Oasis Care and Training Agency (OCTA)

Oasis Care and Training Agency (OCTA)

Inspection report

24-32 Murdock Street
Peckham
London
SE15 1LW

Tel: 02076396192
Website: www.somalicareagency.org.uk

Date of inspection visit:
31 August 2016
02 September 2016

Date of publication:
14 October 2016

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Oasis Care and Training Agency is a domiciliary care service, which provides personal care to people in their own homes in 14 London boroughs. At the time of the inspection there were 374 people using the service. The service had a registered manager in place. '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.'

Prior to the inspection the CQC had been informed of a concern about an aspect of the service. This was being investigated by other agencies at the time of the inspection. CQC will continue to monitor the progress and outcome of this investigation.

This inspection took place on 31 August and 2 September 2016 and the inspection was announced.

The provider was given 24 hours' notice because the location provided a domiciliary care service and we needed to be sure that someone would be in.

We last inspected the service on 14 and 23 March 2016 and the service was meeting all areas inspected.

People were not always protected against the risk of unsuitable staff. The service did not have robust employment practices. Staff files did not always contain two references and references did not always reflect people's work history. Records showed that the service did not have adequate systems in place to ensure they had suitable disclosure and barring services [DBS] certificates in place. Where concerns about criminal records were identified, action to ensure people's safety was not robust or well documented.

People were not always protected against the risk of harm and abuse because the service did not have robust vetting practices in place when employing staff. Staff were aware of the different types of abuse and how to report suspected abuse. Staff had received safeguarding training and were aware of the service whistleblowing policy.

People were at risk as the service did not have robust auditing systems in place. Audits relating to medicines, employment and records did not identify concerns in a timely manner.

People were at risk of unsafe medicine management. The service did not have robust systems in place to ensure people received their medicine in line with good practice. Medicine Administration Recording [MAR] sheets were not always completed correctly. People's dose, and route of medicine was not always clearly documented.

People were aware of how to raise concerns and complaints, however their concerns were not always recorded appropriately. Staff kept notebooks of concerns and complaints raised, which were not always

kept securely in a locked office. The service did not have adequate storage and filing systems in place to ensure records were kept securely and easily obtainable.

People were protected against identified risks. The service had risk assessments in place that identified the risk and gave staff guidance on how to minimise and mitigate the known risk. Risk assessments were reviewed regularly to reflect people's changing needs. Staff were aware of the importance of reporting any concerns regarding risks to their supervisors.

People received care and support from staff that received on-going training to enhance their skills and knowledge. People received a comprehensive induction that followed the care certificate from skills for care. Staff were shadowed by an experienced staff member, to ensure they were competent in their role prior to lone working.

Staff and the registered manager were aware of their role and responsibilities in providing support to people within the principles of the Mental Capacity Act 2005 [MCA]. People's consent was sought and respected prior to care and treatment being delivered. Staff were aware of the importance of seeking people's consent. People were supported to access health care professional services when required and agreed in their care package. Staff were aware of the importance of monitoring and reporting concerns regarding people's health.

People were encouraged to make decisions about the care and support they received. People's decisions were respected by staff. People were treated with kindness and compassion by staff who respected and promoted their privacy and dignity. People had care plans that were person centred and detailed people's health and medical needs. Care plans were routinely reviewed to reflect people's changing needs and people were encouraged to develop their care plans.

The service carried out quality monitoring surveys to gather feedback on the service provision from people. Where areas of concern were identified these were then acted on in a timely manner. The registered manager operated an open door police, where people, their relatives and staff could meet with him at a time that was convenient to them.

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 always safe. People did not always receive care and support from staff that had undergone the necessary safe recruitment checks to ensure their suitability.

People did not always receive their medicines safely. Medicine Administration Recording Sheets [MARS] were not always completed in line with good practice.

Risk assessments were in place and gave staff guidance on how to minimise and manage known risks. People were supported by sufficient numbers of staff to meet their needs.

Staff were aware of the different types of abuse and knew the correct procedures in reporting suspected harm and abuse.

Is the service effective?

Requires Improvement

The service was effective. People were supported by staff that underwent training to meet their needs.

People's consent to care and treatment was sought prior to being delivered. Staff respected people's choices.

Staff had knowledge of the MCA and DoLS legislation. This meant that people were supported against having restrictions placed on their liberty.

People were supported to access health care services to monitor and maintain their health and well-being.

Is the service caring?

Requires Improvement

The service was caring. People received care and support from staff who were kind, caring and compassionate.

People were encouraged to make decisions about the care and support they received and had their decisions respected.

People's privacy and dignity was encouraged and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were confident in raising concerns and complaints. Complaints were not always recorded securely and investigation minutes were not always kept in the complaints file.

Care plans were person centred and detailed people's health and medical needs. Care plans were routinely reviewed to reflect people's changing needs and people were encouraged to develop their care plans.

People were encouraged to make choices about the care and support they received and had their choices implemented and respected.

Is the service well-led?

Requires Improvement

The service was not always well-led. Systems and procedures in place to monitor and improve the quality and safety did not always highlight areas of concern.

The service did not have adequate storage systems in place to enable easy access to records.

The service carried out quality monitoring surveys to gather feedback on the service provision.

The registered manager operated an open door policy, where people, their relatives and staff could meet with him at a time that was convenient to them.

Oasis Care and Training Agency (OCTA)

Detailed findings

Background to this inspection

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

The inspection took place on 31 August and 2 September 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by two inspectors on the first day of the inspection and two inspectors and an expert-by-experience on the second day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed the information we held about the service, including notifications sent to us from the provider, information received form members of the public and health care professionals. Prior to the inspection the CQC had been informed of a concern about an aspect of the service. This was being investigated by other agencies at the time of the inspection. CQC will continue to monitor the progress and outcome of this investigation.

During the inspection we spoke with 12 people, 14 relatives, 21 care workers, two care coordinators, the human resources manager and the registered manager.

We looked at 20 care plans 25 staff files, quality assurance questionnaires and other records the service is required to keep in relation to the management of the service.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe. One person told us, "I feel safe". Another person told us, "I feel very safe with them [staff]." A relative told us, "I feel quite happy that my (relative) is safe with them." However, prior to the inspection the CQC had been alerted to concerns about the safety of the provider's recruitment process and the suitability of staff. At the time of the inspection these concerns were being investigated by other agencies.

People were not always supported by staff that had undergone the necessary pre-employment checks to ensure they were safe to work at the service. We looked at 25 staff files and found instances where application forms were not completed correctly or were completed by people other than the prospective employee. We found the employment histories of staff did not always relate to their references and that some references had been supplied by referees who had not been stated by staff on their applications. We also found examples of where people's references were incomplete, with no dates, roles or suitability for their role documented. We identified three staff that had one reference on file.

Staff were unable to give satisfactory explanations as to how their application forms were completed by different people. One staff application had three different handwriting styles, when asked about this the staff told us, "I can't tell you who wrote that." Another member of staff told us, "I did not fill it all out [application form], either my son or my daughter completed it with me". When asked why, they told us, "I like their handwriting, it's better than mine". Some staff also were unable to explain what role they held and the location of their previous employment. The human resources manager told us, "There are applications that have different handwriting, I do not know why this is". When we showed the registered manager copies of application forms that had been completed by different people, he told us, "That is different handwriting, I agree. I don't understand why that would have happened. We can look into this". There was no evidence that anomalies were investigated by the service.

People were at risk of receiving care in their homes from staff who had not been appropriately vetted. The provider was unable to confirm that three staff had received a Disclosure and Barring Services [DBS] check prior to working at the service and delivering care. The DBS confirms information about an applicant's criminal record and whether they are barred from working with vulnerable adults. The records of one member of staff indicated they had previous criminal convictions. The service had not followed their own policy by ensuring a risk assessment was completed to ascertain the staff's suitability to safely support people.

These issues are a breach of regulation19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected against the risk of abuse. Prior to the inspection we saw there had been an allegation of abuse, due to risks a staff member may pose to people receiving support at the service. We noted a recommendation by a senior staff member that the staff member in question should not work alone with people in their own homes, without a robust risk assessment in place. Although the person was no

longer working for the service we were made aware the staff member did work alone and unsupervised for a period of time, which was confirmed by the registered manager. At the time of the inspection a risk assessment had not been completed. This recommendation was not followed and meant people were placed at risk of unsafe staff. The local authority have confirmed this information has been shared with them and we will monitor the outcome.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not always protected against the risk of unsafe medicine management. One person told us, "I do my own medicines so I don't need staff helping me." People either administer their own medicines, require prompting from staff or have their medicines administered by care workers. We looked at medicine administration record [MAR] sheets for five people and found four were not completed in line with good practice. One MAR sheet did not detail the dose of medicine required or where on the person the medicine should be administered. We also noted the MAR sheet was not signed correctly. We spoke with a care manager about this, who showed us evidence that the person was in hospital and therefore did not receive the medicine from the service. However staff had failed to use the codes to explain the absence of a signature. We looked at the medicine prompting sheets and found there were three instances where staff had not signed the sheet correctly. This meant it was difficult to ascertain if the person had received their medicines.

We recommend that the service consider current guidance on medicine recording and take action to update their practice accordingly.

Subsequent to the inspection the registered manager has sent us an action plan, which details how they will be addressing our concerns.

Staff knew how to keep people safe. All staff spoken to were aware of what action to take if they became aware of an adult safeguarding incident. Staff confirmed they had received safeguarding training during their induction programme. Staff were aware of both the safeguarding and whistleblowing policy. One member of staff told us, "I always make sure people are safe and comfortable before leaving their home". Another staff told us, "If I have any safeguarding concerns I would report it to the office."

People were not always protected against identified risks. We received mixed feedback from people and their relatives regarding risk assessments. For example, one relative told us, "[Relative's] risk assessment isn't filled in." The service carried out risk assessments which highlighted areas of risk and gave staff guidance on how to minimise and known risks. The risk assessments covered both environmental and personal risks. For example, risk assessments looked a medicine and mobility, and where risks were identified, a further detailed assessment was carried out. This included a picture to demonstrate to staff the level of support required with mobility for example getting in and out of the bath or support with walking. Environmental risk assessments looked at fire hazards, trip hazards, equipment such as hoists, wheelchairs and bath chairs. Risk assessments were regularly reviewed and updated. Staff were aware of people's risk assessments and gave feedback to senior staff when new risks had been identified. We saw examples of where identified risks had been addressed in a timely manner and action taken to minimise these risks, for example, we saw that the service made requests to the London fire brigade for further support when fire hazards had been identified. One staff member told us they liaise with the fire officer if a fire risk is identified.

People were supported by sufficient numbers of staff to meet their needs. One person told us, "I know who is coming. I have never had any missed calls or anything." A relative told us, "We have a regular carer." Staff

told us they thought the service had sufficient staff and they always obtained cover from colleagues whilst they were on leave. The service used bank staff and senior staff, who would cover visits when there was a shortage of staff. We looked at staff rotas and the electronic monitoring system the service used, which highlighted missed or delayed visits. We found where visits were classed as missed, there were explanations clearly documented and local funding authorities informed.

Requires Improvement

Is the service effective?

Our findings

People did not always receive support from people who could communicate in a manner they understood. We received mixed reviews from people and relatives regarding effective communication. One person told us, "It's hard to understand some of the [staff]. They don't speak English as a first language, so that can be a barrier. They [staff] don't always understand what I ask of them and I don't always understand them. Another person told us, "I have no problems with communicating with them [staff], we understand each other". A relative told us, "The [staff] are very nice but their English language is very poor, so it's difficult to communicate with them, especially if people have hearing difficulties." We spoke with the registered manager who told us, "We do match people with staff who speak the same language. For example Arabic or Somali. We do a strict cultural language and gender specific match."

People received care and support from staff that actively reflected on their working practices. Staff received ongoing supervision, which looked at their skill sets, training needs and staff received feedback on their performance. Staff confirmed they found supervision beneficial to their role. During the inspection we looked at staff files and found only one staff had a completed appraisal. We spoke with office staff who told us staff appraisal records are kept in people's care plans. No further appraisals were provided to us during the inspection however staff confirmed they received annual appraisals.

People were supported by staff that understood their responsibilities in line with the Mental Capacity Act 2005 [MCA]. 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.

People gave consent to care and treatment prior to care being delivered. One person told us, "Yes they [staff] ask for my consent before they do things and help me." Staff were aware of the importance of seeking people's consent. One care worker told us, "I ask them what it is they want me to do". Staff confirmed they would seek guidance and support from their seniors should people decline consent to care and treatment, however would not deliver care without the persons authorisation.

People were supported by staff who had undergone a comprehensive two day induction programme. Upon successful employment all staff were given an induction, this supported staff to understand their roles and responsibilities. The induction programmed followed the Skills for Care, care certificate. The care certificate follows 15 key standards for care workers, which includes, duty of care, communication, person centred working and safeguarding. Care workers informed us they were shadowed by experienced staff on their initial two weeks, or until they were deemed as competent to carry out their role alone. All staff spoken to told us they found the induction beneficial in carrying out their role.

We received mixed feedback from relatives regarding staff's skills and knowledge however we found people

received care and support from skilled and knowledgeable staff. One relative told us, "The [staff] do not have sufficient knowledge/training to deal with a client with Dementia. They do not have the capacity to deal with the risks/warning signs of the situation deteriorating. Other feedback was more positive. One person told us, "They [staff] do appear to be very well trained". Another person said, "They [staff] seem well trained." A relative told us, "They [care workers] certainly seem to know what they are doing." One care worker told us, "I am doing my National Vocational Qualification [NVQ], they [the service] put me forward and support me". Another staff member told us, "I have done a lot of training here". Staff confirmed they had access to training and could request additional training if they felt this was required. Staff files showed staff had attended all mandatory training including, moving and handling, safeguarding, medicine administration and fire safety. At the time of the inspection 5 senior staff were undertaking the NVQ level 5 in health and social care.

Team co-ordinators and care managers carried out spot check visits periodically, to ensure people were receiving quality care in line with good practice. One person told us, "Someone comes out from the office to check sometimes". Another person told us, "Managers [care managers] come by often." Staff told us, spot checks were carried out and they received feedback of the findings. Where appropriate this was then addressed in care workers files. Records confirmed what people and staff told us.

People were supported to access sufficient amounts to eat and drink as agreed in their care plan. We received one negative comment about the food hygiene management of staff, for example, one relative told us, "Basic food hygiene is not adhered to. Out of date food not disposed of and inadequate food offered/given." One person told us, "My family help with my meals, but the carer always makes me a drink before she leaves." Another person told us, "The staff will go to the shops for me to get me any additional food I need, but I prepare my own meals." A staff member we spoke with told us, "I always check what they would like to eat and show them a range of food so they can make a choice." Care plans indicated if people were to receive support around meal preparation to which staff followed. A detailed assessment of people's nutritional requirements was recorded for staff to adhere to. Staff confirmed that if they noticed a decrease in someone's weight or loss of appetite they would record this and then report it to their line manager. We saw records from the service to health care professionals, highlighting their concerns over one person's depleted appetite and requested guidance and support.

Requires Improvement

Is the service caring?

Our findings

People did not always have their confidentiality maintained and respected. People's records were not always kept securely in locked rooms, with only those with authorisation having access to records. Records relating to complaints were not always kept in the main office. We spoke with staff who told us, staff recorded people's concerns in a note book. This was confirmed by the registered manager and the human resources manager. There was no evidence the note books were returned to the office and kept securely or people's complaints were then addressed using the complaints procedure. Staff were aware of the importance of maintaining people's confidentiality however did not identify the issues of documenting people's concerns in a note book and ensuring people's confidentiality was maintained. One staff told us, "You only speak to staff that are meant to know the information, not everyone."

These issues are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care and support from staff that were kind, caring and respectful. People we spoke with spoke highly of their care workers. For example one person told us, "They [staff] are lovely. They come and help me every day, I couldn't do without them." Another person stated, "The carers are very good to me and I like them." A relative told us, "They [staff] are very kind and respectful to my parents; they do exactly as they are asked." A care worker told us, "There is enough care staff."

People had their privacy and dignity respected. One person told us, "I'm very happy with it, the [staff] are smashing. I get embarrassed that I need help, but the [staff] are ever so good to me." Another person told us, "The staff come and see me and keep my dignity." A relative told us, "They [staff] know my relative really well. They are really good and listen to what we want and then do it, and they are really kind and respectful to my relative." Staff were aware of the importance of maintaining and encouraging people's privacy and dignity. One member of staff told us, "I always make sure they [people] are covered up. You need to keep the doors shut so others do not see them when you're helping them with personal care."

People were encouraged to maintain their independence wherever possible. One person told us, "They help me to do things, the things I can't do for myself". Staff were aware of the importance of supporting people to remain independent, one staff told us, "I'm there to help them [people]. Sometimes they need lots of help and sometimes they can do things alone. I am there when they need that help". People's independence was monitored through observations and staff recording information in their care plan daily logs.

People had their health and well-being monitored. People were supported to access health care services if required and agreed in their care plan. One person told us, "I don't need the staff to take me to my appointments, but I know they would if I asked them to." Care plans detailed people's health care needs and level of care and support required. Where people's health care deteriorated, staff recorded their concerns and health care professionals were contacted to give guidance and support. We found examples of staff requesting referrals for people whose health and well-being were a cause for concern.

People were kept informed about what was happening regarding their care and support. One person told us, "Staff talk to me about what they are doing." Another person told us, "They [staff] don't need to tell me what's going on, they know what it is that needs to be done. I can change things if I need to, but all in all things remain the same." People and their relatives confirmed information was shared with them about their care and could make changes as and when they wished.

Requires Improvement

Is the service responsive?

Our findings

People were aware of how to make a complaint or raise a concern. One person told us, "I had to complain once, a while ago, they dealt with it alright." A relative told us, "I have never had a complaint, we've had the service five years and it's always been good." Another relative told us, "I have the supervisor's and the office number." Staff were aware of the correct procedure to follow should someone wish to make a complaint, including documenting the information and sharing it with senior staff. The service had a complaints policy and a service agreement whereby people were given the contact details and information on how to make a complaint. We looked at the complaints file and found the service had received 16 complaints in 2016, which had been investigated and action taken to minimise repeat incidents. For example, one complaint was about a late call, which had been addressed with staff during their supervision. We spoke with a care coordinator who told us, "Notes were kept in general note books belonging to each manager/coordinator and not put in the complaints file." This meant that not all complaints and concerns were logged in the complaints file. The complaints file did not always document the investigation process.

We received mixed feedback about the quality of people's care plans. One relative had concerns about how up-to-date their family members care plan's was. The provider and the local authority were following this up and we will monitor the outcome. People did not always receive care that was person centred and tailored to their individual needs. The majority of people we spoke with told us they had received a care plan review. However one relative told us, "[Relative's] care plan is inaccurate and out of date by four years." One person told us, "The supervisor was only here last week to do the check". Another person said, "I have had a review, the care manager comes out with the care workers." A relative told us, "The Supervisor was out only a fortnight ago and checked everything with us." Care plans were developed which included information and guidance for staff about each person needs. Staff told us they had access to the care plans and that they recorded on a daily basis the care provided at each visit. The service completed care plans which looked at all aspects of people's care, medical and health needs. For example, care plans contained information about people's life history, preferences, medical requirements and care and support required. We looked at people's care plans and found these to be person centred and reviewed regularly to reflect people's changing needs. People were encouraged to contribute and develop their care plans which was evidenced.

People were encouraged to make choices about the care and support they received. One person told us, "I can always change things if I want to, I just ring up the office". Another person told us, "Yes, I do make choices." Staff told us, "People make choices, we [staff] as them what it is they want us to do, they make the decision." We looked at care records and found people's choices were documented in the daily notes made by staff. Staff were aware of the importance of encouraging and respecting people's choices.

People were encouraged to participate in activities and where agreed in their care plans, staff would support people to attend. One person told us, "They [staff] come every day but they know I go to the day centre, so they [staff] come early to get me ready for the ambulance, they know I like my days out." Another person told us, "I don't need their [staff] help to access the community, but I could ask them if I wanted them to help me, but I don't at the moment." There were a wide range of activities people were supported to access for example, swimming, shopping, day centres, bingo, gym, and social groups.

People were protected from social isolation. Staff were aware of the negative impact social isolation can have on people and told us, as soon as they were concerned they would contact their senior and report their concerns. Staff had a clear understanding on the importance of social integration.

Requires Improvement

Is the service well-led?

Our findings

The registered manager failed to ensure systems and procedures were in place to monitor and improve the quality and safety of the service, which did not always highlight areas of concern. The service had in place a quality assurance monitoring team, however audits failed to identify unsafe practices were acted upon to ensure people's safety at all times. The service did not have a robust auditing process in place. For example audits relating to safe medicine management, safe recruitment of staff and on-going disclosure and barring service renews. During the inspection we identified numerous concerns about the way in which the service was managed, which had failed to be identified by the service's auditing system. We addressed this with the registered manager and highlighted our concerns. Subsequent to the inspection the registered manager has sent us an action plan, which details how they will be addressing our concerns.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about the registered manager. A relative told us, "The registered manager is unaware of what actually goes on." People were not always clear on who the registered manager was. One person told us, "I'm sorry, I don't know who that is". However, people were familiar with senior staff members and spoke positively of them. One person told us, "The supervisor [field supervisor] comes out and checks in on me". Another person told us, "If I have a problem I ring [supervisor] she sorts everything out and I ask her for advice and she sorts it. I have had no problems at all." A relative told us, "The supervisor comes and sometimes checks on things and I can ring them if I need to, they are very helpful if you ring."

The manager operated an open door policy, whereby people, their relatives and staff could meet with him. Staff told us the registered manager was approachable and they could raise any concerns with him. However one relative told us, "They [service] do not return your calls when you try to contact them." One member of staff told us, "I do feel supported by the registered manager". Another care worker told us, "I can speak with him [registered manager]." Throughout the two day inspection we observed staff speaking with the registered manager seeking guidance and support.

People received care and support from a service that actively sought partnership working. Records showed where appropriate staff sought guidance and support from health care professionals and where given, staff followed their advice. For example, we saw care plans identify staff recognise deterioration in people's health and request referrals to health care professionals. We spoke with the registered manager who told us, "The links with other organisations is very important. We have linked with charities who have helped people we support with housing and tenancies. We can achieve a lot more for people if we use partnership working."

The service carried out quality assurance reviews to gather feedback on service provision and where appropriate took action to address concerns. One person told us, "Yes they [the service] send me some questions about what I think." A relative said, "I had a questionnaire and sent it back." Surveys included both telephone and home visit reviews across all of the boroughs the provider serves, and annual quality

assurance questionnaires. The service received over a hundred completed surveys, which were in the 2016 file. The surveys we reviewed all gave positive feedback to the agency on the services they received. We found one survey feedback asked for a care review as the time allocated was not sufficient. We found from the care file a review had taken place alongside a referral to social care.