Sabaoth Care Ltd

Sabaoth Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 5 January 2017 and was announced. The provider was given 72 hours' notice of our plans to complete the inspection. This was because the provider was a small domically care agency and we needed to be sure someone would be available to assist with the inspection.

Sabaoth care provides personal care to adults living in their own homes in Liverpool. The service had previously operated from a different location and moved to its current location in July 2017. This service is a domiciliary care agency. At the time of our inspection, the service was providing personal care to 12 people living in their own homes in the community.

There was a manager in post at the service who became registered with the commission on 11 January 2018 following our inspection site visit. 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.

Some care records contained confusing and inconsistent information regarding risk and measures to mitigate risk. This was, in part, attributable to the fact that the provider had recently acquired a new electronic system and people's information had not been transferred fully as yet. This placed people at risk of harm in the interim as staff did not have access to all relevant information they needed to support people safely.

We saw some evidence of systems to monitor, review and assess the quality of service however; there was a lack of established and routine audit which meant some areas of the running of the service were not being effectively and consistently monitored.

The majority of people who used the service managed their own medication but received prompts and reminders from staff. People told us they were happy with the support they received with their medication. Staff had received training in the safe administration of medicines. We identified some anomalies with the recording on Medication Administration Charts which we brought to the attention of the registered provider during our inspection.

People were supported by sufficient numbers of staff. However, staff were not always effectively deployed to promote punctuality of visits. We have made a recommendation regarding this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People told us that consent was sought and staff offered them choice before providing care. However, care files did not always reflect this and people had not signed their own care plans. We have made a recommendation regarding this.

Care records contained confusing and conflicting information in respect of people's nutritional and hydration needs and what support staff were required to provide with this.

All of the people we spoke with who used the service told us they felt safe when receiving care and support from the staff at Sabaoth Care.

People were protected from the risk of harm because staff could identify the potential signs of abuse and understood the reporting procedures.

We found that staff were recruited safely to ensure they were suitable to work with vulnerable people.

Staff were assisted in their role through induction, training and supervisions and staff told us they felt well supported in their role.

Care records showed that people's health care needs were addressed with appropriate referral and liaison with external health care professionals when required.

People told us that staff delivering their care and support were caring and respectful when they visited their home.

Care files contained relevant information around people's routines, preferences and level of care and support they required.

People had access to a complaints procedure and complaints were dealt with appropriately and in accordance with the provider's policy.

People who used the service were able to provide feedback about the quality of the service through quality assurance surveys.

The registered provider was aware of their responsibility to notify the Care Quality Commission (CQC) of notifiable incidents which occurred at the service.

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.

Some care records contained confusing and inconsistent information regarding risk and measures to mitigate risk.

Staff were not always effectively deployed to promote punctuality of visits.

People who used the service felt safe and staff demonstrated an awareness of safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider's records did not show how people were consulted with regards to their care and support needs. We have made a recommendation regarding this.

Care records contained conflicting information in respect of people's nutrition and hydration needs.

Staff were supported in their role through induction, supervisions and regular training. The training matrix reflected this.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and treated them with respect.

Staff worked with the aim of improving or maintaining people's independence.

Staff understood the importance of ensuring people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and outlined people's preferences, wishes, likes, and dislikes.

People had access to a complaints procedure and complaints were dealt with in accordance with this policy.

Systems were in place to gather feedback from people; in the form of quality assurance surveys.

Is the service well-led?

Requires Improvement

The service was not well-led.

Systems in place to monitor the quality and safety of the service were ineffective and quality assurance checks were not completed consistently.

There was a registered manager in post at the service.

People and staff spoke positively about the registered provider. There were regular staff meetings.

Sabaoth Care

Detailed findings

Background to this inspection

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

The inspection took place on 5 January 2017. We gave the provider 72 hours' notice of the inspection site visit because the service is small and we needed to be sure that someone would be available to assist with the inspection.

Prior to the inspection we contacted the local authority quality monitoring team to seek their views about the service. We were not made aware of any concerns about the care and support people received. We also considered information we held about the service, such as notification of events about accidents and incidents which the service is required to send to CQC. Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the last PIR received in January 2017 and used this information to inform our inspection.

The inspection team consisted of an adult social care inspector and an expert by experience who made phone calls to people who used the service and their relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we spoke with two people who used the service and nine relatives. We made efforts to speak to all of the people who used the service but some were unable to engage with us due to ill health. We visited the office and met with the registered provider and HR manager of the service. We spoke to three members of care staff and a senior carer. We also looked at five care plans for people who used the service, three staff personnel files, staff training and development records as well as information about the management and conduct of the service.

Requires Improvement

Is the service safe?

Our findings

We saw that risks to people's health and well-being were assessed. These explored areas such as; nutrition, falls and pressure areas. Assessment identified the hazard to the person and the control measures or action needed to help minimise the risks to people so they were kept safe. However, we found that some care records contained conflicting and inconsistent information regarding risk and the level of support people required to manage this. For example, one care plan contained a choking risk assessment completed in July 2017 which identified the person as being at high risk of choking. This had not been reviewed despite a further episode of swallowing difficulties in December 2017 which would have impacted on the scoring of risk. Furthermore, this information was not transferred to the electronic database which staff now used to inform their work with people. The electronic database also contained conflicting information because the nutrition and hydration plan recorded that the person's partner supported them with preparing food and drinks but also specified that staff were to assist and outlined a reminder to staff, 'I like drinking milk with thickener, carers to support me with my drinks and ensure I take them.' However, there was no information as to what consistency of drinks the person's drinks should be to prevent the risk of choking. The registered provider told us that staff were not required to support the person to eat and drink yet a review of the staff care visits indicated that staff had done this because staff had recorded what food and drink the person consumed during the care visit.

During this inspection we looked at how staff supported people with the management and administration of their prescribed medicines. The majority of people we spoke to managed their own medicines but received prompts from carers to check that they had taken their medication. Others, who required support with medication, were happy with how this was administered. We found that medication support plans sometimes contained contradictory information as to whether staff were required to prompt or administer medications. For example, one care file outlined that staff were to assist but also documented that the person's relative was responsible.

We reviewed the MAR's for three people. The MAR's we looked at were completed electronically with details of the medication dose and frequency. However, we identified some anomalies with the record keeping which indicated that some improvements were needed. We noted that some people had not received their medication, such as topical creams, but that there was no reason code entered as to why this had not been administered. We saw that the registered provider maintained oversight of MAR recording through their electronic system which raised an alert when a designated task of medicine administration had not been completed, however this was sometimes signed off as 'resolved' with no explanation as to what occurred. We discussed with the registered provider the need for MAR charts to be completed accurately.

The registered provider sent us documentation following our inspection which showed that two Medication Administration Audits took place on 4 October 2017 and a third audit which was undated. We found that these audits were not robust as they did not elaborate on concerns identified and did not specify what remedial action was taken in response. For example, one audit asked the question, 'Are all directions clear, i.e. not as prescribed?' The auditor had ticked 'no' but with no explanation or record of remedial action planned to address this issue. Similarly, the second audit answered no in respect of the question 'Are any

blanks in MAR charts being justified in daily notes?'. These audits appeared to have been completed by care staff with no evidence of managerial oversight. Furthermore, there had been no audits since this date which meant that the error we identified in respect of staff failure to record the reason code for medication not administered was not addressed by the registered provider prior to our inspection.

These findings constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who administered medicines had received medicine management training. Records contained information in respect of the medication people used, the route of administration, dose and level of support people required. There were electronic records to track whether people had been administered topical preparations (creams) and we saw body maps on charts which recorded the areas of the body the cream was to be applied to.

We saw that there was sufficient numbers of staff employed to meet people's needs. There were 12 members of staff employed to meet the needs of the 12 people receiving a service. One person's relative told us, "Double up calls are covered always and they arrive at the same time."

People's visits were planned on a rota. Some relatives told us that their loved one had experienced missed calls on occasion and staff sometimes arrived late for visits. They told us communication when this occurred was poor. Comments included, "They don't call if running late", "No they don't inform, I have to call up" and "Today's call was due at 1pm and its now 1.45pm, no call and no carer."

Some people's relatives told us they thought staff were rushed. Two relatives commented, "[Staff] don't stay the amount of time that they should" and "Some rush and leave early, but I get invoiced the full amount, have informed the office but haven't had a response."

We reviewed the staff rotas and saw that travel time was not built in to rotas. Most people who received a service lived in close proximity to others which meant that staff did not have to travel much between visits however we identified some back-to-back visits which were 14 minutes travel time apart. This meant that staff could not be on time for their planned visits and that punctuality was not promoted by the registered provider.

We reviewed the electronic database and saw that staff did not stay for the allocated time and consistently logged out of visits early. For example, we saw that staff stayed between five and eleven minutes for calls which were allocated for 30 minutes between the 17 and 22 December. We raised this with the registered provider who told us that the people who received a service preferred staff to leave after the tasks had been completed. However, the provider's own records showed a memo was issued to staff to remind them to stay for the allocated time for each call and a recommendation from the findings of the quality assurance survey was for staff to stay for the full time booked. Furthermore, a review of the provider's records showed that people's relatives had previously raised concerns about these issues and suggested that staff stay for the allocated time to provide emotional support and companionship outside of the 'tasks' which needed to be completed.

We recommend the registered provider review their rotas and staff scheduling to ensure that visits are effectively managed to promote punctuality of visits and in accordance with the time allocated.

People told us they felt safe receiving a service from the staff at Sabaoth Care. One person told us, "I have the same staff which is great so I know who's coming." People's relatives told us, "They talk to my [relative]

and make her feel safe" and "I feel safe as I know they are coming."

We checked how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We reviewed three personnel files of staff who worked at the service and saw that there were safe recruitment processes in place which included references from previous employment and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments.

Staff had access to safeguarding policies and procedures as well as a whistle blowing procedure (the reporting of unsafe and/or poor practice without fear of reprisals). Having a whistle blowing policy helps to promote an open and reflective culture within a service. Training records showed and staff confirmed that safeguarding adults and children training had been provided. Staff we spoke with were also able to explain the procedures and what course of action they would take to ensure actual or potential harm if they felt someone at the service was being abused.

Prior to our inspection, we looked at the number of different incidents which occurred at the service over the past 12 months; this included the number of referrals made to safeguard people's welfare. We saw that where incidents had been substantiated, action plans were drawn up and remedial action was taken to prevent the risk of reoccurrence.

We saw that a log was kept of all accidents and incidents which included issues such as falls and medication errors. Records were entitled 'Lessons learned' and included reference to actions taken following accidents and incidents and staff reflection on what could be done to improve the management of incident. This required the staff member involved to provide a written account of what happened, the potential consequences of the error and any factors which, in their view, contributed towards their error. Action was then taken in response which included supervision and a personal action plan being implemented.

People who used the service and staff had access to out of hours 'on-call' support in the event of an emergency or issue arising. We were told that on-call support was provided by the registered provider and senior care staff.

We saw that environmental assessments were completed on each person's home during the initial assessment process to highlight any potential hazardous working conditions for staff. These explored the safety and suitability of the internal and external environment and assessed the safety of the floors, utility provision and fire detection. Staff were provided with guidance in respect of the location of smoke detectors, electric meters and water stopcocks in the event of an emergency.

Control of substances Hazardous to Health assessments were completed in respect of personal care items such as deodorants and information provided to staff regarding safe usage. We were told and records showed that fire safety, infection control and health and safety training was provided for all staff as part of the induction and updated on an annual basis. Staff spoken with confirmed they had completed training and had access to personal protective equipment (PPE) such as gloves, where this was needed. Catheter support plans outlined the need to ensure good hygiene and reminded staff of the importance of wearing PPE.

Requires Improvement

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to make particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The training matrix showed staff had completed training in respect of the Mental Capacity Act and our discussions showed that staff understood their responsibilities under the MCA. People's lasting power of attorney was clearly recorded in files and supporting evidence of this was also included.

The care files we looked at all contained Mental Capacity Assessments which documented that all the people we reviewed had consent to make decisions around their care. Despite this, none of the care files we reviewed contained the person's own signature and instead, the person's relative signature was recorded. People's relatives had also signed the privacy statement within files which confirmed the person's consent to share personal information with relevant professionals. We brought this to the attention of the registered provider during our inspection who told us that sometimes people are unable to physically sign due to ill health or physical disability. We discussed the need to ensure the method of consultation was recorded and need to include an explanation as to why a relative signed on their behalf.

We recommend that the registered provider refers to the Mental Capacity Act 2005 Code of Practice and reviews their practice for recording consent accordingly.

The people and their relatives we spoke with felt they could discuss with the staff how they wanted to be supported and that they were able to make their own decisions. People said staff asked for their consent and agreement before delivering care. One person told us, "Staff inform me of the tasks they are about to do."

Staff had regard for people's nutritional needs and supported them where required. We saw that staff used a colour coded pie chart to evidence the amount and type of foods the person had consumed during the care visit for example, milk/dairy or bread/potatoes. This helps to ensure that people's intake can be monitored and a variety of foods are consumed within the diet.

Care records included nutritional risk assessments and nutrition and hydration care plans however these did not always contain accurate information. Some care files contained confusing information as to whether staff were to assist with meeting the person's nutrition and hydration needs. For example, one person care records showed that an outcome they wanted to achieve by receiving care at home was to maintain their nutrition. The care records outlined the person's needs in relation to this, 'I need practical assistance to prepare my meals and drinks and to position them near my reach. I like my food to be cut into small pieces.' However, the person's nutrition and hydration support plan contained contradictory information and outlined that the person's family assisted with food preparation and the person's relative was responsible for meeting the person's nutritional needs. This meant that staff did not have access to accurate information

to inform their interventions with people.

People were supported and cared for by trained staff who were familiar with people's needs and wishes. People told us, "They meet all my needs and I can just ask for more help if needed" and "All staff seem to know what they are doing." People's relatives also told us they felt staff had sufficient skills and knowledge to support their loved one. People's relative commented, "I trust the staff know what they are doing", "I'm confident in the carers", "[They are] a good effective little team" and "All staff seem confident in their role." The results of the quality assurance survey completed in September 2017 also echoed this feedback. People's comments included, "[They are] very good with transfers."

Staff reported feeling well supported in their role through induction, supervisions and regular training. We reviewed the staff training matrix and certificates within staff recruitment files which showed staff had training in areas such as moving and handling, catheter care and dementia awareness. Carers also completed their own medication assessment forms where they were involved in the auditing of MAR charts to check and promote their knowledge in respect of this particular topic area. Senior staff completed observations of staff to ensure that they were delivering care in accordance with best practice.

We saw that supervisions sessions were held three monthly and covered topics such as staff development and time management. Supervision sessions between staff and their line manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs.

We saw that the service worked in collaboration with other professionals to ensure people's physical and health care needs were effectively met. A review of people's records showed that people were registered with a GP and had access to the district nurses, physiotherapists and occupational therapist. We saw that staff identified needs and made the appropriate referrals to the relevant health professionals such as the community equipment service and moving and handling team. A professional visit record was kept on which staff had recorded their discussions with health professionals regarding the person. An 'ambulance grab chart' was available in each client's file which contained a summary of all important information such as the person's level of capacity, resuscitation wishes and medical history.

The registered provider showed us evidence of their engagement with wider partners to build and share good practice. We saw that they attended regular meetings with other partners such as the Home Care Improvement Strategy Meeting with a focus on delivering effective care and improving home care across Liverpool.

Good

Is the service caring?

Our findings

People spoke positively about the staff who supported them. People's comments included, "[The staff] talk to and listen to me", "My likes and dislikes are taken into account", "They take into account my feelings", "[They are] lovely friendly carers" and "Some more chatty than others." People's relatives told us that staff demonstrated their caring approach towards their loved ones by, "Talking to my relative and making them feel important", "Respecting [relative's] wishes" and "Respecting what my [relative] likes and dislikes."

People told us that the carers who visited them or their relative were all very caring and kind and would always ask them how they were feeling and ask them what they would like help with. People's relatives commented, "They treat [relative] individually", "I couldn't fault any of them" and "[I] feel the staff really care and pay an interest."

Most of the feedback suggested that the same staff supported people to promote consistency of carer and people valued this. Comments included; "Continuity is good", "Good continuity works well, they get to know [relative]" and "The same carers come to my relative." Staff knew the people they supported well and had built good relationships with them. Staff told us familiarity improved their relationships with people. One staff member told us, "When I first supported [person], they were reluctant to receive personal care or allow me to help them in the shower but now I've built a relationship with them, they will, I think this is because they feel comfortable with me."
Staff we spoke with demonstrated a good understanding of how to preserve people's privacy and ensure their dignity was promoted whilst attending to people's personal care needs. Staff were able to provide examples of how they respected people's privacy, which included asking people's permission before offering support and ensuring dignity was maintained when providing personal care by closing blinds. Care records also outlined that staff were to 'obtain consent for all tasks' and reminders were contained to promote privacy such as 'knock before entering and wait for family to open the door.'

People and their relatives told us staff encouraged them to be independent. One person told us, "The staff encourage me" and a relative told us, "The staff encourage [relative] to do as much as they can." This focus on empowerment and maintaining independence was reflected in people's care files. We saw that care records outlined what the person could do for themselves and what they required some support with. For example, one file outlined that the person was able to brush their own teeth but required prompting to do so. It also reminded staff to encourage the person to wash their own personal areas whilst showering but provide assistance if required. Another care record outlined that one person became agitated if they were unable to lift things and so staff were reminded to encourage the person when they lacked motivation to do this for themselves.

People's communication needs were also recorded within care files to guide staff on how people expressed their individual needs and to ensure people were supported to express their views. This included information on people's health needs which may impact on their verbal communication. One care file documented that the person was blind and partially deaf and requested that staff communicate verbally in a raised voice when they were talking to the person.

People's records were stored electronically in the main office. Computers were password protected. This helped to ensure that confidentiality was maintained. We reviewed the training matrix which showed that staff had received training in the principles of confidentiality and equality and diversity.

Good

Is the service responsive?

Our findings

People and their families told us they were involved in the care planning and were given choices in relation to how they are supported. Each plan contained an outcomes form completed with the person regarding their expectations of the service and what they wanted to achieve from receiving care at home. One person told us, "I was involved in the care plan with my family." People's relatives told us they were also consulted. Their comments included, "Myself and family were involved in the care planning", "They really listened to my [relatives] needs", "I was involved and asked to attend reviews", "Care planning was good and thorough", "Care planning was good and I can call the office for any amendments" and "Very impressed with the detail taken." People told us their relatives care plans were subject to regular review and they held a copy of their care plan at their home.

We noted that care records provided information around the many different aspects of support which staff needed to be familiar with such as health, personal care, catheter care and mobility. These plans were sufficiently detailed to guide staff on how to support people effectively. We reviewed moving and handling plans within care files and found these contained specific and clear instructions on how to maneuverer people safely. For example, one care file contained step-by-step guidance on how staff were required to use a specific piece of equipment to transfer the person. We saw that staff were responsive to changes in people's needs, for example, one person's mobility had deteriorated and staff promptly made a referral to the relevant team for standing equipment.

People told us they had a choice of gender specific carers and their wishes in this regard were respected. One person told us, "I requested no male carers and they listened."

Through our discussions with people using the service, their relatives and staff, it was evident that staff knew the people they supported well and delivered a person centred service. Care plans were person centred and contained information about people's likes, dislikes, hobbies and backgrounds. People's files contained a document entitled 'What is important to me' and 'Places and events important to me' which outlined the person's living arrangements, preferred daily routine, interests and significant family relationships. For example, one care file documented that the person liked to watch football and enjoyed country music. This information enabled staff to understand more about the person and promotes rapport building between staff and the people they support.

People told us they were able to raise any concerns and give feedback regarding the service. People's comments included, "I would tell my carer" and "I would tell my carer or call the office." People's relatives also felt confident to raise any concerns regarding the service. Relative comments included, "The office send a questionnaires and I can call the office with any concerns", "I can call the office and they will listen", and "[I] feel listened to if I call the office with any concerns."

The registered provider had a detailed complaints policy in place to support people to raise concerns about the service which included details for the local authority and the Local Government and Social Care Ombudsman. We reviewed a selection of recent complaints and saw these were related to a variety of issues

such as staff conduct, missed visits, punctuality and tasks not completed. We saw that complaints were recorded, investigated and actions were taken as a result. For example; one client complained about staff attitude, we saw that staff were asked to provide a written account in respect of the incident and discussion was then held before the staff member was taken off the rota for the person.

The service was not yet supporting anyone who received palliative care but had given consideration as to their processes in respect of people at the end of their lives. The staff training matrix showed that end of life training was being arranged for 2018 and the registered provider was aware of their obligations in relation to this. Care records contained information in respect of whether people had completed 'Do Not Attempt Resuscitation' (DNAR) forms.

Requires Improvement

Is the service well-led?

Our findings

People spoke positively about the registered provider and the management of the service. One person told us, "I met the owners and they are lovely and friendly." A relative told us, "I've no issues with the management, they seem good." The staff we spoke to all said they thought the service was well-led and that the organisation was manged effectively. Two people's relatives told us they were unhappy with the organisation of the office based staff. One told us, "I tell the office any issues but don't feel I'm listened to."

There had been recent changes to the management structure at Sabaoth care. The last registered manager left in September 2017. The registered provider had applied to become the registered manager in the interim and was registered with the commission on the 11 January 2018 following our inspection site visit. The registered provider told us of their ongoing attempts to recruit an alternative registered manager. This would offer an additional layer of governance, checks and balances. 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 registered provider had recently acquired a new electronic care management systems named 'Pass'. The acquisition of the new system was in response to feedback received from the local authority. We saw that the new system was user friendly and effectively designed to meet the individual needs of people receiving care. Features of the new system included the ability for staff to update electronic records in 'real time' as they delivered tasks and the ability to log in and out of calls without having to use people's landline. We saw that people's families also used this system as a means of communication and could access information about their loved ones and the care they received. At the time of our inspection, the systems were not yet fully embedded and information was being moved from the paper records to the electronic database which was introduced in December 2017. During this transition period, we found that some important information had not been effectively transferred to the new system. This placed people at risk of harm in the interim because staff did not have access to all the relevant information on to how to support people safely.

The registered provider maintained some oversight of the day to day care delivery through the electronic system. This raised alerts when assigned tasks were missed, not done or incomplete. We could see that the registered provider reviewed these tasks and provided an explanation for when the tasks were not done before marking the issue as resolved. However, we found there were gaps in the audit systems and processes as there was no evidence of audits, in areas such as Medication Administration Records since October 2017 or in respect of complaints since August 2017. The gaps in the quality assurance process appeared to correlate to the period when the last registered manager left. This meant that there was no consistent audit process and that governance arrangements were inconsistent.

Following our inspection the registered manager provided us with some care plan audits completed in October 2017 and one completed in November 2017. We found that these were not robust as they did not identify the issues that we found during our inspection in respect of the contradictory information around

people's nutritional and hydration support needs.

The registered provider's failure to complete regular and robust audits meant that they had not detected the issues we raised in respect of the contradictory information in relation to people's nutrition and hydration needs and the monitoring and recording of risk. Furthermore, the registered provider had not identified the concerns in relation to the recording of consent. This meant that the systems and processes in place to monitor the quality of the service were ineffective. The HR manager told us that they were in the process of trying to recruit care co-ordinators and team leaders whose responsibility it would be to review and audit care records.

The registered provider had a system in place to gather the views and opinions about the service from the people who received the service or their relatives. Quality assurance surveys were circulated to people using the service and this information was reviewed in September 2017. People were asked to rate their satisfaction levels of the service. We saw that the majority of respondents answered positively to the questions such as, 'I receive good quality care and support' and 'My carer workers are reliable'. However, some people made comments that carers did not always arrive on time or stay for the allocated duration. Recommendations were made following this including the need for carers to stay for the full time booked or for the duration of the call. However, we found that this recommendation had not been effectively implemented and carers were regularly logging out of calls early.

These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The vision of the service focused on empowerment and the promotion of independence to enable people to live independently in their own homes. The registered provider had a vision to expand the services they offer to a greater range of people in the local area. They had recently appointed a HR manager in order to support the organisation with their recruitment needs and were in the process of trying to recruit a registered manager, care co-ordinators and team leaders.

The registered provider attended multi agency meetings with other providers with the aim of sharing good practice and to promote the ongoing improvement in homecare services in the local area. This showed that the organisation was working in partnership with different establishments, to help shape and develop the future of service delivery.

Staff meetings were held on average every three months. We reviewed minutes of meetings which showed that discussions were help about topics such as people's individual needs and memos to staff, refresher training requirements, infection control and data protection. Staff told us there was an open culture within the service and they were also able to raise any issues informally. Separate management meetings were also held regularly.

The registered provider had a range of policies and procedures for the service that were accessible for all staff. Policies and procedures support decisions made by staff as they provide guidance on best practice. At the time of this inspection the HR manager was in the process of reviewing and updating the policies and procedures in place to ensure that they contained up to date guidance and best practice.

The registered manager was aware what was required to be reported to CQC by law. As this was the services first inspection under the new provider's registration there were no requirements for previous ratings to be displayed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always appropriately managed because care records contained inconsistent and conflicting information.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure that effective systems were in place to regularly assess, monitor and improve the quality of service that people received.