Claire Meade Care Limited

Caremark (Bradford)

Inspection report

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Date of inspection visit:
05 June 2018
06 June 2018
07 June 2018

Date of publication:
14 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Caremark took place between 5 and 8 June 2018. The inspection was announced and the service was given 24 hours' notice to ensure someone would be in the office. At the last inspection in May 2017, the provider was in breach of legal requirements concerning safe care and treatment and good governance. The service was rated as 'requires improvement.' At this inspection, we found work was still required to achieve compliance with Regulations.

Caremark - Bradford is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to both older people, adults, young people, people with learning and profound disabilities and people at the end of life. Not everyone using Caremark receives regulated activity; CQC 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. At the time of the inspection 260 people were receiving personal care from the service.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe. Staff knew how to recognise and report any concerns about people's safety and welfare. Risks to people's health and safety were not always assessed to help protect people from harm.

We found medicines were not always managed in a safe or proper way. In particular, we found discrepancies with documentation, namely between medicines administration records (MARs), information recorded in daily logs and recording of topical medication.

People were provided with care and support by staff who were trained. Staff were skilled and competent to meet the needs of people. Staff told us they had received induction and training relevant to their roles. This was followed up by competency checks, however, these were not always effective. Training was tailored to meet people's care and support needs. People were supported by kind, caring and compassionate staff. Staff demonstrated a sound awareness of infection control procedures.

There were enough staff deployed to ensure people received care. However, staff did not always arrive on time or stay with people for the allocated amount of time. Safe recruitment procedures were followed to help ensure staff were of suitable character to work with vulnerable people.

Care records contained sufficient detail so staff knew what support to offer people. People felt they participated in planning their care. Care records included information about people's preferences, likes and dislikes.

The service was compliant with the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People's consent was sought before care and support was offered.

People said staff were kind and caring and treated them well. We saw good positive relationships had developed between people and staff. People mostly received care from specific staff to enable familiarity between people and staff. This meant people received consistent care.

The service worked in partnership with other agencies including health professionals to help ensure people's needs were met. People's healthcare needs were assessed and plans of care put in place.

A complaints procedure was in place, which enabled people to raise any concerns or complaints about the care, or support they received. However, the service did not always respond to people in line with their complaints policy.

Staff told us they felt supported in their roles and their views were listened to through supervision and team meetings.

People using the service, relatives, staff and healthcare professionals we spoke with were generally positive about the management team. Staff said the registered manager was approachable and supportive.

We found the providers quality monitoring systems were not always working as well as they should be. Some of the concerns we found at our inspection should have been identified through a robust system of checks.

We found two breaches of regulations in relation to safe care and treatment and good governance. We are considering the appropriate regulatory response to our findings.

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.

Medicines were not always managed safely.

There were enough staff available to meet people's needs.

Plans were not always in place to mitigate risks to people's health and well-being.

Staff knew how to recognise and report concerns about people's safety and welfare.

Is the service effective?

Good

The service was effective.

Staff received regular training appropriate to their role. This meant they had the skills and knowledge to meet people's care and support needs.

The service was working within the legal framework of the Mental Capacity Act 2005.

People's choices and preferences were respected.

Staff liaised with health professionals about people's healthcare needs.

Is the service caring?

Good

The service was caring.

Staff knew people and their care and support needs.

People provided positive feedback about the standards of care, telling us staff treated them with dignity and respect.

People were comfortable in the presence of staff and good relationships had developed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records and people's assessed needs were regularly reviewed.

Where possible, people received calls around the agreed time period. Plans were in place to monitor where this wasn't happening.

A complaints policy was in place; outcomes and actions were not always recorded.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were complimentary about the service and most people we spoke with said they would recommend it.

Most people, relatives and staff told us they felt the registered manager was approachable and acted quickly in response to any concerns or issues.

Improvements were needed to the processes for checking the quality and safety of the services provided. This was the case at the last inspection.

Caremark (Bradford)

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.

The inspection took place between 5 and 8 June 2018 and was announced. We gave the provider a short amount of notice that we would be visited the office, because the registered manager may have been out of the office. We needed to be sure that they would be in. On 5 June, we made phone calls to people to ask them about the quality of care they received. On the 6 June, we visited the provider's office to look at care related documentation and speak with the registered manager of the service. Between 5 and 8 June, we interviewed care staff on the telephone.

The inspection was carried out by two inspectors, an assistant inspector 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. In this case the expert-by-experience had experience of services for people with disabilities, older care and people who lived with dementia.

Before the inspection, we reviewed the information we held about the provider such as notifications and information people had shared with us. We also spoke with the local authority commissioning and safeguarding teams to ask them for their views on the service and whether they had any concerns. We reviewed the information on the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with 14 people who used the service and three relatives. We spoke with seven care workers, the registered manager and the operations manager. We looked at eight people's care records and records relating to the management of the service, including staff training records, audits and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

At our last inspections in May 2016 and May 2017 we found medicines were not consistently managed in a safe and appropriate way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we still found this was the case.

Some people had a medicines profile in place which provided information on the medicines people were prescribed and the reasons why. However, other people did not have medicines profiles in place to indicate information including possible side effects of prescribed medicines and some others did not contain a full or up to date list of prescribed medicines. Protocols were not in place for some people's 'as required' medicines. Although staff received medicines training and had their competency to administer medicines assessed, they were unable to explain how they would manage these medicines.

Some medicines administration records (MARs) were well completed which provided assurance these medicines were given as prescribed. However, we found other MARs were not always properly completed. For example, staff had not signed a person's MAR to indicate a medicine used to lower cholesterol had been administered on numerous occasions in March and April 2018, namely in the evening. We saw other medicines prescribed for the same person had not been signed. The daily records indicated 'medicines given', although did not state what these medicines were. Although this appeared to be a documentation error, this meant the record did not provide sufficient evidence the person was getting their medicines as prescribed. Of particular concern was that documentation discrepancies which indicated unsafe practice, had not been identified by auditing systems to ensure they were promptly investigated to check whether people were safe. We had also identified this as a concern at our previous inspection in May 2017.

The administration of topical medicines such as prescribed creams was not always recorded in a consistent way. MARs did not always contain details of topical medicines and records did not always contain information in medication pen pictures or body maps to indicate where and how topical creams should be applied. For example, one person's daily records indicated staff applied three different creams. There was no information in the person's current medication pen picture about these creams and the person's body map only indicated where one cream was to be applied. From the detail recorded in their daily records, we were unable to confirm which cream was applied or required to be applied at any given visit. This meant the record did not provide evidence the person was getting their medicines as prescribed. We had also identified this as a concern at our previous inspection in May 2017.

The provider was unable to demonstrate they consistently followed safe medicine procedures. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us they felt safe with staff. One person told us, "I am really proud of these girls, I was a nurse, I am certainly safe at all times. A few months ago, I fell in the shower there was a full investigation. This really knocked my confidence; I was scared to go into the shower. This care worker is wonderful; she worked with me. Now I can go in the shower and within 10 mins we are done." Other comments included, "Yes, certainly safe and comfortable; never come to any harm with the care workers,

"Yes, I feel safe, they're very good", "Oh yes, certainly safe" and "Yes, I feel safe, they are alright." One person's relatives told us, "Yes, my relative is safe from harm and is comfortable. This really depends on which care workers and when." Other comments included, "Yes, no harm or bullying. [Relative] is safe" and "There is no issues with safety. My relative is safe, harm free and certainly not bullied at all."

Safeguarding policies were in place and staff had been trained to recognise and report signs of abuse. We saw appropriate safeguarding concerns had been raised with the local authority or the Commission. The registered manager was aware of their responsibility to make safeguarding notifications when required.

Accidents and incidents were recorded which included details, actions taken and outcomes from the incident. For example, a number of incidents had been recorded around medicines errors and we saw actions including staff disciplinary processes and/or medicines observations and supervision had taken place following these. However, further analysis was required to indicate trends and lessons learned from these incidents. Some accidents/incidents required further information recording about the action and investigations which had taken place. We spoke with the operations manager who assured us full details would be documented in future. Memos were used to keep staff up to date with incidents and any changes to practice.

Assessments were mostly in place to mitigate risks to people's health and safety which included those for moving and handling, epilepsy, environment, use of the bath/shower and management of behaviours that challenge. These provided information to staff on how to deliver care safely, although some of these needed to be more tailored to people's needs. For example, one person's needs assessment in their care file stated they lived with epilepsy. There was no care plan or risk assessment to reduce the risks associated with this. Another person's family had supplied information about a specific health condition and how this would impact on the persons behaviour. However, this key information was not recorded within their behavioural support plan.

In another person's care records, we saw their mobility had decreased rapidly. In the daily log notes it stated a moving and handling assessment had been completed in April 2018. However, no assessment was present in the persons file. For other people who had moving and handling needs, risk assessments were present but not the initial assessment stating a person's mobility and the type of equipment they had been assessed as requiring. One person's records demonstrated they required the use of a slide sheet. However, this was not recorded in their risk assessment. Therefore, we concluded there was a risk of some people not receiving the correct support. One person told us, "Some (staff) really good, some really rubbish to be honest. Some care workers slow on the uptake. Do feel they need some more hoist training; one care worker was very disorientated with the hoist." The registered manager told us and we saw in people's training records that staff received a full day of theory and practical moving and handling training as well as an observational competency. If concerns were raised from this, these would be discussed at staff supervision. Where the service had concerns about people's moving and handling needs, the service sought the advice of an independent moving and handling specialist.

Daily records of care demonstrated there were sufficient staff to provide care. They provided evidence that calls consistently took place and staff largely attended at appropriate times each day, indicating there were enough staff deployed. Staff told us, "Cover is not always arranged, no; we do struggle sometimes. We tend to rely on certain people who are reliable." However, other staff told us, "There are plenty of staff employed as far as I know; there's almost 200", "Yes there's enough staff on", "I don't see many staff just because of my role, but I would say yes; from what I've heard, they have enough. There's always someone who turns up when they say they will."

People who use the service and relative told us, "It's difficult to say if there are enough staff; I think a few have left recently. We chose Caremark because they promised us that [person] would have the same carers every day. This hasn't happened. It's always different ones and we never know who is coming. It's disruptive for my [person]. [Person's] favourite carer left. I haven't said anything to them but I think I will." Other comments included, "There are not enough staff; they are often late as they have taken on extra calls as there are staff off sick. It's never the same people; always changes."

Daily records of care showed calls mostly took place at the correct time and staff stayed the correct amount of time. In one person's records, we identified staff were not always staying for the correct length of time, sometimes only remaining for 15 minutes when the call length was supposed to be 30 minutes. One person told us, "Some staff are ok, some are here less than the time they should be." Another person told us, "Some are good, some are not professional. They have an hour to do the work, they do it in 45 minutes." We spoke with the registered manager who told us that they had appointed a call monitoring officer. They reviewed the call monitoring system daily and any staff identified as not tagging in or leaving early were invited to attend a meeting under Caremark's disciplinary process.
The service used an electronic call monitoring system which meant staff logged in and out of calls. The registered manager told us there had been some missed calls. This information was received by the office and a report was generated. This meant the service could promptly identify any missed calls and was a key safety net to ensure people were not left without care and support. We saw missed calls were investigated with actions taken where required. We saw on call arrangements were in place and a member of the management team held the 'out of hours' phone.

The registered manager told us they turned down care packages if they felt unable to fulfil these due to not having sufficient staff coverage in that area. They told us they tried to match people with care workers of their own ethnic background if possible.

We saw the service had a recruitment policy in place. We checked ten staff recruitment files. We saw appropriate checks such as references and Disclosure and Baring Service (DBS) were obtained prior to employment. All staff files checked demonstrated correct procedures were being followed.

Where the service assisted people with shopping, we saw appropriate transaction records were kept, including a record of monies spent, receipts and monies returned to the person.

We saw aprons and gloves were kept at the head office and staff collected these to ensure they had adequate stock to provide safe personal care. Staff told they had received infection control training and always used person protective equipment (PPE) when caring for people.

Good

Is the service effective?

Our findings

We saw people's needs were assessed prior to commencement of the service to ensure the service could fulfil these needs.

The registered manager explained the service matched people and their care workers from the same backgrounds wherever possible since the service supported people with a wide range of cultural needs.

Where the service supported people with their dietary needs, these were assessed and care plans put in place to support people effectively. This included documenting people's dietary preferences. The daily notes we reviewed demonstrated staff supported people with meals, drinks and snacks where this was part of the person's assessed care needs.

Where staff were concerned about people's health or had noted a change we saw they had made referrals to health professionals. This showed the service worked with other agencies to ensure people were supported to meet their health care needs.

A training matrix was in place which indicated what training staff had completed and when refresher training was required. Staff received training and updates in a range of subjects including safeguarding, moving and handling, epilepsy, support planning, Mental Capacity Act (MCA), dementia, food hygiene and infection control. New staff completed training on the Care Certificate in-house. This is a government-recognised training scheme, designed to equip staff new to care with the required skills for the role. We looked at staff training records and saw training was up to date or booked and records indicated when training was due. Training was provided using a mixture of on-line training and face to face sessions held at the training rooms at the provider's head office.

Most people we spoke with felt staff were adequately trained. Comments included, "A while ago they were not good, a year ago, but they are ok now", "Yes, they are good; no issues with training", "The care workers are really trained; I am happy", "I am a nurse; I know what the level of expectation is. These girls are extremely good; they know what they are doing" and "No problems with the skills and training - the care workers do a good job for me."

New staff received a five-day induction programme which included initial training, familiarisation with policies and procedures, and shadowing an experienced staff member for a number of shifts, dependent upon their experience. Most staff said the induction was good. One staff member told us, "Induction was in the office two or three days. I had a few days shadowing after that and then I was confident. I've worked in a care home before so I had an idea what I was doing anyway." Another staff member told us, "I had a full five-day induction; I've been doing care for eight years so I already knew a lot of it, so I would say I felt confident after it. It was more for formality reasons really.". However, one staff member told us, "Yes, I did over five days. Everything was very new to me and it was a lot of information to take in. I did one shadowing but after that I had to go alone to clients. I was pushed to do one day but I wanted two."

Staff received supervision, appraisals and spot checks of their practice. This included checking they arrived at the person's home on time, stayed for the correct amount of time, completed the required tasks and treated the person with dignity and respect. This provided a support mechanism and allowed the service to monitor staff performance. One staff member told us, "I find these very supportive; we have our supervisors allocated for our areas as well. We can contact our supervisors any time; if they're unavailable we can call out of hours or the office.". Other comments included, "I feel supported; yes, I like them (supervisions)", "I don't find them very helpful but they are useful to pick up on things we could improve on"' "I think our supervisions are really useful; if there are any issues we can raise them in these instances. There's been a period where the client has been very moody and there's a doctor who's come out so we communicate this through supervisions as well."

The service was proactive in keeping update with best practice guidance. For example, the registered manager attended provider meetings and training delivered by and in conjunction with the local authority.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care applications must be made to the Court of Protection. We found no DoLS had needed to be made. We spoke with staff to gain their understanding of MCA and DoLs. However, no staff were able to explain how this could impact on the people they were caring for even though they had received training in this.

Staff told us they asked consent when carrying out personal care. People we spoke with told us staff asked for their consent before providing care and respected their choices. Care plans considered people's capacity to consent to their care and treatment. Where people lacked capacity, we saw relatives had been involved in decisions as part of a best interest process. However, this was not always documented fully. For example, one person's care records stated their relative had been granted power of attorney. However, there was no documentation to show this, or if this had been granted for their financial affairs or their health and welfare. Following our inspection, the registered manager sent us confirmation of this.

Good

Is the service caring?

Our findings

Daily records showed people's consent was sought and their decisions and refusals of care respected. For example, one person chose to eat one particular type of food and staff prepared this for them, suggesting a healthier alternative on occasions.

Staff were able to explain how they communicated with people who found it difficult to communicate their needs, as they visited them regularly and had got to know them well. One staff member told us, "I get to know people a lot through their families as well as from the person themselves. We just get into a routine and a lot of people are used to me now. I know what they like and what they want. I can tell when my clients feel poorly as well." Another staff told us, "They're very regular, my clients. I get to know them so well, but everyone is different. Some people like me, some don't like me but I do know them." Another person told us, "I've had regular clients; I know them really well. I've been with them for 16 months now. I just see them almost every day so I just know we have great relationships with people we see."

People told us staff treated them with respect and dignity. Comments included, "The care workers are very kind and respectful towards me, always give me respect and dignity", "They are extremely caring, they give me dignity all the time; I could not live without them", "I am extremely happy with my care worker; [care worker] is very kind, caring, respectful to me" and "They always give me respect and dignity; I would not have it any other way."

Care plans were person centred and showed the service had sought information on people's past lives to help better understand them and the care they needed. Care plans focused on improving and/or maintaining their independence, highlighting the tasks they could do for themselves and maintaining links with the community wherever possible.

Where people were unable to speak for themselves or had no relatives to do so, we saw the service used independent mental capacity advocates (IMCAs) to speak on their behalf and in their best interests.

The service was organised into teams based on geographic location. This helped improve the continuity of care workers. We looked at daily records of care, which showed people had a core group of care workers; this helped ensure good relationships developed between them. One person told us, "My care workers are brilliant. They support me, they give me that support I need, the independence I need, they give me that comfort that I can do things. I trust them more than ever. They are very caring. The young ones are very young but they are wonderful." Another person told us, "They talk to me; they joke with me, they are so caring. I really look forward to seeing them." A relative told us, "They laugh and make my relative smile; my relative cannot talk but they have such a good understanding by actions. They are so caring, respectful, they give [person] dignity."

We saw people's views and opinions were listened to by the service. People received a quarterly telephone monitoring call and the service had just sent out the annual satisfaction survey to people who use the service and relatives.

The registered manager told us where possible they matched care staff according to the background of people they supported, such as those whose first language was not English. This demonstrated the service was responsive to the diverse needs of people who used the service and working within the framework of the Equalities Act 2010. Other protected characteristics are age, disability, gender, marital status, religion and sexual orientation.

Staff had received training in equality and diversity and the service had an equality and diversity policy in place. However, in two people's care records, we saw the quality assurance check list stated in capitals, 'Service user guide not applicable.' We were concerned this was potentially discriminatory and spoke with the registered manager. They agreed this was not an appropriate statement to make, that every person should receive a service user guide, in an appropriate accessible format if required, and told us they would investigate this.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and care plans formulated to meet these needs. These included detailed information about the care and support staff were to provide at each visit. We saw care records focussed on achievable goals for people, such as being able to remain in their own home, or to maintain contact with the community.

Care plans were person centred and contained information about people's preferences and how they wanted their care to be delivered. For example, one person's plan said, 'I do not like to be called love, darling or pet, call me by my name. Do not put your gloves and aprons on until we are in the bathroom.' People told us, "I have met them when I have to go through the care plan." Another person told us, "Everything is always in the care plan, I sat down with them and we did it together."

Care records were reviewed with changes generally made where required. We saw people were asked if they were satisfied with the care and support they received. For example, we saw one person had requested a change in the time of their care visit and this had been actioned. However, one person's quality assurance checklist completed on 11 May 2018 stated, 'changes to tasks in care plan to be implemented' and 'care plan updating' with a completion date of 18 May 2018. This had not been completed at the time of our inspection on 6 June 2018.

People we spoke with told us they knew who to complain to. Responses from people about the concerns and complaints process were mixed. One person told us, "The office is good; they do listen and rectify things." Another person told us, "I have met the office when they come out to discuss the care plan; they are pleasant and nice." Other comments included, "Office staff are rude, they are defensive towards their staff, they do not listen to me" and "The office do not listen. I tell them that my [person] does not need care workers. They still send care workers. They also should ring themselves if they know their care workers are going to be late." We spoke to the registered manager who told us they had customer service training planned for all office staff and this would be completed by 2 July 2018. As further personal development, scenarios were going to be added to staff supervisions to ensure people had the skills and knowledge to deal with various types of calls.

The service had a complaints policy which stated, 'all complaints will be acknowledged in writing in three working days' and 'Caremark will provide you with a written response detailing the results of the investigation and any action that has been taken.' We saw 13 complaints had been logged in 2018 which detailed actions taken and the outcome of the complaint. We saw in most cases the complainant was contacted with details of actions taken and an apology where required. However, some information contained in the log did not include investigation information and we did not see written responses or acknowledgements in others. The operations manager told us they would ensure this was put in place.

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

The registered manager informed us they were not currently providing care for people at the end of life. However, they have cared for people at the end of life, and would work alongside other to meet people's needs and wishes.

A number of compliments had been received, including praise for staff and end of life care. Comments included, 'All the carers were absolutely fantastic. They arrived on time, took time to talk to my [relative] and they were so gentle with [relative] in [relative's] last days. We as a family could not have asked for a better carer or provider at such a sad time for me and my family. I would always recommend them', '[Name of care staff] was wonderful. She made [relative] feel special toward the end… has a natural compassion to care. All the staff were great', 'I have nothing but praise for [name of care staff's] standard of work and her caring interaction with my [relative]' and 'If there are any issues, they are addressed by management promptly.'

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service in May 2017, we found the service was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because although there were some quality assurance systems in place designed to continually monitor the service, they were not sufficiently robust. This was discussed with the provider at the time of inspection who confirmed they would address this matter.

However, on this inspection we again found some shortfalls in the service, which had not been identified through the audit and quality assurance monitoring systems in place.

Throughout the inspection, we found the provider's governance and record keeping systems had not been operated effectively. For example, call logs were audited sporadically and concerns we identified with medicines administration records should have been identified through a robust system of checks.

A range of audits and quality assurance processes were in place with actions and analysis to learn and drive service improvements. These included medication audits. However, some of the monthly audits for January 2018 documentation had not been completed until May 2018. This meant that systems were not sufficiently effective as regular checks to monitor and improve the quality and safety of the service were not always in place. We saw where actions had been identified these were not included in a continuous improvement action plan with time frames for completion to ensure that service was learning and managing future performance.

We were concerned about the repeated breach of Regulations found at this inspection. Robust governance and quality assurance processes should have ensured the service was compliant with Regulations.

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

The provider used a number of tools to gauge people's perception of the service quality and include people in the running of the service. This included quarterly telephone quality satisfaction calls and annual surveys. People who use the service told us, "Good company, they communicate with me. I would recommend this company to others", "They are well managed. They come to see me. They send questionnaires out. I could not wish for a better company. I know what I am talking about as I was a nurse for 30 years" and "Excellent company, we get heard, they listen." However, other comments included, "Management are busy, they listen, but too busy to come back to me" and "Management change, they do not inform service users or carers. They listen but do not act upon anything. We fill in questionnaires but we get no feedback."

Electronic call monitoring system had been introduced. This allows real time monitoring of staff activity to help improve the safety of the service, whilst providing greater oversight of staff activity whilst working in the community.

Team meetings were held regularly. Staff told us, "Yes, we do have staff meetings quite frequently; they encourage positive and negative feedback as well. They ask us for advice as well", "We have regular staff meetings which I always go to, I find them okay it's nice to see everyone when I go" and "We have them; we've had 2 in the last 7 months I think. It's mainly the managers who lead it so no I don't speak up."

Monthly newsletters were sent to staff as well as annual staff satisfaction surveys. We looked at the responses from the latest staff survey which had just been completed and was awaiting analysis/collation. Responses were mainly positive, although some staff had concerns about travel time and receiving timely information about changes to care packages for people they supported. The monthly news letter was used to recognise staff and their achievements and good news stories.

Staff competency to administer medicines was regularly assessed to help monitor and improve the medicines management system. Staff received spot checks on their practice. This looked at a range of areas, including how they interacted with people, whether they completed care and support tasks correctly and if they of appropriate appearance. This helped ensure staff worked to consistently in relation to medicines. However, we were concerned about staff's lack of knowledge around 'as required' (PRN) medication.

Most staff told us the registered manager was approachable. Comments included "I feel comfortable raising concerns with the manager; the culture of the team is good I would say. I do see new faces in the office a lot but I tend to stick to my team", "Yes, it's a good team and culture; I would raise anything with the manager and I know they would do something about it "and "If we picked the right time to visit the manager I think they would listen but sometimes they don't. In terms of poor practice, I would hope they would but I can't be sure."

The manager told us they attended local provider meetings and work with the local authority commissioning team to keep updated and share best practice. This demonstrated the service actively worked in partnership with other agencies to offer effective solutions for the people they supported.

People's views were sought and used to make improvements to the service. People's feedback was sought through spot checks, care reviews, quality surveys and regular phone calls.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines not administered safely.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits and monitoring not effective.

The enforcement action we took:

Warning Notice