Harmony Home Aid Services Limited

Harmony Home Aid Services Limited - Unit A2 Broomsleigh Business Park

Inspection report

Unit A2 Broomsleigh Business Park
Worsley Bridge Road, Sydenham
London
SE26 5BN

Tel: 02086989911
Website: www.harmonyhomeaidservices.co.uk

Date of inspection visit:
15 December 2016
20 December 2016

Date of publication:
12 April 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 15 and 20 December 2016 and was announced. Harmony Home Aid Services Limited - Unit A2 Broomsleigh Business Park is a domiciliary care service. The service provides personal care for people living in their own homes. At the time of the inspection, 167 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 on 8 January 2014 the service was meeting all the regulations we inspected.

At this inspection, we found the provider had breached three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to safe care and treatment, good governance and notifications. 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 were no processes in place for the monitoring, and reviewing incidents of missed call visits to people. People we spoke with told us that they had either late of missed care visits. They said sometimes the office staff would contact them and other times no contact was made. The service could not appropriately manage missed care visits because there were no records of the numbers or details of them or accurate numbers of people using the service.

The registered manager did not always effectively manage the service. They did not have insight of the quality of care because there were no systems in place that gave an overall view of the service. The Care Quality Commission were not informed of safeguarding incidents that should have been reported to us by law.

Risks to people's health and well-being were identified. Risk management plans were not always effective because they did not often relate to the identified risk. Staff were not able to manage risks to people because risk assessments did not give clear guidance to manage and mitigate them.

People's medicines were not always managed safely. The management of people's medicines were not safe because staff did not always complete Medicine administration records (MARs) accurately. There were no processes in place to collect completed MARs from people's homes on a regular basis, therefore the quality audit of these could not be reviewed promptly. The registered manager could not detect medicine errors and take action to reduce the likelihood of unsafe medicine management.

The quality assurance systems were not effective. Checks and monitoring of the quality of care at the service took place. This included feedback from people using the service, staff observations and spot checks. However we found that people's care records and risk assessments were not regularly checked to ensure they were of a good standard and reflected people's current needs.

A recruitment process was used by the service to ensure staff employed had appropriate checks carried out before working with people. The registered manager did not always formally follow up results from criminal records checks appropriately to ensure the continued safety of people.

Staff had access to an induction, training, supervision and an appraisal. Staff underwent and induction and shadowed experienced staff. There was a training programme in place that ensured staff completed mandatory training. Supervision meetings occurred with staff and their manager. These identified issues with staff employment and these were recorded but staff or the supervisor did not always sign these records. Staff completed self-appraisal that discussed their progress within their role over the past year. There were not processes in place for staff requests made in their self-appraisal to be considered or followed up by a manager.

There was sufficient staff to meet people's care needs. Records showed when people's care needs required a certain number of staff. However people told us that they had missed care visits and staff were often late.

The registered provider had safeguarding policies and processes in place to give staff guidance to protect people from abuse. Staff understood what abuse was and was able to act promptly by raising an allegation of abuse promptly.

Senior staff had an awareness of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff supports them in the least restrictive way possible; the policies and systems in the service support this practice. Staff we spoke with had not completed training in MCA. There was training in MCA offered and arranged for staff in February 2017.

People gave staff their consent to receive care and support. Any concerns with a person's ability to give their consent were recorded and discussed with the local authority. A mental capacity assessment would be completed to assess their decision making ability. People were supported to make decisions about their care and support needs. Care records reflected the views and opinions of people that showed that they made care decisions.

Assessments of people's care needs were recorded. Assessments were person centred and showed clearly what the person's health and support needs were. People's contributions were gained to ensure they were relevant and were used in the planning of their care. Care delivered was regularly reviewed to ensure these accurately met people's needs. Care records contained personal information about people. These records were stored appropriately and kept locked when they were not in use.

Staff supported people to access health care when required. People who required healthcare in an emergency was acted on by staff. When people's health needs changed appropriate advice and support was sought to manage the change.

People were treated with kindness and compassion by staff. People we spoke with told us staff were kind and caring. Staff spoke about people in a way that showed they respected them and understood their needs and wishes.

The registered provider had systems in place for people to complain about the service or aspects of their care. The service user's handbook had a copy of the provider's complaints policy and process. The provider sought people's feedback on the service. People and their relatives had opportunities to give their views about the quality of care. Staff gave their feedback meetings about any concerns regarding their role and in the quality of care.

People had their meals provided by staff, which met their needs and preferences. When required staff helped people with shopping and preparing meals of their choice during their care visits.

People said staff treated them with kindness and compassion. Staff delivered care in the privacy of people's homes. People told us that staff showed respect to them and their home.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

There was no process in place to manage incidents of missed call visits to people. Therefore people were at risk from unsafe care.

People did not receive their medicines safely because MARs were not accurately completed.

Risks to people's health and well-being were identified. The risk management plan did not give clear guidance to staff of how to manage those risks.

Recruitment processes were in place. Criminal records checks taken up before staff worked with people. However risk assessments were not carried out on staff whose criminal records check came back with concerns.

There was a safeguarding policy in place at the service. Staff were aware of how to raise an allegation of abuse for investigation.

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

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had an induction, training, supervision support them in their roles. Appraisals occurred on a regular basis, however appraisal goals and outcomes were not discussed and recorded with their line manager.

People had access to healthcare professionals when required.

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

Some staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). .

Is the service caring?

Good

The service was caring. Staff understood and recorded people's needs and wishes and their care was delivered in line with them.

People and their relatives were involved in making decisions about how they received care.

Staff treated people with kindness and compassion. People had the dignity and privacy that they needed.

People were supported to be as independent as they chose.

Is the service responsive?

Good

The service was responsive. People and their family were involved in assessments of their needs.

People were able to choose how they wanted to receive care.

People, relatives, and staff provided feedback to the provider about the quality of care.

Systems were in place for people to make a complaint.

Is the service well-led?

Inadequate

The service was not well led. There were not effective processes in place to monitor missed care visits, the number of people receiving a service and the quality of the service.

The registered manager did not notify CQC of incidents that occurred at the service.

Staff sought feedback from people and their relatives.

There was a registered manager in post.

Harmony Home Aid Services Limited - Unit A2 Broomsleigh Business Park

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 15 and 20 December 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 one inspector and two Experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also asked the registered manager for an updated contact list of people who use the service and professionals involved with people who use the service.

We spoke with 15 people who use the service and six relatives. We also spoke with the registered manager and head of training.

We looked at 20 care records, 11 medicine administration records (MAR) for people, 10 staff records and other documents relating to the management of the service.

After the inspection, we spoke with four care workers and two representatives from the local authority commissioning teams.

Inadequate

Is the service safe?

Our findings

People told us they felt safe using the service. However, we found that the service was not delivered to people in a way that would ensure people were safe. One person told us "I feel safe, [the carer] wears their ID and I know whom to expect." A relative said "[my relative] feels safe, [my relative] has a good relationship with the carer. [The carer] makes an effort with [my relative]." A person also said "I have the same person- she is very good usually." A relative added "I suppose [my relative] is fine with them, [my relative] seems to okay with them."

However, people were at risk of unsafe care because missed care visits were not managed safely. People's views about their care visits and staff punctuality were mixed. One person said "No they have never let me down. They are very helpful." A second person said "Never been let down, someone always comes." However some people had different experiences of missed care calls. One person said "Today, when I phoned the office they said they couldn't contact her but thought she was on route, she didn't come. No it's not happened before." A second person said "There's no set time, but I'm okay with this, its fine. They do everything I need to be done and I know when to expect them within the hour." One Another person said "She didn't turn up today. Nobody phoned." A third person said "[This] happens quite frequently, no they don't ring, I ring them. Communication is not good, flexibility isn't good either." Another person said "They are not often on time, the carer has no car and uses public transport, she was late today. She can be late sometimes, she has to take her kids to school too."

We asked the registered manager how missed visits were managed and requested they show us record of these incidents for the last three months. They explained office based staff managed missed calls. They said record of the incident would be documented on people's care records and discussed with staff and note made on their files too. The registered manager was unable to show us a list of missed calls available for the period we requested and was also unable to tell us how many missed visits they have had. This meant that people were at risk of not receiving care and support that they required to maintain their health and well-being.

Risks to people's health and well-being were identified. We found that people had risks to their health and well-being identified. For example when a person was identified as being at risk of falls, this was documented on their risk assessment records clearly. Staff were able to tell us about risk assessments and how these were used to manage them for people they cared for.

However, we found the guidance for staff on how to manage those risks did not relate to the identified risk. For example, a risk assessment identified that a person was at risk of falls particularly when going into and out of the bath alone. Although their risk management plan identified the person needed to use a walking aid outdoors, there was no guidance of how to manage the relating to when the person was using the bath. We saw two other examples were people were identified at risk of non-compliance with taking their medicines. Their risk management plans did not clearly state what actions staff should take to manage this risk safely.

We spoke with the registered manager about this they told us they had discussed the accuracy of the risk management plans with the office-based staff who were asked to review people's risk management plans. Risk management plans were not robust because they did not give staff guidance on how to manage the identified risks. Staff were not able to manage risks to people because the risk management plans in place did not give clear guidance to manage and mitigate them. This meant that risks to people were not managed appropriately or mitigated against; therefore, they were at risk of harm.

The provider's medicine policy stated that staff only support people with their medicines dispensed in a dosette box and information on the MARs stated this too. The policy does not take into account people who have their medicines dispensed in a blister pack or medicines such as treatment with antibiotics. This meant that people were at risk of not receiving their medicines because staff had no guidance to manage medicines not dispensed in a dosette box.

Staff told us that people's blister pack had the names of the medicines on them. However, the names of the medicines were not always attached to or written on each MARs when these were returned to the office. This meant that office based staff were unable to review whether people received their prescribed medicines safely during the medicine audit.

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 found errors on the records of the administration of people's medicines. On each of these MARs, there were errors, gaps or missing information on them. Staff had not always recorded a reason for the gaps and had not used any medicine management codes to explain them. There was a risk that people did not have their medicines as prescribed to help maintain their health and well-being. There was a risk that people received unsafe care because their medicines were not given safely because MARs were not recorded accurately.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff that had been assessed as suitable to support them. People were allocated sufficient staff so they were cared for safely. When people required two members of staff for to meet their needs, arrangements were in place to ensure this was made available for them. The registered provider had a safe recruitment practices. Checks took place on staff's suitability to work with people. Staff records held recruitment related documents such as and application form, two references, criminal records checks and interview records. However, we found where there were concerns identified from criminal record check, a formal risk assessment was not completed before the member of staff started working with people. We discussed this with the registered manager and they explained how they assured the safety of people the member of staff worked with. The member of staff received regular supervision with their supervisor and had regular spot check visits reviewing at their care delivery. Their stafff records reflected this. People had complemented the member of staff on their work with them and raised no concerns. The registered manager was satisfied with the quality of care the member of staff provided. The registered provider undertook visa checks and references before staff came to work at the service.

People were protected from the risk of harm and abuse. The registered provider had effective processes in place to reduce the risk of abuse and manage this risk. The registered provider had guidance for staff on how to protect people from risk of harm. Staff understood their responsibilities in the management of an allegation of abuse. They told us that they would first speak with the registered manager if they suspected this. The registered manager had followed their safeguarding policy, managed allegations of abuse and also made appropriate referrals to the safeguarding team for investigation.

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff who were support by their line manager. We spoke with staff about the support they received from their manager. Staff had regular appraisal of their performance in their role. This process helped staff and their line manager identify any training, learning and development needs should be identified, planned and supported. Staff had completed a self-appraisal, however their supervisor had not reviewed this information or formally discussed any issues raised in the self-appraisal. One member of staff had requested training that would support them in their role. No actions arising from staff appraisal were documented. Staff told us that they had regular supervision with their line manager. Records showed that staff had supervision. These included any concerns with their role, additional training needs or any planned annual leave. One member of staff said "I have supervision with my manager which I had quite often."

Newly employed staff were supported so they cared for people effectively. Senior experienced staff supported newer members of staff during a period of induction. The induction programme introduced staff to the organisation's ways of working. New staff undertook training and became familiar with the policies and procedures of the service. During their induction the newer members of staff were had the opportunity to shadow experienced staff whilst they were caring for someone. This allowed staff to become familiar with the care environment they would be working independently in. Once staff had successfully completed a period of induction, shadowing and observations by senior staff, they were signed off as meeting the provider's standards.

People were cared for by staff that had access to regular training to help them develop their knowledge. One person said "They are very well trained and a great help to me" Another said "Mine are experienced- yes skilled mostly kind and caring." A third person said "[my carer] is quite experienced, [my carer] and does a good job." The service had a training programme in place for staff. The training consisted of safeguarding adults, infection control and moving and handling. Staff told us that they enjoyed the training and felt it equipped them to carry out their roles. One member of staff said "the training is very good and helpful, I learn a lot about how to care for people properly." Staff had access to training provided in-house and by local authorities. Staff had appropriate training for their role and helped them to care for people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met. When required people had a mental capacity assessment, best interests decisions recorded and followed by staff. People were cared for in a way that protected them from risks from the unlawful deprivation of their liberty. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

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. DoLS applications for people living in their own homes must be made to the Court of Protection. We checked care records to see whether people received their care in line with the DoLS authorisation. The records we looked at did not contain DoLS authorisations in them.
Staff had not completed training in MCA. Staff we spoke with told us they were not involved in, or aware of, mental capacity assessments. A health or social care professional completed MCA assessments before a person used the service. On other occasions senior staff would contact the local authority if a member of staff identified concerns with a person's ability to make decisions for themselves. Senior staff had attended MCA training. Care and office based staff were scheduled to attend MCA training in February 2017.

People gave consent to staff when providing care. People signed their care records and agreed to the care. During care visits staff obtained consent from people or their relative when providing them support to meet their needs. One person said "They always ask me before they help me." Another said "[my carer] always ask permission or what I want [my carer] to do." Another person said "[my carer] will ask what I need doing, [my carer] will ask if it is ok to do something like, can "[my carer] make me a drink or would I like to go with [my carer] shopping."

People had access to appropriate health care and support when their needs changed. For example, staff had contacted a person's GP when their health deteriorated. The GP had made recommendations to support the person at home and staff were able to implement the guidance so the person's health improved and they were able to remain at home as they chose. We found that when people's needs changed staff took appropriate action to contact office based staff to make referrals to health and social care professionals for guidance and specialist advice.

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. One person said "They [carer] prepare my breakfast, and lunch. I have cereal or porridge and something heated up for lunch." Another said "The meals are fine, I get a sandwich at lunchtime, and they will make a fruit salad also. [My relative] will do my breakfast and dinner." People were provided with meals their enjoyed and staff provided this for them. This meant that people had meals which they liked and met their individual needs.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were caring. People we spoke with were complimentary of the staff that provided them with care and support. One person told us "They are a great lot. Mostly the same people [come]. They help me and reassure me when they use the hoist -they have time to chat." Another person said "They are kind and caring. Natural really." A third person told us "Yes, kind and caring [my carer] will have a nice chat." One social care professional said "I have found them to be consistent with the care they deliver and quick to deal with any concerns raised by myself or by the clients."

People or their relatives contributed in their care planning and made decisions about of their own care. People likes, dislikes, how they would like their care and what was important in their lives were recorded. People's opinions and views were also gathered on how they wanted their care and supported delivered. One person's care plan described how they wanted to be supported with their personal care. Daily care logs showed that staff had respected the person's wishes and noted clearly the care provided to them.

People and their relatives were involved in the review of their care and support plan. Health and social care professionals were involved in the review of people's care. For example, we saw records were a mental health professional attended a review of their health and social care support. Any changes in their care and support needs updated in the support plan. This meant that staff had access to the most relevant and accurate information about the person the cared for.

People told us that they felt staff respected them and staff showed them kindness and compassion when supporting them. A person said "Yes, they are never rude or disrespectful." Relatives we spoke with told us that the staff that visited them respected them, their relative and their home. One relative said "They are very caring and considerate, always cheerful, they never moan and always do what I ask. I have known them for years." A person said "I'm very pleased with them. The carer is quite nice, she's helpful, she is doing all I need." This meant that staff cared for people in a way that showed they respected their views, their home and relatives whilst delivering care to them.

People were treated in a way that helped protect their dignity and privacy. One relative said "They close the doors and keep [my relative] covered, they treat [my relative] like a person." People could be confident that staff treated them in a way, which valued them. Staff spoke about people in a way that demonstrated they were respectful and caring. The service had a "Dignity Champion". Staff who achieved and demonstrated skills in treating people they cared for with dignity were nominated as the dignity champion.

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 enjoy their local community or go on shopping trips with staff. A health care professional said staff were "professional, caring know their roles and what service care is needed to promote independence and wellbeing in our client group." People were supported to maintain their independence while taking part in activities they enjoyed.

Good

Is the service responsive?

Our findings

People received care and support from staff that was responsive to their needs. Staff at the service carried out care assessments to determine the level of support people required and if they could be met by the service. A person told us their assessment had been "fully explained" to them and they understood what care they received. Another person said "It has been discussed to a certain extent-I am fully aware of it." A third person said "Yes it has all been explained." Assessments were person centred, they sought and recorded people's views. For example, people had an opportunity to agree the timing of their care visits and staff recorded and implemented this request.

People were provided with explanations about their care and support needs. After an assessment people or their relatives received copies of their care plan. We saw people signed and agreed to the care and support they received. One person said their care plan "had been discussed. They [staff] have been quite flexible when needed." People's changing needs were identified and responded to promptly. There were regular reviews of people's care and support plans and these updated to reflect any changes in needs. Records showed that people were cared for by staff that involved and supported them in making care decisions.

Changes in people needs were recorded and their care records updated. For example when people were admitted into hospital, this was reflected in their care records. The service carried out regular updates with the local authority to ensure the person care was co-ordinated on discharge from hospital. Any requests for changes in the care service were also updated accordingly.

People had accurate records of the care and support they received. Staff completed daily care records when they visited people to provide care and support to them. These records had detailed the care and support provided to people that reflected was required in the care or support plans. We looked at copies of care logs and saw these reflected the care plan. A person told us "They fill in the care plan when they come." A staff member told us, "I completed these records on each visit."

People had access to a complaint process. People understood that they were able to make a complaint about the quality of care they received. "I wouldn't complain. No not had any cause." Another person said "Never had to make a complaint." A third person said "I would ring the office- No have not needed to complain." People and staff were aware of the service's complaints policy and were able to support people in its use if needed. The service users' handbook had information in it that described on how people were able to make a complaint or raise a concern with the service. One person said "[I have complained] only about one [member of staff] who wasn't very nice to [my relative]." This demonstrated that the service actively acted on people's complaints and took action to resolve these issues.

People were complimentary about the service. We saw records that demonstrated that people and their relatives were happy about the care they received from the service. These were shared with all staff.

Inadequate

Is the service well-led?

Our findings

People had mixed views of the management of the service. One person said "Oh yes- they are a great crowd and a second person said "Oh yes, very good team." A third person told us "Communication is not good but [my carer] is a gem." A fourth person said "They're okay, they are adequate. [My relative] likes them." We found feedback from provider's survey was positive and showed people were satisfied with the quality care they received.

There was a risk that people did not receive visits because the service did not have clear records which showed how many people received care. The registered manager told us they provided care to 150 people. They then gave us a list of 167 people. When we checked that list we found there were 160 people who received care.
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. They told us they stopped receiving in July 2016. We contacted another person and we were told that the person had died some months before our call. We provided the registered manager of this information during and again after the inspection. 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

The registered manager carried out monitoring checks of the service. However these were not always effectively carried out. There was no effective management of missed call visits. People told us of the missed visits they had and office based staff did not always inform them if staff were late or would not arrive. We asked the registered manager for details of the numbers of missed care visit, what actions were taken and how the incidence of missed visits were managed to reduce their occurrence. The registered manager told us that office based staff managed these individually and they would discuss any concerns with the member of staff concerned. We asked for a copy of this information along with the record of missed calls. This was not available because there was not a compiled list of any missed visits. This meant that the service could not monitor patterns and trends missed visits to plan and improve the service because there were no clear processes in place to manage them.

We asked the registered manager for a service improvement plan so we could see how the quality of care of the service was monitored, reviewed and improved. The registered manager told us they had made changes which improved services for people. We asked for a copy of this information to review. The registered manager told us this information was not recorded in one location but on individual care records. We looked at people's care records these contained care assessments, feedback from the provider's survey and care plan reviews. These records did not demonstrate how the service used this information to improve the service and the care people received.

Staff did not have a process in place to review the quality of care records to ensure they maintained standards of accuracy and remained relevant. The care support plans contained information that referred to CQC outcomes. We spoke to the registered manager about this and informed them that we no longer used

outcomes. They agreed to update their documentation. We asked for a copy of the audits of care records, this was not available because there was no process for this to occur. This meant the registered manager did not have methods in place to assess and routinely monitor the quality of care of the service.

There were no systems in place for the effective audit of returned MARs to the office. We found errors and gaps in each of the MARs we received. We discussed this with the registered manager who provided an explanation for these errors and gaps these included people going into respite care, people being hospitalised, people taking medication themselves or a family member, staff being denied access to MARs, staff being denied access to a property or staff error in not completing the MARs. The MARs did not give a clear indication and staff did not use the appropriate codes to explain the gaps we found in them. We saw one record that had contained the name, dose, frequency and support the person required to take the medicine. The head of training looked at four other care records with us and these did not contain this information. The registered manager said that all "new care records had this [information] older [care records] this wasn't the case, but our working methods evolve and improve over time, so new care plans do have the listing of medications. The older care plans do have the information as well, however it is held on another document within the care or support plan." This mean that staff did not have access to accurate information regarding people's medicines. This put people at risk of deteriorating health due to unsafe management of their medicines.

We asked for a copy of the medicine audits completed for people who had their medicines managed by staff. We were not provided with this information because the registered manager did not have arrangements in place to audit medicines. We asked how the quality of MARs was managed to ensure they were accurate. The registered manager told us any errors or gaps in MARs were discussed with staff and recorded on their records. They added that they did not complete a MARs audit because this was not required because of the method used by staff to support people with their medicines. This practice was in conflict with current guidance of the Royal Pharmaceutical Society of Great Britain on the safe management of medicines in a domiciliary care setting. We could not review the management of people's with medicines because the registered manager did not know who or how many people required this support. The registered manager did not appropriately investigate, monitor, record, review and learn from and reduce the recurrence unsafe medicine management because they did not know how many people they supported with their medicines. This meant that people were at risk of not receiving their medicines as prescribed because errors in the management of their medicines were not detected promptly.

These issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

The local authority commissioning team completed monitoring visits to the service. The report highlighted some of the concerns we found on two separate monitoring visits in March 2016 and the second in August 2016. Concerns were with the quality of risk assessments. They found these did not specify how risks identified were mitigated. The report discussed MARs were not completed correctly, not dated and had missing entries of doses of medicines. They recommended regular MARs audits should take place to ensure action on errors were identified and managed promptly. The report showed a decline in the quality of the management of risk assessment of people's medicines. The recommendations on the report included staff to carry out medicine spot check and monthly MAR chart audits to ensure that staff are managing people's medicines safely. We identified the same concerns which meant that they had not been acted on by the registered provider or registered manager. There was a risk that people did not have their medicines as prescribed because there were no processes in place to monitor review and manage them. This increased the risk of unsafe care and did not use guidance from the Royal Pharmaceutical Society of Great Britain.

The registered manager had not informed CQC of one notifiable incidents that occurred at the service. Safeguarding allegations are notifications that the service are required to by law to tell us about. We asked the registered manager for records of safeguarding allegations we were not provided with this information. After the inspection we received a list that contained three safeguarding allegations. CQC were not notified of any of them. This issue was in breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

The registered manager carried out monitoring checks of the service. For example, people's care reviews and assessments were accurate and updated on a regular basis. Paper care records were available to authorised people if necessary could access these records. People's records were stored securely. Staff understood why people's records were kept safe and secure. Records related to people's care needs were stored appropriately.

The service regularly sought feedback from people or their relatives using the service. Written questionnaires were sent to people who were able to comment on how they felt about the service. The feedback was positive of the service and people and relatives were satisfied with the quality of care provided to them.

The registered manager encouraged staff to become involved and improve the service. For example, staff had regular team meetings and discussed issues relating to the service and their job. Staff had the opportunity to discuss and share concerns with their role as they arose. The registered provider had a Performance Award Scheme for staff. This incentive aimed to encourage staff to perform at their full abilities whilst delivering safe and quality care. The eligibility for the financial incentive was for staff that had achieved a recommended standard in their training, communication, comments and compliments from people and team working. Staff that received those four commendations would be eligible for the award. The service recognised staff that performed well in their roles and "went the extra mile". They were celebrated as the Carer of the Month.

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 18 Registration Regulations 2009 Notifications of other incidents The Care Quality Commission were not informed of safeguarding incidents that should have been reported to us by law.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The registered person did not have effective systems in place to mitigate any such risks to the health and safety of service users receiving care or treatment. Service users were at risk from the unsafe management of medicines.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Service users were at risk because their care records and risk assessments were not regularly checked to ensure they were of a good standard and reflected their current needs.

The enforcement action we took:

Warning notice