Direct Carers Ltd

Direct Carers - York

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We completed an announced comprehensive inspection on 31 January 2017. We gave the provider 48 hours' notice of our intention to undertake an inspection. This was because the organisation provides a domiciliary care service and we needed to be sure that someone would be at the agency office that could assist us with the inspection. The registered provider first registered this service with the Care Quality Commission on 29 April 2015. During a previous inspection in March 2016 the registered provider was rated as Good in all domains.

This domiciliary care agency is registered to provide personal care for people with a range of varying needs including dementia, learning disabilities or autistic spectrum disorder, mental health, older people, people who misuse drugs and alcohol, people with an eating disorder, physical disability, sensory impairment and younger people who live in their own homes. At the time of our inspection nineteen people received a personal care service.

The registered provider is required to have a registered manager in post and on the day of this inspection there was a registered manager registered with the Care Quality Commission (CQC). A registered manager is someone who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We found that the agency had not followed their own policies and procedures when recruiting new staff and that this could have resulted in people receiving care from staff who were not suitable to work with vulnerable people.

This was a breach of Regulation 19 (1)(a)(b) (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Fit and proper persons employed.

Staff had received training in medicines management and the registered provider had an associated policy and procedure in place. However, the registered provider had not maintained accurate and up to date records when people received support with their medicines.

Systems and processes in place that ensured staff received up to date training were not always effective in their purpose as some staff training and most supervisions were overdue.

The registered provider had implemented an electronic call monitoring system. However, we found that care workers did not always stay for the full call duration which brought into question the effectiveness of the electronic call monitoring system.

The above concerns were a breach of Regulation 17 (1) (2)(a)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance.

Staff and management understood the requirements of legislation under the Mental Capacity Act 2005 (MCA). Staff told us they always assumed people had capacity unless assessments identified otherwise.

Staff encouraged people to make their own decisions. People were involved in their care planning and we saw where people had capacity to do so they had signed their consent to the care and support.

Care workers we spoke with understood the types of abuse they might see and knew how to respond to protect people from avoidable harm and abuse. People's needs were assessed and risk assessments put in place to protect people from avoidable harm.

Staff confirmed they received induction training when they were new in post and told us that the training provided for them ensured they had the necessary skills required to commence their role. The training records showed that staff had completed induction training and the training that was considered to be essential by the agency, although we found some refresher training was overdue.

The feedback we received confirmed that people had positive relationships with care workers and it was apparent that care workers genuinely cared about the people they supported. People received their care and support from regular staff which meant that care workers knew how best to support the individual person. This consistency helped people to develop meaningful caring relationships.

People told us that care workers treated them with dignity and respect and staff told us they understood how to maintain their confidentiality.

There was a complaints policy and procedure and this had been made available to people who received a service and their relatives. People and their relatives we spoke with told us they were confident of raising any concerns and that these would be acted upon.

There were systems in place to seek feedback from people who received a service and we saw that most of this feedback was positive. There were minimal systems in place to request feedback from staff.

We found the registered provider was in breach of two regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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.

Staff were not recruited following the agency's policies and procedures and this could have resulted in people who were not suitable to work with vulnerable people being employed.

People received their medicines safely. However, accurate consistent and up to date records of medicine administration were not always maintained.

Systems and processes were in place to protect people from avoidable harm and abuse and staff understood how to report any concerns.

People's needs were assessed and proportionate risk assessments put in place to minimise risks and prevent avoidable harm.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to meet people's individual needs and this was electronically recorded. However, some refresher training required updating.

The service was following legislation under the Mental Capacity Act 2005 and staff assumed people had capacity unless assessments proved otherwise.

People were supported to eat and drink and care workers were aware of individual dietary requirements and people's food preferences. These were recorded in people's care records.

Is the service caring?

Good

The service was caring.

People using the service had developed meaningful and positive caring relationships with the care workers.

Care workers supported people using the service to be actively involved in making decisions about the support they received.

People were treated with dignity and respect and care workers understood the importance of maintaining people's confidentiality.

Is the service responsive?

Good

The service was responsive.

Everybody receiving a service from the registered provider had a care plan in place and this was reviewed and updated annually or in response to any change in people's needs.

The service was responsive to people's needs. Both the carer and the person being cared for were involved in discussions regarding their care and support needs.

There was a complaints procedure in place and people told us they knew who to speak with if they had a concern or a complaint.

People were consulted on the quality of their care and corrective measures were implemented where required.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance checks including audits had been completed but had failed to identify and address concerns we found during our inspection.

Policy and procedures for the safe administration and recording of medicines were not followed which led to incomplete records.

Employees were aware of their roles and responsibilities and when to escalate their concerns.

Direct Carers - York

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 registered 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 site visit to the agency office took place on 31 January 2017 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the agency office to assist us with the inspection. The inspection was carried out by two adult social care inspectors.

Before this inspection we reviewed the information we held about the agency, such as information we had received from the local authority who commissioned a service from the registered provider and feedback from people who used the service.

The registered provider was asked to submit a provider information return (PIR) before this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with a care coordinator, the registered manager and the registered provider and other staff in the office. We also spent time looking at records, which included the care records for five people who used the service, the recruitment records for six care workers and other records relating to the management of the service, including quality assurance, staff training, health and safety and medication. We visited one person receiving a service in their own home and following the inspection we spoke with one relative, two people who used the service and three members of staff.

Requires Improvement

Is the service safe?

Our findings

We looked at the recruitment records for six members of staff. These records evidenced that an application form had been completed, references had been requested and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults.

However, we found that one care worker's employment references had arrived two months after they had commenced work and another care worker's employment references had arrived four months after they had commenced working for the agency. In addition to this, two care workers had only one employment reference in place instead of two when they first started work. One of these references contained information of concern and there was no evidence that this had been followed up by the registered provider. The agency's recruitment and selection policy stated that two written references would be obtained prior to people commencing work.

We saw that one care worker's DBS check had not arrived for almost two months after they had commenced work. Again, the agency's recruitment and selection policy stated that a DBS check would be obtained prior to people commencing work.

This meant there was a lack of assurance that everyone who was employed by the agency had been confirmed as suitable to work with vulnerable people when they first commenced work. This is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Fit and proper persons employed. You can see what action we told the provider to take at the back of the full version of the report.

Where people required assistance from staff to take their medicines, care plans included information and guidance for staff based on a completed risk assessment. This information included the amount and type of support the person required to take their prescribed medicines in a safe way. This was signed by the person or their representative, which demonstrated their agreement.

We saw care workers had received training in Medication. However, medication refresher training was scheduled for two employees in May and December 2016 and this had not been completed. The registered manager told us, "These employees were scheduled to receive the training in December 2016 but this was postponed; they have now been scheduled to attend the training at the end of February 2017." People confirmed they were happy with the way their medicines were managed. One person told us, "It's something I don't have to worry about, they manage it all; they order replacements, give me what I need when I need it and I am very happy with this." The registered provider had an up to date medication policy and procedure and an audit system was in place that was used to check medication administration records (MARs) where they had been completed by staff. We looked at MARs for six people. We found these records contained omissions and insufficient information was documented to provide a reason where a person had not received their medicines. This meant the registered provider had failed to maintain accurate and up to date

records for people's medicines. You can see the action we took regarding this in the well led section of this report.

Staff and people we spoke with confirmed there were enough staff to meet people's current needs. A care worker said, "We are a really great team and work well together, we always have cover available where it's needed." People confirmed that staff arrived on time. One person told us, "It's York, traffic can be busy so sometimes care staff are a few minutes late but it's infrequent; if they are going to be really late then they let me know." And "They always have plenty of time to do what is required." We looked at daily records that showed when a care worker had arrived and departed from a person's home. The registered provider told us these calls should be for thirty minutes in duration. However, we found one recorded the visit had lasted five minutes and another, ten minutes. A further record showed calls of between 15 and 20 minutes duration had been recorded. The registered provider showed us an electronic call monitoring system that flagged up any late, missed or short calls. They told us they would be implementing measures to evaluate this information to improve call duration for people.

People told us they felt safe when care workers were in their home. Comments included, "Yes, I do [feel safe]; I have a regular group of care workers and I trust them all." This was supported by the relatives who we spoke with who told us, "I wouldn't leave [person's name] if I had concerns over their safety, the care staff are very good."

People were protected from abuse and avoidable harm. The registered manager showed us records that confirmed care workers had completed training on safeguarding adults from abuse and the staff who we spoke with confirmed this. However, we saw refresher training in safeguarding for two members of staff had not been completed. The registered manager told us, "[Staff name] has been overlooked due to an admin error and the trainer has been informed," they continued, ""[Staff name] will be booked onto training immediately."

Staff were able to describe different types of abuse and were clear about the action they would take if they had any concerns. They told us that they would report any concerns to the registered manager and that they were confident any concerns would be looked into and actions taken in accordance with the agency's policies and procedures. We looked at the folder where information on safeguarding adults from abuse was stored. This included a copy of the agency's policies and procedures and information about the local arrangements for reporting concerns to the safeguarding adult's team. Our checks confirmed these were followed and where appropriate to do so, concerns had been escalated for further review. Two of these concerns had been referred to the local safeguarding team but notifications had not been submitted to the Care Quality Commission (CQC) in line with the requirements of registration. You can see what action we took under the well led section of the report.

The registered provider showed us the whistle blowing policy and procedure. Care workers told us they would use the whistle blowing policy if needed and they were confident that this information would be handled confidentially. A whistle blower is a person who raises a concern about a wrongdoing in their workplace or within the NHS or social care setting.

We checked five care plans for people who received a service from the registered provider and saw they contained a risk assessment that recorded any identified risks to the person's environment and how these could be minimised to protect the person concerned and any staff who visited their home. In addition to this, there were risk assessments that were specific to the person whilst they were in receipt of support, for example, with their mobility and the administration of medication.

We saw that, when people received support with shopping, staff obtained receipts and completed a financial form to record this transaction. This protected people from the risk of financial abuse.

Accidents and incidents were recorded and maintained in a file. Blank templates were available for completion that included a report form, an investigation form and a monthly audit. This meant accidents and incidents could be analysed so that any patterns that were emerging could be identified and any improvements needed to practice could be actioned.

There was a business continuity plan that recorded how staff should deal with emergency situations such as loss of IT equipment, loss of utilities, flu pandemic and severe weather conditions, as well as the level of risk involved in each of these scenarios. This provided staff with advice on how to manage unexpected or emergency situations.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection. We checked whether the service was working within the principles of the MCA and found that people using the service did not have any restrictions in place at the time of this inspection and that no applications had been made to the Court of Protection. The registered provider told us, "Where we have any concerns regarding people's capacity, we involve the local authority who complete additional assessments and submit any applications under the MCA."

Care plans recorded whether the person had the capacity to consent to their care plan. They included a form that recorded the person's consent to receiving 'examinations and treatment'. We discussed with the registered provider how it would be more appropriate for these forms to record 'support or assistance with personal care' as the agency did not provide nursing care.

People's care plans included information regarding whether they had the capacity to make decisions about their care and support. Staff told us they had completed training awareness of the MCA as part of their induction to their role and confirmed their understanding of the MCA. A care worker said, "It's about assuming people have capacity until they are assessed as not; as such they make their own decisions." Another care worker said, "I always seek consent from people, I discuss what I am doing and I ask them their opinion; I don't make decisions for people when they are capable of making their own."

Care workers we spoke with confirmed they had completed an induction programme and had been provided with a copy of a job description, a staff handbook and a 'codes of practice' handbook that contained information about their employment and the standards that they were expected to adhere to. Staff also received copies of various policies, including the policy on confidentiality and the use of social media. Along with this information, the induction included the topics of working in a person-centred way, health and safety, safeguarding adults from abuse, moving and handling, medication and basic life support. This training had led to the completion of the Care Certificate for three out of five of the care workers employed. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

The registered manager told us that new care workers shadowed experienced care workers as part of their induction process. However, this was not evident in the staff records we looked at. The registered manager explained that forms to record shadowing were introduced at the end of 2016. One person had been employed in January 2017 and we were told they were completing the shadowing process. We recommend

that the registered provider ensures all staff complete shadowing as part of their induction training, and that this is clearly recorded.

Staff were supported with training that helped them have the skills and knowledge they required to meet people's needs. The care coordinator provided us with a copy of training records for staff. This recorded when staff had completed training considered to be essential by the registered provider, the date that the care worker had completed the training and the date refresher training was due. We found that not all refresher training that had been scheduled for staff had been completed. This included refresher training in safeguarding, medication, basic life support and the MCA. . We discussed this with the registered manager who told us, "The refresher safeguarding training for one person was an admin error; we had the other scheduled but the trainer left; we have recruited a new trainer and we are rescheduling this as a priority."

The training record also showed when staff had completed the Care Certificate and a National Vocational Qualification (NVQ). The Qualifications and Credit Framework (QCF) award has replaced the NVQ award and is the national occupational standard for people who work in adult social care. Staff told us their training was well managed and was a mixture of on-line training and some face to face training in the agency's training room. We saw that one care worker employed in August 2016 had not completed all of the required induction training with Direct Carers Ltd. but this was scheduled in for their completion.

Staff told us they felt supported in their role. Care workers said, "We don't have structured supervisions at the moment but we are only a small team so we have plenty of opportunities to discuss any concerns." And, "We have spot checks and where there are any concerns we have a meeting to address any issues." We saw from staff records that staff received periodic supervision in their role that highlighted any concerns and checked their competency in delivering care and support and associated activities. This included medication competency assessments and unannounced observations but we found these were not routinely scheduled. The care coordinator told us that, if any concerns had been identified during these checks, a supervision meeting would have been arranged. An improved structured programme of reviews with staff was being implemented and this included a shadowing check register, a medication competency check register, a six-week review register, a quarterly review register, an informal appraisal register, a spot check register and a formal appraisal register. These had only recently been introduced and none had been completed at the time of this inspection.

Care plans included information about any dietary or nutritional needs for people. We saw that where people were supported with their meals, any preferences were documented. Care workers we spoke with told us they would follow these guidelines but that the final choice was up to the person. One person told us, "I like anything from a potato; chips, crisps and my favourite egg, chips and beans." They continued, "Care staff know what I like and I help out with the preparation and get things ready." Another person said, "They [care workers] help me with my shopping; I make a list and they always get me what I have asked for."

Care plans recorded information about people's general health and any medical conditions that had been diagnosed. Staff told us they would ring the agency office if they had concerns about a person's general well-being and either a care coordinator or senior care worker would then ring the person's GP.

Good

Is the service caring?

Our findings

People and their relatives told us that care workers who visited them in their homes were caring. One person said, "They [care workers] are so helpful, they help me get up and are patient with me." A relative told us, "We had two care providers but I choose Direct Carers Ltd. over the other one because they have a good reputation and are a very caring organisation; it's true they really care about [person's name]." Care workers confirmed they were a small team of people who really care. One care worker said, "It is a job but it is not about the money, the people I visit are like family, we build close caring relationships; the people I visit matter to me." Another care worker told us, "We have good communication between us [staff] and we all know people's needs, it helps us to provide a really caring service."

People confirmed they knew the care workers that came to their home. They told us they received care from regular carers and when these were away they usually knew the person who stepped in. One person said, "[Care co-ordinators name] will step in when [care workers name] is off and they are on the ball; I never have to worry about who is coming to see me - they are all a good bunch."

The registered provider told us in the PIR, 'From the very beginning a new staff member working with us will understand that we encourage all staff to involve and treat people with compassion, kindness, dignity and respect.' This was confirmed in our observations and discussions with staff. Care workers understood the importance of treating people respectfully and in a dignified manner. We asked staff how they ensured they protected people's privacy and dignity whilst assisting them with personal care. They told us they would make sure doors were locked, curtains were closed and that people were covered to protect their dignity. A care worker said, "When I am providing personal care such as bathing, I always ensure the person is happy with what I am doing and I ask them if they would like to cover areas we are not bathing and encourage them to do what they can to help out." People confirmed care workers were respectful. One person said, "Staff know it's my home and they respect that, they are always considerate of what I ask and they always announce themselves when they arrive."

Care workers told us they understood how to maintain people's confidentiality. A care worker told us "I never discuss things that people I care for tell me with other people, except those that are involved with their care." And "I always keep any discussions private, people need to be able to trust us and sometimes they don't have anybody else to speak to."

People were supported to maintain their independence where ever possible. Care plans included information about people's wishes and preferences and care workers were aware of this information and told us they were respectful of people's choices. One care worker said, "There is one visit I make and the person likes to help out with their meal." They continued, "I always encourage them to be involved as much or as little as they want to and I know how happy that makes them, you know, to have some control over their lives." People confirmed care workers were supportive and encouraged them to be independent. A person told us, "Without the care staff I wouldn't be able to remain living in my own home, they are brilliant."

One person had the details of an advocacy service recorded in their file. The care coordinator told us,

"[Person's name] has a history of mental health issues and has some communication difficulties." They said, "As part of the care package the local authority put the advocacy in place to help support the person to understand their choices and have a voice." Advocacy services are impartial and help people particularly those who are most vulnerable in society to access information and services so they can be involved in decisions about their lives. They help the person to explore choices and options and defend and promote their rights and responsibilities.

The induction process ensured staff had an understanding of the Equality Act. The Act is a law that came into effect in October 2010 and protects people from being discriminated against because of seven protected characteristics; race, sex, sexual orientation, disability, age (in certain situations), caring responsibilities (in certain situations), religion or belief. The registered manager confirmed the service did not discriminate. Staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

People had a copy of the service user handbook in their home file and this contained information about the complaints procedure, as well as confidentiality, equal opportunities, risk taking and risk management, safeguarding, the philosophy of care, privacy / confidentiality, the principles and values of the service and personal choice, as well as the contact details for the agency both within and outside of office hours. This ensured people had been provided with information about the agency and the service they could expect to receive.

The registered provider told us they completed both announced and unannounced spot checks on care workers. They told us this included observations to confirm staff were upholding the fundamental core values of care from their uniform to their approach, and how they communicated with the individual person. A care worker confirmed, "We have spot checks, it can be a bit unnerving when they are unannounced but I don't mind as I always try and do my best for people."

The registered manager told us they were not currently caring for anybody receiving end of life care. They told us they worked closely in partnership with health professionals including Macmillan nurses to ensure that any rapidly changing care needs were responded to. The registered provider told us in the PIR, 'Direct Carers has a full policy and procedure regarding end of life care but we know care of the dying and terminal illness requires a team approach and we liaise closely with family and other professionals to ensure a caring and coordinated service.'

Good

Is the service responsive?

Our findings

Everybody who received care and support from the registered provider had a record of how they wanted to be supported and we saw people had been involved in an initial assessment and reviews of their daily needs. Care records we looked at included an assessment of the person's care and support needs that included personal care, general health, mental capacity, continence, dressing, diet and medication. Care plans also included details of a person's medical condition and details of other people who were involved in their care.

People told us that their care plans were reviewed on a regular basis and the care plans we saw in people's own homes contained up to date information. A person told us, "My care plan was last reviewed when I had a water infection, they [care coordinator] updated the information so everybody knew what was going on; they are pretty good at managing everything." Care workers told us they thought care plans were good and reflective of people's needs. A care worker said, "The care coordinator will visit the person and will go through the records with them and their families, it's quite an informal process." Another care worker said "People's records are updated at least once a year and when there are any changes in their needs."

We saw that care plans included brief information about people's likes and dislikes. This provided staff with some background information about the person and enabled staff to provide care and support that was person-centred. The registered provider told us that they planned to re-introduce a 'one page profile' that included easily accessible information about the person's previous life history and lifestyle. They told us this would give staff more information so they could provide individualised care and support to the person.

The registered provider showed us a complaints and compliments log and we saw these included forms ready for people to complete if they wished to make a complaint. The registered provider told us on the PIR they had received four compliments and two complaints in the previous twelve months. The registered provider confirmed they evaluated complaints for trends and they told us on the PIR, 'As there have been so few there is no recurring theme'.

People were encouraged to raise their concerns. The registered provider had a complaints policy and procedure in place and information that provided guidance for this process was available in people's care plans in their own homes. We asked people if they would be happy to raise a concern or complaint and who they would speak with. A person said, "I don't really have cause for complaint but if I did I would have no problem speaking with one of the care workers or the care coordinator." A relative said, "There is some information about complaining or raising concerns in [person's name] file; I would speak to the office if we had any concerns about staff or anything else but we are quite happy with everything." Care workers confirmed they encouraged people to discuss their feelings during everyday conversation. A care worker said, "I always ask people how they are, if they are happy with everything; they [people] know how to complain and as a team we make sure anything people raise is addressed without delay." One person we spoke with told us, "My daughter has power of attorney and sorts out all my daily concerns; I would speak with my daughter if I wasn't happy and she would liaise with the office and I know they would do something about it."

The registered provider told us how they obtained feedback on the service. They told us in the PIR, 'We have separate questionnaires for all areas but we feel that collating the information and sending bi-annually will get a better response as we will get individual concerns highlighted during spot checks, reviews, support plan updates throughout the year and we do not wish to overwhelm the service users or staff with too many surveys.' People confirmed they provided feedback on the service they received as part of their reviews and when senior staff were completing spot checks on care workers in their homes. Some care plans included records of spot checks that had been carried out by care coordinators or senior care workers. These gave senior staff the opportunity to observe staff practices but also to ask people if they were satisfied with the service they received.

The registered provider told us they sent out a generic 'service user survey' but that this information was not evaluated by individual service location. We checked the quality assurance records and noted a 'client / family' questionnaire had recently been distributed. We noted the responses had been rated and this was used to focus on any areas that required improvement. A commissioner for the local council told us, "Feedback from customer surveys in the form of 'you said we did' was circulated showing where action had been taken and [registered provider name] is always keen for feedback on areas where there could be improvements and to learn from experience."

Requires Improvement

Is the service well-led?

Our findings

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely. However, some records were not up to date including those in people's care plans and some medication administration records.

The registered provider completed quality assurance checks such as audits of areas of the service that included people's care plans and the management and administration of medicines. During our inspection we found that Medication Administration Records (MARs) contained errors and omissions. For example one MAR included 17 entries that had not been signed or completed by care workers to evidence the persons medicines had been administered and a further 16 where a 'O' for 'other' had been entered but no further narrative for the reason had been documented. Another MAR for a person recorded a prescription for antibiotics that were prescribed four times a day and an additional prescription for AM and PM. The MAR had been signed twice a day for the antibiotic and once a day for the other prescription. It was unclear if the medicine had been administered as prescribed. The care coordinator explained the person self-administered some of their medication where staff had not signed and they showed us where this had been documented in diary notes for the antibiotics. A third MAR included an audit chart but this had not been completed and when a person required the application of creams there was no body map in place to direct staff where the cream was required. We raised these concerns with the care coordinator who told us this information was recorded electronically and on paper. They showed us a body map template that was being introduced to record the administration of creams and they told us that the person had regular care workers who had knowledge of where to apply the cream. Further checks confirmed that complete accurate and up to date records had not been completed for each person and medicines audits in place had failed to pick up and address the concerns we found.

Additional monitoring systems were in place that highlighted anything that was overdue, such as staff training, appraisals and spot checks. Training information was passed to the in-house trainer and information about appraisals or spot checks was passed to the relevant care coordinator or senior care worker. However, despite the systems and processes in place we evidenced these checks were not always effective in their purpose as some staff training and most supervisions were overdue.

There was a policy and procedure in place that included checks that helped to ensure only those staff deemed suitable to work with vulnerable people were employed. However, we found that this guidance was not always followed and audits to ensure these checks had been completed had failed to identify some of the concerns we found.

The registered provider had implemented an electronic call monitoring system. They told us in the PIR, 'Direct Carers have introduced new call monitoring forms which allow us to plot late calls and allow us to anticipate any problems in a more proactive manner.' During our inspection people told us they were happy with the times their carers arrived. However we found that care workers did not always stay for the full call duration. For example we found some calls that should have been for thirty minutes were recorded between

five and twenty minutes of duration. This made us question the effectiveness of the electronic call monitoring system.

We discussed our concerns with the registered provider and we were assured that the planned actions and new procedures which they advised us were due for implementation would result in improvement. However these shortfalls in recording and inconsistencies in the service provided are a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance

The registered provider is required to have a registered manager as a condition of their registration. At the time of our site inspection there was a manager who had registered with the Care Quality Commission.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. We discussed the submission of notifications with the registered manager. We found two events had been recorded, investigated with outcomes and actions in place. However notifications for the two events had not been sent to the CQC. The manager was recently registered with the CQC and was completing outstanding tasks. The registered provider told us they understood the importance of submitting notifications and they submitted those outstanding retrospectively during the inspection period.

Where accidents and incidents had occurred the registered provider showed us how associated information was recorded and investigated, with documented outcomes and actions completed and signed off by the registered manager. This meant the registered provider had effective systems and processes in place to manage and learn from accidents and incidents that helped to protect everybody from avoidable harm.

Everybody spoke positively about the way the service was managed. There was a clear structure of staff in place and those we spoke with had a clear understanding of their individual roles, responsibilities and where and when to escalate any concerns.

There had been no recent quality assurance surveys distributed to staff. The registered provider told us they planned to send one out by the end of February 2017, and we saw details of the staff questionnaire that was due to be sent out.

The registered provider had not held any staff meetings since February 2015. We discussed how it would be helpful for staff to meet periodically so they could discuss the people who received a service and the registered provider informed us this was on their 'to do' list. Care workers told us they felt staff meetings would be beneficial, as long as they were held in York.

Care workers told us they felt they were very well supported and were able to contact somebody in the organisation should they need to. They told us they were kept up to date with best practice, information about the organisation and people's individual needs in a variety of ways including a newsletter. We saw the newsletter for the Christmas and New Year period included a thank you to staff for their hard work, the importance of call times, staff appearance, information on an open day and other social events such as 'Secret Santa' and 'Christmas jumper day'. The registered provider told us they were in the process of amending the newsletter to include information from the central team based in Beverley as they informed us this office was integral to the administrative support of the York office.

It was apparent from the information we saw that the registered provider was aware of good practice guidance in respect of supporting people who lived in their own home, such as local authority information about safeguarding adults from abuse and the requirements of the Health and Social Care Act 2014. They

told us they kept up to date with new developments by checking the CQC website, the local authority website and by reading care sector publications.