Caring Moments Limited

Care Matters

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

Caring Moments Limited provides personal care and support to people living in their own homes in the Lowestoft area. When we inspected on 11 and 20 October 2016 there were 45 people using the personal care service. This was an announced inspection. The provider was given 48 hours notice because the location provides a domiciliary care service and we needed to know that someone would be available on our arrival.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The deputy manager had made an application to become the registered manager and this had not yet been confirmed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

During this inspection, we found that the registered provider was in breach of six regulations 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 provider was failing to protect people using the service against the risks associated with the management of medicines. Medicine Administration Records [MAR] were not always completed or

accurately recorded by care workers. This meant that we could not be confident people were receiving their medicines as prescribed. Refusal of medicines had not been reported to relevant health professionals.

The provider had not ensured that people were protected from the risks of unsafe care because people's needs had not been routinely reviewed, and checks on documentation had not been carried out. We found risk assessments that did not reflect current needs, and this meant that care workers did not always have up-to date and clear guidance to help them support people safely. Some people's care plans were not accurate in all areas and needed to reflect more fully people's individual preferences. Where risks were documented, some people's care plans did not state actions to reduce risk.

Care workers asked for consent prior to carrying out any care or treatment, however, people's capacity to make decisions was not properly assessed, and there were no MCA assessments or best interest decisions in place.

Care workers understood their role in protecting people from abuse, types of abuse they may come across in their work, and who to report concerns to. However, a recent incident had not been reported by the management team, and therefore we could not be sure that all levels of staff understood when to raise concerns.

People who used the service told us that generally care workers were kind and caring. Care workers took steps to maintain people's privacy and dignity, such as closing doors and curtains.

People's feedback was not routinely sought to enable the service to understand people's experiences of the care they were receiving. Complaints were logged, but actions taken were not always recorded. It was therefore ineffective at identifying themes and was not being used to drive improvement or make changes in the care people received.

Robust quality assurance systems and audits were not in place to monitor the service provided to people, and so the provider was unable to identify shortfalls in the safety and quality of the service. The provider did not undertake regular checks to ensure the quality of care or to use this to drive improvement. Observations to assess care workers competence had not been carried out. The provision of on-going supervision and performance management for care workers was not consistent. This resulted in poor practice in areas such as the management of medicines.

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 provider had not ensured that people using the service were protected against the risks associated with the unsafe management of medication. Clear and accurate records were not being kept of medicines administered by care workers. This meant we could not be sure people were always given their prescribed medicines.

Care workers recognised types of abuse which they could come across in their work, and their responsibility to protect people from abuse, however, not all levels of staff demonstrated a good understanding.

Risk assessments were not always accurate or reviewed in a timely manner. Care workers sometimes completed these but had not been trained to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

Care records we reviewed did not make reference to people's ability to make decisions. There were no MCA assessments or best interest decisions in place for people where their capacity to consent to care was in question.

People received support from care workers who had received training, however, the provider had failed to ensure whether care workers were competent to apply the learning gained at the service.

People were supported to access health care professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

We could not be assured that people were fully involved in the planning of their care. People's views on the care they received

was not routinely sought.

Peoples' privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not always provide care workers with the information needed to provide individualised care. People's care plans did not always reflect their current needs as they had not been reviewed in a timely manner.

Rotas were not consistently provided to people so they knew who was visiting them and at what time.

The provider had not established an accessible system for identifying, receiving, recording, handling and responding to complaints by people and others.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

Governance systems were not in place to effectively monitor the quality of service people received and this had placed people at risk of not receiving safe and effective care.

Roles and responsibilities in the leadership and management of the service were not clearly defined. Resources were not adequate to carry out essential checks, such as observations of care workers and reviewing of care records.

The views of people and their relatives were not routinely sought.

Care Matters

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 11 and 20 October 2016 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service, we needed to be sure that someone would available on our arrival. The inspection was undertaken by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service; what the service does well and improvements they plan to make.

We reviewed information we held about the service, such as notifications and information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with 10 people who were using the service, and eight relatives. We also spoke with the deputy manager, two directors of the provider, and six care workers. To help us assess how people's care needs were being met, we reviewed 12 people's care records and other information, including risk assessments and medicines records. We also looked at records relating to the management of the service, recruitment, training, and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Care workers did not always ensure that the administration of people's prescribed medicines were accurately recorded. Medicine Administration Records [MAR], which care workers signed to record when people had been given their medication, did not always clearly demonstrate which medicines had been administered on each occasion. For example, one MAR chart had not been completed for four days. It was therefore not possible to be certain whether these medicines had been administered. Another MAR chart had not been renewed since 30 August 2016 which again meant records did not show what care workers had (or had not) supported them with. The deputy manager told us that the updated MAR charts were usually replaced in the records by care workers, however, this had not been completed. Some MAR charts did not include all medicines which were being administered and not all doses were recorded. This did not demonstrate the proper and safe management of people's medicines that identified potential risks and demonstrated what action was being taken.

We found that one person had not been taking one of their medicines for two weeks because it was still contained in their blister pack. Care workers had not escalated this to a senior member of staff, consulted with their GP, or considered the potential implications or risks to the person's health and welfare of this routinely being refused.

There was a lack of consultation with best practice guidance in relation to medicines. For example, some medicines needed to be taken an hour before food, and in an upright position. There was no instruction on the safe administration of this recorded on the MAR chart or within the care plan. Care workers had no documentation to refer to in order to understand the potential harmful side effects of not administering this correctly. We also saw an incident form which stated that a care worker had administered medicine to a person via the incorrect route which put them at risk of harm and had not sought medical advice to ensure that potential harm was minimised.

Details of the strengths and dosages of some medicines were not recorded. There were unexplained gaps on MAR charts, which meant we could not tell whether their medicines had been given correctly, and one MAR chart showed that one weekly medicine had been taken on the incorrect day [Not a full week between doses as prescribed]. For people receiving medicines 'as required' there were no protocols in place for care workers to follow on when to offer these medicines. This information is necessary where people may not be able to verbalise how they are feeling. A protocol would provide care workers with information on symptoms a person may display if they were in pain.

The director and deputy manager told us that all care workers had been trained in medicine management [training records confirmed this]. However, it was evident that some care workers had not gained sufficient knowledge or competency from the training provided, and observations of care workers had not been carried out by the provider or management team due to lack of resources. One care worker said, "I do not feel confident with completing the MAR charts. Medications can be different from what is written on the MAR chart, and this leaves me feeling uncertain". Another said, "I am concerned for clients welfare, ive brought up my concerns about medication with [management team] but I don't feel listened to". We considered that

the service was failing to protect people using the service against the risks associated with the unsafe use and management of medicines.

People's care records contained some risk assessments which provided guidance on how to minimise risks which could affect a person's daily life, for example, environmental factors, falls, skin integrity, nutrition and mobility. Risks to people were not consistently reviewed [some had not been reviewed for six months and some had no dates recorded on them]. In some cases moving and handling assessments were not accurate, for example, one person's plan made reference to assisting the person to get out of bed into their wheelchair, however, the person was no longer able to physically do this. Another persons plan said they used a stick, but they were now using a walking frame. Neither plan had been updated to reflect this. In another case a Waterlow [skin integrity] risk assessment had been completed, showing the person was at high risk. There was no information provided to guide care workers on how to minimise the risk for the person, for example, regularly checking pressure areas on the skin. The deputy manager told us that care workers completed the risk assessments, however, care workers had not received formal training to do so and therefore there was a risk that people's needs would not be met appropriately.

The deputy manager told us they were aware that documentation relating to people's risk assessments needed updating. They said that care workers were aware of current risks affecting people, as they held a weekly meeting to handover relevant information relating to people's care and any emerging risks. However, important information, such as people not taking specific medicines, had not been raised.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have asked the provider to take at the back of the full version of this report.

We looked at the staffing arrangements for care visits. We checked the punctuality and reliability of care workers when carrying out their visits. Some people and relatives expressed concerns about the punctuality of care staff. They told us that care staff sometimes arrived late, and that there were occasions when people had to telephone the office to tell them that a care worker had not turned up. One person told us, "I don't always know who is coming, and the carer was late today. I had to phone the office to find out about it as nobody turned up and I don't know what's happening". Another said, "Sometimes they do lunch visits at 3pm".

In August 2016, a total of seven visits were missed. Missed visits pose a serious risk to people who may be vulnerable and unable to summon help. The deputy manager told us that when a visit is missed, they try and contact people, or their next of kin [where appropriate] to ensure the person was safe. However, people's care records did not make reference about who to make contact with in the case of a missed visit, or the risk this posed to the individual. There was no formal policy and procedure in place or being adhered to, to ensure people were safeguarded as far as possible in these events.

We recommend that the service explores current guidance from a reputable source in managing risk associated with missed or late visits, planning for these incidents, to mitigate potential serious implications on people's health and well-being.

There were concerns about ensuring that care workers followed good security practice in relation to people's belongings and homes. The service did not have a clear procedure relating to people's keysafe codes [a locked box for care workers to gain entry]. Confidential information such as keysafe codes need to be provided separately to a person's address, and a clear process needs to be in place for care workers to follow.

Care workers had been provided with training in safeguarding people from abuse. They understood the different types of abuse they may come across and how to report concerns. One care worker said, "I always think, if my mum and dad were receiving care, how I would like them to be treated. We have to raise any concerns to keep people safe". Another said, "I have raised concerns to the manager before. I would go to the police if I needed to". However, we also found details of a recent incident which should have been reported to the local authority safeguarding team [who have responsibility in these matters] but had not been. We therefore could not be assured that all staff and the management team understood when concerns should be raised.

People were protected by the procedures for the recruitment of care workers. Care workers we spoke to, and records we reviewed, confirmed that reference checks and Disclosure and Barring Service (DBS) checks [which provide information about people's criminal records] had been undertaken before new staff started work. Where appropriate, we saw that risk assessments had been completed to ensure staff were suitable for their role.

Requires Improvement

Is the service effective?

Our findings

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 checked whether the service was working within the principles of the MCA. People being cared for had identified mental health needs including dementia, which meant that the service needed to have regard to these principles. The service did not have a policy or procedure relating to MCA to provide guidance to staff and ensure the principles of the MCA were being followed. Care records we reviewed did not make reference to people's ability to make decisions. There were no MCA assessments or best interest decisions in place for people where their capacity to consent to care was in question. For example, one person had their medicines locked out of their reach for their own safety. The deputy manager told us that discussions around this decision had taken place with the person's representative, however, there was no formal capacity assessment in the persons care plan. There were no documents in place to show how the person's capacity was monitored, or record any changes in their ability to make their own decisions. Therefore people's capacity to make decisions was not being properly assessed.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The deputy manager and directors were aware of the need to improve in this area. Following the inspection, the provider forwarded a new MCA policy for the service which provided more detailed guidance for all staff in the team to refer to.

The deputy manager told us that they aimed to deliver one to one supervision sessions for care workers every three months in order to give them the opportunity to discuss the way they were working and give them feedback on their work practice. However, these supervision sessions had fallen behind as the deputy manager was the only person providing this support and did not have capacity to keep up. Areas of practice which needed to be improved, such as record keeping and the process for reporting as unwell for work, had been communicated numerous times via memo's which had been sent out by the management team. However, the deputy manager told us that these had been ineffective at improving practice. The memo's provided a message to the whole staff team, rather than identifying individual care workers who needed to improve their practice, which supervision sessions would provide. One care worker said, "We don't have regular supervision sessions, we all meet informally on a Monday, and [deputy manager] pulls you to one side if something needs to be discussed". Minutes from the weekly meetings were not taken, so we were unable to see what was discussed within these. Therefore it was not clear how the service was able to demonstrate that care workers were supervised adequately to ensure their competency and learning was effective.

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

People's views about the skills and experience of those providing their care varied. One person told us, "I'm very happy with the care, they [care workers] know what their doing. Another said, "Some are better than others". A relative said, "I'm not sure all of the care workers are trained in dementia care".

All care workers were undertaking the Care Certificate, which is a set of standards that care workers are assessed on to ensure they are providing good quality care, and standards that should be covered as part of induction training of new care workers. It also enables existing staff to refresh and improve their knowledge. Part of the care certificate includes undertaking observational assessments of care staff to ensure they are competent. The management team had not regularly assessed the performance of care workers. The lack of regular observations of care workers had resulted in poor practice, in areas such as medicines management.

Care workers received training relevant to the needs of the people they were caring for, the majority of whom were elderly with physical disabilities. This included moving and handling, and dementia awareness. Some of this training, such as medicines management, was delivered via an online course with no practical assessments to support the learning. In specific areas, such as dementia, monthly questionnaires had been sent out to care workers which tested their knowledge. After the questionnaires were returned, one of the directors told us that they arranged specific training in areas where knowledge was identified as needing to improve. One care worker told us, "We [care workers] recently received a questionnaire about medicines, to test what we know". However, this approach had not prevented shortfalls in the care people received.

Care workers were provided with an induction before they started working in the service consisting of mandatory training such as moving and handling and safeguarding. The director delivered training sessions for care workers. On the day of our inspection we saw training being carried out for three new care workers. The service had a training suite, which consisted of equipment such as a hoist and a bed where care workers received practical training in meeting people's needs. One new care worker told us, "I only started two weeks ago, but last week I was doing my moving and handling training, we used slide sheets [equipment used to move people in bed] and the hoist. It was good".

Where people required assistance, they were supported to eat and drink and maintain a balanced diet. This included keeping records of their food and fluid intake when there were risks, preparing and providing food and drinks and encouragement of drinks. Information on the importance of keeping people hydrated, and the symptoms of a urinary tract infection, were visible in the office for care workers to read. However, one care plan we reviewed made no reference to the fact they had diabetes, for example, foods they should avoid, and what they liked to eat. This information would provide guidance to care workers, and ensure the person received an appropriate diet to support the management of their diabetes.

People were supported to maintain good health and have access to healthcare services. Records showed that where concerns in people's wellbeing were identified, health professionals were contacted with the consent of people. We also observed this; during the day the deputy manager made a request to a district nurse to visit a person who they were concerned about, had a discussion with an occupational therapist, and relayed the information to care staff to ensure that care was in line with the advice given.

Requires Improvement

Is the service caring?

Our findings

The service had remained relatively small, and this had resulted in care workers getting to know people well. There were examples where people told us they had a regular group of care workers who visited, enabling them to build up good relationships. One person told us, "I get regular carers, I rely on [name of care worker]. When they have a holiday I get someone else, but that's ok". Another said, "[Name of care worker] brings a good atmosphere into my home", and, "Before they do anything they ask me how I am, they are very kind". However, one relative told us, "[Relative] seems to have lots of different carers, but as soon as they are trained up, they seem to be off to other people". Another said, "[Relative] has her favourites, and less favourites". The deputy manager told us they tried to ensure people received continuity of staff where possible, but this was not always possible with staff holidays and sickness. Care workers told us they generally had a regular group of people they supported.

We received mixed views as to whether people felt involved in the care and support they were provided with and the development of their care plans. One person told us, "Yes, [deputy manager] came yesterday, we went through my care plan together, I know what's in it". Another said, "No, they [care workers] may update it [care plan] but not with me".

In some cases, where the person was unable to sign the care plan, representatives of the person had involvement and had signed on their behalf. The deputy manager had liaised with relatives [where agreed] so they felt involved in their relatives care planning. They told us that care plans had not been reviewed in a timely manner due to the lack of staff resources. We could therefore not be assured that people were fully involved in the planning of their care and that their views and preferences were routinely listened to. The deputy manager told us that in the event that people's needs changed significantly, they would always visit the person promptly to update their records.

People's records provided guidance to care workers on the areas of care that they could attend to independently and how this should be promoted and respected. One person told us, "Our regular carer is really good. They stop and chat and they never rush off. I like [care worker] because they help me keep my independence by helping me do things, not taking over".

Records guided staff to make sure that they respected people's privacy and dignity, for example when undertaking personal care or with toileting. One person said, "We have a lovely carer who comes to us, very helpful and does what we need, so no complaints". A relative told us, "The carers are good with [relative]. I watch them with [relative], and they cover her up, close the curtains and make sure she is comfortable".

Requires Improvement

Is the service responsive?

Our findings

People's care records included care plans which guided care workers in the care that people required. These included support required with personal care, how they mobilised, and how they liked to spend their leisure time. We saw that reviews were carried out inconsistently across the service.

Some care plans had not been reviewed for six months and people's needs had changed. One relative told us, "I need a new care plan for my [relative], but they've not been back to assess, even though I've asked them to". This meant that the person's needs may have increased, but were not reflected in their care plan due to a delay in reviewing this. We found other examples where people's care plans did not reflect their current needs. For example, it was identified that one person's memory was deteriorating, and that care workers needed to adapt the manner in which they communicated with them to ensure their understanding, but this had not been updated in their care plan. In another case a person had started to display some behaviour which challenged care workers, but the care plan did not provide guidance on best approaches or methods of communication to ensure the best outcomes for the person, and also to guide staff. This was particularly important as care workers had not received training in this area of care provision.

Two people we visited had recently had their care plans reviewed, but the care workers had not returned this to the person's home. This meant that there was no guidance available to care workers who were visiting the person. Although care workers knew people well, documentation should be available at all times, not only to care workers, but to family members [where agreed] and other professionals who may be caring for the person.

Despite the shortfalls in care records, the deputy manager told us they met with the care workers weekly to discuss people's care, and where there were changes, this was verbally handed over. Some care reviews had been carried out and included consultation with people and their relatives, where appropriate, but this was not consistent across the service. Some people [or representatives where appropriate] had signed to consent to the terms and conditions of the service, but some had not and some were not dated. Some were written in pencil or blue ink [It is usual best practice to ensure documentation is written in black ink to prevent records being altered].

Care plans would also benefit from having increased detail about people's specific wishes and preferences. Care plans were created from a generic template, and therefore some wording was repetitive through all care plans, for example, in areas such as 'leisure pursuits' and 'sexuality'. This did not demonstrate a person centred plan of care which would enable the service to tailor people's care to reflect their individual needs and preferences.

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

The service user guide included a section on how to complain. When we looked at this it stated that people could speak to the management team or their care workers to raise any issues. It also said that people could

contact the CQC [but no contact details were listed], or the General Social Care Council [which is no longer in existence]. The services' complaints policy had not been updated since 2014. We brought this to the attention of the deputy manager and directors, who were unable to explain how this had been missed, and agreed they were not correctly listed and would amend these.

The provider had not established an accessible system for identifying, receiving, recording, handling and responding to complaints by people and others. Although some complaints had been investigated and responded to, these were logged either in people's care plans, in a folder held at the office, [which included incidents and accidents] or on the services electronic care system. This made it difficult for the management team to have effective oversight of all issues raised. They were therefore unable to identify any emerging trends, or use the information as an opportunity to drive improvement and make changes to the care people received. There were no 'lessons learnt' logs which could identify actions that the service were taking to minimise the risks of similar events happening again. On the second day of our inspection complaints were logged individually, and the deputy manager had started to update the paper copies they held with actions that had been taken. Providers must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reason for this should also be recorded.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they did not always know who was coming to provide their care. One person told us, "I normally get a list of who is coming but this week, one is off sick, and the other has resigned, so not sure who is coming". Another said, "We get a schedule, but haven't had one recently". The deputy manager told us that care workers are given a schedule to take in to people, however, we did not see any schedules in place for the people we visited.

We recommend that the service explores current guidance from a reputable source in delivering person-centred care, taking into account the specialist needs of people and the risks/benefits of continuity when planning people's care.

Inadequate

Is the service well-led?

Our findings

The registered manager had left the service in March 2016. The day to day running of the service was being undertaken by the deputy manager. They had made an application to become the registered manager and had recently completed a qualification in leadership. There were two directors of the provider, one of whom dealt with the financial requirements of the service, and the other who delivered training to care workers.

Leadership roles and responsibilities within the service were not clearly defined. For example, the deputy manager and directors knew that observations of care workers were over due, and that people's care plans needed reviewing, but it was not clear who would be undertaking these tasks due to lack of resources. The provider had failed to ensure sufficient oversight of whether care workers had the right knowledge and were competent to apply learning gained at the service, and this had resulted in poor practice in areas such as the safe management of people's medicines. One relative told us, "If I could change one thing about the agency it would be the management. Simply not proactive enough with their service users".

There was a lack of regular auditing and analysis of quality assurance systems to continually monitor the service provided to ensure people received safe and effective care. There were no quality assurance audits being carried out routinely with regard to checking documentation, for example, care plans, daily records, or MAR charts. As a result the management team were unable to demonstrate how they monitored the quality of the service to make sure the overall management of the service was safe and effective. The lack of any formal monitoring or auditing meant that issues relating to people's care and treatment were missed and risks of potential harm were not being mitigated as far as possible.

We looked at accident and incident reporting. Though information had been documented, many of these did not include actions that had been taken, or lessons learned. The information was not being used as an opportunity to identify themes and recurring trends thereby limiting future occurrences.

People and relatives were not routinely asked for their views as a method of continually evaluating and improving the service. Care plans contained a satisfaction survey in the back of the folder, and people randomly completed these, but surveys were not regularly sent out to people. One relative said, "How do they know the service is working if they don't phone and ask, or come round to visit?". Another said, "The office phoned me up recently, but they never asked me how my [relative] was getting on, that says it all really".

Care workers said they felt able to raise issues with the management team but that communication needed to improve between them. One care worker said, "The management team are ok, but communication needs to improve. I raise issues and no one comes back to me with a response". Another said, "We have a team meeting this afternoon about MAR charts, only because of you [CQC] coming in, can't remember the last one we had", and, "I don't always feel appreciated for what I do, we all need some nice feedback now and again". The culture in the service was not conducive to effective team working, and care workers views about the service and how they felt it could improve were not routinely sought.

Providers are required to send the CQC statutory notifications to inform of certain incidents, events and changes that happen. Whilst the service had sent in some statutory notifications to the CQC , they told us that this particular task was undertaken by the registered manager who had left in March 2016, and were unsure which specific incidents they needed to report. We advised the management team to familiarise themselves with the range of incidents that require a notification to be sent to the CQC.

Although the deputy manager and directors were open and transparent throughout the inspection, seeking feedback to improve the service provided, the above evidence has demonstrated failings which have exposed people to the risk of harm. Systems were not sufficiently robust to ensure that the registered provider was operating within expected standards of governance and ensuring effective oversight of the service. They were unable to demonstrate up to date knowledge around best practice for domiciliary care providers and lacked effective systems for keeping themselves informed on these matters independently. The Provider Information Return we received did not reflect robust plans for continually driving improvement, and when asked for an example of planned improvements, the response stated "Continue as we are". This does not reflect the required standards of continually improving what is offered to people using services.

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

Following the inspection we issued the provider with a warning notice outlining how they are failing to comply with regulations, specifically the safe management of medicines. This included a timescale by which they are required to become compliant. Failure to achieve compliance within the given timescale, may result in further action being taken.