Carewatch Care Services Limited

Carewatch (Rugby)

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Carewatch (Rugby) on 11 May 2017 as an announced inspection. Carewatch (Rugby) is registered to provide personal care to people in their own homes across the Rugby and Northampton area. At the time of our inspection visit the service was supplying care and support to one hundred people in their own homes. Four of those one hundred people lived in shared accommodation and were supported by care staff over a 24 hour a day period.

This was the first inspection that had taken place at the service. This was because the service had only recently been registered with us in March 2017, It had however previously been registered under a different owner/provider. The previous provider operated as a franchise business under the 'Carewatch' brand. Carewatch are a large organisation that operates services across the country which are run under their own company, or as franchise services. After the franchise service went into liquidation, the service had been taken over by the Carewatch company in early December 2016.

A requirement of the service's registration is that they have a registered manager. 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. At the time of our inspection visit there was a registered manager working at the service.

We found the governance of the service was not always effective. Systems to monitor the quality of care to people were not consistently effective as people's care records required updating to ensure they always reflected people's individual support needs. In addition the provider was not following the Mental Capacity Act (MCA) to assess people's capacity to make decisions where this was required. Risks to people's individual health and wellbeing were not always identified and care was not always planned and delivered to minimise risks to people. Medicines procedures required improvement to ensure people always received their prescribed medicines safely.

Staff understood their responsibilities to protect people from the risk of abuse. The manager made sure there were enough staff to support people safely. The provider checked staff were suitable to support people before they began working at the service and in people's homes.

People were supported by a consistent staff team to meet their needs. Staff completed an induction to ensure they understood their role and responsibilities. There was a training programme in place to refresh staff knowledge and ensure they continued to work in accordance with best practice, however, this was being developed further at the time of our inspection visit.

Staff knew people well and respected their privacy and dignity. People were supported maintain their nutrition which met their preferences and were referred to healthcare services when their health needs changed.

People knew how to make complaints and provide feedback about the quality of the service. Complaints procedures were in place to ensure complaints were investigated and responded to in a timely way. The provider monitored feedback from complaints to identify trends and patterns, and continuously improve.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 consistently safe.

Staff had been recruited safely and there were enough staff available to meet people's needs. Most people told us they felt safe with the staff from Carewatch (Rugby), and we found people were protected from the risk of abuse as staff knew what to do if they suspected abuse.

However, the risks to people's health and safety were not always identified and managed to ensure risks to people were minimised. Medicines were not always administered to people safely and in accordance with the provider's policy.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments had not always been conducted in order to determine capacity levels, prior to important decisions being made. People's involvement in decision making had not been recorded. Care records showed some restrictions on people's liberty and consideration had not always been given as to whether an application to deprive people's liberty should be submitted to the supervising authority.

Staff completed induction and training organised by the provider. People were supported to maintain their health, as they were referred to health professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were comfortable around staff and described them as being friendly and caring. Most people spoke positively about the care and support they received. People's privacy and dignity were respected in their own homes. People were supported to maintain and develop their independence. However, staff felt they were not always valued and respected by the provider.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records were not always up to date, and did not always provide staff with information they needed to meet people's needs.

People knew how to make complaints and provide feedback about the quality of the service. Complaints procedures were in place to ensure complaints were investigated and responded to in a timely way. The provider monitored feedback from complaints to identify trends and patterns, and continuously improve.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider sought feedback about how the service could be improved through people and their relatives. Quality assurance procedures were in place to identify where the service could be improved, however, these did not always consistently identify where the service needed to make improvements. Staff told us communication with the management team could be improved. Records about people's care were not always held securely.

Carewatch (Rugby)

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 was 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.

We inspected the service on 11 May 2017 as an announced inspection, we gave the provider two days' notice of our inspection visit; so that we could be sure the manager and staff were available to speak with us. This inspection was undertaken by two inspectors.

Before our inspection we reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who contract service, and monitor the care and support the service provides, when services are paid for by the local authority.

We spoke with seven people who used the service and five people's relatives across the two areas.

We wrote to seven members of care staff to ask for their views, we also spoke with three members of care staff, Quality Service Improvement Manager, the registered manager and the Regional Operations Director. We received written feedback from three care staff.

We looked at a range of records about people's care including four care files, daily records and charts, medicines records and staff call rotas. This was to assess whether people's care delivery matched their records. We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service.

We looked at staff files to check staff were receiving supervision and appraisals to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

Two members of staff told us they didn't always have the information they needed to care for people safely. One member of staff said, "The care records are not up to date." They added, "The lack of information we are given worries me."

When we looked at care records we found that risks associated with people's health and wellbeing had not always been identified and actions put in place to manage those risks. For example, one person who was supported by staff 24 hours a day suffered from seizures, and could have several seizures during the course of a day. There were no risk assessments or risk management plans in place to guide care staff as to what may cause the seizures, so that seizures may be prevented. There was no guidance for staff about the signs of seizures so that they could be aware a seizure was imminent, or how to support the person during a seizure. In addition there was no guidance about when emergency support should be called if the seizure was prolonged. We discussed this with the Quality Service Improvement Manager who agreed documentation was important so care staff had the necessary information to keep the person safe.

We asked the manager whether staff were trained in supporting people with epilepsy, the manager told us, "Carewatch do not routinely train staff in epilepsy management." They added that since the transfer of the Northampton branch to their control they had organised staff training in the area of epilepsy management for four members of staff, another four care staff were awaiting training in this area. This meant that at the time of our inspection visit people with epilepsy were being supported by staff who were not always trained in how to minimise the risks of epilepsy. In addition, the lack of detailed guidance for staff to follow meant staff might not know how to care for people safely if they had a seizure.

One person was at risk of falls due to a physical disability and records demonstrated there were occasions when they had fallen when being supported by care staff outside their home. There was no information about what action care staff should take to minimise the risks of the person falling again.

In addition, we found environmental risk assessments were not consistently maintained to ensure the safety of people and staff. For example, we saw one person was at risk from several environmental factors in their home, and the actions of people who lived with them. There was no risk assessment and risk management plan in place to guide staff on minimising those risks to the person, or themselves.

We found staff were not always provided with the guidance they required to ensure people were given their prescribed medicines safely. All care staff were trained to administer medicines to people. The provider had a medication policy that had been reviewed on 24 February 2017, which all staff were given. However, we found that medicines were not always administered to people in accordance with the policy.

The medication policy defined the levels of assistance people needed such as supporting them to take their medicines or actually giving them their medicines. The policy also stated that care staff could not give people medicines that needed to be given 'as required' unless there was a care plan and risk assessment in place. One person whose records we looked at, was given medicines 'as required' for seizures. There was no

clear instruction contained in their care plan or risk assessment to guide care staff when to give these medicines to ensure they were given consistently and safely. The medicines administration record (MAR) stated they should be given after the second and fourth seizures. Records showed the person suffered 'absence seizures' and 'tonic clonic seizures'. It was not clear which type of seizure the MAR was referring to. This was important as a different level of response could be required depending on the type and severity of the seizures. There was also a risk that staff might not give the person their medicine when it was required, as the policy directed them not to do so. We identified that staff did not always have epilepsy training to competently respond to the person's needs. As the person did not live with family members, and was supported only by staff, it was important that staff knew how to respond to the person's needs when an epileptic seizure occurred. One staff member we spoke with who was required to support people with epilepsy told us, "If I was unsure I would call 999."

We found there were other medicines people received that were to be taken "when required". There was no information available to staff on why some of these medicines would be needed, how much to give and when.

There were no body maps or additional information available where care staff applied prescribed creams to people's skin, to show where and how often the creams should be applied to each person. On one person's MAR we saw that staff were signing to confirm they had applied a person's topical medicinal creams and sometimes they had put the code 'O' to demonstrate it had not been applied. 'O' meant 'other' but there was no explanation on the back of the MAR to indicate the exact reason for the non-application, which meant we could not be sure people always got their cream as prescribed or as needed. There was no evidence to reflect that the person had suffered any harm as a direct result of this, however, a person's skin condition may not be treated effectively if creams are not applied as the doctor intended.

The medicines policy stated that care staff were only able to administer medicines from a pre-prepared container supplied by the pharmacy. Care staff signed to confirm they had given people the contents of the container, but each individual medicine was not recorded separately on the MAR. We found when reviewing care records the medicines that people received, prepared by the pharmacy, did not always match the information contained in people's care records. This meant staff would not know what medicines they gave to people, and any risks these might pose to the person.

In addition, one staff member told us they were not always confident the manager would act appropriately to investigate their concerns, when an error occurred with medicines management. This was because, "There was a recent incident with a medication error that I felt should have been investigated, but I'm not sure this happened." We spoke with the manager regarding this who said, "I would always report and investigate medication errors, and any concerns that were raised with me."

This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Most people told us they felt safe with the care staff from Carewatch. Comments from people and relatives included; "The service is good", "They look after [Name] well", "I feel it's totally safe. I work full time and can be out of the house for 10 hours and I trust the staff completely", "I know [Name] couldn't get this quality of care anywhere else."

Staff had received training in how to protect people from abuse and understood their responsibilities to report any safeguarding concerns. They explained they would not hesitate to report things to the manager. However, they were not always confident the manager would act appropriately to protect people and

investigate their concerns. We raised this with the registered manager who assured us all concerns would be investigated and reported appropriately according to the provider's policy.

The provider had a safeguarding policy that clearly informed care staff what their responsibilities were if they identified any actual or potential safeguarding issues. There had been two safeguarding referrals made by the registered manager since the new registration. The registered manager understood their responsibility for reporting any concerns they had about people to the local authority safeguarding team and to us. The provider also had a whistleblowing policy and procedure which meant staff knew they could share concerns about other staff's practice in confidence.

Staff told us and records confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of staff prior to them working at Carewatch. For example, criminal record checks, identification checks and references were sought before staff were employed to support people.

The provider had a business continuity plan for the service which had been reviewed on 3 May 2017. The continuity plan identified potential risks to delivery of the service such as severe weather or the loss of a significant number of care workers due to illness or co-ordinators/managers to plan daily service delivery. The continuity plan clearly set out the actions to be taken to minimise the risks to people such as prioritising the most vulnerable people based on their level of dependency, whether they lived alone and their propensity to fall.

Most people we spoke with told us care staff arrived on time, and stayed for the agreed length of time. One person said, "Yes they do, they always ask if there is anything else I want doing as well."

People also said staff usually informed them if they were going to be late arriving. One person told us about how the service had improved since being taken over by the new provider. They said, "It is improving a bit. I'm beginning to be told if my carers are being changed and I'm getting a schedule now at last." A relative told us, "Staff didn't always come on time, but just lately it's been better."

Most people told us there were enough staff available to meet people's care and support needs. However, staff told us they were sometimes asked to work more hours than they would like. The manager explained Carewatch always tried to use their own staff wherever possible, and did not use temporary staff unless there was an emergency. We saw on the day of our inspection visit, two staff members had been transferred over to the Rugby area to cover calls due to staff sickness, from another Carewatch branch. The manager said there were eight new members of staff who had been recruited in the Rugby area, who would be ready to start work in June 2017. This would increase staff numbers to allow for holiday and sickness, and increase staff flexibility.

We looked at a selection of schedules/rotas for care staff. The schedules showed that calls were planned for when people expected staff to arrive and at consistent times. There was also travel time provided between calls.

The provider planned to introduce an electronic call system for monitoring calls to make sure staff arrived around the time people expected. This was due to be introduced the week following our visit. If care staff were more than 30 minutes late arriving at a call, an alert would be sent through to the office so action could be taken to investigate the cause, and ensure the person received the support they needed.

Requires Improvement

Is the service effective?

Our findings

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 reviewed people's care records to see whether they had a mental capacity assessment in place, where it was clear the person may lack the capacity to make all their own decisions. We found the manager and provider were not conducting mental capacity assessments where a need to do so had been identified. For example, in one person's records a relative had stated the person 'doesn't really know if they are safe or not' which indicated they lacked the capacity to assess risks to their own safety. A mental capacity assessment had not been completed.

In another person's records we saw they had a diagnosis of dementia. There was no mental capacity assessment in place to assess what decisions the person could make for themselves, and what decisions should be made in their 'best interests' in consultation with health professionals and relevant family members.

Another person had been described by their doctor as having a 'mild to moderate learning disability', but there had been no assessment of what decisions this person was able to make about their own care.

None of the records we reviewed contained mental capacity assessments, or documented people's consent to care and treatment where they had the capacity to do so. We asked the manager and Quality Service Improvement Manager why such assessments had not been completed. The manager explained they were not sufficiently trained to conduct and record mental capacity assessments. However, we found the provider had not provided additional resources or training in this area to conduct these assessments.

We checked whether the manager was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found four people who had been transferred from the Northampton office had 24 hour care packages in place, and shared their home with other people who used services. These type of arrangements are often referred to as supported living arrangements. Where people had 24 hour care and support, records were not clear whether the level of supervision might be a deprivation of their liberty. The registered manager had identified this for one person and had arranged a meeting with a social worker to discuss whether an assessment needed to be completed, and an application for a deprivation of liberty submitted to the Court of Protection by the funding authority. Following our feedback they understood they also needed to arrange assessments for the other people living under these arrangements in the near future.

We found this was a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for Consent

People we spoke with told us care staff respected their rights to make decisions about their care, they did this by seeking their verbal consent before supporting them with daily support tasks. People told us staff were trained in how to support their individual needs, because they gave staff the information they needed to support them. One person said, "I've trained them to my routine." Another person commented, "The care is very individual and it needs the input of the person."

The provider's policy was for all new staff to have an induction which included shadowing an experienced member of staff. The induction programme was aligned to the Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. The provider required care staff to complete mandatory training in areas such as health and safety, manual handling, safeguarding, infection control and medicines management.

The provider had appointed a new trainer for the service who was due to take up their role the week following our visit. Records showed the new trainer was due to deliver refresher training for all care staff immediately upon taking up their appointment.

The registered manager recognised the importance of providing care staff with the right skills and knowledge to provide effective and safe care for people. They recognised that during the transition of services the method of training staff had changed, and therefore some training had slipped. For example, on reviewing the needs of some people whose care packages had transferred over from the Northampton office, they had identified that training in learning disabilities, supporting people with behaviours that challenge and epilepsy was essential for some staff. They had arranged this training as a priority and this was being delivered by the provider. The provider paid staff to complete training, so there was no reason why staff could not attend any offered training. The registered manager explained, "That was my first priority (updating training) to make sure people who use the service are safe."

We found the provider was working with other health professionals in the community to ensure people who required support with healthcare were referred to the appropriate professionals. For example, people were referred to their local doctor, district nursing team, or nutritionist where a need had been identified. One relative told us, "[Name] has never had a pressure sore. Staff check her skin and if there are any marks the first thing they do is tell me." A referral could then be made to the district nursing team if required.

Where people received support with their nutrition, this type of support was listed in their care records. For example, where people required staff to assist them with preparing a meal, information was contained in their care records for each visit they received, instructing staff on any specialist diet requirements and how they should ensure the person received a meal of their choice.

Requires Improvement

Is the service caring?

Our findings

When we asked people if they felt staff were kind and caring they said they did. One person told us, "They are so caring. They are gentle, caring and very helpful." Comments from relatives included; "They [staff] are all very friendly", "The attention [Name] gets when staff are there, it is quality, consistency and continuity; that is fantastic because they know [Name] so well", "I can't fault the service [Name] has had and continues to have", "The carers are very conscientious and genuinely caring."

People told us they were usually supported by regular staff who knew them well. Comments included; "Predominately the girls on the rota are local and know [Name]", "I'm very lucky because the girls are all local."

People told us their regular staff knew them well and treated them with respect. One relative told us how staff used their knowledge to ensure they met their relations needs saying, "[Name] has a demanding personality, they [staff] all take it the right way. When they need to, they remove themselves for a minute and then come back to them."

Some people told us they enjoyed the opportunity to continue living at home for as long as they could. Staff supported people to maintain and develop their independence where possible, to increase people's life skills, or help them feel more independent. One person said, "I've got an insight into my condition. I don't ask the carers to do anything I can do myself." Another person's relative said, "The staff encourage [Name] to change their own bed clothes."

People's privacy was respected. People told us that staff left them to do as much personal care as they could themselves, which respected their dignity. One relative told us, "[Name] is able to do most of her hygiene herself and that is left to her." Staff told us they always respected people's privacy, they used techniques such as closing doors and curtains when providing people with personal care. Staff also described covering people with towels when assisting them with bathing to protect their dignity as much as possible.

People told us staff respected their individual choices about what they wanted staff to do in their home. One person said, "When I hurt my shoulder the staff were great, they helped with extra things like washing etc.," Another person said, "I can't find fault, they do as I ask."

However, some staff told us that although they enjoyed their role they would like more communication and support from the provider and management team. For example, one member of staff told us they worked longer hours than they would like. They felt pressured to do this as there had been a recent shortage of staff. Another member of staff told us they did not always feel valued and respected. This was due in part to the recent changes to the provider, and the recent amalgamation of services into one office. This had affected staff morale even though staff had been moved over to a new provider and manager.

One member of staff from the Northampton area explained they were not always able to get hold of a

manager when they needed to, and they felt the concerns they raised were not always followed up. For Northampton staff they explained it was not possible for them to go into the office each week to speak with managers due to the distance from the Northampton area to the Rugby office. They added they weren't paid for visits into the office.

Requires Improvement

Is the service responsive?

Our findings

People told us if their care package included staff supporting them to go out into their local community, they had the care and support they needed to do so. One relative told us, "We know [Name] goes out because family members have seen them out and about." Another relative told us, "[Name] goes out all day. They are very active and very mobile."

Where people had a been involved in planning and reviewing their care they were positive about their involvement and told us, "They [staff] had to go through all the care package and type everything up. I have had to sign numerous things." Another person said, "If they ever do change anything, they negotiate with me."

The registered manager told us they were up to date with telephone reviews for people they supported which took place every three months; however, we found face to face reviews were not up to date, which were due every six months. In addition, care records were not always updated when people's health and support needs changed. For example, one person's care record was not up to date with the amount of calls they received each day, and what care staff should do at each call. This meant staff might not always have the information they needed to support the person as they would wish.

We looked at four people's care records, to see whether they were up to date and whether they reflected people's individual support needs, choices and preferences. We found care records were designed to inform staff on what they needed to do on each scheduled call. However, the information was not always up to date and did not include information about people's preferences, likes or dislikes. Care records were not always dated, so we could not be sure when they had been reviewed, or whether they accurately reflected what people's current needs were.

For one person we found it was unclear whether they had the capacity to make their own decisions about their care and support from their records, or whether they consented to their care and support. However, the records did state the person had a diagnosis of dementia in 2016. The care records had not been reviewed following the diagnosis. Care records did not describe the person's needs and wishes, or how these might have changed since their diagnosis. This meant we could not be sure the person consented to care staff supporting them, or their preferences were being met.

We reviewed the records of one person who had a catheter. We found there were directions for staff around emptying the catheter bag. Records stated the bag should be changed once a week, but there was no direction about what day it should be changed, which meant there was a possibility it could be missed. There was no information in the records about the person's preferences. The information about when staff changed the catheter was not always recorded in the daily notes of the person's care, this meant staff would not always know when the bag had last been changed. This put the person at risk of receiving inconsistent care and also placed them at risk of infection.

People told us their preferences around who visited them at home were usually met. For example, one

person explained that they felt nervous around male staff, so Carewatch only sent female care staff to support them.

People told us they knew how to make a complaint if they needed to. However, people told us they had no reason to complain. Comments from people included, "I haven't had any reason to complain." The service user guide given to people when they started to use the service provided people with information about how they could make a complaint, together with timescales for how their complaint would be dealt with. The information also provided people with information about how they could escalate their concerns outside the organisation if they were not happy with the response. This included information about the CQC and the Local Government Ombudsman.

Any complaints were recorded electronically and the record provided prompts to ensure they were dealt with in accordance with the provider's complaints procedure. There had been one complaint in the six weeks since the provider's new registration. This related to changes in care staff who did not arrive when scheduled. The registered manager had visited the person to discuss their concerns and schedules demonstrated they now received calls from a consistent team of care staff. All complaints could be scrutinised and analysed by head office to identify any trends and ensure that timescales for the management of complaints had been maintained.

Records demonstrated that under the previous registration, the registered manager had always fully investigated any complaints received and taken appropriate action to resolve any issues identified. This included disciplinary action and further training when a need was identified.

Requires Improvement

Is the service well-led?

Our findings

This was the first inspection that had taken place at the service. This was because the service had recently been registered in March 2017; two branches of a previous service (one in Rugby and one in Northampton) had been amalgamated under a new owner/provider. Staff and people supported by the two services had both been transferred over to the Rugby office.

The previous provider operated as a franchise business under the 'Carewatch' brand. Carewatch are a large organisation that operates services across the country which are run under their own company, or as franchise services. After the franchise service went into liquidation, the service had been taken over by the Carewatch company in early December 2016.

There was a registered manager in post at the time of our inspection visit. There was also a management team in place. The registered manager was supported by a deputy manager, quality officers and administrative staff. The provider also supported the manager by visiting the service regularly and supplying training and development support, recruitment expertise and quality assurance tools.

We found people's personal details and records were held securely at the provider's office in Rugby. However, a member of staff told us some people's records had been transferred in boxes from the Northampton office to the Rugby office, and had been mislaid. The records were people's daily logs of the care they received, and contained confidential information about them and their care. The registered manager and provider did not tell us about the missing records, but when we discussed this with them, they informed us they were conducting a search for the missing records at the time of our inspection visit. Although a search was being conducted, these had been missing for a number of weeks. The relevant notifications had not been sent to people, or other organisations, to alert them to the loss of the records. In addition, an investigation had not been conducted in accordance with the provider's policy.

The manager explained the service had been taken over under difficult circumstances when the previous provider closed. The Northampton customers had only been transferred seven weeks prior to our visit. They were therefore still assessing what improvements needed to be made to ensure people always received care and support that met their needs.

The previous owner controlled both the Northampton office and the Rugby office. They had completed an audit in its Northampton branch. The audit from the Northampton branch dated November 2016 showed several areas which required immediate improvement. This included information on how the MCA was not being met, and information that risk assessments were not always up to date in people's care records. The provider was aware of the findings of the audit, as they had been involved in its completion. However, the manager and provider had not drawn up a comprehensive action plan to address all areas where concerns had been highlighted.

There were no records of audits the previous provider had completed at the Rugby office for the registered manager to refer to.

The provider instructed its quality assurance team to undertake frequent audits of its services, which were completed every three months. This was to highlight any areas of improvement, and any concerns. Audits were completed by the provider's Quality Service Improvement Manager, however, we found that although Carewatch (Rugby) had been taken over by Carewatch in December 2016, the Rugby office and the Northampton office had not received an audit by the new provider. The quality service improvement manager told us one was scheduled before the end of May 2017.

We found breaches in the regulations when we inspected Carewatch (Rugby). This was because people's care records and risk assessments were not always up to date, or detailed enough to provide staff with the information they needed. Medicines procedures required improvement to ensure people always received their medicines safely and as prescribed. In addition, the provider was not following the MCA and respecting people's rights to make decisions in line with the Act.

The provider instructed the manager and their quality officers to conduct regular checks on medicines records, care records, and staff rotas. We found that audits on medicines records were taking place on a monthly basis as directed. Quality officers and the registered manager used forms and procedures which were in place from the previous provider; however, there were more up to date audit forms available from Carewatch to assist with the review of medicines records. We found the audits had not highlighted the issues we found during our inspection visit. We brought this to the attention of the Quality Service Improvement Manager, the registered manager and the Regional Operations Director. They explained the new audits forms would be utilised at the branch in the future.

The registered manager was open about the challenges they faced. They explained, "Auditing procedures are new to this branch, so it isn't yet to the standard it should be." They also told us that staff; including themselves, were to have updated training in how audit checks should be completed by the provider in the next few weeks.

The manager told us they were reviewing all people's care records over a three month period, to ensure care records were up to date. Going forward reviews of people's care would take place every three months. The review was due for completion in early June 2017. However, the registered manager was unable to tell us how much of the review had already been completed, or show us the outcome of the reviews already undertaken.

This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance

People told us they were fully aware of the recent changes to the provider of their care. They said this had not affected their care, as staff were the same. One person told us, "I haven't had any issues."

The registered manager was receptive to advice. Following our initial feedback they told us they would review their improvement plan to ensure those areas where we had identified improvements were required were prioritised. They later sent us a copy of their improvement plan which detailed improved communication with staff, the continued review of care records, re-training of staff and review of paperwork used in the administration of medicines.

They also planned the Introduction of mental capacity assessments, and further training for the manager and staff on Carewatch policies and procedures to embed into their practice.

The manager told us about some of the improvements they had already made since taking over the service. These included the introduction of new policies, paperwork and procedures which had been provided by

the new provider. They had also reviewed all call rotas in the Northampton area, and made changes to some staff rotas to improve travelling time for staff. The manager told us, "We pay staff a mileage rate, and organise travelling time between customers. We are trying to make improvements to how we support staff and people in the Northampton area."

Some staff told us they felt communication with the management team needed to be improved, for example, staff told us they didn't always get a response from a manager when they raised issues with them about their working arrangements. In addition staff could not always go into the office when they needed to see a manager. This applied specifically to staff who were located in Northamptonshire.

The manager said, "Team meetings have gone a bit wayward. They are happening now, they are scheduled and we have had a few." The manager stated they wanted to improve the scheduling of team meetings to ensure staff had regular contact with managers to share their feedback and concerns. We found team meetings were taking place informally on a weekly basis with Rugby staff, as the manager had an 'open door' policy, and staff usually visited the office once a week to collect paperwork and supplies. The manager told us in future arranged team meetings would take place every two months.

The provider expected all care staff to have regular meetings with their line manager to ensure they understood their role and identify any training or developmental issues. The registered manager told us they had recently completed these meetings with the majority of the care staff. They explained, "I've concentrated on supervisions, one to one, because I needed to get to know the staff." However, they still needed to complete supervision meetings with some staff by end June 2017.

People told us they were able to comment on the service they received, as they were asked for the feedback in frequent questionnaires. The manager explained the provider sent out questionnaires to people who use services on a random basis each month. Any issues identified in the feedback they gathered would be shared with them.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring the care and treatment of service users was being provided with the consent of the relevant person. The provider was not acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way to service users. Risk assessments were not always in place to assess the risks to the health and safely of people receiving care. The provider was not doing all that was reasonably practicable to mitigate risks. The provider was not ensuring the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of services provided, and maintain securely an accurate, complete and contemporaneous record in respect of each service user.