AMMG Care Limited

Caremark (Wakefield)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 and 14 October 2016 and was announced. The service was previously inspected on 3 June 2013 and met all the requirements in place at that time.

Caremark (Wakefield) provides a domiciliary care service for approximately 70 people in the Wakefield area of West Yorkshire. They are registered to provide the regulated activity of personal care to people from birth upwards with a physical and sensory impairment. It is a condition of registration with the Care Quality Commission that the service has a registered manager in place and there was 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.

Staff had received training in safeguarding adults and children. They demonstrated a good understanding of how to recognise abuse and ensure people were safeguarded. They knew the procedure to follow to report any concerns.

Environmental risks had been assessed to ensure a safe working environment for staff. The service had assessed the risks to people supported, but we found the measures put in place to mitigate risk were not always recorded.

We found people had assistive equipment in place which was not referenced in their moving and handling care plans and the method staff were to follow when moving and positioning people did not contain sufficient detail for staff to follow.

We found some issues with the management of medicines including medicines not individually listed on the medicine administration record when provided in a monitored dosage system and some gaps in the records which had no reason recorded against this.

All staff had been checked against the Disclosure and Barring Services (DBS) to ensure they were safe to work with vulnerable people. However, gaps in employment history had not been recorded and one candidate's reference contained incorrect dates which had not been picked up.

Staff received regular training to ensure they developed skills and knowledge to perform in their role and received regular ongoing supervision and an appraisal to support their development. Staff competency was checked through frequent spot checks by the field care supervisor.

The registered provider was not meeting its responsibilities under the Mental Capacity Act 2005. No capacity

assessments or best interest decisions had been recorded and staff did not have a good understanding of the principles of the Act.

People were cared for by staff who were caring and compassionate and who respected their dignity and privacy.

People told us staff were responsive to their needs and provided care to their preference and choice. They told us they were frequently asked for their views about the care provided and felt they could influence how care was provided.

The service had a complaints policy in place and complaints were handled appropriately to ensure a satisfactory outcome for people using the service. A record was kept of all compliments received and when these related to staff, these achievements were publicly recognised.

Staff told us they enjoyed working at the service and wanted to provide a good standard of care to the people they supported. They told us the registered manager was supportive.

We found shortfalls in audits to monitor the quality of service provision around for example, the safe administration of medicines, and care plans.

We found two breaches in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in Regulation 12; Safe Care and Treatment and Regulation 17; Good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff we spoke with demonstrated a good understanding of how to recognise abuse and ensure people were safeguarded. They knew the procedure to follow to report any concerns.

Generic risks to people were identified. However, specific measures to protect people were not always recorded and moving and handling care plans did not include detailed methods for staff to follow.

Medicines were not always recorded as administered safely as gaps in records where people had not taken the medicines had not been explored.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider had not understood their responsibilities under the Mental Capacity Act 2005 and no capacity assessments or best interest decision had been recorded.

Staff had received training to ensure they had the knowledge and skills to perform in their roles and were supported to develop through supervision and appraisal.

Staff ensured people's wellbeing and liaised with other professionals to ensure their health needs were met.

Is the service caring?

Good

The service was caring.

Staff knew how to ensure privacy; dignity and confidentiality were protected at all times.

Staff knew how to maximise people's independence to help them to live fulfilled lives.

Staff supported people with kindness and compassion and

people spoke highly of the staff, with particular reference to those they were familiar with

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and referenced people's views, preferences and choices, and people were provided care in a way that reflected their wishes.

People told us the service was responsive to their changing needs.

The service had a complaints policy and process in place to ensure concerns about the service were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had not been monitored against the fundamental standards of care to evidence what they did well and what they could do to improve and to enable them to have plans in place to improve the delivery of the service.

Day to day monitoring was taking place such as call times, spot checks, supervisions and appraisals. However, there was a lack of audits such as around medicines and care plans which are fundamental to evidence safe care and treatment.

Staff told us the registered manager was supportive. We found staff were motivated and supported to provide good care and they told us they enjoyed working at the service.

Caremark (Wakefield)

Detailed findings

Background to this inspection

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

The inspection took place on 12 and 14 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service.

The membership of the inspection team consisted of one adult social care inspector and an expert-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 gathered and reviewed information from statutory notifications. 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 contacted Healthwatch to see if they had received any information about the provider. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team and reviewed all the safeguarding information regarding the service. The local authority told us they did not commission a service directly from Caremark (Wakefield). This meant they had no monitoring information to share with us. We also contacted the Clinical Commissioning Groups (CCG) and West Yorkshire Police safeguarding to share information they might have about the service.

We reviewed three staff files and associated recruitment records. We spoke with seven people using the service and five relatives of people. We interviewed the registered manager, the care coordinator, the field care supervisor, one care assistant at the service and a further five by telephone. We reviewed six care files and daily records for people using the service. We also reviewed records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service whether they felt safe with the care staff who supported them. One person said, "Oh yes, quite. I've always had nice people and we get on together. I haven't had cause for concern." Another person said, "Well, the experienced ones, yes. We get quite a few beginners, so you obviously don't have the same degree of certainty until they're trained." One person told us, "Yes. The girls that come are very good." We were also told, "Yes. I've got two very good ones who get me up in the mornings and put me to bed at night."

Staff we spoke with had a good understanding of how to identify abuse and act on any suspicion of abuse to help keep people safe. They were able to describe the type of abuse you might find in a community setting and the signs of abuse. They all told us the steps they would take if they suspected abuse. Staff also knew the principles of whistleblowing, the duty by a staff member to raise concerns about unsafe work practices or lack of care by other care staff and professionals.

Staff told us the field care supervisor or registered manager undertook the risk assessments for people using the service. Care staff told us they signed people's risk assessments to confirm they had read and understood these. Most people utilising the service were supported with companionship and social inclusion and had minimal physical disability requiring hands on personal care.

The initial assessment included a review of the home environment with a view to promoting the safety of people and staff. We saw evidence of this document titled "My Environment" in all the care files reviewed. We also saw risk assessments in relation to nutrition and hydration, finance, medication and pressure area care. The service had detailed risk assessments forms from the Caremark franchise. We reviewed a nine page skin integrity risk assessment in one person's care file which detailed all the possible risks to skin integrity but where a high risk had been identified, the section on "How the risk is reduced" had been left blank. In addition the section for staff to sign had also not been completed to demonstrate they had read and understood the risk assessment. This meant the service could not evidence it had mitigated risk in relation to skin integrity. We found no evidence to suggest actual harm had occurred to the person concerned but the lack of recording demonstrated a potential for exposure to harm. Staff we spoke with told us they regularly monitored people's pressure areas and they would contact the district nurses if they had any concerns.

Where people used bed rails to prevent them falling from bed, we found that this risk had not always been assessed. For example, in one person's daily notes we found reference to the use of bed rails and when we asked the field care supervisor and the registered manager about the risk assessment for these rails, they were unaware this person had bed rails. It is important that the use of bed rails is assessed to ensure that the person is not placed at risk of entrapment in the rails or if they might try to climb over them. The registered manager told us they would action this.

The service supported two people who had complex disabilities. We reviewed the moving and handling risk assessment and care plan for one person. We found the moving and handling risk assessment had not listed

all the tasks involved or all the equipment in use. The method was not detailed in the care plan and there were no instructions for staff to follow. The care plan stated, "Moving from bed to chair- two care support workers to support with this move. Use sling and overhead hoist." The service only supported two people with moving and handling needs. However, the lack of a detailed risk assessment and a moving and handling care plan meant the service was not appropriately assessing, mitigating and recording risks in line with legislation.

The service had a medicines policy in place which detailed how medicines were to be administered safely to people. The registered manager told us generally people they supported had locked medicines cabinets in their home and we saw risk assessments in relation to the management of medicines. The service completed Medicines Administration Records (MAR) to record people's medicines. Medicines in blister packs were not listed individually on the MAR sheets. We found several gaps in one person's MAR sheet without a reason recorded. We highlighted this to the field care supervisor who checked the daily log which confirmed the person had taken the medicines on some of these dates, but we could not see confirmation for all the dates. The member of staff responsible was no longer working at the service. The MAR sheets were randomly audited which meant there was no close monitoring of people's records to ensure staff were consistently recording what medicines people had taken. Not all creams people used were listed although when cross referenced with people's daily logs some staff had clearly recorded where they had applied the cream. This was discussed with the registered manager who agreed to improve the governance arrangements around the management of medicines.

The above examples demonstrated a breach in regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the staff we spoke with were able to confidently describe to us what they would do in an emergency situation such as if they found a fallen person or could not get an answer at the door. They told us they did not hold people's telephone numbers so would ring the office to make initial enquiries if a person did not respond to their arrival. Alternatively if they had consent, they would let themselves into the property using a key from the key safe if necessary. This demonstrated the service had systems in place, which staff were aware of, to deal with emergencies as they arose.

The service used an electronic system to monitor calls and we saw this was a live system which was on a large screen in the office for all staff to see and constantly monitor. Staff logged in and out of their calls so the office based staff were able to know exactly where staff were in relation to their calls. The care coordinator told us they did not have any missed calls and they monitored all calls to ensure they could identify a reason why staff were not on time.

We asked people using the service whether any calls were missed, were late and whether they received calls at a time of their choosing. One person told us, "No, not of any consequence. The traffic is dreadful around here, but they're very prompt really. I've no complaints on that score." Another said, "Occasionally, they might be 5 or 10 minutes late because of traffic, but I don't have any missed calls at all." Another person told us, "It's usually road works that makes them late, traffic and such like. Sometimes they let me know, but sometimes they don't and I have to ring up and find out what's happened to them. It's not usual that they're so late." Only one person we spoke with was unhappy with the timing of their calls. They told us, "For the past 2 years it's been brilliant, but the last few months have been terrible. But now, it's anything from 09.15 - 12noon." We reviewed this person's record and found over a nine day period the calls varied from 09.15 to 10.45 am. However, this was the only file we reviewed where timing was an issue.

Some of the staff told us they had been employed to work with specific people and those people told us staff were consistent and were very positive about their experience of care with Caremark (Wakefield).

We looked at three staff files to see whether all necessary recruitment checks had been made to ensure staff suitability to work. The registered provider kept a detailed record of their recruitment processes which included checking candidates against the Disclosure and Barring Services (DBS), reviews of candidate's employment history and reference requests and receipts for each person. We found in two out of the three files we checked there were gaps in the candidate's employment history and no evidence to confirm this had been explored. This was discussed with the care coordinator during the inspection and mentioned to the registered manager on the second day of inspection. They showed us the form had recently been changed and now contained a section to record an explanation of gaps in candidate's employment history. In one file we looked at we found one reference had incorrect dates of employment were recorded with no evidence this had been spotted or checked. The care coordinator could offer no explanation for this. The registered manager told us recruitment and retention of staff was difficult into the service and there had been a turnaround of 50% of the staff in six months, which created a high workload for both office and care staff to ensure people were safely recruited, inducted and trained.

The care coordinator told us staff were provided with personal protective equipment (PPE) which enabled them to carry out their caring duties safely. Supplies were kept in the office and in people's homes. Staff collected these from the office and there was a system in place to record the issuing of PPE. Community equipment such as hoists and slings were provided through local community equipment arrangements.

Requires Improvement

Is the service effective?

Our findings

We asked people using the service whether the staff who supported them had the knowledge, skills and training to care for them. One person who used the service told us, "A few months ago I was very poorly and they persuaded me I needed to go to hospital. As it happened I had double pneumonia, but they picked up on it straight away." Another person said, "Oh yeah, they seem to be fine, absolutely fine. Nothing seems to be any trouble for them." Other people told us there had been a high number of new staff lately and one said, "Some of them are, but some of them are just learning. I've been having them a long, long time, so I've got used to them. Mostly, if they're new people, it's the regulars what bring them." Another person told us, "The regular ones, yes. It's like everything else, some pick it up straight away, others need to come a few times. I usually tell them what to do. If it carries on, I ring the office and tell them."

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.

The registered manager was not aware of their responsibility to carry out capacity assessments when a person was unable to consent to care due to a lack of mental capacity. Although most staff had received training in the Mental Capacity Act, staff demonstrated during our discussions they were unable to define the principles of the Act or explain how they were working within the legislative framework. Several of the staff told us if a person could not make a decision, they would seek consent from their relative which does not comply with the Act. When we discussed Lasting Power of Attorney with the registered manager they told us they felt uncomfortable asking relatives for this information and had recently lost a large package of care provision when a relative had not wanted to disclose this information. People who were able to consent to care told us staff consistently sought their consent before providing care. However, for those that lacked capacity, the service could not evidence they had followed the legal process to asses and record capacity and best interest decision making in line with the Act. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The field care supervisor told us introductory visits took place when staff visited a person for the first time. This system was designed to help ensure that people were introduced to new staff and that staff understood people's needs and wishes. We saw evidence this practice was taking place for people new to the service. For those already receiving care, they told us new staff shadowed people. One person said, "The very first time they shadow, but then they come on their own." Another person told us, "Occasionally there's a new person, but generally they're supervised by someone."

We looked to see how new members of staff were supported in their role. The registered manager told us all new staff received an induction into the service. They utilised the Care Certificate which staff completed within their first 12 weeks at the service. The Care Certificate is a set of standards that social care and health

workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The registered manager had received training to be able to authorise staff had completed the required training and competency checks. Regular spot checks were undertaken by the field care supervisor on both new and experienced care staff.

Staff told us the training had equipped them with the skills and confidence to support people effectively. We found the office had a dedicated training room with a separate area containing a bed, hoist and moving and handling equipment and an area which contained examples of medicine training. The registered manager sent us the training matrix following the inspection which showed most staff had been trained in health and wellbeing, moving and handling, medication, and safeguarding. Approximately half the staff had received basic life support/first aid awareness, and undertaken an online dementia awareness course. We received one comment from a relative about staff lack of understanding of working with people with dementia. They told us, "Staff say they are 'dementia friendly' but I really do wonder how much training they get about dementia."

Additional training had been provided for staff supporting people with Percutaneous Endoscopic Gastrostomy (PEG) feeding (a tube placed directly into the stomach through which food, fluids and medicines can be delivered). The registered manager told us the district nurse undertook this training and regularly refreshed staff to ensure they were competent to undertake this task although this was not included on the training matrix. We asked about other specific training to meet the needs of people they were supporting such as stoma care and catheter care, and the registered manager told us this training was not available locally and staff learnt this from the person themselves or the field care supervisor. This training was not recorded which meant there was no evidence to confirm staff had received the training or were competent in this area.

Records showed staff had received supervision and staff who had been at the service for over 12 months had received an appraisal. Staff we spoke with as part of our inspection process told us they had received supervision and several direct observations of their care. One member of staff told us, "We discuss how we are getting on with the job, whether we require any more training, and any issues." Staff require supervision to be supported to develop in their roles and to identify any gaps in knowledge and skills. The registered provider was meeting this requirement.

People told us the care staff were effective in dealing with their health issues and involving other professionals when required. One person at risk of pressure sores said, "They always look and check. If I get a bedsore, they always write it in the book to let the district nurse know. Another person told us, "Absolutely. I pass out from time to time. They ring the office or an ambulance. Things happen very quickly; I can't fault the girls."

Staff told us they ensured people maintained a healthy diet. One member of staff said, "If someone had a sandwich at lunchtime, I'd make sure they had a cooked meal at tea time. All carers write down what meals they are having." Some people were supported to prepare meals and drinks and to ensure that they ate and drank enough. People's care plans included details on their dietary preferences and how to support them. One person told us, "They cook me a meal from scratch, but I get what I want. Sometimes I have to tell the young ones what to do; we talk it through and have a laugh." In one care plan we found the following information, "It is important that one meal daily is balanced and hot. Staff to assist and make this meal. Please record on nutritional sheets. Family will order meals for delivery. Due to my diagnosis, I often do not feel hungry and I will say that I'm not hungry." The records for this person demonstrated staff were encouraging and supporting the person to maintain their diet and nutritional wellbeing and offering choice

to involve the person in decision making.

Good

Is the service caring?

Our findings

We asked people who used the service whether the care staff were kind and compassionate. One person told us, "Very. They're very caring and have a chat with me. They know what they're doing." One said, "Oh yes. In fact a lot treat me like a friend." Another person told us, "Yes, of course. We have some laughs and things; they're nice people." One person the service supported told us their relative had been taken ill whilst the carer was present. They said, "They had to call an ambulance and they stayed until it arrived even though it was past their time. I was supported throughout."

Relatives of people who used the service told us staff were caring and compassionate. One relative said, "From what I've seen, they are, very." Another said, "I find that they are. They're all very good actually." Another relative told us, "Absolutely." A further relation said, "Yeah. If there's a new person on, they come with the manager or someone, but [relative] usually has a number of regular ones. [They are] getting used to these and there's no problems."

People told us they felt involved in their care. One person said, "Yeah, they're very good to me and ask me what I want." They told us staff respected their dignity and privacy when carrying out personal care. Comments included, "Absolutely; they're very good," and "Yes. If I'm sat with no clothes on, they drape a towel over me and I'm not sat there like a lemon." Another person told us, "Yes, definitely. They don't make me feel uncomfortable if I'm naked and things like that." A further person told us, "Yes, they're very helpful around my personal care." Relatives also confirmed this. One relative told us, "They do [relative's] shower and dressing in the bathroom and of an evening, they always make sure the curtains are closed in the bedroom." Another relative said, "They deal with [relation] sensitively regarding personal hygiene." When asked whether staff treated their relation with respect one relative told us, "We're in and out at different times and I've never seen any problems. I hear the staff talking to them. I've no reason to believe otherwise."

The care coordinator told us respecting people's human rights was discussed at induction. This included the right to a private life and what was expected from staff when they were going into a person's home. They were taught to respect confidentiality and not to talk about people's business to ensure they respected people's right to confidentiality. This meant the service was working within the legislation and protecting people's rights to privacy.

People told us staff encouraged them to be independent. Relatives told us, "They do try and encourage him to do little things. He can't, but they do try". Another family member told us their relation was "given the opportunity to be independent." Another relative told us, "They are encouraging, suggesting he has a drink for instance." This was confirmed by the staff we spoke with who told us how they encouraged people to remain independent and have choice in how they liked their care to be provided.

The service supported both adults and children at the end of their lives and they worked in partnership with other services at this time. The care coordinator told us they had an open door to support staff emotionally at this time as staff had developed relationships with the people they were supporting. This showed that the registered provider supported staff and people using the service appropriately at this time.

Good

Is the service responsive?

Our findings

Some of the people we spoke with told us they had a care plan and daily record book. One person told us, "They write everything down in a book." Another person said, "Yes, they're following the book." Another person said, "Yes, but I don't look at it or read it." One relative we spoke with said, "Reliable, efficient and they know what they're supposed to do. They do follow the care plan."

We reviewed six care plans as part of our inspection process. We found the records were person centred and detailed people's choices and preferences and how they wanted their care to be provided. Each person had an individual care and support agreement which detailed when and at what time and duration of each call. There was a section on a person's background information, personal history and interests. This referenced how people wanted to be addressed.

In one of the care files we reviewed the following information, "My independence is important to me and my choices must be respected at all times. I am fully able to choose and make my own choices." The desired outcomes from a person's care and support were listed. The care plan listed on each day, what care and support the person would like to be provided at each intervention including for example, for moving and handling, personal care, and meal preparation. Whilst some information was very detailed and listed tasks for staff to do, other information was minimal such as around moving and handling. We found daily records which staff completed at each intervention detailed a more holistic picture of the care staff had provided and a more accurate picture of people's daily lives.

The care coordinator told us they reviewed care plans whenever people's needs changed and at least yearly. We could see from the care files that people's needs were constantly under review and the service was responsive to people's changing needs. Although we found in some cases, the reviews consisted of copying forwards information from the old plans which was not always detailed. We asked people using the service whether their needs were reviewed. One person said, "They come and visit me at home, the supervisor, and talk about things."

Relatives of people using the service told us they were always kept informed about their relation's needs. They said, "Everything's written down so we can see it. A couple are very good; when she had a rash on her legs, they pointed that out." Another said, "They definitely let us know; they're very good on that point." Another relative said, "If there was any problem they'd let me know. Recently, [relative] had problems with their toe and they phoned me. I contacted the GP and Caremark took them to see the doctor."

People understood how to make a complaint about the service and information on the procedure was included in the folders kept at their homes. We received the following comments from people using the service, "We've got a complaints form that tells us what to do", "I'd look in the blue book and that tells who to contact" and "There's an office and a number in the front of the book." People told us they were confident their concerns would be acted upon. One person who complained said, "I had a young lady and I didn't like her. I asked them not to send her and she didn't come again." Relatives were also confident complaints would be acted upon. One relative told us, "I realised one day that [relative's] medication hadn't been given.

I phoned them up and they looked up immediately who was involved. I know it was dealt with because the next time I saw her, she apologised." Another person told us, "Well, I haven't. I've never had a serious complaint at all." Very few complaints had been recorded formally, as not all concerns were recognised as complaints. As the service was responding to people's concerns to try and make their experience of care more positive, recording how the service actioned these informal complaints would have demonstrated how they were using this information to drive improvements at the service.

Requires Improvement

Is the service well-led?

Our findings

The registered manager who was also one of the owners of Caremark (Wakefield) had been in post since the branch opened in 2012. They shared their vision for the service with us, "To make sure the care is grandma centred. I want it to be that a staff member would give the same care they would give to their loved ones." There had been a recent changeover in office staff at the time of our inspection with both the care coordinator and field care supervisor only being in post for a few months. Both were keen to provide a high standard of care and ensure they were continually striving to improve the service. The registered manager told us the new team shared their passion and vision for good care. The registered manager said the biggest challenge for the service was retaining staff. They were currently working on various enhancements to encourage staff to stay, but the demand for care staff in the area was high with staff having a choice of where they wanted to work. They realised constantly changing staff impacted on people using the service and this had been a regular comment from the people we spoke with during our inspection.

Staff all told us they liked working at the service and said this was because they had time to be able to provide the care people needed. They told us the registered manager was strict but this was necessary to ensure staff did what they were supposed to do. They told us they felt listened to, they could speak openly without fear of retribution and the registered manager was supportive. Staff were praised when people complimented them about their care and they had their names placed on a board outside the office to publicise their achievements.

We asked people who used the service what they thought about the service they received. One person said, "On the whole, excellent. I've had quite a few care companies over the years and some of them have been absolutely awful, but Caremark come out streets ahead of them all." Another person told us, "I don't know any other services, but I'd say they were fairly good. If I wasn't satisfied, I feel I have the confidence to tell them and they would change things for me."

People who used the service and their relatives' views were regularly sought usually by a telephone monitoring call which was recorded on a standardised form and by regular visits from the field care supervisor. We were told by the office staff and people using the service that their views were sought at every opportunity. One person told us, "I had a telephone call asking me if there are any problems and if I'm happy. If I ring and have contact with them, they'll always ask if everything's OK." And another person told us, "We do get the occasional phone call asking if everything's alright sort of thing."

The registered manager carried out a yearly survey and were waiting the results of the most recent survey. We were shown some of the responses already received which were positive about the service delivered.

The registered provider was provided with a weekly operations report and met with the management team once a week. This weekly update reported on areas such as call monitoring, hours of care delivered, recruitment, staffing issues, training and administration. The latter reporting on the number of spot checks carried out on staff, outstanding supervision and file checks. Actions were agreed at this meeting, detailing who was responsible for undertaking these actions and when they had to be delivered.

We were told by the registered manager, the service had been audited by a member of staff from the national Caremark operation in May 2016 but they had not yet been provided with this feedback, although they had requested it several times. Therefore, this information was not available to us at the time of this inspection.

During our inspection we found areas where quality of service provision had not been managed effectively and audits had not driven up improvements. For example, we found medicines management audits had not been completed or had not found the issues we had found in the safe management of medicines. Not all MAR sheets were audited when they were returned to the office, which meant the service had not identified where they needed to improve. Care plan audits had not identified the discrepancies between what was recorded in the care plan and what had been recorded in the daily records in relation to the delivery of care. We saw evidence in each file we reviewed there had been regular quality checks on care files to check that they contained the correct paperwork and had all been updated. However, this did not extend to an in-depth audit of the quality of the content of care plans and daily records which did not always contain accurate information. We found information had not been transferred into an overall audit which would have enabled the registered manager to come to an informed view about the quality of care planning and recording and to drive improvements in this area.

The registered manager had not utilised the registered provider handbook provided by the Commission to assist in an audit of the service against the fundamental standards laid down in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This would have enabled the registered manager to benchmark their provision and identify where they could improve. The registered manager was directed to this during our inspection.

The lack of robust system and processes in place to monitor all aspects of service delivery evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some areas of good practice during our inspection. For example, staff had been invited to take part in a monthly pop quiz which for the month of October asked questions about safeguarding. One staff member returned their questionnaire whilst we were at the service and the registered manager told us the winner of the quiz won a prize which encouraged staff to complete.

We asked the registered manager how they kept up to date with best practice. They told us they were a member of the United Kingdom Homecare Association Ltd (UKHCA). This is the professional association of home care providers from the independent, voluntary, not-for-profit and statutory sectors. They told us they had contacts with other registered managers in the area and read reports from other inspections that had taken place.

Staff meetings are an important part of the registered provider's responsibility to improve the standard of care and support for people using the service. We were given the latest three team meeting agenda and minutes which evidenced the service was meeting this requirement.

As part of their regulatory responsibilities the registered provider must notify the Commission of any allegations of abuse. Due to a misunderstanding from the registered manager, they were unaware they had a duty to notify the Commission of all cases whether or not abuse had been substantiated following a local authority investigation. The registered manager agreed going forwards to notify the commission of all safeguarding concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The inaccurate recording of medicines and the lack of individual risk assessment and risk reduction plans demonstrated the service had breached this regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been robust in identifying gaps in service provision and improving practice. Records such as mental capacity assessments and best interest decisions were not in evidence.