Castlerock Recruitment Group Ltd

Castlerock Recruitment Group Limited Gateshead

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This inspection took place on 24, 25, 26 and 27 May 2016 and was announced.

We last inspected this service in November 2013. At that inspection we found the service was meeting the legal requirements in force at the time.

Castlerock Recruitment Group limited is a domiciliary care agency that provides personal care predominantly to adults and older persons, some of whom may have a dementia-related condition in their own homes. It does not provide nursing care. At the time of this inspection, the service was providing care to 14 people in Sunderland and North Tyneside.

The service did not have a registered manager. The previous registered manager had left the service in May 2015. A new manager was in post at the time of this inspection and advised us they were in the process of registering. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe from harm. Staff received regular safeguarding training and were aware of the different types of abuse people might experience. Staff were aware of their responsibility for recognising and reporting signs of abuse. People told us they felt safe. People were asked to give their written consent to their plan of care and staff always requested verbal consent from people prior to providing care or assistance.

Possible risks to the health and safety of people using the service were assessed and appropriate actions were taken to minimise any risks identified. People were assisted to take their medicines safely by staff who had been appropriately trained.

Robust systems were in place for the recruitment of new staff members. Risk assessments were completed on any potential staff members with a criminal record to determine whether or not they were suitable for the role. Staff were given the appropriate support and training they required to work effectively, and received regular supervision.

People's health needs were assessed prior to them joining the service. Care packages were produced with people's input. Care records provided staff with step by step instructions on how to support people in a way of their choosing. Support was provided to people in a manner that reflected their wishes whilst also enabling them to remain as independent as possible.

Staff were described as kind and caring and people told us they were treated with respect. Regular reviews were undertaken of people's care packages to ensure these continued to meet their needs. Where people

asked for changes to be made to their care packages, they told us this was completed promptly. There was regular contact between the provider and people using the service, seeking feedback and offering support. People and their relatives felt able to raise any questions or concerns and felt these would be acted upon.

People told us they were happy with the management of the service and knew who to contact should they have any concerns. Staff we spoke with felt supported by the manager and were able to easily access support when they required it. The provider had a range of systems in place for checking the quality of the service. However record keeping around actions taken to resolve areas for improvement was poor. We recommend the provider introduces a more robust system for capturing areas for improvement and the actions taken to resolve these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of the signs and symptoms of abuse and their responsibility for reporting these.

Risks to people were assessed and appropriate measures taken to keep people safe from harm.

Robust systems were in place to check the suitability of new staff members.

People were assisted to take their medicines safely.

Is the service effective?

Good

The service was effective.

Staff received appropriate levels of training, supervision and appraisal.

People's rights were protected, and they were asked to give their consent to their care and treatment.

Is the service caring?

Good

The service was caring. People spoke highly of the caring nature of the staff who supported them.

People's privacy and dignity were protected. They were encouraged to be as independent as possible and make choices about their daily lives.

People were treated as individuals and encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People's care plans were reviewed on a regular basis and where changes were required these were made promptly.

People were regularly asked for their feedback on the service they received and action was taken to address any areas of concern.

Is the service well-led?

Requires Improvement

The service had not always been well-led. The service did not have a registered manager in post.

There was an open culture in the service that sought and acted upon the views of people, relatives and staff.

Systems in place to monitor and develop the effectiveness of the service did not capture details of actions taken to address areas for improvement.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24, 25, 26 and 27 May 2016. This inspection was announced. The provider was given 48 hours' notice of this inspection as the service is a small domiciliary care agency and we needed to make sure the provider's representative was available to assist us with this inspection.

This inspection was undertaken by two adult social care inspectors. Before the inspection, the provider completed a provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we talked to four people who used the service by telephone and three relatives. We spoke with staff including the manager and four care workers. We reviewed a sample of three people's care records, three staff personnel files and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they had no concerns about their safety and felt able to raise any issues they had with the provider. One person said; "I would feel comfortable to raise concerns," and another said; "If I was unhappy with anything I would call the number in the red file." Relatives of people who used the service told us they felt their relatives were safe and that they felt able to leave them with the carers either overnight or when they went out.

The provider had a safeguarding policy and procedure in place. These documents provided details of the provider's responsibility for recognising and reporting abuse. Guidance was provided to staff on the different types of abuse and the signs and symptoms people being abused may display. Staff received safeguarding refresher training on an annual basis. Staff we spoke to showed a good awareness of what constituted abuse and of the process for reporting any concerns or suspicions of abuse.

Records showed the service had reported two incidents of potential abuse in the previous 12 months. Full details of these incidents and any investigations undertaken were clearly documented. We found the service had made appropriate referrals to other agencies including the local authority and the Police.

The 'service user guide' given to people using the service contained details of the provider's responsibility for protecting them from abuse. It also provided people with relevant contact details so they could raise any concerns they had directly with the provider or other relevant agencies, including the Care Quality Commission.

The service had a business contingency plan which covered the actions to be taken in order to continue the service in the event of an emergency. This covered emergencies, for example the loss of the office and ICT (Information Communication Technology) access, such as the computer system used by the service. It also covered the action to be taken in the event of high levels of staff sickness and severe weather conditions. This ensured that staff were clear on the processes to follow if such an emergency should arise.

We reviewed care records for three people using the service and found as part of their initial assessment potential areas of risk were identified. We found risk assessments were in place for areas such as medication, personal safety, moving and handling, home environment, finances and food and nutrition. Where appropriate, these risk assessments provided guidance to staff on reducing risks. One person using the service had been identified as being at risk of falls, their care record instructed staff to; "Encourage [name] to use their walking stick or walker in the house and in the community." Risks were reviewed on a regular basis and where there was a change to a person's needs, their care package and any associated risk assessments were updated to reflect this.

We reviewed the financial records for one person using the service. These consisted of a bound book which contained entries for small items purchased for the person. In general we found the records to be clear and there was evidence these were regularly audited by the manager. Although receipts were not retained with the records we were advised by the manager these were reviewed during audits and then archived. With the

exception of one minor error which we highlighted to the manager we found the entries balanced. We did however highlight that receipts weren't numbered and there was nowhere to record the name of the person using the service on the financial record.

The safety of staff was protected by the provision of health and safety training, regular reviews of people's care packages and the use of personal protective equipment such as disposable gloves and aprons. The provider had a lone working policy and procedure which provided advice and guidance to staff on maintaining their personal safety when completing calls on their own out in the community. Staff we spoke to felt supported by the provider and said they were easily able to contact the office for advice when required.

We spoke to the manager about staffing. We were told as part of the initial assessment of people's needs an agreement was reached about the number of hours of care a person required. The manager advised this was then checked against staff availability before a decision was made about whether they could support the person.

We reviewed the client visit sheets for three people using the service. These informed people of the times of their calls and the member of care staff who would be providing them with care. We found calls had generally been scheduled in line with the persons care package. We found a discrepancy between one person's care package and their allocated calls and highlighted this to the manager. The manager confirmed the care package information was out of date and that this would be updated following the inspection.

The manager advised client visit sheets were sent to people using the service at the end of each week. People using the service were then able to contact the office if they had any concerns or queries. One person told us when they contacted the office to ask for a change to be made to their calls for personal reasons "They were very understanding, it was no bother and was sorted straight away."

Staff we spoke with felt they were allocated sufficient time to complete their tasks whilst still having time to speak to people and ensure they were okay. One staff member told us the only exception to this was the occasional 15 minute call they completed, which they felt could be quite rushed if they had a number of tasks to complete. We highlighted this to the manager. People we spoke with felt staff had sufficient time to complete their tasks during calls and said staff always stopped for the full length of their calls.

Robust systems were in place for the employment of new care workers. We found interview questions were very comprehensive and covered people's understanding of abuse, privacy, dignity, equality and diversity and choice as well as their skills, experience and qualifications. Appropriate checks were undertaken with the Disclosure and Barring Service (DBS) and where a potential staff member was found to have a criminal record, a risk assessment was completed to determine whether the person was suitable for employment as a care worker. References were sought and people's right to work in the UK was also checked.

From the records we viewed and our discussions with people, relatives and staff we established the vast majority of people using the service only required minimal assistance with their medicines. We viewed the Medicines Administration Records (MAR) for two people using the service. These were on pre-printed charts which were well laid out, with ample space for clear record keeping. We found there was a gap in the records for one person using the service but were advised by the manager this was because the person had cancelled their scheduled call that day.

We found some of the codes used on the MARs, such as "A" did not correspond with the key on the

document and there was nowhere for staff to record notes explaining the use of this or other codes. We highlighted this to the manager. Following the inspection the manager contacted us to provide us with a copy of the new MAR chart which was being introduced by the service on 1 June 2016. This included the addition of other codes used regularly by staff, as well as an additional sheet for staff to record notes.

We reviewed the provider's policy and procedure for administration and assistance with medication. In general we found this to be appropriate, however we did highlight to the manager that the guidance did not refer to the Royal Pharmaceutical Society of Great Britain's guidance; The Handling of Medicines in Social Care. The manager advised this was a companywide policy but that this would be brought to the attention of the area manager.

Staff members we spoke with had received recent medicines training and were aware of the importance of checking medicines prior to administering them. Staff were also aware of the need for good hand hygiene practice and explained specific details about people's medicines could be found in their care plans, a copy of which was always kept in the person's home. We found regular audits were completed of people's MAR charts. Where issues were identified it was not always clear what action was taken to resolve this. The manager explained that this was a recording issue and advised this was something that would be reviewed following the inspection.

Good

Is the service effective?

Our findings

People told us they felt they received an effective service from staff who knew what they were doing. Comments included; "I look forward to seeing them…. they know what they're doing," "They're exceptional, they do exactly what I ask," "I would give them ten out of ten" and "They seem very competent." Although people told us that their carer's were not always on time, they explained they were normally only a couple of minutes late and they always apologised for this. People told us where staff were going to be longer than a few minutes late, they were generally informed of this by the office; "They always phone to let me know if they're going to be late". Overall people we spoke to told us the service they received was very good and they were satisfied with it.

New staff received an induction before starting work with people. This included an initial period of classroom based training, during which they worked towards the Care Certificate in health and social care. It also included a period of shadowing during which new staff attended calls with existing staff to observe their practice. Staff we spoke with were complimentary about their initial induction and in particular the level of training they received. Staff members told us they felt supported by the provider and felt able to contact the office for advice and guidance where required.

The provider's policy for supporting staff included a commitment to providing six supervisions and an annual appraisal each year. Staff records we viewed contained supervision records. Supervision meetings covered topics such as; time keeping, employment issues, team working, health and safety issues or concerns as well as training and development. We found areas of concern were openly and clearly addressed, with expected standards explained and actions agreed where necessary. Records we reviewed indicated staff received supervisions on a frequent basis, in line with the provider's policy and staff we spoke with confirmed this.

We looked at the training records for four members of staff. We found they had received all received mandatory training in areas such as medicines, safeguarding and the Mental Capacity Act (MCA). The provider had a system for checking compliance against training records on a monthly basis and any required training was scheduled in advance.

Staff we spoke with felt they had received sufficient training to complete their jobs effectively and spoke highly of the training in general. One staff member told us; "It's probably the best I've ever done." Another staff member told us they had requested additional training and this had been arranged for them straight away.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had a policy with regard to the MCA and DoLS, and staff training records we reviewed confirmed staff members had received training in connection with the MCA. The care plans we viewed showed a person's mental capacity was assessed when they joined the service. Care plans informed staff of a person's capacity and gave guidance for decisions where a person required assistance, for example around personal care. We saw evidence the provider was aware of people's right to make advance decisions. One person had a relative who held a lasting power of attorney or LPA (LPA is a legal tool that allows the person or the courts to appoint someone to make certain decisions on a person's behalf). This person had been consulted on all decisions about the person's care and had signed relevant documentation to confirm their involvement in this process.

In the three care records we reviewed we saw consent to care and treatment had been obtained when the person first joined the service. This had then been reviewed on a regular basis in line with reviews of the person's care plan. In one of the records we viewed we saw a relative had signed some documents on the person's behalf despite the person being assessed as having capacity. We asked the manager about this and were advised the person was visually impaired and on occasions was unable to sign documentation. On these occasions, the person's relative, with the person's consent, had been asked to sign relevant documentation on their behalf.

Staff we spoke with were aware of the need to seek people's consent prior to providing care and treatment. Staff were also aware of people's right to refuse care and treatment and said they would respect people's wishes where this was the case. People we spoke with told us staff always asked them for their permission prior to providing care and were respectful of their wishes.

From the records we viewed and our discussions with people, relatives and staff we established the vast majority of people using the service only required minimal assistance with their food and fluid intake. Records showed staff generally prepared meals for people using the service and training records showed staff had received appropriate food hygiene training.

Where a person had a specific care need in relation to food or fluid intake we found food or fluid monitoring charts were available. Staff members we spoke with were aware of these documents and of the importance of completing these.

Care records highlighted the importance of ensuring people had sufficient food and fluids and where necessary, specific guidance was provided to staff. People's care plans included details of any dietary needs including any allergies as well as their likes and dislikes. Staff told us they would always offer people a choice when preparing food and people we spoke with confirmed this. Where people had asked for specific food or fluids, we found this had been captured in their care plans, for example: "[Name] would like CRG staff to prepare breakfast of a small amount of cornflakes with 3 prunes and a splash of milk, 2 slices of toast with butter and marmalade and a cup of tea with milk and no sugar."

People's health needs were assessed when they first joined the service and then on a regular basis thereafter. Contact details for relevant healthcare professionals were documented in people's care plans and staff we spoke with knew where to find these details. We found the provider worked in conjunction with

other agencies in the provision of care to some people using the service and this was managed efficiently.

Good

Is the service caring?

Our findings

People spoke very highly of the caring nature of the service they received. One person described their carer as "Lovely, with a very caring attitude." Other comments included; "I can't fault the care I receive," "Their presentation and everything is marvellous," "They're very considerate, very gentle, very patient" and "They're very nice, very kind." One relative told us the carers were "Very respectful, they do everything my [relative] asks them to do" and another told us "They're very polite, helpful and understanding… I think they're excellent overall."

Care records we reviewed contained details of people's life histories including their likes and dislikes, places of importance, details of their immediate support network and their preferred communication method. Staff we spoke with told us they used this information to start up conversations with people when they first started to support them. One member of staff explained how they would try to find common interests with a person in order to get to know them.

People we spoke with did not feel rushed by staff during calls and told us staff always asked whether there was anything else they would like doing before they left. Staff we spoke with confirmed this, telling us that with the exception of 15 minute calls, they felt they were allocated sufficient time to provide people with the support they required. One person told us their carer would always "sit and have a chat whenever they have time" and another person told us how their carer had assisted them to go out into the community when the lift in their accommodation had been broken. People and relatives we spoke with felt their carers knew them quite well and one person told us; "I can tell them anything."

The service was aware of the need to respect people's preferences and people we spoke with told us where they had specifically requested male or female carers this had been respected. We found people's care plans were developed with people's input and agreement and, where changes needed to be made to any aspect of a person's care package, they were consulted about this. For example, one relative told us when the service had proposed a change to the time of their relative's calls this had been discussed with them beforehand.

Care records we reviewed had been signed by the person using the service or a relevant representative and people we spoke with were aware of the information contained in their care plans. People we spoke with told us their care plans were reviewed on a regular basis and the records we reviewed confirmed this. We saw where there was a change to a person's circumstances new care plans were created in consultation with the person or their representative, where appropriate.

Staff we spoke with were aware of the need to involve people in their care and told us how they offered people choice. For example one staff member told us when preparing food for someone they would "Offer them options after looking to see what was in the fridge or ask them first what they wanted." People's care records provided information to staff about decisions people required assistance with. Care plans contained step by step instructions for staff to support people in making these decisions.

People and relatives we spoke with told us staff were very respectful. Staff we spoke with were able to give examples of how they would maintain a person's privacy and dignity, for example through ensuring blinds and curtains were closed prior to providing personal care. People confirmed staff always asked them for permission prior to providing care. One relative we spoke with told us how staff would encourage their relative but if their relative declined care, they would respect their wishes. Staff members told us where people declined assistance they would document this in a person's communication log book and also inform the office.

As part of an assessment of people's needs, factors such as their age, disability, gender and religion were taken into consideration. Where people were identified as having a particular need in any of these areas, there was the capacity to incorporate this into their care plan. For example where a person was identified as having faith or religious beliefs, there was a section of their care plan which provided advice and guidance to staff about how to support the person in maintaining these.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One person told us "Staff know what they're doing and always ask if there's anything else I want doing before they leave." Another person told us they had requested a change to their care package and they had received "An immediate response, they reassured me and understood why, they were absolutely marvellous." Another person told us when they had reduced the care package for their relative they had "No bother changing it."

An assessment of a person's needs was completed when they were first referred to the service. These assessments were comprehensive, covering areas such as health, mobility, fears and phobias, life history, preferred communication methods and areas where support was required, for example medicines. There was evidence people were fully involved in this process and they were asked about their perception of their needs. Views and opinions of people's relatives were also sought as part of this process.

The information gathered from the initial assessment process was used to draw up detailed, person-centred care plans, which provided step by step instructions to staff on how best to support people in the way they preferred. Care plans provided guidance to staff on the level of assistance a person required and where they were able to self- care this was clearly documented. This meant people's independence was not unnecessarily compromised. Staff we spoke with confirmed care plans were always available in people's homes and provided them with the information they required to meet people's needs.

Regular reviews were completed of people's care plans to ensure they were accurate and, where changes were required, these were made in a timely manner. One relative we spoke with told us that following a change in their relatives care needs a full review had been completed and new care plans had been produced and implemented quickly. People told us where changes had been required these had been made "Straight away… had been no bother," and staff had been "Very understanding."

The "service user guide" contained an overview of the provider's complaints policy and procedure and informed people what action the provider would take should they make a complaint. Information was also provided about other agencies people could escalate complaints to if they were not satisfied with the response they received from the provider.

We reviewed the provider's policy and procedure for dealing with complaints. These stated complaints would be investigated using a four stage process and gave specific details about the action required at each stage of this process. For example, stage two stated the provider would confirm receipt of a complaint within three days. Staff would be informed of the allegation and asked to respond in writing. The provider's policy and procedure emphasised the importance of good quality responses to ensure continuous improvement and internal reporting measures were in place to ensure complaints were dealt with appropriately.

We reviewed the complaints log and found two complaints had been made in the previous 12 months. Both of these complaints related to the same person and had been made by the district nurse. Although we found

the level of detail recorded on the complaints log to be quite limited, there were separate more detailed records within the file itself. These provided details of the nature of the complaint, any investigation and the outcome. We could not find a copy of the outcome letter in relation to these complaints. The manager advised one had not been issued on this occasion as it had not been the person who had complained. Instead, we were advised a meeting had been held at the person's home with both the district nurse and the person's social worker in attendance.

We also reviewed the provider's compliments file. An entry from 6 February 2016 stated; "Staff handled [relative's] care needs with efficiency and professionalism; always with a friendly attitude. [Name] brought experience and compassion." Although the vast majority of compliments were not dated we noted very similar remarks; "they were all so wonderful … comforted [relative]," "[Name] was very understanding and compassionate towards my [relative]," "[Name] was an outstanding carer. Compassionate and considerate. An asset to your group." Comments in the compliments file supported what people we had spoken with had told us about the service and the staff.

We reviewed the summary report for the results of a quality questionnaire carried out in April 2016. The service received largely positive responses throughout. 100% of the people asked stated they felt staff kept them safe, understood their needs, were flexible and willing to do things the way they wanted them done. 100% of people said staff respected their dignity and choice at all times, were caring, polite and respectful and responded to their needs. 100% of people asked also said they had very good, regular communications.

We saw action had been taken to address the only negative response received in the survey; where two people had commented that their carer's were not always on time. An action plan had been implemented and there was evidence this issue had been discussed in further detail with the people using the service and their relatives. In addition to this, we saw evidence this had been addressed through supervision and additional spot checks with the members of staff concerned.

Care records we reviewed showed regular telephone monitoring reviews were completed to get feedback from people about the service they were receiving. People also told us they received regular contact from the office to check that everything was okay.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with felt the service was managed well. People told us the manager contacted them on a regular basis to check to make sure they were happy with the care they were receiving. People said they felt the manager was friendly and approachable and they would have no concerns about raising any issues with them. Comments included: "The service is good overall," and "[manager] comes out on a regular basis to check everything is okay." One person told us they felt the manager was "Very sensible and easy to speak to," and another told us they liked the way the manager spoke to their relative, describing the manager as "Encouraging them."

The service did not have a registered manager in place at the time of this inspection. The previous registered manager had left the service in May 2015. An acting manager was in post and they advised us they were in the process of registering with the Care Quality Commission to manage the service.

People and staff described an open culture within the service with good communication channels. People we spoke with told us the manager visited them or spoke to them on a regular basis and that they had contact details for the office should they require them. Where people had raised concerns about the service they felt they had been listened to and appropriate action had been taken in a timely manner to resolve their concerns. One person said, "When I asked about a change to my carer it was an immediate response." Staff told us they felt able to raise concerns with the management team and had access to relevant contact details in order to do this. Staff we spoke with were aware of the provider's whistleblowing policy and procedure and said they would have no concerns raising issues with the manager, head office or other agencies such as the Care Quality Commission where appropriate.

The manager advised us that they had an open door policy and staff were able to come into the office or call to speak to them at any time. Staff we spoke with confirmed they felt the manager was approachable and that they could always contact the office for assistance; "I ring the office all the time" and "They're all really canny, very approachable and easy to speak to."

During the inspection we asked to review the accidents and incidents log but were advised they hadn't been any in the previous 12 months. We did however view the provider's policy and procedure for dealing with accidents and incidents. We noted staff were encouraged to report any concerns including near misses and the provider had a process for investigating and reporting on accidents and incidents.

Records we reviewed indicated staff team meetings were held on a quarterly basis. We found there was a clear record of the topics discussed during team meetings and evidence that staff had been praised for hard work. Areas covered during team meetings included; feedback from people using the service, carer of the month, confidentiality, communication books, MAR chart recording and use of personal protective equipment. We found topics were covered in adequate detail and informed staff of expected standards of work. However, we noted there was no attendee list and as such it was not possible to determine which staff had attended. Not all of the staff we spoke with were aware that team meetings took place. Staff members who were aware that team meetings took place told us they were not always able to attend. Where staff had

been unable to attend team meetings, copies of the minutes were not sent to them. We discussed this with the manager who confirmed the service did not keep a record of attendance. The manager advised this would be rectified following the inspection and a system introduced for circulating meeting minutes to staff members who had been unable to attend team meetings.

Staff we spoke with felt they received an appropriate level of support from the manager and the provider as a whole. Staff members felt they were kept up to date with relevant information and were notified promptly of any changes in care required for the people they supported. One staff member told us when a person they supported had passed away they were notified of this immediately. The staff member advised this prompt notification had prevented them from attending the person's home for a scheduled call and potentially causing distress to the person's relatives.

The provider had a range of systems in place for checking the quality of the service. These included the completion of regular surveys and reviews with people using the service and monthly quality monitoring checks on people's medication records, communication log books and finances if applicable. In addition to this, the manager completed regular spot checks to assess staff performance. Internal audits were also completed and included areas such as health and safety, service management, staffing and comments and compliments.

We saw evidence that issues or areas for improvement identified during audits and surveys were carried forward and action was taken to resolve these. However we found records documenting this were poor. For example we found a client file audit completed in January 2016 had identified one person as requiring a new care plan and service user agreement. We checked this person's care records and found a new care plan and service user agreement had been completed. However the client file audit sheet from January 2016 had not been updated with the action taken. This meant it was not initially possible to determine what action the service had taken to resolve the area for improvement identified in the January 2016 client file audit. We highlighted this to the manager, who agreed the documentation could be improved.

We recommend the provider introduces a more robust system for capturing areas for improvement and the actions taken to resolve these.