

Xtracare Agency Ltd

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Inspection report

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Requires improvement



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



Overall summary

This inspection took place on 12 and 19 January 2016 and announced. Xtracare agency Ltd is a domiciliary care service. The service provides personal care for people living in their own homes. At the time of the inspection, 26 people were using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last time we inspected this service in February 2014 the service was meeting all the regulations we inspected.

At this inspection, we found the provider had breached six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to person-centred care, need for consent, safe care and treatment, safeguarding service users from abuse, good

Summary of findings

governance and staffing. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of these regulations. We will report on action we have taken in respect of these breaches when it is complete.

The provider had safeguarding policies in place to give staff guidance to protect people from an allegation of abuse. However, people were at the risk of abuse because staff had not promptly raised allegations of abuse we found. People were at risk of receiving unsafe care because the registered manager and staff had not updated and reviewed people's care plans or assessments. Risks to people were not routinely identified or plans were not in place to monitor and manage risks. There were insufficient staff to meet people's care and health needs because the service did not have an accurate record of the numbers of people they provided services for.

The management of people's medicines were not safe because staff did not have medicine management training. Medicine administration records (MAR) were not fully completed and medicine audits did not occur. Therefore, it was unlikely that the registered manager could detect medicine errors and take action to reduce the likelihood of unsafe medicine management.

Staff did not have any support, induction, supervision, appraisal, and training to support them in their caring roles. The registered manager did not provide staff with an opportunity to discuss and plan training and support. The registered provider did not have processes in place to ensure that staff were equipped to appropriately care and support people.

The registered manager and staff did not understand the requirements and their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had not obtained consent from people or their relative when providing them support to meet their needs. Staff we spoke did not have an awareness or knowledge of consent or mental capacity assessments.

Staff did not support people to access health care when required. People did not receive a service, which was responsive to their needs. Staff did not respond to people's changing care needs and the way care and

support was delivered did not meet their individual needs promptly. Staff had not recognised that people could benefit from referrals to health and social care professionals for additional support or equipment.

People were not always treated with kindness and compassion by staff. People we spoke with told us staff were kind and caring. We found that staff did not identify and act on people's needs promptly which demonstrated a lack of kindness and compassion.

People or their relatives did not make decisions about their care because they did not have the opportunity to do so. The registered manager had no arrangements in place to enable people's involvement in or make decisions about their care.

Assessments of people's care needs were completed on an initial visit to them. However, people did not contribute to the assessment or planning of their care. There were no processes or systems in place to ensure people had regular reviews of their care needs.

The registered provider had systems in place for people to complain about the service or aspects of their care. When people started using the service, they had a copy of the service's handbook, which had a copy of the provider's complaints policy and process.

The provider did not have a system in place that sought people's feedback on the service. People and their relatives did not have opportunities to give their views about the quality of care. Staff were not able to provide feedback to the registered manager, because this was not in place. The registered provider did not arrange meetings for staff and they did not have the opportunity to make suggestions about how to improve the service.

The day to day operation of the service was not effectively led, coordinated, and managed by the registered manager. They did not demonstrate an understanding of their responsibilities as a registered manager. Office based staff did not receive clear leadership and support to deliver their roles effectively. The registered manager did not have an overall view of the service because they were not always in the office.

Summary of findings

The recruitment process used by the service was robust; staff employed at the service had appropriate checks carried out before working with people. People had their meals provided by staff, which met their needs and preferences.

People had respect from staff and their dignity maintained. People had care delivered in their home and had privacy when they wished. People told us and records showed that staff had delivered care which, demonstrated staff respected their privacy and whilst retaining their dignity.

People's care records were stored securely in a locked cupboard. Staff had access to people's record when they required this.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of 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?

This service was not safe. There was a safeguarding policy in place at the service. However, staff failed to raise an allegation of abuse promptly.

Risks to people were not routinely identified and plans to monitor and manage them were not in place.

People did not receive their medicines safely.

The service had inadequate staffing levels to ensure people were safe.

Recruitment processes were effective and appropriate checks taken up before staff worked with people.

Inadequate



Is the service effective?

The service was not effective. The registered manager and staff were not aware of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff did not have any training, supervision, and appraisal to support them in their roles.

Staff did not support people with access to healthcare professionals when required.

People had meals, which met their healthcare needs and requirements.

Inadequate



Is the service caring?

The service was not always caring. Staff did not understand people's needs, wishes, likes, dislikes, and their care was not delivered in line with them.

People and their relatives were not involved in making decisions about how they received care.

Staff did not always treat people with kindness and compassion. People had the dignity and privacy that they needed.

People were supported to be as independent as they chose.

Requires improvement



Is the service responsive?

The service was not responsive. People and their family were not involved in or have the chance to contribute to assessments of their needs.

Staff did not act on people's changing needs.

People, relatives, and staff did not have an opportunity to feedback to the provider about the quality of care.

Systems were in place for people to make a complaint.

Inadequate



Summary of findings

Is the service well-led?

The service was not well led. There effective processes were not in place to monitor the quality of the service.

Meetings for staff did not occur so they did not have the opportunity to make suggestions about how to improve the service.

Staff did not seek feedback from people and their relatives. There were no processes in place for people to give formal feedback to staff or the registered manager.

There was a registered manager in post.

Inadequate



Xtracare Agency Ltd

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 12 and 19 January 2016, and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by two inspectors. Before the inspection, we looked at information about the service we held, including notifications. A notification is information about important events, which the service is required to send us by law.

We spoke with three people and two relatives who use the service. We also spoke with the registered manager, the care co-ordinator and six care workers.

We looked at ten care records, five staff records and other records relating to the management of the service.

After the inspection, we spoke with representatives from the local authority commissioning teams and safeguarding teams in the London Borough of Lambeth and in the London Borough of Southwark.

Is the service safe?

Our findings

People told us that they felt safe with the care that they received. However, we found that people did not always receive a service, which was safe and met their needs.

People were at risk of abuse because the registered manager did not have effective processes in place to reduce the risk of abuse and manage this risk. The provider had a safeguarding policy in place to give staff guidance on how to protect people against the risk from harm. Staff told us that they would raise an allegation of abuse with the registered manager if they suspected this. However, we did not find any evidence that the registered manager had followed their safeguarding policy or made appropriate referrals to the safeguarding team. The registered manager had not sent us a notification of a safeguarding allegation. We found the registered manager and staff had not identified when people were at risk of abuse. During the inspection, we found two people were at risk of neglect. This was because they did not have an assessment of their individual needs, and support or appropriate equipment was not in place to reduce the risk from physical harm and neglect. For example, a person was at risk of developing pressure ulcers but there was no risk assessment in place and therefore risks were not identified. We also found appropriate equipment was not in place to reduce this risk.

The registered manager had not identified that staff practices put people at risk of abuse because of the unsafe delivery of care. People were at risk from harm because staff practices had not protected them from this. For example, staff did not have an awareness of safe moving and handling techniques to keep people safe. After the inspection, we made two safeguarding referrals to the local authority safeguarding team and they were investigating our concerns.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not identified and managed appropriately, increasing the risk of them receiving inappropriate care. In all the care records we looked at, we found there were no risk assessments or management plans in place for people. For example, we found concerns about a person who had limited mobility as well as other complex needs. Their assessment identified that they were at 'high risk of falls'. We checked their care records and

found there was no risk assessment or risk management plan in place to manage and reduce those risks identified. We asked the registered manager how staff supported the person to manage the risk of falls. The registered manager told us that staff knew the person well and cared for them safely. One care worker told us "No I don't know anything about risk assessments but we don't need them, we know what [person] needs." We spoke with a relative of the person who told us that two carers lift their relative from their bed into their wheelchair at the morning care visit and back to bed in the evening. The relative confirmed there was no moving and handling equipment in place for the person to support them safely with their individual moving and handling needs. We were concerned about this practice and raised a safeguarding alert with the local authority for investigation. Risks to people were not identified, managed appropriately, or mitigated against; therefore, they were at risk of harm.

We found another incident, which made us concerned that the care delivered was unsafe. A person had complex health needs and was dependent on staff to deliver full care. They required the assistance of two care workers with their moving and handling needs. We asked the registered manager for the daily logs record for this person to evidence that they had the support in place as needed. The registered manager gave us three copies of the most recent daily logs record held in the person's care records in the office. These logs were dated 5 June 2015 to 5 July 2015. The records did not indicate that two carers supported the person while using a hoist. After the inspection, we spoke with a care worker about the moving and handling needs of the person they cared for, they told us they helped to move the person with the assistance of their relative. The person's care records did not state that their relative helped with moving and handling and whether they had training in safe moving and handling practices. Therefore, people were at risk of harm because staff had no risk assessments and management plans for guidance to support people appropriately.

Staffing levels were not regularly assessed and monitored to ensure they met people's needs. People were at risk from not receiving care because the registered manager was not clear how many staff required to care for people or who should be receiving care. The registered manager gave us a list of nine out of ten care workers and names of people they visited. We were told that the list was incomplete. We asked the registered manager to provide us with the details

Is the service safe?

of the numbers of people using the service. We were provided with five different numbers of people using the service. These were; seven people, 10 people, 23 people, 25 people and 26 people. We discussed the level of staffing with the registered manager they told us there should be 25 people using the service. We contacted two local authorities commissioning team who confirmed 26 people had a care service commissioned with the agency. There was a risk that people did not receive visits because the service did not have records which showed how many people received care or which care workers visited people. The registered manager did not have processes in place that monitored or reviewed care visits undertaken therefore staff had not identified, monitored, or resolved promptly missed care call visits. We found that most people and their relatives spoken with told us their care workers were reliable and arrived on time.

We contacted one person, who the manager told us was receiving care from the service by telephone. The person told us they had ceased to use the service for some months because they no longer required it. The registered manager demonstrated that they were not clear on the numbers of people they provided a service for. Therefore, the registered manager could not assess and monitor the level of staff based on the needs of people.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of these regulations. We will report on action we have taken in respect of these breaches when it is complete.

People were at risk of harm because their medicines were not administered safely. We found errors on the records of the administration of people's medicines. We asked for all people's medicines administration records (MARs) to evidence that people received their medicines as prescribed. We received MARs charts for three people. There were no other MARs available because there were no others were stored in people's records. On each of these

MARs, there were errors. For example, all MARs we looked at had gaps or missing information on them. There were no descriptions or a reason given for the gaps because staff had not used any medicine management codes to explain them. Staff we spoke with did not understand their role in supporting a person with the management of their medicines.

People were placed at risk of receiving inappropriate treatment because the MARs charts were not accurate, increasing the risk of medicine administration errors, affecting their health and well-being. We spoke with the registered manager about the gaps in the MARs and they told us that staff had completed the MARs incorrectly. The registered manager told us that staff had completed medicine management training. However, staff told us that since their employment with the service, they had not completed medicine management training. We asked the registered manager how they assessed staff competency to manage people's medicine. The registered manager told us there was no process in place to make this assessment. This meant that there was a risk that people would not have medicines as prescribed, increasing risks to their health.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of these regulations. We will report on action we have taken in respect of these breaches when it is complete.

People were cared for by staff that had been assessed as suitable to support them. The provider had a safe recruitment practice. Checks took place on staff's suitability to work with people. We spoke with staff who told us that they had completed an application process and had an interview. The provider undertook criminal records checks and references had been taken up before staff came to work at the service. Staff records held copies of documents used in the application process.

Is the service effective?

Our findings

People were cared for by staff that were not supported in their caring role. We spoke with staff about the support they received from their manager. Some staff said they had supervision with their line manager, while other staff said they did not. However, we found that staff had not received regular supervision.

Staff did not receive any supervision from managers to ensure they were supported to carry out their duties properly. When we spoke with staff about their supervision, one care worker told us, “No, I don’t get supervisions or spot checks. The manager just calls me to keep a tab on what’s going on.” Another care worker said, “No I don’t think I get anything like supervision. I just go to the office if I need help.” We asked the registered manager whether they had arranged supervision for staff. The manager told us that they had not organised supervision for staff since 2014. We checked the staff records and found that there were not any supervision records on them. This meant that people were at risk of receiving inappropriate care because staff did not have a formal method to raise and discuss concerns while caring for people.

Some staff said that they had ‘spot checks’ carried out by the manager who would attend when they were providing care to check the quality of their work. For example, one care worker said, “The manager comes to see me from time to time and I don’t know to expect her. She calls me up afterwards and tells me I’m doing a good job and I get feedback from person’s family too.” Another care worker said, “I get a spot check every month. The feedback is good and is focused on improvement.” We asked the registered manager whether staff had ‘spot checks’ we were told they were carried out on a regular basis. We asked the manager for records of staff ‘spot checks’. The manager informed us that they had not recorded them. People were at risk from harm because there was no record, which proved that the provider assessed and reviewed staff competency to care.

People were at risk because they received care from poorly supported staff that did not have an opportunity to gain knowledge and skills to provide effective care. This increased the risk to people’s health and wellbeing. Staff did not have the opportunity to identify their training and professional development needs to enhance support them in their caring role. The provider’s policy stated staff would receive an annual appraisal. We asked the registered

manager whether they had completed appraisals for staff and for copies of them. They told us that they had plans to complete staff appraisals, but there were no confirmed plans in place for this. We did not find any staff appraisal for 2014 or 2015. All the staff we spoke with and staff records we looked at confirmed that they did not have an annual appraisal.

Staff did not receive support through effective training, supervision, and appraisal to carry out effective care. One relative told us, “they [care workers] need more training in dementia, they don’t understand my relative’s needs properly.” One care worker told us, “I have not had safeguarding training with [provider]. I am doing it on my own.” Another care worker who supported a person living with dementia had not undertaken dementia training from the provider. They told us, “I have done dementia training years ago before I started this job, nothing while working for this agency.” The registered manager had not arranged for staff to complete mandatory or specialist training. Staff did not have training or an understanding of moving and handling, management of medicine, basic life support, dementia care, or safeguarding awareness necessary for their role. For example, we asked the registered manager for a copy of the staff training programme. They told us there was no staff training programme in place and staff had not received any training from the provider since the last inspection in February 2014. Staff were not provided with guidance from current best practice to care effectively for people. Staff did not gain current knowledge through training to equip them to provide care.

These issues were in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider did not have an understanding of their responsibilities of how to support people within Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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

Is the service effective?

their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. DoLS applications for people living in their own homes must be made to the Court of Protection.

The registered manager and staff we spoke with did not have any knowledge of the principles of MCA. For example, all staff we spoke with told us they were not involved in, or aware of, the MCA or mental capacity assessments. They told us relatives worked with the registered manager if there were concerns about capacity. We did not see a record of people's mental capacity in their care records. People were at risk of their liberty unlawfully deprived because the registered manager was not knowledgeable about how to care for people using the principles of the MCA.

We checked care records to see whether people gave consent to staff when providing care. Care records did not record that staff obtained consent from people or their relative when providing them support to meet their needs. Staff we spoke with told us they were not involved in, or aware of, mental capacity assessments. Staff did not seek consent from people because they did not have training in MCA to enable them to support people to consent to receive care. People were at risk of receiving care and support which they had not agreed to or which they did not consent to.

These issues were in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not have access to appropriate health care and support when their needs changed. For example, a relative told us that their relative's mobility needs had changed and

deteriorated in the past two months. They said their relative needed support with moving about their home as this had become increasingly difficult but they did not have equipment in place. We checked the person's care records this was not recorded. When we spoke with the registered manager about the person's needs, they told us that staff were able to manage the person's needs and staff had not raised any concerns with them. The registered manager told us they had not made any referrals for additional support. We found that when people's needs changed the registered manager did not take any action to make appropriate referrals to get help from health and social care professionals. Therefore, people were at risk of deteriorating health because staff and the provider had not acted promptly to take action.

These issues were in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of these regulations. We will report on action we have taken in respect of these breaches when it is complete.

People had meals, which met their needs and preferences. For example, the care logs we looked at demonstrated that people were provided with meals and drinks which met their preferences and needs. We asked the registered manager how staff knew what people liked to eat and drink, they told us that people told staff on the day. However, people's care records did not record the food people liked and disliked. People were provided with meals they enjoyed and staff provided this for them. This meant that people had meals which they liked and met their individual needs.

Is the service caring?

Our findings

People we spoke with told us that staff were caring. One person told us “My regular carer helps me when I need her to. She is very kind and caring.” One relative said of the care workers, “They’re not bad. The carer is doing their best and they’re always on time.” However, what we found did not always reflect what people told us.

People or their relatives did not have the opportunity make decisions in planning their own care. For example, staff completed assessments with people, but their opinions and views were not recorded. Assessments did not take into account the full care and support needs of the person. They focussed on the completion of tasks, such as supporting people with their personal care. We asked the registered manager about people’s assessments. They told us that they were going to review their assessment form and the new assessment form would allow people to be more involved in the planning of their care. People did not receive person centred care because staff had not sought and understood their likes, dislikes, how they would like their care provided and what was important in their lives. People did not feel listened to or have the opportunity to contribute to their assessments or for their views to be taken into account when planning their care.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of these regulations. We will report on action we have taken in respect of these breaches when it is complete.

People told us that they felt staff respected them and most staff showed them kindness and compassion when supporting them. For example, when staff were helping them to carry out their personal care. One person told us “My carer helps me a lot and has patience with me, she is kind and gentle.”

People had the dignity and privacy that they needed. We were unable to observe interactions between staff and people. However, staff spoke about people they cared for in a respectful manner. They described how they delivered care to people while maintaining their privacy. People told us that staff respected their wishes and were flexible to meet their needs. People could be confident that staff treated them in a way, which valued them.

People were supported to be as independent as they chose. Staff were able to support people to take part in activities important to them. For example, some staff supported people to go to college every day and take part in activities provided by community support and social groups. This meant people were supported to take part in activities they enjoyed and were supported to attend social groups of their choosing.

Is the service responsive?

Our findings

People's support needs were not responded to promptly. People had an assessment of their needs before receiving a care service. However, once the care service began they did not have regular reviews of their needs. For example, we found a person did not have a review or assessment since they started to receive a service in April 2014. We found another example where a person had not had an assessment or review of their care since receiving a service in January 2015. We asked the registered manager for all the assessments and reviews for people they cared for. They gave us two people's initial assessment. There were no other assessments people's care records we reviewed. We found that there were no systems or processes in place to ensure people had an ongoing assessment of their needs.

People were exposed to poor care and support because their needs were not assessed and appropriate care put in place for them. One care worker told us that they were not involved in care plan reviews. They said, "The assessment and care plan is more or less left to the relative. We discuss what should happen and anything that might arise about extra need is dealt with by healthcare professionals." The registered manager told us they had intended to reassess all people's needs. We asked for but did not receive a copy of the care review plan, because care review assessments had not been organised.

People did not have up to date care plans, which met their needs. For example, we found only one care plan out of the care records we reviewed. The care plan did not contain people's personal histories, individual interests, and preferences. Care records did not demonstrate people were involved in their assessments collaboratively with staff. The registered manager told us that there were plans to

develop care plans with people so that their needs were current and accurate. We asked the manager for a copy of this plan, but there were no current arrangements in place for the review people's care plans.

People were at risk of receiving inappropriate care, because the provider did not review of people's care records. All people and their relatives we spoke with told us that they did not know what a care plan was and were not involved in or had not contributed to the planning and development of their care. One relative explained to us that they did not understand what care planning, care plan or risk assessments were. This meant that people were at risk of unsafe care because people did not have the opportunity to discuss how they would like to receive their care.

We saw an example where a person's care needs had changed. The person's care and mobility needs had changed but their care records were not update to reflect this. Staff did not follow the providers care management policy, which stated staff would regularly review people's care needs.

These issues were in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of these regulations. We will report on action we have taken in respect of these breaches when it is complete.

There was a system in place for people to complain about the service. Staff were aware of the service's complaints policy and were able to support people in its use if needed. Staff gave each person a client handbook, which contained information on how to make a complaint or raise a concern with the service. People we spoke with said that they did not have any complaints about the care or the service.

Is the service well-led?

Our findings

People did not receive a service that was well-led. The day to day operation of the service was not effectively led, coordinated, and managed by the registered manager. They did not have an overall view of the service because they were not always in the office. The registered manager did not understand their responsibilities and did not provide clear leadership and support to other staff to deliver their roles effectively. The office based care co-coordinator managed the service. They arranged for care workers to visit people in their homes to provide care. The care co-coordinator told us that they also dealt with enquiries from the local authority for example, managing care package referrals.

The registered manager had not taken actions to review, monitor, and improve the quality of care for people. Audits did not take place on the quality of care provided to people. We found that no quality checks of care records had taken place. This increased the risk that people received care and support that did not meet their needs. We found a number of gaps and missing information in service user's care records. For example, there were no care plans completed to detail people's needs and care support delivered to meet that need. People were at risk of receiving unsafe care, because the provider had no quality assurance systems in place.

The provider did not ensure that people's medicines were not managed safely. There were no processes in place to carry out an audit of medicines to ensure people's safety. For example, we found errors in the people's MARs but staff did not identify these. People were at risk of not receiving their medicines safely because there was no process in place to detect and manage medicine errors. The registered manager did not have a plan in place to monitor the quality of the management of medicine increasing the risk to people. This meant the people were at risk of an unsafe service.

People and their relatives were not encouraged to feedback of the quality of service. We spoke with the registered manager about how people gave feedback. They told us that staff made regular telephone calls to people to discuss with them any concerns or issues they had. We asked the registered manager, for records of these conversations. The registered manager told us that they had not made a record of them. The registered manager did not ensure people's wishes, views, and opinions were collected and analysed. This increased the risk of service users receiving poor quality care because systems in place did not accurately identify areas of concern we found during our inspection. We also found the service could not identify concerns promptly to reduce risk because the provided did not have any quality assurance processes in place to mitigate risks to people.

Staff were not supported to be responsible in their caring roles. The registered manager did not organise staff meetings. We asked them for minutes of the previous staff meetings; however, no meeting occurred since the last inspection in February 2014. One care worker said they had never had a staff meeting. They told us, "I've never met any of the other carers who work for the agency." This meant that staff did not have the opportunity to develop the service, share their concerns, or talk with other care workers to develop strategies relating to concerns raised in their caring roles.

These issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of these regulations. We will report on action we have taken in respect of these breaches when it is complete.

The registered manager and provider informed CQC of notifiable incidents that occurred at the service.

People's records were stored securely. We asked staff for people's care records and saw that they were kept in a securely locked cupboard in an office. People's personal and private information was kept safe and confidential.