and their relatives thought the same. One person told us, "I have had carers in the past from another company and did not feel safe at all with them, but these girls [care staff] are very good." One relative told us, "I am confident [person's name] is very safe."

Staff that we spoke with had undergone safeguarding training and were aware of how to implement whistleblowing procedures. They knew how to report an issue if they felt that someone was at risk. One staff member told us they had not been involved in reporting any safeguarding concerns, but said, "I would not hesitate to tell my manager if I thought something was wrong." Another staff member told us that if they saw anything untoward and the provider did not do anything about it, they would report to the appropriate local authority and contact the Care Quality Commission.

Daily entries were made of accidents and incidents and recorded by the provider in a book kept at the main office. These were checked by the registered manager and any actions taken were noted.

Risk assessments were completed to minimise risks to both the person and the staff supporting them. For example, one person had a risk assessment in place for infection control as staff provided personal care to them. It recorded that staff should wear personal protective equipment when completing the task (gloves/apron) and we saw they did during our observations. This meant that the provider had assessed the risk and mitigated against any issues arising. We noted that some risk assessments were in place when there was no need. For example, one person had an oxygen cylinder risk assessment in place when they did not use this type of equipment. Another person had a road vehicle risk assessment in place when this did not apply to them. Another had a behavioural risk assessment in place, when there were no issues with their behaviour. We also noted that one person did not have a risk assessment in place around their cognitive/dementia needs but their records showed that they were vulnerable due to this. The registered manager told us they were in the process of reviewing people's records and this would be prioritised and done straight away.

One person was provided with 24 hour care and staff completed health and safety checks on their home and ensured that equipment was regularly checked and monitored. Evacuation procedures were in place for each person who received support and staff knew what to do in the case of an emergency.

The provider had procedures for staff to follow, and on call numbers available for staff to use in the event of an emergency; for example poor weather conditions. We saw these details in people's records at their homes, when we visited them. One member of care staff told us, "If we have a problem, there is a number to call. We are never left to sort things out ourselves if we struggle."

We saw the provider had a system in place to ensure each person received their care package in a timely manner. They recognised staff sickness or other absences had an effect on scheduling from time to time and worked hard to ensure staff were replaced by others when this happened, including on occasions utilising the team leader or the registered manager. The provider tried to ensure people received continuity of care from the same staff members, although they recognised this was not always possible due to the type of service. One person told us, "The staff sometimes run a bit late, but it's not too bad." Another person told us, "I don't fret that they are not coming when they are running late. They are very reliable." One person, however, told us they wished staff would phone them when they were running late as it would stop them

getting anxious. They continued. "I know the staff are coming, but I still get a bit anxious about it." Any extremely late or missed calls were logged and the provider investigated why this had occurred, although we noted that the list was small.

The registered manager explained that the provider used a separate training and recruitment company to help them choose potential new staff. He told us that the company completed initial interviews to sift out unsuitable candidates. We found appropriate checks had been undertaken to ensure staff were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Staff records confirmed potential employees had to complete an application form from which their employment history had been checked. Suitable references had been provided and taken up in order to confirm this. Eligibility checks had been carried out and proof of identification had been provided.

We noted, however, that one recent staff member's employment history on their application did not match with the dates on the reference received. Although the references were very good, we spoke with the registered manager about this and he said this had been accidentally overlooked and he would investigate the difference. Once staff had been recruited they were supplied with an ID badge which had to be worn at all times when out in the community providing support to people. When we spoke with staff during the inspection, we noted that they all wore photographic ID badges as instructed by the provider. This meant that people could be assured that the care staff visiting them were from the organisation and not bogus callers.

Requires Improvement

# Is the service effective?

## Our findings

People felt the team of staff who supported them were trained sufficiently. One person said, "I would not let them in if I thought they did not know what they were doing." One relative said, "The staff seem trained to do the things they are asked to. I am sure [registered manager's name] would put extra training on if it was needed."

Staff completed an induction programme on joining the organisation. All staff received a handbook which set out how they should conduct themselves while at work and ways of working. As part of the induction process, staff completed a self-evaluation of their own performance. This covered areas such as, appearance and punctuality with staff rating themselves between good and poor. If stated gave themselves a lower score, additional support was provided to them.

While working through the 12 week induction programme, staff also shadowed more experienced staff before they were allowed to support people themselves, and staff told us that if they reported they were still lacking in confidence, then the provider would allow them more time to shadow. The provider had updated the induction programme to incorporate the changes with the introduction of the Care Certificate. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards.

Staff told us they had received suitable training to support the people they worked with. One staff member confirmed they were in the process of gaining an additional health and social care qualification to support them in their role. We saw training records that confirmed staff had gained a level 2 or 3 in a health and social care qualification. Other training records showed that the majority of staff had received up to date training in a range of subjects, including first aid, dementia, health and safety, fire safety and mental capacity. Staff told us healthcare professionals (for example district nursing staff) had shown them in the past how to perform particular tasks for individuals; for example, catheter care. The registered manager told us they had a programme of training planned for the future to refresh any training due.

Staff told us they felt supported by the provider. Supervision and appraisal records showed that staff had played a part in the process and were given a chance to discuss any developmental opportunities they were interested in. On one staff record it was noted that there was a need identified to update their training in challenging behaviour and an action had been made for the team leader to support them with this. We found, however, that staff supervision and appraisals were not always up to date. The registered manager told us that it was difficult to keep on top of these, due to the geographical area staff covered, but said he was in the process of completing this task and had trained additional staff to support him as he knew how important it was for staff to receive regular sessions.

Staff communicated well with each other. Daily notes stored in each person's care records showed support that had been given to the person each day. In the home of the person who received 24 hour care, staff had a communications book in which they recorded any pertinent information for staff to be aware of that were

coming on to a new shift with the person. This meant that appointments or any other issues that needed to be addressed on particular days would not be missed.

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.

The provider had considered people's capacity and we observed staff encouraging people to make decisions for themselves. Where there was any concern over a person's capacity to make a particular decision, staff consulted with family and other health care professionals to ensure that decisions were made in the person's best interest. The provider had acted appropriately and in line with the MCA, although decisions were not always documented. It was only through looking through records and speaking with relatives and staff that we were able to fully confirm that the MCA had been adhered to. The registered manager told us that they were reviewing the care planning process and this would be addressed through that. He was aware of which people had a lasting power of attorney in place and which people were subject to a court of protection order, although this was not always recorded on documentation and no copies of these lasting powers of attorney were retained in the office files.

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

Staff supported people in their own homes with the preparation of meals and drinks if that was required as part of their care package. Comments people made included, "They [staff] sort my meals out so I only have to microwave them later or they put me sandwiches up if I fancy them, they see to everything."; "The lasses [staff] make me something for dinner and make sure I have something for later too with a drink."; "I feel I have enough food and staff help me with it." When we visited one person we noted staff had prepared them meals in line with guidance received from the speech and language therapy team (SALT). The SALT team support people who have difficulty in eating food or swallowing. This meant that the provider supported people to eat enough food and in a way that was tailored to their individual need.

People were supported with any additional healthcare support they required. For example, one person was assisted to make GP appointments when they were needed and another person was supported to attend GP and hospital appointments as the need arose, including for example, visits to the breast screening clinic. The records people kept in their homes detailed when they had visited a healthcare professional with the support of staff. We noted there had been liaison with occupational therapists as a personal moving and handling risk assessment was in place for one person. This meant that the provider ensured that staff supported people to access healthcare professionals when the need arose.

Good

# Is the service caring?

## Our findings

All of the people we spoke with where either happy or very happy with the care provided by the staff who supported them. One person said, "She [care staff] is lovely. I could not fault them. She does more than she should. She is a proper little worker that one." Another person said, "I am very happy with the staff that visit me. They [care staff] are all very caring people, just wish they would call when they are running late; although I do understand it's hard to be exactly on time to the dot." A third person told us how they liked all of the staff that supported them and said, "I have a favourite, but better not say as it might upset the others!" They continued, "We have a nice chat and carry on while she does the work that needs done." One relative said that one particular member of care staff was "marvellous" and that they hoped they stayed with the organisation.

People had good relationships with care workers because levels of trust and confidence had been built upon over time. Staff were seen to be caring and compassionate in their approach and people responded well to this. New care staff were introduced to people and they worked with more experienced staff as they gained experience with individuals, although one person told us that new staff did not get very long to "practice" with them, but said they had not had any problems. The registered manager explained that he tried to keep consistency with the staff teams visiting people, but this was not always easy due to unforeseen circumstances. He said that most people had the same carers going to visit them and provide support on a regular basis and from what we saw we agreed with this comment.

We heard staff explained to people what they were going to do in advance of delivering care. For example, while giving medicines or when about to complete a personal care task with them. Staff bent down as they talked to people, so they were at eye level as maintaining eye contact helps enhance effective communication. We asked staff why they bent down to communicate with people and staff said that it felt better than standing over people talking down to them. One staff member said, "Some people cannot see so well and it's nice to show them your face."

When we spoke with staff about people they provided care for, they responded in a positive and respectful way and it was clear from what we observed staff cared about the people they were supporting. We heard staff giving words of encouragement to people in order to support them to maintain their own independence. When we visited people in their own homes and staff were present, we heard warm and naturally caring conversation taking place which showed staff knew people well.

People's privacy and dignity was maintained. We observed staff correctly transferring one person from upstairs to a downstairs sitting room. They ensured that the person was covered after their lower garments needed to be lifted to support the move. They ensured the person was comfortable before moving on to another task. At all times, they spoke with the person to ensure they were aware of what was occurring and to confirm they felt comfortable and safe. The same person was spoken to in a way that did not compromise their independence with reassurances from staff that "they would be up and about soon enough." One member of care staff told us, "It's important not to take away people's independence, otherwise they would rely on us [care staff] too much and we are not here all the time."

Requires Improvement

# Is the service responsive?

## Our findings

When people first started to use the service an initial assessment of their needs was carried out and we saw the provider also obtained a copy of the person's assessed needs which the local authority had completed. Initial assessments, included details about the person's mobility, their sensory needs and any medication support they would require. Senior staff at the service would then draw up a care plan to address these needs and agree this with the person. A small number of people using the service were not provided with personal care and only received support with cleaning and shopping.

Staff at the service provided care that was person centred and people gave us examples of this when we spoke with them. People told us that staff provided them with the care they required and at a time they needed it. One person told us staff had supported them with requests that were not part of their agreed care package. They said, "They [care staff] go the extra mile." They went on to say, "They [care staff] do what I want in the way I want it done. Some carers I have had do what they want and not at all in the way I want them to; but these girls are very good."

Although people told us they received person centred care, people's records did not always reflect this, with records varying in the amount of information they held on how staff should support people in an individual way. Some were written in the form of a task based list. We discussed this with the registered manager and he said that he was aware that records needed to be updated in line with best practice and that care records were in the process of being reviewed.

People's care needs were reviewed if changes were required by the person or their individual circumstances changed. One person told us, "They [senior staff] came out to see me and asked lots of questions about what I wanted, but if I want something different they do it." One member of care staff told us, "We can take [person] out if they want. We just have to let the office know." To ensure that they had completed all of the support required for each person, staff completed a caseworker note sheet, which itemised what support had been given, when and by whom. Staff told us that if anything changed on this document or people's needs changed, they would inform management who would review the care package.

Some people, as part of their care package had staff support to facilitate them going out into the community to go shopping or visit other venues, including the homes of friends or family. We saw that staff documented these events in the daily records of people they supported. Staff knew what people liked to do and one person told us, "I like to pop to the shops from time to time and staff have walked with me many a time." Another person told us they visited a family member regularly. This meant people avoided social isolation and were able to participate in activities which they had chosen and preferred.

People had the choice to decide what they wanted staff to do and how staff supported them. We observed this during our inspection and the visits to people in their homes. One person was asked if they wanted staff to make them some breakfast and what they wanted. The person was able to say what they preferred and the staff set about making it. Another person was asked how they wanted domestic work to be completed in their home first and the staff member checked if the person required any assistance with the meal that was

prepared for lunch. This confirmed that staff asked and took account of people's decisions about how they wanted their care and support delivered and had an opportunity to choose how this was done.

When we asked people and their relatives if they knew how to complain, they told us they did. One person said, "I would ring the office and speak to [registered manager name]." One relative told us, "I have had to complain in the past, nothing major with these [Safe Hands Home Care Limited]. They sorted it out straight away. I would have no hesitation in ringing if I needed to." We saw that people had copies of the complaints policy and procedure in their records and this had details of contact numbers and what people should do if they wished to log a complaint. Since the last inspection one complaint had been received in relation to a carer allegedly falling asleep during overnight cover and this had been dealt with appropriately by the provider.

A number of compliments had been received by the provider for the support they had given to people in their care. The registered manager showed us a recent cutting from a local newspaper in which all the staff had been commended by a relative for the care and support they had given to a family member.

Requires Improvement

# Is the service well-led?

## Our findings

The appointed nominated individual was no longer working with the organisation and had also deregistered as the registered manager on 6 January 2014. When we pointed this out to the registered manager, they told us they had not realised and that the person named had nothing to do with the organisation now. They said they thought the owner was the nominated individual and said they would speak with them about this issue. We followed this up with a telephone call to the owner of the organisation who then sent us the relevant forms to update the details of the new nominated individual.

People's care records were not completed fully and were not always up to date. Care plans were minimal in content and although people told us that staff provided them with the care they needed, we found it was only because staff knew people well and had achieved a good understanding of their needs through working with them over a period of time. One person's care record included out of date information, particularly in regard to the details of another person which was no longer valid. Some records did not fully contain likes or dislikes, personal history or their preferences, although the registered manager told us that these records were in the process of being reviewed.

People's names were not always present on all documentation in relation to their care. We found most risk assessments had no names entered on them, other than on the first sheet.

One person's care records had not been signed by them and when we asked them if they had been asked to sign in agreement, they said, "I agree with the care and am more than happy to sign, but have not been asked to." We noted that a number of other care records had not been signed by either the person or their representative.

We found that some documentation did not have a date entered which meant we were unable to confirm which period of time the documents related to. For example, a staff meeting had taken place in connection with one person who was in hospital. No date was in place and when we asked the registered manager, they could not confirm with certainty when the meeting was held.

The provider recorded any accidents or incidents which had occurred in the service. As there were very few accidents recorded and the service had a small number of people who used it, the registered manager was able to monitor any trends without a full written analysis. However, this system was not robust and meant that any trends forming could be missed.

We asked the registered manager what quality checks and audits they completed at the service to ensure they provided high quality care. The registered manager told us they completed quality checks but did not always record that they had completed them. For example, staff told us the registered manager checked people's finances to ensure they were in order and receipts were in place, but we found no record that this had taken place or when. The registered manager said they visited people in their homes and we confirmed this on one of our home visits. They said this was to either perform caring duties or to check on staff work, but confirmed that this was not recorded. This meant we were unable to confirm that suitable checks had

been made to monitor the quality of the service and to ensure that the governance of the service was robust.

The registered manager was unable to provide us with any evidence of oversight by the provider, other than the finance meetings held with the owner to discuss company funding and money matters. This meant that we were not assured the provider demonstrated good leadership and we concluded they did not have processes in place to monitor the quality of the service it provided to its clients.

A number of policies and procedures were out of date. For example, the complaints policy was due for review in April 2015 and the safeguarding policy was last reviewed in November 2013. We spoke with the registered manager about this and he told us that they were in the process of being updated.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled good governance.

The service had a registered manager in post and they had worked at the organisation for 14 years after a change of career. The people we spoke with knew who the registered manager was and all of the people we visited confirmed they had met him and said how approachable he was, with one person in particular receiving hands on support with their care needs from him. The relatives we spoke with were also positive about the registered manager and knew them by their first name. Staff told us they felt supported by the management team and said they regularly had contact with either the registered manager or the team leader.

Staff meetings had taken place in the provider's main office to discuss matters in connection with the people who used the service and other work related issues. House meetings took place within the home of the person who received 24 hour care and staff confirmed that regular communication was important to ensure that staff worked together for the wellbeing of the individual. There had also been regular financial meeting which had taken place between the owner and the registered manager, which focused on arrangements within the business.

Surveys were completed every year with people to check their views of the service being provided. Questions included, "Are you happy the way new staff are introduced?" and "Do you know the services we offer?" The surveys were analysed to monitor findings, however, the analysis we checked had no date to confirm which year's surveys it corresponded with.

We noticed on the surveys seen, that all but one person completing them had commented that they preferred staff not to wear uniforms. The registered manager told us that they asked people about uniforms before the decision was made for staff not to wear them and said, "We checked with everyone to make sure they were happy, and this shows that they were and still are."

The registered manager was aware that published reports needed to be displayed in the service and on the provider's web site.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not protected because the provider did not always operate safe and proper procedures related to the management of medicines.<br><br>Regulation 12 (1) (2)(g) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Records were not fully detailed, were not always accurate or up to date. Risk assessments were not always in place or tailored to individual needs. Accidents and incidents were not analysed for trends forming. Audits were not effective at identifying shortfalls in practice and were not always recorded when complete.<br><br>Regulation 17 (1) (2) (a)(b)(c)(f) |