

Three Sisters Care Ltd

# Three Sisters Care Ltd

## Inspection report

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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?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

### About the service:

Three Sisters Care Ltd is a domiciliary care agency registered to provide personal care to people living in their own homes. At the time of our inspection approximately 360 people were using the service. Of those 360 people, 329 received personal care and the remainder received domestic assistance only. For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### People's experience of using the service:

Where consent to care forms and other documents were signed by relatives or friends, it was not always clear whether they had the legal authority to do so.

People told us they felt safe with staff. People reported that staff were reliable, caring and respectful. Some people and relatives found that members of the care staff team did not have satisfactory English language skills. Structured staff recruitment processes were followed, however the provider needed to check that all criminal record checks were valid.

Risk assessments were in place to reduce risks to people, but sometimes lacked relevant details. Staff had received training to administer medicine, but some staff needed further guidance to correctly complete medicine administration records.

People's care plans identified the tasks that needed to be carried out but did not demonstrate an individual approach that reflected people's preferences and personal circumstances that were important to them.

People's entitlement to confidentiality was promoted and the provider supported staff to meet people's diversity needs. People and their relatives knew how to make a complaint and thought the provider would respond professionally to any concerns they raised.

Staff generally reported they felt well supported by the management and received the training they needed to carry out their roles and responsibilities.

Positive links had been established with local organisations with similar aims to support the local community. Systems were in place to monitor the quality of the service, which did not always ensure that areas for improvement were addressed in a timely manner.

### Rating at last inspection:

At the previous inspection the service was rated as requires improvement (23 Feb 2018). The service was rated as requires improvement at the two previous inspection and continues to be rated as requires improvement.

Why we inspected:

This was a planned inspection based on the previous rating.

Enforcement:

We found two breaches of regulation in relation to consent and good governance. Please refer to the 'action we told the provider to take' section at the end of full report.

Follow up:

We will ask the provider to inform us how they will make changes to make sure they improve the rating of the service to at least good. We will continue to monitor information and intelligence we receive about the service until we return to visit in line with our re-inspection scheduling guidelines for services rated requires improvement. We may inspect this service sooner if we receive any concerning information.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective

Details are in our Effective findings below.

**Requires Improvement** ●

### Is the service caring?

The service was caring

Details are in our Caring findings below.

**Good** ●

### Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

**Requires Improvement** ●

# Three Sisters Care Ltd

## Detailed findings

### Background to this inspection

#### The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

#### Inspection team:

The inspection was carried out by four adult social care inspectors and two experts by experience. Two inspectors visited each day, apart from the final day when one inspector visited to give feedback to the provider. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our experts by experience areas of expertise included supporting older people with general health care needs and older people living with dementia.

#### Service and service type:

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service for older adults and younger adults with disabilities and/or long-term health care needs. The Care Quality Commission only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service did not have a registered manager. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager resigned in November 2017. The provider had appointed a new manager in March 2018, who resigned in March 2019. The manager was present at the beginning of the inspection.

#### Notice of inspection:

We gave two days' notice of the inspection as we needed to ensure that key staff would be available at the office when we arrived.

Inspection activity commenced on 18 February 2019, when we visited the office location. Visits to the office

also took place on 19, 25 and 28 February 2019, to see the management and office staff; and to review care records and policies and procedures. Our Experts completed their telephone calls to people who use the service on 11 March 2019 and we attended the office to give feedback to the provider on 1 April 2019.

What we did:

Prior to the inspection the provider completed a provider information return (PIR) form. This form asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, for example notifications from the provider, safeguarding alerts and any information of concern from anonymous sources. A notification is information about important events which the provider is required by law to send us. We also contacted the local authority contracts monitoring team and safeguarding team for their feedback.

During the inspection we spoke with the nominated individual, the managing director, the manager, 12 care workers and supervisory/managerial staff. We spoke by telephone with 15 people who used the service and 10 relatives. We looked at 15 care files for people who used the service, seven staff files for recruitment, training, supervision and appraisal, medicine administration records, the complaints log, selected policies and procedures, and a range of quality monitoring documents.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Requires improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People who used the service told us they felt safely supported by care staff. One person said, "I've got used to them. I am very lucky" and a relative told us, "He/she is safe and happy with his/her carers."
- The local authority reported to us there had been an increase in the number of safeguarding concerns and other concerns about the quality of care and support in the six months period prior to the inspection.
- Staff had received safeguarding training and were familiar with the provider's safeguarding policies and procedures. Staff were aware of the actions they should take if they had any concerns about people's safety and felt assured that any concerns they reported would be taken seriously by the management team. The provider appropriately reported safeguarding concerns to the Care Quality Commission.

Assessing risk, safety monitoring and management

- Risk assessments had been carried out to identify risks to people's safety during the delivery of their care. These included risks associated with moving and positioning, falls, medicines, use of bed rails and the occurrence of pressure ulcers. However, not all risk assessments ensured care staff had sufficiently detailed and up to date guidance about how to manage and minimise identified risks. For example, two people who used the service were assessed to be at high risk of experiencing falls but did not have a falls risk assessment in place.
- Risk assessments had been conducted in relation to people's home environments.
- Where people used equipment for mobilising and transferring, for example wheelchairs and hoists, current information was not always recorded in care files to demonstrate the professional maintenance was up to date.

Staffing and recruitment

- The staff files we looked at demonstrated appropriate recruitment practices, apart from one file which contained a Disclosure and Barring Service (DBS) check carried out by the staff member's previous employer. The employee had transferred to Three Sisters Care Ltd via TUPE arrangements which is the Transfer of Undertakings (Protection of Employment) Regulations, when employees move from their former employer to their new employer by operation of law. The provider had not evidenced the DBS had been checked through the DBS update service.
- People and relatives mainly told us that care staff were quite punctual and most people stated they were advised by telephone if their visit would be subject to a delay. Comments from people who used the service included, "The new ones come on time, at 10.30, the agreed time. One time it was missed, that's all" and "They're usually on time. I had a couple that didn't come on time and I wouldn't stand for it. But I make allowances for them if it doesn't happen too often." One person said that staff were less reliable for time keeping at the weekends.
- The provider used an electronic call monitoring system (ECM), which meant that care staff electronically

logged their times of arrival and departure at people's homes. The randomly selected sample of ECM data we looked at showed that people received their visits within the agreed timescale and care staff stayed for the allotted time. A member of the office team monitored ECM to check that people received their visits in line with their schedules. The provider informed us that there were technical problems with the system at times which resulted in care staff not being able to successfully log in and out, which they had reported to the local authority.

- People thought there were enough care staff in post to ensure their visits were attended to in a reliable and consistent way. One person said, "Yes, I feel safe. I have the same girl" and a relative commented, "It's the same group of carers, it helps to be consistent."
- People mainly felt that staff had enough time to provide the care and support they needed. One person told us, "There is generally enough time. They get longer on a Thursday" and another person said, "They have an hour, it's enough time for the two of them." However, we received other comments that care staff did not get enough time for each visit.

#### Using medicines safely

- People told us they were appropriately supported by care staff with their medicines and received their medicines within acceptable timescales.
- Medicine administration record (MAR) charts were brought to the office by care staff and scrutinised by a designated field care supervisor. Systems were in place for the management team to investigate any discrepancies found on MAR charts and action taken where required.
- Staff had completed training in the safe handling of medicines, and their competency was assessed and checked during spot check visits by field care supervisors. During our discussions with care staff, we found that some staff did not demonstrate a satisfactory understanding of how to correctly complete medicine administration record (MAR) charts. For example, some staff were not clear in their explanations to us about the difference between prompting and giving medicines.
- The care plan for one person stated that care staff needed to prompt medicines, but there was no record of this prompting taking place and no risk assessment to address the person's medicine needs. We spoke with the manager and were informed that a district nurse visited regularly to change a medicine patch. There was no guidance about this medicine patch in the care plan, for example what action care staff should take if it dislodged.

#### Preventing and controlling infection

- People told us that care staff wore disposable gloves when supporting them with their personal care and regularly washed their hands. A relative said, "Yes, I don't have to tell them (care staff), with gloves and aprons in the wet room. They put on the slippers too."
- The records for spot check visits evidenced that supervisory staff consistently checked that care staff appropriately used personal protective equipment, for example disposable gloves, aprons and shoe covers.
- Staff had received infection control training and understood their responsibilities in relation to protecting people from the risk of cross infection.

#### Learning lessons when things go wrong

- The provider had systems in place for recording, reporting and analysing accidents, incidents and safeguarding concerns. The management team identified actions to learn and improve from these events. For example, we noted that individual care staff were given additional supervision and were required to repeat elements of their mandatory training where it was established that the quality of care and support provided failed to adequately promote the safety and wellbeing of people who used the service.

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. A regulation was not met.

Ensuring consent to care and treatment in line with law and guidance

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

We checked whether the service was working within the principles of the MCA

- People and their relatives told us that staff supported them to make daily choices about how they wished to be assisted and politely asked for their consent prior to delivering care and support. One person using the service said, "Yes, they do ask permission" and another person commented, "They do now. To start with it was a different story." A relative informed us their family member was unable to communicate their needs and wishes to staff due to their health care condition, and they were satisfied that care staff understood how to meet their family member's preferences.
- At the previous inspection we had found in some people's care files that consent forms and other documents had been signed by people's relatives, however there was no recorded evidence that the relatives held Lasting Power of Attorney (LPA) for Health and Welfare. LPA is a legal document that lets people appoint one or more relatives or friends (known as 'attorneys') to make decisions on their behalf in the event they no longer have mental capacity to do so themselves. We issued a breach of regulation.
- At this inspection the care files we looked at demonstrated that the provider had not satisfactorily met this breach. We noted that a revised assessment form had been introduced since the previous inspection, which prompted managerial and supervisory staff to gather the information needed to determine whether people's relatives or friends had the legal authority to consent on people's behalf. The nominated individual told us that staff who carried out assessments and reviews of people's needs had received applicable training. However, it was acknowledged by the provider that some members of this staff team did not properly understand their responsibilities.
- The absence of robust information about whether some relatives or friends had the legal authority to consent on people's behalf meant the provider could not always determine when it was necessary to carry out best interests reviews for people who did not have capacity to consent to their care.
- We spoke with the nominated individual about specific problems the provider had encountered with meeting the breach, which included language difficulties. During the inspection the provider ensured that managerial and supervisory staff received refresher training about LPA to enable them to effectively carry

out thorough and accurate assessments of people's needs, including re-assessments where necessary.

This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices: delivering care in line with standards, guidance and the law

- The assessment form used by the provider was suitably detailed and addressed a broad range of relevant areas. It also constructively used information from people's social services assessments. However, we found instances where assessments were not properly completed by designated staff, in line with the provider's own guidelines. For example, the provider had implemented the five-step approach to preventing and treating pressure sores, known as the SSKIN system. This is an acronym for the risk factors that contribute to pressure sore development, which includes the need for care staff to check people's skin (S), keep people mobile (K) where possible and support people to maintain good nutrition (N). One care file showed that a person was assessed as being at risk of developing pressure sores but there was no further written information in relation to how to manage this.
- People's preferences in relation to whether they were allocated a male or female care worker were adhered to. One person told us, "Yes, they did, I prefer a male when showering" and the relative of another person stated, "We prefer males and that's what we have."

Staff support: induction, training, skills and experience

- People predominantly thought their allocated care staff had the right skills and knowledge to meet their needs. One person said, "Yes, very much so" and a relative stated, "Yes...because they have been doing it for a while now and they seem to know what they are doing." Another relative said that they had to inform care staff what to do as the staff did not appear to have the right level of training.
- Staff told us they were pleased with the quality of training they were given and confirmed they were supported by the provider to access training, which included moving and handling, safeguarding, basic life support, health and safety, person centred care and care for people living with dementia. The provider supported staff to undertake nationally recognised qualifications, for example vocational qualifications in health and social care and the Care Certificate. This is an agreed set of standards that sets out the knowledge, skills and behaviour expected of specific job roles in health and social care.
- We noted there was a clear expectation by the provider for newly appointed staff to receive induction training and opportunities to shadow senior and experienced colleagues prior to caring for people on their own.
- One member of the care staff spoke about the usefulness of the epilepsy training, however another staff member who told us they were supporting up to five people living with dementia was unable to recall fundamental information from this training. Staff presented a varied level of understanding in relation to mental capacity issues, and one care worker spoke about mental capacity as a mental health issue.
- The provider kept records to monitor staff compliance with the training programme and identify if any additional training sessions needed to be arranged. Records demonstrated that staff received regular one to one and group supervision, although some individual supervision documents were not signed by the supervisee and supervisor to confirm they were an accurate account of these meetings.

Supporting people to eat and drink enough to maintain a balanced diet

- People and relatives told us care staff supported them with eating, drinking and food preparation, where this formed part of their assessed needs. One person who used the service said, "Yes, they help me with breakfast and depending on how good I feel they will help me prepare lunch" and a relative commented, "They (care staff) will do [family member's] lunch and he/she eats well."
- The care files contained information about people's dietary needs, for example if they required a Halal diet, had a food allergy or dislike of certain foods, or needed to eat soft foods due to swallowing difficulties.

- Staff told us they received training and guidance from the provider to meet people's nutritional and hydration needs, which included how to monitor people's food and fluid intake if required and report to their line manager if they detected any concerns.

Supporting people to live healthier lives, access health care services and support. Staff working with other agencies to provide consistent, effective, timely care

- Staff told us they liaised with community health care professionals to support people to meet their personal care and health care needs. Care staff gave us examples of this, which included reporting concerns about people's skin integrity to district nurses or informing their line manager that a person was struggling with their mobility and may need a referral to a physiotherapist or occupational therapist.

- People's care files contained information about their health care needs and how these needs impacted on their day to day health, wellbeing and independence.

- We noted that the provider was providing personal care for a person who also received an extensive package of nursing care from another provider. The person's care file did not have adequate information about the input from the nursing professionals or a copy of instructions given by physiotherapists, which meant that care staff may not have had access to up to date and comprehensive information to effectively meet the person's needs.

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People spoke positively about the caring approach and helpful attitude of their care staff. Comments from people included, "I've got used to them. I am very lucky. They always wave if they go past the house", "They're good girls. Really lovely" and "Very kind ... marvellous. I've had the same girl, but they are all very nice."
- Relatives also stated they were pleased with the kind and caring manner of the care staff. One relative told us "It's just the way they are with (my family member), they know how to make him/ her laugh. The two carers that he/she's got are amazing and bubbly" and a second relative said, "They always ask (my family member) if there is anything else they can do."
- We found that people's life history and interests were not always documented in their care plans, which meant that staff did not readily have access to useful information to help them develop relationships with people they supported. However, some people who used the service and relatives told us they thought the provider matched staff with people with shared interests, and cultural and linguistic backgrounds. A relative told us, "The carer speaks Bengali and (my family member) doesn't speak English so that helps. They come and keep him/her company and they know how to please him/her."
- The provider had carried out joint training for their staff with an organisation with expertise in providing services for people who identify as Lesbian, Gay, Bisexual and Transgender (LGBT).

Supporting people to express their views and be involved in making decisions about their care.

- People told us they felt involved in the planning of their care and were consulted by the provider about how their care and support should be delivered. One person who used the service described how they liked the flexible and individual approach of their care workers, "I'm a very independent person and have my good days and bad days. I need help to go out and they do that." Another person said, "They help me do as much as possible. They communicate really well and give me a bit of space, which I think is really good."
- There were systems in place to seek people's views about the quality of their service. We noted that the return of surveys sent out by the provider was low and contained mainly positive feedback. Out of 237 surveys sent out, 37 responses were received with 90% of the respondents stating positive views about their care and support. The provider had developed an action plan to address the identified issues for improvement, which we looked at during the inspection.
- People confirmed they were asked for their views about their care in different ways. One person told us, "I have filled in surveys or (office staff) give you a call. They come to the house to ask how the service is."

Respecting and promoting people's privacy, dignity and independence.

- People and relatives told us their care staff and other staff based at the office provided respectful care and support. One person who used the service said, "We have a good communication, they help me beyond and

above", and a relative told us, "They always treat [my family member] with respect. I always know when they are washing him/her so don't go in there."

- The care staff we spoke with told us they had received training during their induction about how to support people in a dignified way. Staff explained how they protected people's privacy and comfort during personal care, for example by ensuring windows, curtains and doors were closed, during the delivery of personal care. People's records were properly stored at the provider's office. The service ensured they maintained their responsibilities in accordance with the General Data Protection Regulation (GDPR). This is a legal framework that sets guidelines for the collection and processing of personal information of individuals.

## Is the service responsive?

### Our findings

Responsive-this means we looked for evidence that the service met people's need.

Requires improvement: People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- At the previous inspection we had issued a breach of regulation in relation to care planning. We had found that people had received care for a significant period but did not have an individual care plan in place. At this inspection we noted that people and relatives were involved in developing their care plans. One person told us, "I did my care plan" and most of the relatives we spoke with confirmed their involvement in the care planning process.
- The care plans we looked at did not have an adequate level of personalised information. Care staff were provided with information listing the tasks that needed to be carried out but insufficient detail in relation to how the tasks should be performed. For example, whether it was important for people to use preferred products for personal care, or whether they wished to be supported to dress in a specific manner on days they were attending community services or places of worship.
- There were sections within the provider's own assessment and care planning tool for supervisory staff to gather information to enable care staff to provide a personalised service. This included areas to record people's pastimes, pets, hobbies, significant dates and events, the role of relatives and friends, likes and dislikes, and any other information that people thought it was important to share. We found that these sections were frequently left blank or described as not being applicable, even where people lived with relatives who contributed to their daily care and support.
- We saw evidence to demonstrate that people's care plans and accompanying risk assessments were updated annually.
- People's communication needs were assessed, in line with the Accessible Information Standard (AIS). This was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.
- Some people and relatives expressed mixed views about whether care staff had competent English language skills to proficiently understand and respond to their needs and wishes. One relative told us, "Yes, I have done questionnaires and so on and told them about the language and they still send people who can't speak English" and another relative stated, "There was an issue with a language barrier. They (care staff) don't communicate very much so they can't explain to my father what they are doing."

Improving care quality in response to complaints or concerns

- People and relatives told us they knew how to make a complaint and thought the provider would respond professionally to any concerns they expressed. Comments from people who used the service included, "No complaints, very rare ever to have a complaint. I phone the office and speak to the girls", "Yes, I know how to (complain), but all good" and "I wouldn't stand for no nonsense from anyone, definitely would complain if I needed to. Just don't need to."
- The provider confirmed they gave people and relatives written information about how to make a complaint, although the local authority contracts monitoring team had found files without this information

during monitoring checks undertaken since the previous inspection.

- The complaints log did not consistently record the outcome for complaints that had been investigated by the provider to ensure a clear audit trail and promote learning from mistakes where necessary.
- We saw that the service had received compliments from people, relatives and health care professionals.

#### End of life care needs

- We saw limited evidence of people being asked about their wishes in relation to end of life care. The provider was not supporting any people with end of life care at the time of our inspection.
- The provider's end of life care policy promoted close working with relevant health care professionals, for example Macmillan Nurses. Staff had received end of life care training.

## Is the service well-led?

### Our findings

Well-Led-this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Requires improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. A regulation was not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The provider had not taken suitable and timely action to satisfactorily address the breach of regulation at the previous inspection, in relation to ensuring that correct procedures were followed in relation to consent and the Mental Capacity Act 2005.
- The provider did not demonstrate there were sufficiently robust systems in place to monitor the safety and quality of the service. The provider's own checks had not effectively identified and addressed aspects of the service where we found shortfalls in relation to safety and quality. For example, risk assessments, record keeping for complaints investigations, the planning of personalised care and staff knowledge for the accurate completion of medicine administration records.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service did not have a registered manager. The provider had recruited a new manager who will apply to become the registered manager. Additional office staff had been recruited since the previous inspection to improve the smooth running of the service.
- A range of systems were used to monitor the quality of the service, which included 'spot check' visits to people's homes so that the supervisory and management staff could observe how care staff supported people who used the service. People told us, "Someone comes to talk to me" and another person said, "Yeah, they come in every now and again. They come the other week." A relative who was pleased with these checks told us, "Twice a year they check up and make sure I've had a carers assessment" although another relative stated, "Not really, I tend to contact them. In comparison with the last agency that used to come around, it doesn't really happen here."
- We found that some records for the spot checks and telephone monitoring calls did not have the date written on the form. The nominated individual told us the dates could be established by checking the schedules of office staff, however the absence of key information on documents fell short of the provider's own guidance for staff in relation to acceptable record keeping.
- The provider appropriately informed the Care Quality Commission of notifiable events, for example safeguarding alerts, in line with the law.

Engaging and involving people who use the service, the public and staff, fully considering their equality characteristics

- People and relatives spoke positively about how the service was managed, and their interactions with the supervisory and managerial team. Comments included, "They are great, really helpful", "They are very welcoming and will call me back if need be" and "I think they are quite reasonable, they just want to make sure everything is okay."
- Staff we spoke with during the inspection were positive about how the service was managed and told us they felt well supported by the senior management. Staff said they were kept up to date with relevant information and guidance at team meetings, and they felt able to raise any queries or concerns. However, we received anonymously sent written information from an unknown number of staff members who did not view the organisation as being supportive.

#### Continuous learning and improving care; Working in partnership with others

- The provider had implemented changes to the service since the previous inspection, for example the more detailed type of assessment and care planning tool, and the increase of office based staff to support care workers, develop risk assessments and care plans, and monitor the quality of the service. However, at this inspection we did not find enough evidence to demonstrate that these changes had produced the level of embedded improvements that the provider wished to achieve.
- The provider worked in close partnership with local voluntary sector organisations with similar aims and objectives. They were a member of the Tower Hamlets Voluntary Service (THVS) and had established links with resource centres, for example the provider supported people who used the service to access different groups at a local organisation that enabled and empowered people to combat social exclusion and deprivation.
- Records showed the provider attended provider meetings with local authorities.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider did not always ensure that care was only provided with the consent of the relevant person. This is a repeated breach. Regulation 11(1)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems were not in place to ensure the service operated in compliance of regulations. Systems to assess, monitor and mitigate risks were not always up to date or appropriate. Systems to monitor the quality and safety of the service were not sufficiently robust. Regulation 17(1)(2)(a)(b)(c)</p>