Core Outreach and Care Services Uk Ltd

479 Green Lanes

Inspection report

Core Outreach & Care Services UK Limited
479 Green Lanes, Palmers Green
London
N13 4BS

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18 January 2019

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 January 2019 and was announced.

At our last inspection we rated the service good. However, the key question 'Is this service safe' was rated as requires improvement as we had found some minor concerns with medicines management and administration processes and a lack of information in some care plans around people's risks and care needs.

At this inspection we found the service had not maintained its' overall rating of 'Good'. We found a lack of individualised risk assessments, concerns with medicines management and administration, consent to care had not always been appropriately obtained and documented and a lack of management oversight processes.

479 Green Lanes is a domiciliary care agency who provide a wide range of personal care options to people living in their own houses and flats in the community. It provides a service to older people, some of who are living with dementia. At the time of this inspection the service was supporting approximately 183 people.

Not everyone using 479 Green Lanes receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

A registered manager was in post at the time of this inspection. However, the registered manager was away on leave and was not able to support the inspection process. The deputy manager and other members of the management team were available. 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.

Risks associated with people's care and support needs had not always been identified and assessed so care staff were not given information on how to manage or minimise the risk to keep people safe and free from harm.

Medicines management and administration processes were not clearly followed and documented, which meant that people may not have been receiving their medicines safely and as prescribed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this in practice. However, records kept as part of people's care plans did not always support this practice. People's level of capacity, decisions made in their best interests and consent to care had not been obtained or appropriately documented within people's care plans.

Care plans were person-centred and gave information about people's likes, dislikes and preferences. However, information contained in the current care plan format was not always clear and easy to find. Some statements documented about people were not respectful and did not promote people's dignity.

People and their relatives knew who to speak with if they had any complaints or issues to raise. However, the service did not always record complaints that had been directly raised with the service by people or their relatives.

Quality assurance systems in place did not identify any of the issues we found as part of this inspection process. Care plans, medicines administration records and daily records were not checked or audited to ensure that people were receiving care and support that was safe, effective and responsive to their needs.

People and their relatives told us that they felt safe and assured with the care and support that they received from care staff. Care staff knew about the different types of abuse and were clear on the actions they would take to protect people from abuse.

Safe recruitment processes were followed to ensure only those care staff assessed as suitable to work with vulnerable adults were employed.

Care staff received appropriate training and support to effectively carry out their role. This included induction, refresher training, supervision and an annual appraisal.

People were supported with their nutrition and hydration needs where this was part of the person's package of care.

The service supported people with their health care needs where required. Where people required additional care, appropriate referrals had been made to the relevant healthcare professionals.

People and their relatives told us that care staff were caring and engaged with them whilst supporting them with their needs.

Most people and their relatives knew the deputy manager and other office staff more than they knew the registered manager.

At this inspection we have made two recommendations around best practice when applying the principles of the MCA 2005 and managing complaints. We also found the provider to be in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risk assessments had not been completed to assess people's individualised risks and provide further guidance to staff on how to minimise the risk.

People may not have been receiving their medicines safely and as prescribed due to the lack of appropriate recording and monitoring.

Appropriate recruitment processes were being followed to ensure only those staff assessed as safe to work with vulnerable adults were employed.

People told us they felt safe with the care staff that supported them. Care staff understood how to safeguard people from abuse.

There were sufficient numbers of staff available. People confirmed that they received care and support from a regular team of care staff.

Is the service effective?

Requires Improvement

The service was not always effective. People's capacity to make decisions, decisions made in their best interest and consent to care was not always clearly documented.

Care staff understood the principles of the Mental Capacity Act 2005 and how this impacted on how they supported people.

People's needs were assessed prior to any package of care being introduced.

Care staff received appropriate training and support to effectively carry out their role.

People were supported with their nutrition and hydration where this was an identified and assessed need.

The service supported people to access health care services where this was a required need.

Is the service caring?

Good

The service was good. People and their relatives told us that care staff were kind, friendly and good and supported them in a caring manner.

People and their relatives had been involved in the planning and delivery of their care.

People and their relatives confirmed that their privacy and dignity was always maintained and that they were always treated with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. People and their relatives knew who to speak with if they had a complaint or concern to raise. However, the service did not record any complaints raised directly by people or their relatives.

Care plans were person centred and gave information about people's likes, dislikes and preferences. However, these were not always full completed, information in different sections was inconsistent and significant information that had been recorded was not always easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well-led. Lack of appropriate quality assurance systems did not enable the service to check or identify concerns so that improvements could be made. The service had not picked up any of the issues that we identified through this inspection process.

Written references about people and their care and support needs were not always respectful and did not promote the person's dignity.

The service encouraged people and their relatives to engage with them in giving feedback about the quality of care and support they received so that improvements and further development of the service could be explored.

Staff told us that the management were supportive and were always available when needed.

The service worked in partnership with the local authority and other healthcare professionals to ensure that people received appropriate care and support.

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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 17 and 18 January 2019 and was announced. We gave the service 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with the inspection process.

This inspection was carried out by two adult social care inspectors, an assistant inspector, a pharmacist inspector and four experts 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. The experts by experience supported this inspection by carrying out telephone calls to people who used the service and their relatives.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with 24 people using the service, 20 relatives, ten care staff, a field care supervisor, an office administrator, a care co-ordinator, a care manager, an office manager, a HR officer and the deputy manager. On the second day of the inspection we also spoke with the registered manager who had called us to get feedback on the inspection findings.

We reviewed the care records for 15 people receiving a service to see if they were up-to-date and reflective of the care which people received and six people's medicine administration records. We also looked at

personnel records for 12 members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including complaint and safeguarding records, to see how the service was run.

Requires Improvement

Is the service safe?

Our findings

Feedback from people and their relatives was that they felt safe and reassured with the care and support that they received from their care worker. People told us, "I feel that I am safe and my home and things", "I feel really safe and trust my carer" and "I feel safe with them, yes, I do, they are good." One relative explained, "Yes, they know he is epileptic and away from that when hoisting him they are aware of how he should be handled; they are very sympathetic of how to handle [person]. He knows them and they know him, they trust each other. They know how to keep him safe." However, despite this positive feedback we found that the service was not always safe.

At the last inspection in December 2016, we found minor concerns with the lack of detail recorded in a person's care plan about the care and support they required. This meant that care staff were not given the information that they required to support the person safely. During this inspection we found that although care plans contained information and clear direction on the support people required, risks associated with the person's health and social care needs were not identified and assessed. Risk assessments were not always completed fully and where risks were identified, information was vague and guidance to care staff on how to minimise the risks was not recorded.

For one person who had epilepsy and was at risk of choking there was no risk assessment completed giving detail about how the person's diagnosis of epilepsy affected them, the type of seizure that they presented with and how staff were to support them during the seizure to keep them safe. The care plan only contained generic guidelines on choking and epilepsy. The information had not been adapted to the person's personalised needs.

For another two people, who required support with their moving and handling and had specific handling equipment in place to support this, there was no moving and handling risk assessment in place. Furthermore, there was no information about the type of equipment being used, the type of sling to be used and the specific settings at which the sling was to be used which would be specific to the person. For both these people, the risk assessment had identified them to be at risk of pressure sores, however, no further information or guidance had been provided on how to minimise the risk.

One person had been identified with behaviours that challenged the service. The care plan recorded, ''Fear of aggressive behaviour towards the care assistant'. There was no risk assessment in place which detailed the person's behaviours and any known triggers and guidance to staff on how to support the person and to ensure their safety and the safety of the vulnerable person.

At the last inspection in December 2016, we found minor issues with systems in place to ensure safe management and administration of medicines. People's prescribed medicines, especially those dispensed in a dossette box were not always clearly listed in the person's care plan or on their Medicine Administration Record (MAR). Dosette boxes are pre-packed boxes, normally prepared by a pharmacy, for each time the medicine is required. Eye drops that had been prescribed to people had not been listed on a MAR or the care plan, so that staff could record administration. The service was not aware staff were supporting some

people with the administration of eye drops. People were receiving medicines earlier than prescribed especially in the evenings and the service did not complete competency assessments of staff to ensure the competency of staff administering medicines. We had made a recommendation to the provider at this time.

During this inspection, we found that the recommendation made at the last inspection had not been addressed. Medicines were prescribed by individual GPs and in most cases delivered to people by local pharmacies. We saw records confirming that care staff made attempts to ensure that people had enough medicines supplies by liaising with other healthcare professionals.

Care staff administered medicines from dossette boxes and signed MARs to confirm people had received their medicines. However, not all care plans or MARs recorded the full list of medicines that were administered especially including those administered from their original packs such as inhalers or antibiotics or 'as and when required' medicines.

We asked the service what happened when people were prescribed antibiotics which were not in the dossette box. The registered manager told us that these medicines could only be given if there was a letter of authority from the GP to allow them to give the medicines from an original pack. However, the provider's medicines policy stated: 'Do give medicines from the container in which they are supplied.' This suggests that practice was not in line with the provider's medicines policy.

Medicines risks assessments had not been completed for those people who required support with medicine administration. This meant that significant information about the support the person required and any identified risks had not been recorded. The records only stated if medicines support was included in the care package or not. The records we saw were not person centred. People's care records did not detail where medicines were stored for each person. Staff at the service said that each care worker knew this information for the person they supported. However, if new care staff had to provide medicines support, there was no record of this information to assist them.

Allergy information was documented on the medicines care plan stored in the office, however, they were not completed on the medicines administration records that we saw. This meant that care staff did not have access to allergy information at the point of medicines administration within the persons home which may have resulted in them being administered medicines that they may have been allergic to.

Whilst care staff were trained to do medicines tasks, the records kept of their competency assessments were not comprehensive. The form assessed a range of competencies but relating to medicines, the only competency assessed stated: 'Is medication accurately recorded?' Therefore, it was not clear which competencies were assessed before care staff could provide medicines support. Medicines competencies were assessed by one member of staff. This meant that this individual was responsible for assessing and reassessing the medicines competencies of 66 care staff. We saw that 17 care workers did not have a record of when they had completed their medicines competency assessment. In addition, care staff were required to complete medicines training every three years. This was not in line with national guidance which states that medicines training should be refreshed annually.

The service did not keep any records relating to medicines errors, especially where medicines doses were missed due to missed visits. Therefore, we were not assured that any necessary clinical follow up was made. Although MARs were returned to the office for safekeeping at the end of the month, they were not reviewed by any staff member. This meant that there was no process for proactively identifying medicines concerns and dealing with them. For example, we saw that there were gaps on the MAR chart for one person on the 6 January 2019 and 13 January 2019. When we looked at progress notes, we could see that care staff had

administered medicines that day. However, the MARs had not been audited and the gaps we found on the MAR had not been identified by the service.

All of the above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Over the previous 12 months the service had a high number of safeguarding concerns raised by local authorities who had identified concerns or where complaints and concerns had been raised by people and their relatives about the quality of care and support that they received. We spoke with the deputy manager about these concerns who explained the processes involved in dealing with and investigating all concerns raised. Records seen confirmed the process and included details of the investigations undertaken and actions taken to ensure people were safe.

Records confirmed that care staff received safeguarding training on an annual basis. All staff that we spoke with knew about the different types of abuse, how to identify signs that may implicate possible abuse and the steps they would take to report their concerns. Care staff knew how to 'whistle blow' and named the appropriate authorities they would contact, including the CQC, if they needed to escalate their concerns.

Recruitment processes enabled the service to check care staff suitability to ensure that only those assessed as suitable to work with vulnerable adults were recruited. Checks undertaken included proof of identity, right to work in the UK, criminal records checks and references evidencing conduct in previous employment. Care staff were unable to begin work until these checks had been completed.

Recruitment of care staff was continuous due to the nature and demands of the service that was being provided. Rotas showed that care staff were allocated travel time between each care call. This was confirmed by care staff that we spoke with. Feedback from people and their relatives was that they generally received care and support from a regular team of care staff who mostly arrived on time. Where care staff were running late most people or their relatives received a phone call informing them of this and an expected time of arrival. Some people and their relatives did give examples of where care staff did not arrive on time which left them waiting to receive the care and support they required and which resulted in them doing what they could themselves or their family helping them with their needs where possible.

People's feedback included, "They come very late about 9.30am, I would like them to come earlier. I just have to wait", "If they're running late they give me a ring. I've never been missed" and "Yes, they arrive on time, sometimes they are a little late, but not enough to complain." Relatives told us, "If carers are late (rare) they'll phone. They've never not turned up", "Irregular at weekends", "If they are going to be a bit late coming, they ring" and "They are meant to be here at 9am but they come at 9.30. Its not a problem for me but it's a problem for mum, because she wakes up early."

Systems were in place to document all accidents and incidents. The service had no recorded accidents or incidents since the last inspection. Templates of documents that would be used to record incidents included details of the incident, the actions taken and where appropriate any learning or improvements required to ensure people's safety. We discussed with the deputy manager possible scenarios of incidents or accidents that care staff should report and record. The service demonstrated a good level of understanding of what could be classified as an accident or incident to ensure care staff were actually reporting where required.

Care staff received training in infection control and how people were to be protected from the risk of infection. Care staff had access to a range of personal protective equipment which included gloves, aprons

and shoe covers. We observed that care staff were able to come to the office and collect the equipment that they required.

Requires Improvement

Is the service effective?

Our findings

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS. We checked whether the service was working within the principles of the MCA.

We found that care plans did not always document consent to care. Where signatures had been obtained on people's care plans, it was not clear whose signature had been obtained, in what capacity and what they were signing for. Where relatives had signed consent to care on people's behalf there was no information about their relationship to the person and their legal authority to sign documents on the person's behalf.

Where people lacked capacity to make specific decisions about their care and support decisions, the service had not documented any information relating to this and where appropriate, decisions that had been made in the persons best interests had not been recorded. This meant that people may not have been receiving effective care and support that followed the key principles of the MCA.

We highlighted this to the deputy manager and office staff present during the inspection who all demonstrated a good understanding of the MCA but had not applied its principles in practice. Care staff clearly understood and gave examples of how to support people in line with the key principles of the MCA. One member of care staff explained, "We take the time to listen to what's going on, we give them choice, it takes a lot of patience. We prompt and we pay attention. It all depends on them."
We recommend that the service follows current best practice, in line with the Mental Capacity Act 2005, especially when assessing and recording people's mental capacity and where decisions have to be made in the person's best interest.

The service aimed to assess people's needs and requirements prior to accepting the care package so that they could determine whether they could effectively meet the needs of the person. However, we were told by the service that in reality this was not always the case because when referrals for the provision of care were received, care was generally required to start in some cases on the same day as the referral. The service then used the information received on the referral as a basis to commence care and aimed to visit the person in partnership with the person's representative, where applicable, as soon as possible. Following the assessment a care plan was compiled which listed the person's care and support needs.

Care staff received regular training and support to enable them to carry on supporting people effectively and safely. Records confirmed that training was provided in topics which included safeguarding, medicines management and administration, MCA, first aid and moving and handling. All new care staff employed were required to complete an induction which included completing a variety of training courses as well as shadowing experienced members of staff until the new staff member felt confident to work independently.

Care staff confirmed that they received regular training as well as supervision and annual appraisals which further supported them in their role. Records listed the topics that were discussed which included a review of the staff member's performance, strengths, what could have been done better and any identified training needs.

Overall feedback from people and their relatives was that they felt the care staff that supported them were appropriately skilled and trained. One person told us, "All experienced very, very good." Another person stated, "Oh definitely. Even the nurses comment on how good they keep my skin, all the pressure points and that." Comments from relatives included, "Oh God yes, they are brilliant, I am always asking what do you think of this or does [person] seem a bit poorly today. Sometimes I need a second opinion on things and they seem quite knowledgeable" and "We have always had people who are knowledgeable, and helpful with my husband. If they were not, I would tell the office."

The service supported people with their eating and drinking needs where this was an identified need. People confirmed they were offered choice and were always left with drinks before the care staff left. Care plans listed people's likes and dislikes in relation to food and drink and any specific dietary, cultural or religious requirements. One person told us, "I can do my own meals. They make a drink." Another person said, "Yes she used to check everything with me but she knows what I like now and we worked out a routine."

Care staff recorded their daily observations and tasks that they had completed on contact sheets held at the person's home. Information recorded included the tasks undertaken, whether the person had been supported with their medicines and what the person had eaten or drank. Where significant observations or concerns were noted by care staff this was also recorded and reported to the office so that appropriate action could be taken. This included referrals to a variety of healthcare professionals.

People and their relatives confirmed that care staff were attentive to their and their relatives needs, recognised changes in health or care needs and contacted the relevant health and care professionals where needed, especially in emergency situations. People told us, "Yes, they [care staff] rang for an ambulance, stayed and contacted family" and "Once I had a problem trying to get a blood test and the carer did arrange it for me." Relatives feedback included, "I feel her healthcare needs are all met and that her carer will tell me anything" and "Yes, I remember he [person] was having a rash on his leg and they told me and I booked an appointment with the GP."

Good

Is the service caring?

Our findings

People and their relatives described their allocated care staff as "kind", "caring", "loving", "helpful" and "efficient." They told us that they had established positive relationships with the care staff who they relied on. One person told us, "Loving care I call it." Another person explained, "Very nice people, they treat me like a human being, when I am not happy they cheer me up, I look forward to seeing them. When I cry they give me a shoulder, everyone is so good." A third person said, "Yes, they have manners, they come in gently and ask us where things are. I can see that they are caring, the couple that come here are lovely."

Relatives' feedback included, "He's had the same man for all three visits, he is caring, he chats to him, takes an interest, he's very sociable", "Oh, they are lovely, They are friendly. Oh, and when they are going, they wave at him, he has his own way of communicating, they are lovely" and "Yes, I think he is a caring person, he always asks how are you and is gentle and kind."

We asked people and their relatives about whether they had been involved in the care planning process and whether care staff involved them in the delivery of their day to day care needs. Everyone we spoke with confirmed they had. One person told us, "My [relative] did most care planning and hospital too, and I'm involved in my own care too." One relative explained, "They [service] came to us after he was discharged from hospital and talked to us and we told then what we wanted and got what we requested."

Care staff told us that they always involved people in their care and always asked people's permission and choice on what they wanted support with. One care staff told us, "I will ask if they want to do anything on the day."

People and their relatives confirmed that care staff were always respectful of their privacy and dignity and were able to give examples of the things they did to support this. One person told us, "When I've had shower they wrap towel round me and when dry me off keep covered while they do things and protect my dignity." One relative explained, "Oh yes, most of the time they ask are you ready to bathe? or can I help to remove your clothes? They shut the door behind them, these things they do makes me know they respect privacy." Care staff also gave a variety of examples of how they respected and maintained people's privacy and dignity. One care staff told us, "I make sure all doors are closed. I will tell them what I am going to do."

Staff understood people's needs in relation to equality and diversity and that each person was different and possibly had different needs and requirements due to their religion, culture or sexual orientation. One care staff told us, "I have an interest in the person, so I get to know about them which means I also learn about their culture."

Care plans gave some basic detail about people's religions and cultures but did not always describe any significant information that care staff may need to know to fully understand and support with people's religions and cultures.

Requires Improvement

Is the service responsive?

Our findings

Care plans detailed people's care needs and the tasks to be undertaken by care staff allocated to support them. An overview of support needs detailed specific tasks that needed to be completed by care staff in response to people's needs.

A home support plan was also available within the care plan which combined risk assessments, social and life histories, medicines support and consent to care. However, these documents were not always fully completed, information in different sections was inconsistent and significant information that had been recorded was not always easily accessible. For one person who used specific moving and handling equipment, information was not available on the type of equipment being used, the size of the sling to be used and the specific dimensions of the equipment to be used that were specific to the person and their needs.

All care plans included evidence of a six-monthly review or sooner where people's needs had changed. However, where change had been noted in a person's care or medical needs, the care plan had not been updated to reflect this. For example, for one person who during a review had been identified as having a pressure sore, their care plan and risk assessment had not been updated to reflect this change.

People's care plans were person centred and detailed their likes, dislikes and preferences on how they wanted to receive their care and support. Care plans recorded ways in which people were to be supported to maintain their independence so that care staff were aware of people's level of need. This enabled them to support people in ways which were responsive to those needs. One person's care plan recorded, 'To promote independence, please allow [person] to do as much as she is able to do for herself'.

All of the above meant that people were at risk of not always received care and support that was responsive to their needs, We showed the deputy manager and other senior members of staff the issues we had identified, who told us that they would immediately review all care plans to ensure that these were current and reflective of people's needs.

The service recorded all complaints that were raised with them by a local authority. We saw records detailing the nature of the complaint, the actions taken to investigate and resolve the issues raised and a response to the complainant with an apology for the poor level of care they may have received. However, we did not see any information about complaints received from people and their relatives directly. We asked the service about this, they confirmed that they did not record any complaints directly received from people or their relatives. Therefore we were unable to see how people's complaints were acknowledged, addressed, resolved and learning and improvements implemented as a result.

We recommend that the service ensures it follows its complaint policy and best practice in managing complaints.

People and their relatives knew who to speak with if they had a complaint to raise and were generally

confident that their issues or concerns would be resolved to their satisfaction. People's comments included, "If I had a problem with the service, I would tell the office and no messing about", "They're very respectful, no problems. I think they do listen to me" and "Well I would phone the office to complain, but I have never complained." Relatives told us, "I would complain to the Manager if there were any problems and I think I would be listened to", "Yes, I do know who to complain to. I wouldn't put up with anything I didn't like for me or [person]" and "Yes, I have the manager's contact or managing directors contact number. They know I won't keep quiet."

Requires Improvement

Is the service well-led?

Our findings

During this inspection we found that the service did not have the appropriate systems in place to monitor and oversee the quality of care and support that people received. The service had not identified any of the issues we found as part of this inspection. This included the lack of individualised risk assessments, issues with the management and administration of medicines, lack of documented evidence that people had consented to their care and support package and care plans that were not always current and responsive to people's needs.

Quality assurance processes in place only included unannounced spot checks of care staff whilst providing care, phone calls to people and their relatives to obtain feedback about the care and support that they received and annual satisfaction surveys that were sent to people and their relatives again to obtain their feedback. Care plans, daily records and medication records were not audited to check if they were current and if they had been completed fully and appropriately. This meant that the registered manager and the service did not have sufficient oversight about whether people were receiving safe, effective and responsive care and support. Therefore, the service was unable to implement any learning or developments to improve the quality of care people received.

Records kept about people were not always respectful and did not promote dignity. Language used in some care plans was inappropriate. One care plan documented, 'Service User can't be bothered to do anything sometimes. Watches TV when she's in the mood.' Another care plan recorded, 'Friends visiting all the time. Dysfunctional family'.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives did not know who the registered manager was but had more contact with the deputy manager, the care coordinator and the care manager who were always available, answered their call and who they were complementary about. People told us, "[Name of deputy manager] might be manager or assistant manager, and there's another fellow, they're very good and good-natured" and "I call him [deputy manager] if I need anything he is a good man, he listens." Relatives' feedback included, "Yes, [deputy manager] is alright, Like I said I complained about the time keeping and they listen" and "I think they are brilliant. I would pick up the phone and speak to them, I think they are like a family."

Care staff also spoke positively about the management and that in addition to formal supervisions and annual appraisals, a member of the management team was always available to speak with them when they needed. Regular staff meetings also gave them the opportunity to share practices and experiences, learn and give their own ideas and suggestions on how to further improve and develop the service. One care staff told us, "Manager is good, they listen to our views and help us." Another care staff told us, "It depends on concerns and issues raised through weeks and months which include medicines and recording. They are engaging."

Satisfaction surveys were sent to people and their relatives every six months. Feedback was overall positive. People were generally happy with the service they had received. People and their relatives confirmed that they were asked to complete satisfaction surveys to give their feedback about the care and support that they received. Some people and their relatives stated that they also received phone calls from the office to check how they were and if they were happy with the care that they were receiving. People told us, "I filled in a questionnaire last year about my carer" and "They have asked me how carers are doing and do I get on with the carers. Well I am quite happy with them, they are kind and everything." Relatives' feedback included, "I've probably had a questionnaire but I would just fill it in blindly because they're so good", "I have regular minimum annual meetings, and ad hoc should I request it. They're open to suggestions" and "We have face to face meetings and go through the care plan and have received questionnaires. Sometimes I get questionnaires and I do complete them. But I think they are a good service."

Staff were also asked to complete annual staff satisfaction surveys. The survey asked staff questions around training, whether they feel supported and if they had any suggestions for improvement. Feedback given was generally positive. The registered manager reviewed all completed surveys and where suggestions had been made this had been recorded so that learning could take place and improvements where possible could be implemented.

The service told us that they worked in partnership with the local authority by attending provider meetings and training sessions where providers from the locality were invited to engage with the local authority and each other to learn and share experiences and practises. In addition to this the service also worked with social workers, district nurses, occupational therapists, day centres and the hospital discharge team to ensure people received the care and support that they required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always assess people's risks associated with their health and care needs. Sufficient guidance and instruction was not always provided to care staff to minimise or mitigate any such risks. Medicines management and administration was not safe. People may not have been receiving their medicines safely and as prescribed.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not adequately assess, monitor and improve the quality and safety of the service that they provided.