Kamino Homecare LTD

Kamino Homecare Ltd

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

We carried out this inspection on the 12 May 2016. The inspection was announced and the provider was given 24 hours' notice that we would be visiting to ensure that the registered manager would be available on the day of the inspection.

This was the first inspection of the service since it was registered with the Care Quality Commission (CQC) in March 2015.

Kamino Homecare Ltd provides personal care to people living in the community with their own homes and in supported living schemes. There were currently 37 people using the service. The service provides care to older people including people living with dementia, people with physical disabilities and other high care needs.

A registered manager was in post at the time of the inspection. 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.

Each person had a care plan which included basic details about the person and the care and support they required. A pre-service assessment had been completed which incorporated an environmental risk assessment and an assessment of the internal area of the persons home in which care would be provided. However, the service did not identify and assess people's individual risks associated with their care support such as risk of falls, skin breakdown, urinary infections and use of oxygen supply machines.

The service had an accident and incident book to record any accidents or incidents that occurred whilst providing personal care. The service had no recorded accidents or incidents since they began providing a regulated activity.

Care staff that we spoke with had limited understanding of the basic principles of the Mental Capacity Act 2005 (MCA). One care staff told us that they had not received any training in this area. In addition to this care plans that we looked at, consent to care had not been obtained and the service had not identified or completed any mental capacity assessments for those people who lacked capacity to make certain decisions.

Care plans were not detailed and were not person-centred. People's likes and dislikes had not been noted. There was lack of information and detail about how people wanted their care and support to be delivered.

People and relatives that we spoke with were happy with the care that they received and felt safe with the carers that supported them. People told us that staff were caring.

The service had a safeguarding policy in place which gave information and direction on the different types of abuse and how and when to report suspected abuse. Care staff were aware of what constituted abuse and where abuse was suspected whom to report this to.

People were supported with their medicines by the care staff. We confirmed that staff had received appropriate training to undertake this activity. However, the service did not always record sufficient information about the different types of medicines people had been prescribed, any possible side effects and how staff were to support them. We did see that on two care plans a medicine administration risk assessment had been completed but this was not consistent for all the people that were provided with a service where appropriate. We also observed at two people's homes, that there was a medicine recording sheet for carers to sign when medicines had been prompted or administered. This was not consistent for all the people receiving a service when this was required.

The service had safe recruitment processes to ensure that only suitable staff were employed. Each staff member received induction training of all the mandatory topics including moving and handling, first aid, medicines management and fire safety. The service had identified that for the majority of the care staff employed, English was a second language. However, reading and writing skills were not of a standard that the service required to ensure the provision of safe and effective care. As a result the service had begun work with an external company to implement training on enhancing people's functional skills which specifically included reading and writing.

Care staff told us that they felt supported in their role and received regular supervision. Records we looked at confirmed this.

A complaints policy was in place which gave people information on how to complain and the process and timescale in which a person's complaint would be dealt with. We saw that complaints were kept and managed on a management system as part of the person's care records. We saw an audit trail of how the registered manager had dealt with complaints that had been received. However, the registered manager did not have an overview of complaints and when asked how many complaints had been received since they started providing care, was unable to provide a definitive answer and had to refer to people's care plan records.

The service had recently started to carry out spot checks and follow up visits to people receiving care and support to monitor the quality of care being provided with a view to making improvements. The registered manager also had a supervision overview in place which allowed them to monitor when supervisions were due. However, the registered manager lacked management oversight in relation to reviewing complaints, missed, late visits and the work being completed by the staff working within the office. The registered manager told us that they planned to introduce audits and checks for care plans to ensure that the information contained within them was relevant and most current.

Quality assurance questionnaires were sent out to people who used the service and relatives. The first one was sent in December 2015 and will then be sent on a quarterly basis. The format of the questionnaires and the questions that were asked were based on each of the CQC key lines of enquiry. However the service did not hold an overview of the responses received so as to learn from make improvements.

We have made two recommendations in relation to staff training in the area of MCA and management oversight.

We have also identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. These breaches were in relation to assessing risks associated to people's care and support needs, safe medicine management, obtaining consent to care and completing mental capacity assessments. 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. The service did not identify and assess people's individual risks associated with their care and support needs in order to mitigate risks to ensure people's safety.

Staff had a good awareness of safeguarding, the different types of abuse and how to report suspected abuse. People and relatives told us that they felt safe in the presence of care staff.

The service had safe recruitment processes in place to ensure only suitable care staff were employed.

Staff received training in medicines management. However, the service did not always identify or record appropriately, information about medicines that people were supported with or how staff were to support them safely.

Is the service effective?

Requires Improvement

The service was not always effective. The service did not carry out capacity assessments where it had been identified that a person lacked capacity to make a particular decision.

Consent to care was not obtained as part of the care planning process.

Care staff received induction training which covered mandatory topics such as moving and handling and first aid. Certificates that we looked at confirmed that care staff had received training in MCA. However, when we spoke with care staff, they only had basic knowledge and awareness in this area. One of the care staff told us they had not received any training in MCA.

People were supported with their health and where required the service supported people to access appropriate health care services.

Is the service caring?

Good

The service was caring. People and relatives told us that they were happy with the care that they received. People told us that

staff were kind and compassionate and respected their privacy and dignity.

People and relatives told us that they received care from a regular team of care staff who had got to know the person they cared for well.

People and relatives told us that care staff always listened to them and supported them according to their needs and wishes.

Is the service responsive?

Good

The service was responsive. People and relatives told us that they were involved in the care that they received and this was reviewed on a regular basis. People and relatives also told us that care staff were very attentive and responsive especially when related to people's health needs.

The service had a complaints policy in place which provided guidelines on how people could complain and how these would be responded to. The service kept a good audit trail of response to complaints that had been received but the registered manager did not keep and overview of complaints. They did not identify any trends or patters with a view to learning and improving from the information provided.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. The service had systems and processes in place to monitor the quality of care provision. However, the registered manager lacked management oversight in relation to reviewing complaints, missed or late visits and the work being completed by staff working within the office in order to learn and improve.

People and relatives knew the registered manager and had confidence in the way the service was managed.

People and relatives confirmed that the service had sent them a quality assurance questionnaire to complete. We saw records of these. Responses were positive and questions had been formulated around the CQC key lines of enquiry.

Kamino Homecare Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 12 May 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and so we needed to be sure that the registered manager would be available to support us with the inspection process.

As part of the inspection we visited three people, with prior consent, in their own home to speak with them about the care and support that they received. We also looked at the agency records kept at the person's home. In addition to this we spoke with a further three relatives over the telephone.

The inspection was undertaken by one inspector. Before the inspection we looked at the information we had about the service. We reviewed the completed Provider Information Return (PIR). The PIR 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 reviewed other information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and wellbeing of people. We obtained feedback from local authority commissioning officers and social workers who have had involvement with the service.

During the inspection we spoke with the registered manager, two care co-ordinators and four care staff. We looked at four people's support plans and other documents relating to their care including risk assessments. We also looked at three care records that were kept at people's homes.

We looked at other records held by the agency including six care staff files, meeting minutes as well as quality surveys and staff training records. A number of documents were sent to us after the inspection which included a number of policies and procedures and staff supervision records.

Requires Improvement

Is the service safe?

Our findings

People and relatives that we spoke with told us they felt safe with the care staff that supported them with their care. One person told us when asked if they felt safe, "Oh yeah, definitely." One relative told us, "Oh yes, my [name of relationship] is safe. I wouldn't trust them with the care of my [name of relationship] if I didn't think they were safe." Despite these positive comments we found that some aspects of the service were not safe.

The service had devised care plans for each of the people that they provided care to. These included information about the care and support that the person required as well as environmental risk assessments and an assessment to identify potential risks of the internal area, of the person's own home, where care and support would be provided. However, the service did not identify and assess people's personal and individual risks associated with their care. For example, local authority assessments had identified people were at risk of falls, urinary tract infections and skin breakdown. The service had not factored this information into their care planning process. They had not carried out risk assessments in order to provide guidance to care staff on how to support people and mitigate or reduce any risk to ensure their safety.

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

The provider's medicine policy stipulated that care staff would only be able to support and administer medicine, if provided in a dossett box system which had been prepared by a pharmacist or family member. We saw evidence of this whilst visiting people in their own homes. However, for one person, staff were supporting them with loose medicines and an oxygen support machine. The registered manager was not aware of this and there was no recording of this within the person's care plan. The person, during the visit, also told us that they were type 1 diabetic and were dependent on insulin to normalise their blood sugar levels. Again the registered manager was not aware of this and there was no recording of this within the person's care plan.

Two other people whom we visited at their own home had a form in place where care staff would sign to confirm that they had prompted or administered medicines and that the person had taken them. In one care plan that we looked at we noted that the service had completed a medicines risk assessment which detailed the medicines that people had been prescribed and the support that they required. The service was not consistent when assessing risk for people who required support with their medicines.

Certificates confirmed that care staff were trained in medicines administration. Care staff that we spoke with also confirmed that they had received training in medicine administration. However, as per the provider's policy we did not see evidence of the provider assessing staff member's competency to administer medicines.

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

The service had an accident and incident book which recorded the date and time of the accident or incident, information about what happened and details of the action that was taken. The registered manager told us that since they had begun providing the regulated activity, there had been no noted accidents or incidents.

The service had a safeguarding policy which provided information about what constituted abuse and the actions that should be taken if abuse was suspected. The policy also provided contact details for the local authority and the CQC, if people or care staff wished to report to an external authority. Care staff that we spoke with were able to describe the different types of abuse and whom to report if they suspected abuse to be occurring. One staff member told us, "I would report any concerns to the manager." Another care staff told us, "It is my responsibility to safeguard the people that I care for." Care staff told us that they had received training in safeguarding. Training records that we looked at confirmed this.

Care staff had an understanding of the term 'whistleblowing' and knew who to report to if they had a suspicion that someone might be being abused or had witnessed poor practise and that managers had not taken appropriate action. This included reporting a colleague whom they were suspicious about. Staff told us that they could contact the local authority or the CQC to report their concerns. One care staff told us, "I would report to the manager, to the family and to the CQC."

People and relatives told us that there was always enough staff to meet their needs and the needs of the people they cared for. We were told and rotas that we were shown confirmed that people received care from a team of regular carers. One person told us, "I trust my carers" and another person told us, "I don't know what I'd do without [name of carer]." Relatives we spoke with told us, "We have a permanent carer and then another carer who comes regularly" and "We always have the same carers."

The service had a call monitoring system in place where care staff were required to call a telephone number to log that they had arrived at the call and then call the telephone number as they were leaving, after completing the call. After a 10 minute lapse of time, the system would send an automatic alert, informing office staff and the registered manager that the care staff had not arrived at their scheduled call. At that stage calls were made to the person receiving the care to find out if the carer had arrived and forgotten to log in. If not, a call was then made to the care staff to find out where they were and at what time they were expected to reach their scheduled call so that the person and their relative could be informed. One person told us, "My carers always come on time and stay their allocated time." One relative told us, "I have called the manager a few times about lateness and [registered manager] has sorted the issue. They communicate with me and let me know if the carers are going to be late."

The registered manager told us that some people had not agreed to the care staff making phone calls from their home to log in and out and therefore this system was not available for carers to make use of. As a result the registered manager was looking at purchasing mobile handsets for the care staff to log in and out using the mobile handset. As there was a substantial cost implication, this would only be implemented at people's homes where the care staff were currently unable to log in and out.

The service had systems and processes in place to ensure the safe recruitment of staff suitable to work with people. Recruitment files contained the necessary documentation including criminal record checks, two references, identity verification documents including passports, bank statements, national insurance number and evidence of the staff members legality to work in this country. Staff files that we looked at also contained detailed information about people's previous employment, if there had been any gaps in employment and the reasons for the gaps.

The registered manager told us they accepted criminal record checks that held a three month validity, which had been carried out by another company. Following this, within one year of commencing employment, the service would complete their own criminal record check to ensure that staff were safe and suitable to work with people. We did note that for one staff member the criminal record check had been obtained after the person had begun work with the service. We highlighted this to the registered manager who assured us that the staff member in question had to date not worked on their own and had been shadowing and working in partnership with a qualified and trained care staff member. However the registered manager assured us that this oversight would not happen again.

The registered manager told us and we saw records confirming that as part of the interview process, potential care staff were asked to complete a questionnaire assessment. This was designed to assess knowledge and obtained an insight into how the potential care staff member would deal with specific care related situations.

All care staff had full access to personal protective equipment at any time when required. We observed that care staff were able to come to the office and collect supplies they required.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that they found the care staff to be adequately skilled and knowledgeable. One person told us, "Yes they are trained, they are so good" and one relative told us, "As far as I know they are skilled and trained for what they do for my [relationship to relative]." However, despite the positive comments received, there were some aspects of the service that were not effective.

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.

As part of the inspection process we looked at the systems and processes that the service followed in line with the principles of the MCA. The service had a MCA policy in place. However, as part of the care planning process the service was not completing capacity assessments or recording best interest decisions specifically where it had been identified that a person possibly lacked capacity. One care plan we looked at had identified that the person believed that they were someone else. The service had not assessed this and there were no best interest decisions in place to guide staff on how to best support this person. Another care plan that we looked at identified that the person was living with dementia. However, a mental capacity assessment had not been completed to confirm how this affected the person and where they lacked capacity, what actions would need to be taken that was in their best interest.

Consent to care had not been obtained as part of the care planning process. All of the care plans that we looked at had not been signed by the person receiving care and where people were unable to sign, a signature had not been obtained from a relative or advocate. We highlighted this to the registered manager who was unaware of the requirement to obtain consent but assured us that a consent form was being developed and this would be implemented immediately. However, people and relatives that we spoke with confirmed that care staff always took permission and obtained consent before carrying out any care and support tasks. One person told us when asked if carers take their permission, "They are very good like that."

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and care staff that we spoke with had a very basic understanding of the MCA. One care staff that we spoke with told us that they had not received any training about MCA. Another member of care staff we spoke with told us that they had received training in this area but on asking further questions found it difficult to explain what the MCA was and how it applied to the people they supported. During the conversation, information about the MCA had to be broken down and explained before care staff could answer the questions. Upon this taking place one care staff told us, "It's where people cannot make decisions, I have to report this." Another member of care staff we spoke with was more confident in their understanding of the MCA and told us, "We have watched videos about the MCA and it is about how to

support people who are not able to make decisions and consent to their care."

Training records confirmed that staff had received training about the MCA, however, the training had not been embedded and three of the staff members we spoke with were not confident in their knowledge about the MCA.

Upon employment care staff were required to attend a five day training programme as part of their induction process. Topics covered included moving and handling, safeguarding and first aid. Training certificates confirmed that all staff had received this training. A training matrix was available which outlined the courses care staff had attended and the date of completion. The service was also working with an external training provider to deliver the care certificate to all newly employed care staff. The care certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support and is covered as part of induction training.

The registered manager had identified that for the majority of care staff that they employed, English was their second language and the quality of records that were kept by staff were not of an acceptable standard. The registered manager told us that they were working with an external training provider to deliver functional skills training to all of its staff team to improve the standard of their spoken and written English.

Staff confirmed they received regular supervision. They told us they could talk about concerns and any training needs. Supervision discussions covered topics such as personal development, workplace discussions, timekeeping and attendance. The service had a supervision policy in place which stipulated that care staff would receive a minimum of four supervisions per year. Records confirmed this. One care staff told us, "I receive supervision every three months." Care staff members were yet to receive an appraisal as none of the care staff had completed one year of their employment.

The service provided care to people within their own home. Care plans did not provide detailed information about people's likes and dislikes in relation to food and drink and what their preferences were. Care staff were not involved in menu planning for people or ensuring that people's nutrition and hydration needs were met. However, the service did support people with preparing basic meals or heating up pre-ordered ready meals and care plans also noted where people would require encouragement with their meals and fluid intake.

Care plans contained information about people's medical conditions and healthcare needs. Care staff knew the people they supported well and always recorded and reported any concerns or changes in people's health to the registered manager. Care staff knew who to contact if there were any concerns about people's medical health including emergency contacts. One person told us, "The carers are attentive and will report to the family and communicate about any health issues." One relative did make comment about care staff being a bit more "dynamic" and "recognising when people require emergency assistance."

We recommend that the provider organises refresher training for the registered manager and care staff members on the MCA and assesses their knowledge once the training has been delivered. This is to ensure that they have a clear understanding of the principles of the MCA.

Good

Is the service caring?

Our findings

People told us that the staff that supported them were very caring and treated them with kindness and respect. One person told us, "They [care staff] are lovely, they look after me." Another person told us, "The care is really good." Relatives that we spoke with told us, "I find them [care staff] very caring, they are such a great help" and "They are just not doing a job, they really do care."

People's care plans contained information about the person which included information on their religion, their ethnic background, the languages they spoke, their preferred name they wished to be addressed as and any relevant health details. Each care plan had a supplementary support plan which was held at people's own home which outlined information about the daily support the person required. This included details of the tasks to be undertaken and the timing of the call. However, the plans did not always list peoples likes, dislikes and preferences and lacked the element of being person centred. We spoke to the registered manager about this who agreed to look into this in order to improve the care plans so that they were more person centred and less task focused.

People and relatives told us that they were involved in the planning and delivery of care at all times. One relative, when asked if they felt involved with the care of the person receiving the care replied, "Oh yes, I am involved." Whilst visiting people in their own home, we observed care staff had established meaningful and caring relationships with the people they were supporting and their relatives. We observed that people and their relatives felt comfortable telling care staff what needed to be done and how they would like their support to be provided.

People and relatives confirmed that they had a regular team of care staff that supported them on a daily basis. Staff also confirmed that they worked with the same people and had got to know them really well. One member of care staff gave us an example where one person, as they began to trust them, would ask to be supported with their personal care even before the care staff had approached them. The care staff member told us that the person now tells them, "I am glad you have come, please help me."

When we asked care staff about providing person centred care one told us, "I take care of people as I would take care of my own family." Another care staff told us that they had concerns about the time allocated to provide care to people which was not enough. This was reported to the office and the time allocated to the person was increased by 15 minutes.

Care staff demonstrated a good understanding of how to maintain people's privacy and dignity. Staff told us of examples about how they would respect people's privacy and dignity, such as when supporting with personal care or supporting a person to go to the toilet opposed to using the commode. One care staff told us, "If they [person receiving care] is not happy, I am not happy. It's always about asking them what they want, it's all about communication."

Good

Is the service responsive?

Our findings

The provider had a policy and procedure in place to deal with complaints. The policy gave direction and guidance on how a person could complain and the timeframe in which the complaint would be dealt with. The policy also contained contact details of the local authority and the CQC if people chose to contact an external agency where they felt that the provider had not dealt with their complaint appropriately.

We saw records of the two complaints that the service had received. We noted that the service had recorded the details of the complaint and an audit trail was available detailing the action that the service had taken. This included visits to the person and their relative who had complained to confirm that they were happy with the actions taken. This visit was recorded on an outcome form which was signed by the relative.

We noted that all complaints were logged on the care management system under the records of the person receiving the care. However, the registered manager did not hold an overview of the complaints that they had received in order to monitor any trends or patterns with a view to learning and improving the provision of care and support. We told the registered manager about this who agreed to implement an overview for future reference.

People that we spoke with did not have any complaints about the service that they received. They also told us that if they did have any concerns or issues that these would be dealt with promptly with a satisfactory result. One person told us, "We have never had any complaints." Relatives we spoke with told us, "I have contacted the manager a few times about staff arriving late and they have sorted that" and "Oh yes our complaints are dealt with straight away, I'd be the first to make a noise and I'm not afraid to let people know I am not happy."

People told us that they always received their regular carer who supported them with their care needs. People told us that if there was any change to the staff member providing the support, this was always communicated to them. One relative told us, "The office communicates with me to let me know if the carers are going to be late."

Care plans contained an assessment of people's needs prior to the service starting. The registered manager told us that the service carried out quarterly reviews but had also recently begun to complete follow up assessments over the telephone. We saw evidence of these follow up calls on the care plans that we looked at. The service had employed a field supervisor who was responsible for conducting reviews. Information from the reviews was then updated on peoples care records held within the management system. The updated information would then be printed out and a copy held in the person's care file held at their home. However, when visiting people in their own homes, we found that the most recent and current information was not available within their file. This meant that care staff did not have access to the most current information about the person in order to provide good care and support. This was highlighted to the registered manager who told us that records would be updated within people's own homes immediately.

Care staff recorded their daily interactions on recording sheets which were held at the person's home. Notes

recorded the time the carer arrived, the time they left, the general health of the person, food and fluid intake, how the person was supported and if the environment was clean and tidy. Daily recording notes that we looked at were consistent with their recording. We also saw that where care staff had noticed any bruising or marks on a person whilst supporting them with personal care, a body map had been completed with a note detailing the action that they had taken. Relatives we spoke with told us, "Care staff are very observant with the care that they provide and if they see anything unusual or anything health related they will always inform me."

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us that they knew who the registered manager was and were complimentary of the way in which the service was managed. One person we spoke with told us, "I know the manager, [name of the manager] is great, I can always call them." One relative told us, "[name of the manager] is very easy to talk to and approachable. If there is any issues [the manager] wants to sort it out immediately."

Care staff that we spoke with were also positive about working for the service. One member of care staff when asked about how they felt about working with Kamino Homecare told us, "I think it's really good, the best move I have ever made. I know that [the manager] is at the end of the phone if I need them." A care staff member who had just recently started work with Kamino Homecare told us, "I am new working with them but whenever I speak with the manager, they do whatever I ask them."

The registered manager had newly established systems in place to oversee the quality of care that the service provided. This included spot checks, follow up telephone conversations with people and relatives on a monthly basis and the electronic monitoring system where missed and late visits were recorded. However, these checks were not consistent and the registered manager lacked oversight especially in relation to checking how many calls had been logged as missed or late visits. This also failed to note if there were any trends or patterns from which the service could learn and improve from. The same was noted in relation to the monitoring and reviewing of complaints.

Other systems in place also included an annual planner for supervisions of care staff so that the registered manager knew when care staff supervisions were due. The registered manager was also able to use the care management system on the computer to input dates for when people's care and support packages were due for a review. The registered manager did not have any processes in place to audit care plans and staff files but did tell us that they were looking at implementing such systems in the future.

The registered manager had employed a number of staff within the office who had allocated responsibilities in relation to training, care co-ordination, completing reviews and spot checks. However, it was noted that the registered manager did not hold clear oversight about what work the office staff had completed to ensure that tasks such as regular reviews and spot checks had been completed. Additionally the manager did not know if care plans within people's homes had been updated post review, which was an issue identified as part of the inspection.

The registered manager held weekly staff meetings with the office team. Topics discussed within these meetings included introduction of new staff, goals for the next week, rotas and client information. The registered manager had not held any care staff meetings as the service did not have sufficient capacity to cover shifts for staff who were required to attend the meeting. The registered manager made sure that they communicated regularly with carers through the telephone or one to one sessions. The service had also produced a newsletter for care staff when information needed to be communicated to them. Topics covered in the newsletter included lateness and what staff should do if they were running late to a call.

Quality assurance surveys had been devised in line with the CQC's key lines of enquiry. The service planned to send these to people who received a service and relatives on a quarterly basis. The first one had been sent in December 2015 and had been structured around the key area of 'safe'. The registered manager told us that they had sent out 30 questionnaires but had only received four responses. The registered manager was looking at different ways of ensuring that people and relatives completed the questionnaires such as providing pre-paid envelopes so that people would not incur any cost in returning completed questionnaires. One person who had completed the questionnaire had written, "I am very satisfied with the service and attention I receive from my carer."

We recommend that the registered manager develops systems where they can monitor and hold effective management oversight with action plans to ensure that the service learns, develops and improves the provision of care and support.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where a person lacks mental capacity to make an informed decision or give consent, the service did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service were at risk because the service did not assess and mitigate individual risks identified as part of the care and support plan People who use services and others were not protected against the risks associated with unsafe and improper management of medicines