Sevacare (UK) Limited

Sevacare - Washington

Inspection report

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20 April 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13, 14 and 20 April 2016 and was announced. This meant the provider knew we were visiting. We last inspected Sevacare – Washington in January 2014 and found it was meeting all legal requirements we inspected against.

Sevacare - Washington is a domiciliary care agency which provides personal care for people living in their own homes to meet their individual social care needs and circumstances. They mainly support people living in the Washington area of Sunderland but also support some people living in Newcastle. At the time of the inspection there were 160 people using the service who received the regulated activity of personal care.

There had been significant periods of time over the past two years where managers of the service had not been registered with the Commission. A manager was in post at the time of the inspection and they were completing their application to become a registered manager with the Care Quality Commission. They had been in post since October 2015 and had previously worked as a care co-ordinator for the provider.

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.

We found a whistleblowing concern had been investigated as a complaint. This related to an allegation of inappropriate practice which the manager had failed to report to the local authority safeguarding team, nor had they raised a statutory notification with the Commission. This is being managed outside of the inspection process.

Investigations in relation to accidents and incidents were not fully recorded. Analysis of complaints, safeguardings, accidents and incidents was not evident so there was a missed opportunity to learn from these events and improve the service for people.

The quality assurance system had not been effective in identifying areas for improvement. A branch audit had been completed in February 2016 but we saw no evidence of audits completed fully before this date. There were no action plans in place to identify who was responsible for improvements and when they should be made by.

Audits of Medicine Administration Records (MARs) had been completed; however the audit was not sufficiently robust and had not identified the concerns noted during the inspection in relation to the administration and recording of prescribed creams.

There were inconsistencies and contradictions found in relation to risk assessments and care plans. Some contained information which did not match; for others risks had been identified but there were no control

measures and information had not been included in care plans. Care plans did not always provide staff with the specific detail they needed on how to provide care and support for people.

Recruitment practices were appropriate; there were enough staff to meet people's needs and people told us they had regular staff that they were very happy with.

People said staff were kind and respectful and went, "above and beyond" to support them.

Staff told us they were well supported by the office staff and manager and had been well trained. They said they had the skills and knowledge they needed to support people. Records confirmed staff received relevant training and the provider's system for managing training meant staff could not be allocated to visit people if their training was out of date.

Staff understood how to report concerns and were aware of the Mental Capacity Act.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

There was contradictory and incomplete information in risk assessments and care plans.

Medicines, especially prescribed creams, were not managed in a safe way.

Recruitment procedures were appropriate and people told us they felt safe with the staff who visited them.

Is the service effective?

Good

The service was effective.

Staff training was effective and staff told us they felt competent to support people appropriately.

Mental capacity was understood, and there were plans to develop further training.

People were supported with food and nutrition.

There was involvement from external professionals.

Is the service caring?

Good

The service was caring.

People told us they had regular staff visit them who were kind, caring and respectful.

One person said, "[Staff] do everything I want." Another said, "[Staff] will go above and beyond."

Some people had signed their homecare support plan to show they had been involved, family members had also signed on people's behalf.

People told us they did not have an advocate as they made their own decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Home care support plans did not always contain specific detail for staff to follow on how to support people.

There was some initial person centred information but support plans were task orientated.

Complaints had not always been investigated and recorded appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There were significant periods of time where the provider had not had a manager in post who was registered with the Commission.

Statutory notifications had not always been submitted to the Commission.

There was no evidence that a system or process was being operated to effectively ensure the assessment, monitoring and improvement of the service.

A quality audit had been completed in February 2016 but an action plan had not been produced to drive the required improvements.

Sevacare - Washington

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 13, 14 and 20 April 2016 and was announced. We gave the provider 48 hours' notice of the inspection because the service is a domiciliary care agency and we needed to be sure they would be in to support the inspection. This meant the provider knew we would be visiting.

The inspection team was made up of one adult social care inspector and a specialist professional advisor with a background in nursing, dementia support and governance.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also 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 what improvements they plan to make.

We contacted the local authority commissioning team, the local clinical commissioning group (CCG), the safeguarding adults team and healthcare professionals. We also contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection 50 questionnaires were sent to people using the service and 25 were returned. During the inspection we spoke with six people using the service and two relatives by telephone. We also spoke with the manager, the area manager, one care co-ordinator, and eight care staff.

We reviewed ten people's care records, including information about medicines management. We also reviewed six staff files including recruitment, supervision and training information and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were not managed in a safe way as accurate records of medicine administration were not kept. Some people's medicine needs assessments contained conflicting information and lacked important detail.

One person's medicine needs stated, 'barrier creams to be applied on each visit.' The care plan and daily care reports mentioned the application of barrier creams. We asked to see the Medicine Administration Records (MARs) for this person. The manager and care staff told us, "There's no MAR, staff have been using the communication book." Topical medicine application records (TMARs) are used for recording the application of prescribed creams and ointments, and include body maps which highlight where creams should be applied, how to apply and how often. Without this information staff may be inappropriately applying prescribed creams so people may not be receiving the correct care and treatment. There were two medicine agreements in the person's file, one stated, 'care workers will assist with medication, barrier cream at each visit and kept at side of bed,' this form wasn't signed by the person or a representative. The second agreement was signed by the person's next of kin and a representative of Sevacare however there was no detail on the application, timeliness or storage of medicines, it purely stated, 'barrier creams.'

Another person had a medicine risk assessment which stated the person didn't need support from staff. The homecare support plan stated assistance was required and went on to detail where creams and tablets were stored, what support should be provided and where to record the level of support offered. Care records provided evidence that staff were supporting with the application of prescribed creams. The manager told us the person was not having any medicine assistance and there were no MAR charts.

The needs assessment for a person with diabetes stated, 'look for signs of low sugar or no insulin taken, care workers to give glucose tablet immediately or sugar, record and report.' There were no specific details in the homecare support plan on how to recognise the symptoms of low blood sugar. There was no information detailing the exact treatment to be given, such as the number of glucose tablets, the amount of sugar or where the medicine was kept. This lack of detail left the person vulnerable as staff could administer sugar or glucose when the person didn't need it which could result in high blood sugar.

We looked at the process for risk assessment. An assessment of need was completed and a range of risk assessments which specified the area of risk such as 'service user situation'. The level of risk was identified as high, medium or low however there was not always a specific risk, or hazard identified, nor were control measures recorded to mitigate the risks to the health, safety and welfare of people.

We also found that for some areas of need where risk had been identified there was either no information in care plans or the information was contradictory. For example, one person's risk assessment stated they had a leg ulcer however there was no detail in the care plan in relation to this. There was also a risk assessment which stated, 'ensure person is wearing their falls detector on each visit,' this was not included in the homecare support plan. This meant care staff did not have immediate access to full, accurate and up to date information about the persons care and treatment.

A log was in place for recording accidents and incidents but this was blank. We saw an incident had been reported but there was no information on the action taken, whether equipment had been affected or had been safety checked since the incident. We asked how oversight of accidents and incidents were managed. The manager said, "It would be logged on the system by whoever did the form." The area manager said, "There's another part of the form that needs to be filled in, that is the report form, investigation. It hasn't been done." The manager was able to find the action taken as it had been logged on the electronic system. The person's next of kin had been informed and they took further action to ensure safety.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were protected from abuse and avoidable harm. A safeguarding log was in place which included the details of the complaint, the investigation, the outcome and a system to ensure the timeliness of response and alerts to the safeguarding team and the Commission.

The complaints file included a whistleblowing concern raised by a staff member which should have been addressed and reported as a safeguarding issue, but the manager failed to do this as part of the investigation. We asked the manager why it hadn't been raised with the safeguarding team, they said, "Because we couldn't prove it." We noted that the 'complaint' was recorded as upheld so we asked about this, the manager said, "I think we did that because we put [staff member] through training again," they added, "Maybe it should have been." It was noted that the staff member did attend further training but they also made an allegation that other staff in that team behaved in the same way. We asked the manager if this allegation was investigated, they said they didn't know and would have to check. Quality assurance monitoring visits had taken place with other staff however they did not review the specific area of practice that was a concern.

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

We asked people using the service if they felt safe with the staff visiting them. One person said, "Oh yes, we do, the girls are very kind." Another person said, "Very much so, they are very obliging." Care staff knew how to report safeguarding concerns. One staff member said, "It's about looking for unexplained bruising, there might be a verbal disclosure about bathing or food so I'd go to the care plan to see what we should be doing, if it wasn't done I'd raise it. Signs might also be if someone is unkempt, I'd inform the office and take it further if I needed to. I've never been in that situation though." Another said, "I'd report any issues to the office, I wouldn't want to worry the client." A third staff member said, "I'd tell the office if I was concerned about risk, or medicines or the person's presentation."

We asked staff how they would respond if someone they were supporting had a fall or took unwell. One staff member said, "I would phone 111, I wouldn't move them, I'd inform the office as I can't leave until the paramedic arrived." They went on to say, "I would document it in the communications book and if I saw what happened do an accident form." We asked what information would be shared with the emergency services. One staff member said, "Information from the care plan, medical history, I'd ask them to contact the office as a lot of it would be confidential." Another said, "I'd phone 999, don't pick people up, or I might contact telecare if they had it but I'd wait until the ambulance arrived and pass information over in full." We asked what that might include, they said, "The info that's in the file, their history, medicines which would be verbal or I'd show them the dosette box." One staff member said, "I've been told I'm not allowed to contact family, doctors or district nurse but I would ring for an ambulance if it was serious and write it down." Other care staff said they would speak with family if they were present but confirmed the office staff would speak

with doctors or district nurses if the family requested it.

We asked whether there were enough staff to cover all the visits. People told us they had regular staff who visited them. "Sometimes they get too many visits to do so can be late." Another person said, "I think so, now and again they can be late but the majority of the time they are on time." One relative said, "We have regular carers and they stay the full time." Another person said, "They come on time and stay with me, they really do, it's really very good." One staff member said, "There is enough staff but it depends on sickness, it's easy for some to go on the sick or take a day off on a zero hours contract. I do get called to cover last minute but they don't pressure you if you say no." They went on to say, "The length of your day depends on need, it also goes by the availability you give to the office." This meant if staff said they were available to work a long day they often had visits allocated for that length of time with breaks in between some of the calls. One staff member said, "I get a few calls to cover on a weekend, but that's when I can work, I do long days, but I get decent breaks as well."

Recruitment processes were robust and included an interview with scenario based questions so applicants had to explain what they would do in certain situations. If they were successful at interview references and disclosure and barring service checks (DBS) were sought. DBS checks help employers ensure only suitable staff are employed to work with vulnerable people. The area manager showed us the staffing system they used and said, "Until everything is back for new staff we can't allocate them work as the system won't let us." Records confirmed new staff did not commence their employment until all checks had been completed and checked as being satisfactory.

Good

Is the service effective?

Our findings

We looked at the training and support available for care staff. A three day office based induction programme was completed by all staff which included training on safeguarding, mental capacity, moving and handling and medicine management. This was followed by a period of time where new staff shadowed an experienced and competent staff member before they worked alone. We spoke with one staff member who had recently been recruited who said, "I go to the same people's houses to keep continuity and build relationships. I went with a team leader first then by myself. I do medication, breakfasts and chat, it's important we spend the time with people." They added, "I did a three day induction, then 20 hours shadowing and they showed me what to do, meds and moving people." Another staff member said, "I did my three day induction and shadowing for three or four days. I was asked how I felt and if I could do it on my own; I thought I could, so I did." A third staff member said, "I did a three day induction. It included moving and handling, mental capacity, dementia, catheter care; there was a test at the end of it."

The area manager explained the system for logging training and said, "We don't do any E-Learning at all, if someone needed additional training or we had concerns they would repeat the induction. We do workbooks as part of refresher training. If a staff members training is expiring the system will stop staff working." This meant the care co-ordinator wouldn't be able to allocate visits to the staff member until they had completed the necessary training.

One staff member said, "I did safeguarding at Uni, and I've done my NVQ 2 through Sevacare that included it [safeguarding training]. I haven't had any mental capacity training." Another said, I've done my moving and handling training, I did it about 3 – 4 weeks ago. We do it every other year and a refresher." They went on to say, "I've also done meds, safeguarding and mental capacity. We get good training so we can meet people's needs." The people we spoke with told us they thought staff knew how to support them properly. All the staff we spoke with told us they felt well trained and competent to meet the needs of the people they supported.

The electronic system used by the provider to log training also showed that of the 69 staff who were actively working for the organisation only one required a supervision and two required an annual appraisal; spot checks, completed six monthly, were also logged and the system had flagged that two staff needed this completed. Spot checks involved a team leader or senior staff member completing an unannounced observation of a visit.

One staff member said, "I have supervision every one to three months. I haven't had an appraisal yet as I only started in September." They added, "I feel well supported, I couldn't have asked for more." Another said, "I haven't had a one to one with a manager, I've had an annual appraisal." They added, "Spot checks and observations are done, we get feedback there and then." Another said, "[Manager] knows how I do my job, I'm confident they trust me. I've had an annual appraisal, yes; we get appraised all the time. I feel totally supported, we're a really good bunch."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. Home care support plans did not include any information about mental capacity. We asked the manager whether they supported anyone who lacked capacity, they said, "No, no I don't think so." The area manager confirmed there was no one supported at the present time who lacked capacity. They added, "We are looking at increasing the training around mental capacity and probably making the induction a bit longer."

Staff had an understanding of mental capacity. One said, "It's about how you explain things to people so they understand." They added, "I'm not sure about capacity assessments but I think the social worker would do them." Another told us, "It's about the capacity of the user, for example, if they have dementia they might not have capacity, if they do then I follow their lead." Another staff member said, "No one lacks capacity, if the person had deteriorated I would ring the office and record it in the book."

We saw some support plans were signed by the person's relative. We asked the manager why relatives were signing on people's behalf if they had capacity. They said, "They might not want to sign it themselves. For some their hands are poor and they can't sign."

There was conflicting information in relation to support provided with food and nutrition. One person's support plan stated they did not require assistance with preparation of food however the care plan stated, 'breakfast, lunch/drink, tea/drink, snack/drink,' would be provided. In addition an assessment completed by a local authority stated meal preparation was to be provided. We spoke with the manager about this who said, "Yes, I see what you mean." For others we saw detailed food and fluid intake was recorded. For one person it was completed in the daily care reports rather than a specific chart but the detail included the amount eaten and drank. The care plan for this person detailed that the information was required for the district nurse and should be recorded daily. We saw involvement from other external professionals and the manager said, "We have good relationships with the district nurses, they are very supportive."

Good

Is the service caring?

Our findings

We asked people if they were happy with the care and support they received. One person said, "They are very kind and respectful, they help me with lots of things, there's nothing they could do better." Another person said, "There's nothing I would change, they do well, I'm very pleased, they are kind and respectful." Another person said, "I'm very happy with the girls, they are really lovely, the care has been brilliant, I can't fault it." One relative said, "Yes, I'm happy with the carers [staff] they are very good." They added, "They do everything we want, they are very kind and respectful."

People told us the staff did everything they asked of them, and more. Home care support plans showed that some people had signed assessments and care plans to indicate they had been involved in the planning of their care; for other people this had been completed by their relative or representative.

We asked about the time staff spent with people. One person said, "If I've needed extra time, they stay and don't rush, they will go above and beyond, they are good, obliging, very helpful." Another person said, "They always stay the full time." Some people were concerned that staff didn't have travelling time in between calls and said, "Sometimes calls can be ten minutes away so I do worry." Another person said, "Sometimes they can be a bit late but they always let me know." One staff member said, "People never say get yourself away, even if they did I wouldn't leave early. I always stay the allocated time that we are supposed to be there for. It's nice to sit and chat and talk to people." Another said, "We have the time to address people's needs within the call time."

One staff member said, "I start my day 15 minutes early so I can give people the allocated time and have the 15 minutes to travel. I work with the people and they are happy for me to go earlier." We spoke with the area manager about this who said, "We get 15 minute leeway in the contract and a lot of staff use it so they have that time for travel. It's all done with the agreement of clients."

People told us they had care from the same staff on a regular basis, they said, "I'm happy with the staff, they are very good and they do just as I want, they are all really nice." Another person said, "During the day I always know whose coming; night time carer, I never know when they are coming." We spoke with the manager about this who said they would speak with the person and arrange a specific time for the visit.

One person said, "The office staff are very good and helpful, they will allocate different times if I need to change the call." One staff member said, "I have a core group of people who I visit regularly, its good, a better situation really as people trust us." Another staff member said, "I love it. I love helping people, it's nice to know people appreciate it and I just love it! I see the same people all the time so it's good to have a chat with people."

One staff member we spoke with said "I have regular people that I visit, it's better for them and a familiar face that they know. It's good that way." They explained that if they hadn't seen someone for a while or if it was a new visit for them they would read the care plan to see what was needed, they said, "I'd ask the person what they would like me to do, I prefer to do it that way."

One staff member said, "We can be the only person people see so we need to get on with it and spend the time with people, but we do well." They added, "I try and support the family too if I can." We asked how they might do this, they said, "I might suggest better ways to support the person, use a softer approach and make suggestions, show them how things work for me. We need to be patient, understand and encourage people."

There were many thank you cards from people and their relatives, as well as from staff. Comments included, 'thank you for all your care and support, it was much appreciated;' 'thank you for your care and compassion;' 'wonderful staff,' and 'Every single one of you are amazing.' One staff member said, "Knowing I'm helping people out and giving them what they need is really rewarding, I go home thinking I did that! Its fab all round, I would give it a gold star."

Individual satisfaction records were completed with each person as part of a review of care. One person rated the service as excellent, with the attitude of staff being excellent as well. They stated staff were competent and completed all tasks and arrived at the correct time. This person stated an area for improvement was, 'times with calls and regular carers.' Another person was very positive about the competency and consistency of their care staff as was detailed in a telephone monitoring record we saw.

We asked whether anyone had an advocate but people told us they made their own decisions or had family to support them.

Requires Improvement

Is the service responsive?

Our findings

The care planning process included the completion of a range of documents. An assessment of need was completed as well as risk assessments in relation to medicines, moving and handling and whether any specific equipment was needed. This included the person's preferred name, their current living arrangements, healthcare needs, medicine needs, communication and mobility. There was also information on diet and nutrition, personal care, skin integrity, mental health, long term goals and aspirations. This information was used to inform the home care support plan for each person.

The home care support plan included detail on the objective and desired outcome, such as to maintain independence, as well as how to gain access to the persons home and the tasks broken down by when and how, this related to the visits people received each day. Detail on how to support people was not always evident in the home care support plan, for example, one person required support to get out of bed but there was no information on how staff should do this, or how the person liked to be supported. Their personal moving and handling assessment stated, 'poor mobility, suffers with confusion, deafness and poor eye sight.' This information had not been included in the support plan.

Another person had a moving and handling assessment which stated, 'leg ulcers, grade 2 and 3 pressure area dressed by district nurse daily.' We asked the manager about this and they were unsure. They contacted the district nurse and told us, "They have no pressure sores, they have a wound to the shin on the left leg and we dress it once a week and change the catheter every ten weeks." Their support plan for catheter care directed staff to, 'change catheter bag.' However there was no detailed strategy for staff to follow as to the frequency of the change, how to minimise the risk of infection or how to provide quality care. We raised this with the manager who said, "The team leader will write a care plan."

Another support plan stated the person's catheter bag needed to be changed once a week, detail was included on the day this was required and that it should be recorded in the care records when completed. There was no detail on how staff were to change the catheter bag or how they should dispose of the soiled bag. During March 2016 there was no evidence in the care records that this had been completed. We spoke with the manager about this who said they would check, but were confident it had been done.

Another person had an assessment of need which stated they had poor mobility and balance, and 'suffers with fits.' There was no information in the home care support plan in relation to how staff should support the person with their mobility needs, nor was there any information in relation to epilepsy management and support.

One person required specific equipment to support their transfers and mobility. The equipment was listed and the times when staff needed to use the equipment for transfers was detailed, but there was no information for staff to follow on how to use the equipment. The support plan was detailed in relation to how to support the person if they wanted to walk, however there was no information on how to support them if they chose not to walk. This left the person and the staff vulnerable to harm as there was no detail for staff to follow.

There were inconsistencies between the risks identified and the support plans. This meant people did not have individual and specific care plans to ensure consistent and appropriate care and support was provided. In addition, the home care support plans were task orientated and did not promote person centred care.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

A complaints log was in place for 2016 which included three complaints; two in relation to staff behaviour and one noted as 'other.' Whilst one of the complaints should have been dealt with under the safeguarding procedure the other two were investigated and lessons learnt such as monitoring continuity of staff, and spot checks to include looking at the practice of staff.

Prior to 2016 a concerns book had been used and there was no evidence of investigations, acknowledgement of complaints or action taken other than comments such as, 'meeting with family,' and, 'raised with carers.' There was no information about lessons learnt or whether complainants were happy with the outcome.

One person we spoke with told us they didn't know how to complain. We spoke with the manager who agreed to send information on the complaints procedure to people.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not have any complaints and could not think of any improvements that were needed to the service. One person said, "If I had a complaint, I'd speak to the office but there's nothing to complain about."

A 'service user satisfaction report' had been completed in April 2015 and an action plan written in response to feedback. This included an ongoing review of missed visits, informing staff of the importance of working at a pace that suits that person they are supporting and availability of contact numbers for people.

Social activities were not usually commissioned as part of the regulated activity, but the provider did have specific contracts to provide companionship support for some people which involved support to engage in activities of the person's choosing such as meals out, hairdressers appointments and spending time in the local community.

Inadequate

Is the service well-led?

Our findings

The current manager had been in post since October 2015, they were not yet registered with the Commission. The previous manager had been registered with the Commission between 2 July 2015 and 1 September 2015; previous to that the registered manager had left on 27 April 2014. This meant there were significant periods of time where there had not been a manager registered with the Commission.

We spoke with the manager about their role and responsibilities. They said, "[Area manager] has gone through things like notifications such as safeguardings, police incidents and pressure sores." They were unaware that deaths were to be notified to the Commission but they confirmed there had been no deaths. The area manager supported this view.

The manager had recorded and investigated a whistleblowing incident as a complaint and had failed to raise a safeguarding alert or notify the Commission. The area manager said, "No notifications were made and they should have been. All managers are aware of the need to do them now though." This meant the manager was not fully aware of their responsibility at the time of the concern being raised. This is being managed outside of the inspection process.

The area manager said she was holding weekly meetings with the manager in order to support them. The manager confirmed this but we did not see evidence of minutes of the meetings. We saw minutes of a supervision meeting for the manager dated 16 March 2016 which stated, 'this is the first supervision.' This included actions which were to be completed, such as reviews and audits of care records and MARs but these actions were not time specific. As the manager had been in post since October 2015, we asked if this was their first supervision, "They said, I've had weekly meetings."

We asked about team meetings and saw minutes of one team meeting dated 22 March 2016 which included the completion of documentation, confidentiality and social media, the use of on call and sickness. We did not see any other evidence of team meetings other than five which had been held in April 2015. Several staff memos had been sent out during March and April 2016. The memos included reminders for staff that people needed to sign timesheets, but they also informed staff of meetings that were being held throughout April to go through the completion of medicine record sheets, communication sheets and to discuss good practice.

We asked the manager about the quality assurance system. They said, "There's an internal audit annually." There was no evidence that an audit had been completed in 2015. They added, "Medicine audits are completed monthly." They confirmed this was an audit of the MAR chart only and said, "[Administrator] will be auditing them." The area manager confirmed the administrator was previously a member of care staff and so had knowledge and understanding of medicines.

We saw three audit forms had been completed for medicines during March 2016. For one person the findings were recorded as missing entries and the amount of cream to be applied was not listed; the investigation was that the missing entries coincided with the person not having weekend visits from staff. For two people the findings were that blue pen had been used for recording and for one of these the shape and colour of

tablets was missing from the list of medicines. The outcome of all audits was for carers to attend refresher training in medicines and MAR charts completion. Staff meetings were held and a memo put out to staff. Audits completed in February 2016 had identified gaps on MAR charts which had been due to some cancelled visits. The actions were a staff memo, a workshop on completing MARs and a follow up check to be completed by 1 April 2016. We saw no evidence that the follow up check had been completed.

These audits had not identified the concerns raised during the inspection in relation to medicine management, for example the medicine agreement not being completed with detail but it was signed; one person's medicine needed to be administered 30 minutes before food but the audit had not identified this was missing from the care plan and another had conflicting information as the assessment of need stated no involvement with medicines, however there was a care plan and MARs for the administering creams.

The manager told us, "Review of clients are done by the team leaders every 6 months." At the time of the inspection we saw no evidence that audits were being completed by the manager of the service. They told us, "We've started an audit of new files for care plans, risk assessment, and needs assessment." They explained this had just been implemented so they would sign off care records. There was no evidence of an audit record to confirm the quality of information had been assessed, nor was there evidence of an action plan.

The area manager said, "Team leaders do the care plan and the risk assessments. We are introducing a new system where on completion they are signed off by the manager." They went on to say, I requested the February audit [completed by the training and quality assurance manager] as I was given the branch at the end of last year so I wanted to audit so I knew where we were at." They added, "There should have been an action plan, meetings are ongoing about improvements, we've looked at medicines and introduced workshops; care planning has been looked at but we do need a working document for actions."

We saw a 'branch audit' which had been completed in February 2016 by the training and quality assurance manager. Their findings included the following statements, 'care plans to be more person centred and less task oriented, risk management plans to be more robust, re-assess those files which contain the re-assessment form to ensure that the care plan and risk assessment reflect the care being provided, complaints to be recorded in appropriate file and demonstrate a clearly timed audit trail from acknowledgement through to conclusion.' Further statements included 'communication logs, MRC [medicine records] to be audited on a month basis using the File Audit Forms and logged on the system to evidence the audit being completed, action taken as a result and to promote improvement of services across the branch.' It also acknowledged, 'accidents and incidents need to be recorded more effectively and evidence of investigations, corrective actions and outcomes recorded within the appropriate file.' The audit had identified contradictions with regards to the administration of creams as care plans stated there was no involvement with medicines, but communication logs recorded creams were applied. This had not been addressed in the six weeks after the audit. As discussed with the manager and area manager a time-bound action plan had not been produced following the audit so we could not be sure action had been delegated and prioritised for completion or that improvements had been made.

We did not see any evidence of systems for analysing and reviewing safeguardings, accidents and incidents or complaints, so lessons could be learnt and improvements made. The new complaints process recorded lessons learnt from individual concerns raised, however this did not support an overall system.

Staff questionnaires had been completed and included staff ratings for induction, training, support, supervision and the best and worst things about their role. Concerns included travelling time and there not being enough time in between calls; one staff member had stated care plans needed to be updated but all

other comments were positive. No action plan or report had been compiled.

There was no evidence that a system or process was being operated to effectively ensure the assessment, monitoring and improvement of the service.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We asked about the time staff spent with people and how this was managed. The manager explained they did support some people with 15 minute visit as these were commissioned but they were confident they could deliver the commissioned care in that time frame. The manager said, "We would raise concerns if we felt we couldn't meet the needs, sometimes we give people more time than we should if they need it." One staff member said, "If I'm running over, or I need to stay longer I inform the office, they ring the service user and explain so I can just carry on, sometimes the next call is covered. They always find a solution."

We asked staff if they felt there were any improvements needed. One staff member said, "No, they've been great with me, absolutely fab. They make you feel comfortable, not part of a team we are part of a family." They added, "They are really understanding, they'll do anything for you if they know you are good at your job and try to help with anything." One staff member said, "There's been no team meetings for me, while I've been here. We did have a meeting about MAR chart completion though and how to administer meds." Another told us, "They have really supported me, personally. There are no improvements I can think of, not for me anyway." Another said, "Petrol is an issue and travel time, but I love my job so get on with it."

One staff member said, "Communication with the office is fab, you can speak to anyone, whether it's personal or work, they are supportive, [manager] is understanding about childcare needs." They went on to say, "It can be hard to get everyone together for a team meeting but we use phone, memos and emails. If it's about care needs we phone or we speak to someone on a Friday or Monday when we do rotas and timesheets." They added, "It can be inconvenient to have to come to the office depending on visits, and the office is out of the way but it means we see people."

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 did not take formal enforcement action at this stage. 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 The assessment of risks to the health and safety of service users was not effective. There was a failure to do all that was reasonably practicable to mitigate risks. Medicines were not managed or recorded safely. Regulation 12(2)(a); 12(2)(b); 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not fully protected from abuse and improper treatment. Systems and processes had not been operated effectively to prevent abuse. Incidents and complaints had not been assessed to identify potential abuse. Systems and processes were not operated effectively to investigate concerns. Safeguarding arrangements for the raising of concerns and alerts had not been followed. Regulation 13(1); 13(2); 13(3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not being operated effectively to ensure compliance. The provider did not have an effective system to assess, monitor and improve the quality and safety of the service provided. There was a failure to maintain an accurate, complete and contemporaneous record in respect of each service users care and treatment. There was a failure to act on feedback, in the form of complaints. Regulation 17(1); 17(2)(a); 17(2)(c); 17(2)(e)

The enforcement action we took:

We issued a warning notice.