Mr Roger Henry Pickford

Evoke Home Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection started on 21 September 2017 and was announced. We gave the provider 48 hours notice of the inspection to ensure that the people we needed to meet with were available. The service was last inspected in May 2015 and at that time there was no breaches of regulations.

At the time of this inspection the service was providing support to 67 people who lived in their own homes, of these 49 people were receiving the regulated activity of personal care. Another 18 people received domestic assistance or companionship and this part of the service does not come within the remit of the registration. The service was provided mainly to people who lived in Bristol, with a small number of people who resided in North Somerset and South Gloucestershire also receiving the service. The service employed 28 care staff.

There are changes that needed to take place regarding the registration of this service because amendments to the legal status of the registered provider had not been communicated to the Care Quality Commission (CQC). This will be acted upon following this inspection. Previously the registered provider had managed the service on a day to day basis, however following their retirement a manager was appointed who then registered with CQC. The registered manager left in November 2016, a registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. Prior to this inspection, the registered provider had not been in day to day contact with the service and for the last nine months a manager (not registered with CQC) had carried on the regulated activity of personal care.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009 (part 4). You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The service was not following safe recruitment procedure which meant the potential for employing unsuitable staff placed people using the service at risk.

People were not receiving a person-centred service, their care calls were not being delivered at the time that

had been agreed and were on occasions being cut short. People told us about missed care calls. There were insufficient care staff to meet the number of people being supported by the service at the time of the inspection.

Care staff would benefit from more robust training to ensure they were able to meet people's care and support needs appropriately. Examples include dementia awareness and Mental Capacity Act 2005 training since the service is provided to people living with dementia.

People and their relatives told us they had raised concerns and complaints with the manager or the registered provider but they had not been handled correctly. The registered provider did not have effective quality assurance measures in place to check on the quality and safety of the service. Although people and care staff were asked for their views, nothing was done about the response they gave. The registered provider was missing the opportunity to make improvements to the service.

The registered provider had not kept their statement of purpose up to date or provided a service to people that met the aims and objectives referred to in the document.

Although all care staff received safeguarding adults training as part of their mandatory training programme, we were told of examples when some staff had been rude and one person had been hurt because care staff had used moving and handling equipment incorrectly.

A range of risk assessments were undertaken to ensure people being supported and care staff were not harmed. All work activity tasks were risk assessed including moving and handling tasks.

Where people needed support with their medicines, a plan of care detailing the exact help they needed was in place. Where people needed support with eating and drinking, or for contacting health care professionals, they were supported by the care staff.

People were very complimentary about the kindness of the care staff however there was a consistent message that they could only do their best. Care staff told us they continually had to take on extra work and this affected their ability to do a good job.

Each person had a plan of care written. These were detailed and provided a good pen picture of the person and their family and working life. However, the service they received did not match these care plans.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The recruitment of new staff did not follow safe practice meaning that unsuitable staff could be employed. This placed people at risk of harm.

People were placed at risk because care calls were late or missed which meant they had to do tasks which were not safe for them.

Care workers had a good understanding of safeguarding issues and knew to report concerns they had about people's welfare and safety. They knew they had a responsibility to protect people from harm.

Any risks to the person being supported or the care staff were assessed and plans put in place to reduce or eliminate the risk.

There was insufficient care staff to meet the needs of people therefore new packages of care were not currently being taken on.

Where people needed assistance with their medicines this was recorded in the care plan. Care staff received training to ensure they were competent to administer medicines safely.

Is the service effective?

Requires Improvement

The service was not effective.

People did not receive the service they expected or met their specific care and support needs. Care staff were trained but the organisation of the service compromised their ability to do their jobs effectively.

Staff gained people's consent before providing a service but would benefit from greater understanding of the Mental Capacity Act 2005 (MCA).

Where needed people were provided with support to eat and drink and to access health care services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by care staff who were considered to be kind and caring. The staff were respectful and spoke well about the people they supported. However the care staff were not always able to support people in the way they wanted because of constraints on their time.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People were not listened to and their views and opinions were not considered as being important. People were given a copy of the complaints procedure but any complaints were not handled correctly.

People received a service that did not always met their needs. When people's needs changed care staff reported this so the support provided could be reviewed.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of good leadership and management of the service. A new office staffing structure had recently been introduced but it was too early to judge if this would be effective.

There were no effective quality assurance procedures in place. When the views and opinions of people using the service, relatives and staff had been gathered, this did not result in identifying where improvements were needed. Any concerns or complaints were not handled correctly.

Evoke Home Care

Detailed findings

Background to this inspection

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

The inspection team consisted of one inspector.

Prior to the inspection we looked at the information we had about the service. This information included information passed to us by the local authority and the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We did not have a Provider Information Return (PIR) to review because this had not been submitted to CQC. This form had asked the provider to give us some key information about the service, tells us what the service did well and the improvements they planned to make. The registered provider was uncertain whether the form had been completed.

During the inspection we spoke with the registered provider, the care coordinator, one of the team leaders and the office manager. We also spoke with four members of care staff. We spoke with six people who received a service in their own home and two relatives. We looked at eight people's care records, five staff recruitment files and training records, key policies and procedures and other records relating to the management of the service.

We contacted three social care professionals after the inspection and asked them to tell us about their experience of working with Evoke Home Care. They provided us with feedback which we have included in the main body of our report.

Inadequate

Is the service safe?

Our findings

People said, "I don't always know who is letting themselves in to my house because Evoke do not let me have the information any more. Sometimes I worry", "I do not worry when the staff are here, I feel perfectly safe", "The care staff are kind and polite but the office staff can be a little rude and abrupt at times". One relative informed us, "I watched two care staff who were not competent in using the stand aid and they hurt (named person). I had to tell them how to do things". This event has been reported to the registered provider and Bristol City Council adult duty desk as a safeguarding event.

We were provided with examples that evidenced that the service was not safe. These had impacted, or had the potential to impact, upon the health and welfare of people using the service. One relative said their loved one had become 'stuck' but knew the care staff were due to arrive. However they were 90 minutes late for the care call. Another person using the service told us that care staff had not been provided to prepare their hot meal. They had to do this themselves which placed them at risk of injury and scalding. One person who was supposed to be assisted with dressing and undressing tasks had to undress themselves and this put them at risk of falls. We were told about other examples where care calls to people were missed and they went without meals or the support they needed to take their medicines.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the mandatory training programme all care staff completed safeguarding adults training. For new staff this was also covered as part of their induction training. Those staff we spoke with knew what was meant by safeguarding people and would report any concerns they had about a person's safety to the 'office' or the registered provider. When prompted care staff were able to tell us that knew they could report concerns directly to the local authority, the police and the Care Quality Commission. The service had alerted the safeguarding team in Bristol City Council on two occasions in the last year where they had concerns regarding a person's safety. On both occasions Evoke Home Care staff were not implicated in the concerns. We would recommend the registered provider, the newly appointed team leaders and the care coordinator attend formal advanced safeguarding training with the local authority.

As an outcome of this inspection, Bristol City Council have commenced organisational safeguarding monitoring based upon the findings from the inspection and a complaint from the family of one person supported. This is a process led by the Council to look into the service provided by the organisation and ensure it is safe for people.

We checked the recruitment procedures to ensure people were not placed at risk from unsuitable staff being employed. Applicants who wanted to work for Evoke Home Care had completed an application form and an interview assessment had been recorded. Appropriate pre-employment checks had been completed and included written references and a Disclosure and Barring Service (DBS) check. A DBS check allowed employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. In those files we checked there was no evidence that a DBS disclosure record was in

place for two staff members. The registered provider said the details were located elsewhere and agreed to forward these to us on 25th, 26th and 29th September 2017.The registered provider has failed to provide this information to the Commission. They have failed to have safe recruitment procedures in place which means vulnerable people may be looked after by unsuitable care staff who could harm them.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments of people's homes were completed in order to ensure the person's home was a safe place for the person and for care staff to work in. All work activity tasks were risk assessed including moving and handling tasks. There was an expectation that care staff would report any health and safety concerns they had to the office. A fire risk assessment was completed as well as the likelihood of falls and the person's susceptibility to pressure damage to their skin. Moving and handling risk assessments were completed where people needed to be assisted by the care staff and a support plan detailed the equipment to be used and the number of staff required. Care staff were provided with information in the assessments and care plans to ensure they carried out moving and handling tasks safely. However one relative told us they had witnessed two care staff attending to their family member who were not familiar with the equipment or competent in carrying out the task.

Care staff received moving and handling training from an external trainer. The service did not have a key mover, a member of staff who had completed additional moving and handling training and were taught how to instruct staff on best safe practice. This shortfall had the potential to mean that if a person's mobility changed, the care staff would not have the ability to get prompt advice on how they should assist.

At the time of the inspection new packages of care were not being considered by the service. The registered provider explained the service was, 'taking stock and consolidating' after the recent departure of the manager who had been in day to day charge of the service. A number of staff had recently left the service and although we were told there were sufficient care staff to meet the care calls of people being supported, our findings did not support this. People, relatives and care staff told us that scheduled care calls were missed, the timing of calls was not as agreed and calls may be shortened for care staff to fit in extra visits to other people. One relative told us that weekend calls could be covered by agency staff that Evoke Home Care had commissioned. The service was actively recruiting new care staff.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to remain responsible for their own medicines where possible. Where people needed support with their medicines the assessment of their needs would identify the specific assistance they required. The medicine management policy stated that care staff would receive training to ensure they administered medicines safely. Their competency to continue administering medicines safely was rechecked regularly and we saw the records of these checks. People gave written consent to be supported with their medicines as part of their overall agreement to their care plan.

The support people needed with their medicines was recorded in their care plan. The care plans stated whether the person required level one support (general assistance and prompting), level two (assistance and administration) and level three (specialised support). No-one was receiving level three support at the time of the inspection. Care staff had to complete a medicine chart after medicines had been given or creams had been applied. Where people needed medicines on an as and when required basis, there were clear protocols in place with detailed instructions for the staff to follow.

Requires Improvement

Is the service effective?

Our findings

When we asked people if the service they received was effective, we received only negative comments. They said, "I don't have any say when the office ring and want to make changes to the times of the visits", "The girls are not always able to stay the correct length of time because they have to go and help others", "I had a missed call last week and nobody rang me about it or apologised" and, "This used to be a good company but it isn't any more. If it wasn't for the lovely girls I would look to change agencies". One relative told us there had been many occasions when the family had been asked to cover calls because there were no staff available. Another said, "The service is very disorganised, timing poor, never know who is coming. I am afraid I have nothing good to say".

Staff were knowledgeable about the people they supported however felt they were unable to deliver an effective service because they had to cut short visits. They were constantly contacted by the office and requested to do extra calls which meant they were not able to do everything for people and their calls were rushed. Staff said they were not always given sufficient information about people they had to visit for the first time however a care plan was always available in the person's home for them to refer to. They told us they would always look at the care plan prior to providing care and support.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff had to complete an induction training programme before they started working for the service. Some of the training was delivered in-house and some by an external training company. The training files of new staff were checked and these contained many certificates regarding training completed. One member of staff who had started work with the service in December 2016 had completed training on 18 different subjects in January and February 2017. The induction training programme was in line with the new Care Certificate, introduced for all health and social care providers on 1st April 2015, however no knowledge checks had been completed to check on care staff understanding. New members of staff 'shadowed' an experienced member of staff for three, four or five shifts before they worked on their own. We recommend that the registered provider look at best practice for induction training and familiarise themselves with the Care Certificate. This was because some of the modules referred to in the Care Certificate were not covered (dementia awareness and the Mental Capacity Act 2005).

There was a programme of mandatory training for all staff to complete and this was refreshed regularly, however there was mixed views about whether it was sufficient to enable them to do their jobs properly. A training record was kept for each staff member and evidenced the training they had received. Feedback from a recent staff survey had prompted a response from more than one staff member that they felt they would benefit from additional training (no examples were given by the staff). The survey had taken place in the summer time but no action had been taken by the registered provider. Mental Capacity Act training has not been included in the mandatory training programme and the service supports people living with dementia who may lack the capacity to make decisions.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff had been having regular supervision meetings with the manager and spot checks on their work performance by the team leaders. We saw the records to confirm these had been carried out. The registered provider was aware that staff meetings had not been happening and had arranged to see all staff week commencing 25 September 2017.

Mental Capacity Act 2005 training was not included in the mandatory training programme for the staff team. The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. Care staff told us they would always ask a person to give verbal consent before starting to provide any assistance and asked them what they wanted done during that visit. People we visited told us they were always asked if they agreed to be supported.

People were provided with support to eat and drink where this had been identified as a care and support need during the assessment process. The exact level of support a person needed was recorded in the care plan. Care staff told us they reported any concerns they had about people if they were not eating or drinking well. One person told us they were supported with their meals and because on one occasion a care call had been missed, they went without food.

People were supported to contact their doctor to make appointments or request a home visit if they were unwell. One relative told us the service could sometimes be inflexible and unhelpful if timing of calls needed to be changed because of hospital appointment, for example. Care staff worked alongside district nurses, occupational therapists and physiotherapists where necessary to enable people to remain living in their own homes.

Requires Improvement

Is the service caring?

Our findings

People said, "The care staff are lovely but the office staff can be very abrupt and not at all helpful", "All the good staff have left and I don't blame them", "I don't rate the service at all. I continue because I have to, I need to" and, "The girls do their very best but the office is chaotic". Relatives said, "The carers are lovely but they are frustrated by the office organisation. They moan and groan to mum which I don't think is fair. She has enough to worry about" and, "Mum says that the manager does not speak nicely to her at all. I reported this to the provider but nothing was done about it". One staff member said, "Every person I visit is unhappy".

When the service undertook a quality assurance survey in July 2017, one of the questions they were asked was, "Do you feel the care staff respect your dignity throughout your visit". Of the 35 people who responded to this question 26 (75%) said 'Always' and 9 (25%) said 'Most Times'. The registered provider had taken no action to ensure that every person supported by the service was always treated with respect and dignity.

Those staff we spoke with talked about the importance of developing good working relationships with the people they supported. However they felt this was currently very compromised. Several of them said they only stayed with Evoke Home Care because of the regular people they supported and not out of loyalty to the service. Care staff did not feel they were able to do a good job and for that reason would not recommend Evoke Home Care to friends of family.

People were asked by what name they preferred to be called and this was recorded in their care notes. People were asked about any other choices and preferences that were important to them. A very detailed 'pen picture' was recorded about each person detailing their family and working life and these gave a real good sense of what the person was like. Whilst this is good practice and would enable the care staff to provide a person-centred service, the reality was the care staff were rushed and therefore had to be task orientated.

The registered provider shared with us their log of complimentary cards and letters they had received since the beginning of 2017.Comments included the following: "She enjoyed the visits by (named care), "We are most grateful to the staff who helped mum", "We were very happy with the care provided over the weekend – very much appreciated", "(named staff) is an excellent girl. Will have her anytime" and, "The girls were very reassuring and helped (named person) get in to bed safely as was very unwell. Very grateful for their support". A district nurse had also contacted the office in August 2017 to praise all the care staff on how much of a fabulous job they were doing with (named persons) skin.

Requires Improvement

Is the service responsive?

Our findings

People said, "There was a discussion when the service was being set up but just recently the service has been very poor", "We have to have what they say they can provide. It is not always convenient for me but they don't listen" and, "The service I am getting at the moment is poor and so inflexible. I have only two more days to go and then I am starting with another agency". One relative told us they had asked for a temporary change to be made to when the care staff called, because of a hospital appointment. They said the office staff "refused".

People and relatives told us they had raised concerns with the office and the registered provider but said these had not been responded to. Comments included, "I have reported issues to the office but it does not make any difference. No changes", "If you do report something, the manager (now left) used to be very rude and unhelpful", "I have reported missed calls and staff attitude to the registered provider but he hasn't come back to me" and, "You make a complaint but nothing changes".

We looked at the complaints log. One formal complaint had been recorded since the beginning of 2017 and the records evidenced the actions that had been taken in response to that complaint. In view of the feedback we have received from people being supported by the service and their relatives, regarding the concerns and complaints they have made, it is evident that complaints were not being handled correctly. On the last day of the inspection the registered provider informed us they had received a formal complaint from a relative regarding their parents care. This complaint was also reported to the Care Quality Commission and Bristol City Council safeguarding team. The registered provider, by not recording all concerns and complaints made, was missing an opportunity to put things right and to make improvements.

This is a breach of Regulation 16 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People's care records were kept in people's own homes and a copy was kept in the office. We looked at a sample of care plans and found then to be detailed and informative. They described how the planned care was to be provided and how many visits per day or per week the care staff were scheduled to make care calls. The care plans provided a clear picture of the person and their care and support needs and their individual choices and preferences. A 'pen picture' had been written for each person and gave an insight in to the person's family and work life.

Packages of care were reviewed by the team leaders on an annual basis or more often if needed. However unless the service starts to be delivered as planned, people will not be being provided with a service responsive to their individual needs. Care staff told us they were expected to report any changes in people's care, support and health needs to the office so that reviews could be brought forward.

People were provided with a copy of the service user guide and a summary of the statement of purpose and these were kept in the care files in their homes. The guide provided key information about the service,

contact telephone numbers, out of office hours arrangements and the complaints procedure.

Inadequate

Is the service well-led?

Our findings

The feedback we received from people, their relatives and staff was consistently negative. No one we spoke with thought the service was well led and all felt the service was disorganised. People who were supported by Evoke Home Care were not receiving the service they expected and had been let down. The relatives we spoke with also made comments about the disorganisation. Two of them said they had been asked to cover calls because the service was unable to allocate a staff member. Comments included the following, "The manager is not very good. She does not speak nicely to you", "She (the manager) was awful and was a long time leaving", "The office staff are rude to the carers" and "It is chaotic. The girls do their best but the office is disorganised. Timing not good and visits are missed"

Care staff said they were not treated well, were 'bullied' into taking on extra calls and did not feel listened to. There was a consistent message that the registered provider and the office staff were not approachable and were "rude". When we reported this feedback to the provider at the end of the inspection, it was obvious they were unaware of the depth of feelings about the service. Care staff did not feel that Evoke Home Care cared or valued them and did not listen to what they had to say about the quality of the service. They did not feel that action was taken quickly enough when they had raised concerns regarding the manager with the registered provider.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Up until the end of 2016, the service was managed by a manager who was in day to day charge of the service and had registered with the Care Quality Commission. For the last nine months another manager had been in day to day charge of the service but they left in August 2017. The registered provider was in the process or organising on-going management arrangements and in the meantime planned to be present in the office each day.

The registered provider had now implemented a new staffing structure. Along with the office manager and office clerk, there was one care coordinator and two team leaders. The care coordinator was office based and responsible for arranging staff allocation to care calls. The two team leaders were part office based and also worked out in the community covering care calls. The team leaders completed reviews of care packages with people, staff supervisions and spot checks and covered last minute staff absences.

Staff meetings had not been held regularly and the morale amongst the care staff was low. The registered provider said the previous manager had not arranged meetings but had sent out newsletters and memos to the staff. Care staff were able to call in to the office at any time but did not tend to unless they were collecting items. The registered provider had introduced a chat scheme encouraging staff to call into the office and 'have a say'.

The provider's statement of purpose stated that the aim of the service was to provide care and support to people who could not wholly look after themselves. They stated the service would be provided at a

convenient time and in ways that was agreeable to the person. Central to their beliefs was that the rights of people were paramount. The statement of purpose was out of date and referred to the manager who had left the service a year ago. Service delivery did not meet the aims and objectives set out in this document.

We looked at the quality assurance measures the registered provider had in place to check the service was meeting its aims. Their policy stated they would seek the views of people using the services and their relatives, use staff meetings to gather staff feedback and undertake audits to check on the quality and safety of the service. The policy also stated they would use the Care Quality Commission Provider Information Return (PIR) to assess their service against the five key questions. The registered provider was uncertain whether the previous manager had completed the PIR.

It was evident from our findings that these measures were not adequate. There were no records of audits made available to us for 2017. Those that were shared had been completed in 2016. A care staff survey had been completed but there were only six completed forms in July 2017 (the service has 28 staff). There was one positive comment – 'we are trained to a good level'. The rest of the comments were negative. These included the following: care staff would benefit from other training, on call arrangements are inadequate, communication with people and care staff is not good and there are not always medicine charts in people's home. No action plan had been put in place to address the concerns and to make improvements.

At the same time a service users survey had been undertaken and responses had been received from 36 people. They were asked to say whether the care staff arrived at the time they expect (50% said most times with 27% saying sometimes), whether they felt their needs were being met (36% most times and 30% sometimes) and whether the care staff stay the correct amount of time (44% most times and 19% sometimes). Between 2-8% answered 'never' to these three questions. Additional comments were made regarding the need for people living with dementia to have the same care staff and the need for improved communication by the office. No action plan had been put in place to address the concerns and to make improvements.

Any accident or incidents that occurred were logged however there was no analysis to look at the details leading up to the events in order to identify any themes. This meant the service had missed the opportunity to prevent reoccurrences and to make any improvements where possible. The complaints log only recorded that one complaint had been in 2017, however people using the service, their relatives and staff all told us they had raised concerns and complaints with the manager or the registered provider. Again, the service is missing the opportunity to make changes and improvements.

The above examples evidence a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider was aware when notifications regarding events that had occurred within the service (Regulation 18 Care Quality Commission (Registration) Regulations 2009 (part 4) had to be sent to CQC. However, the statement of purpose had not been reviewed and not been revised with the changes made to the management arrangements.

This is a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

All policies and procedures had been reviewed in July 2017 and were due again in July 2018. This measure should ensure they remained up to date and appropriate. We noted that the complaints procedure that was supplied to each person receiving a service contained regarding details of CQC offices that had not existed for many years.

Each person had a plan of care and these were reviewed on at least an annual basis and more often if needed. Some of the care records that were kept in people's homes, were returned to the office on a monthly basis. These included the visit notes and the medicine charts. These were then checked to ensure they had been completed properly.