Saren Limited

Carewatch (Swindon)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Carewatch provides domiciliary care and support services to people with individual needs in their own homes. At the time of our inspection 65 people were being supported by this service under the registered regulated activity of personal care. A further 35 people were receiving domestic visits from the service including support with shopping and cleaning, which was not included in the inspection. This inspection took place on 1 June 2016. This was an announced inspection which meant the provider had prior knowledge that we would be visiting the service. This was because the location provides a domiciliary care service, and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

At the time of our inspection a registered manager was in place at the service. 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 registered manager and the managing director were accessible and approachable throughout the inspection.

Risks to people had not always been identified and risk assessments that were in place lacked detail to support a person. Care plans relating to a person's life history or a specific health condition also lacked detail and guidance for staff. This had been identified and was on an action plan to be addressed.

People were protected from unsafe care by staff who demonstrated a good understanding of safeguarding and whistle-blowing procedures. They knew how to report concerns and had confidence in the registered manager that these would be fully investigated to ensure people were protected.

Staff were appropriately trained and skilled. They received a thorough induction when they started working for the service. Staff received support through regular supervisions with their line manager.

People and relatives were very complimentary about the caring nature of staff. Staff were knowledgeable about people's needs and people's privacy and dignity was always respected.

People had the opportunity to provide feedback on the service; this took place through an annual survey and telephone monitoring calls. People's needs were regularly reviewed and updated accordingly.

People, their relatives and staff felt the service was managed well and could approach the management team if they needed too. The quality of the service was regularly monitored and effective systems were in place which identified shortfalls and took appropriate action.

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 mostly safe.

Risks to people's personal safety had been assessed; however the assessments did not always contain enough detail in order to support the person appropriately.

Protocols for medicines were not always in place for staff to follow.

People were protected against the risks of potential abuse by staff who had the knowledge and confidence to identify safeguarding concerns, and acted on these to keep people safe.

The recruitment and selection process for potential employees was thorough, and gave a good insight into the nature of the role.

Is the service effective?

Good

The service was effective.

Staff were appropriately trained and skilled. They received a comprehensive induction when they started working for the service and regular support through supervisions with their line manager.

For people that were supported with meal preparation and food purchases, staff were trained to encourage a balanced diet where possible.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the care they received.

People's privacy and dignity were respected. People were involved in making decisions about the support they received.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Care plans did not always contain enough detail about a person's background or information relating to specific health needs.

People's concerns and complaints were encouraged, investigated and responded to in good time.

The service valued people's feedback and acted on their suggestions, sending an annual survey out and conducting telephone monitoring calls.

Is the service well-led?

Good

The service was mostly well-led.

Notifiable incidents had not always been reported to the Care Quality Commission (CQC).

People, their relatives and staff had confidence in the management team. They told us they could approach them at any time with concerns or queries and these would be addressed.

The provider had effective systems in place to monitor the quality of the service and identify any shortfalls.

Carewatch (Swindon)

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 1 June 2016. This was an announced inspection which meant the provider had prior notice that we would be visiting. This was because the location provides a domiciliary care service to people in their own homes, and we wanted to make sure the provider would be available to support our inspection, or someone who could act on their behalf. The inspection team consisted of one inspector, and an expert-by-experience who made phone calls to people to gain their feedback on using the service. 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 service was previously inspected in September 2013 with no concerns. This inspection was the service's first rated inspection.

Before the inspection we checked the information we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also reviewed the provider information return (PIR) prior to this inspection. 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 used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 13 people being supported by the service, five relatives, and six staff members. These conversations took place by telephone. We spoke with the registered manager and the managing director face to face during our inspection. We reviewed records relating to people's care and other records relating to the management of the service. These included the care records for seven people, medicine administration records (MAR), four staff files and the provider's policies.

Requires Improvement

Is the service safe?

Our findings

Risks to people's personal safety had been assessed; however the assessments did not always contain enough detail in order to support the person appropriately. For example one person had identified risks around mobilising. We saw a moving and handling assessment had been completed and the risk assessment categorised the person as high risk, however the risk management only stated that the person was 'To use walking frame at all times'. There was no further detail for staff to follow or documented actions taken to minimise the risk. Another person's mobility risk assessment stated the 'Carer to ensure customer concentrates when mobilising'. For a further person, the mobility risk assessment documented simply 'assist to mobilise'.

We saw a recent audit completed by Carewatch had picked up that risk assessments lacked detail and was on the managing director's action plan which was currently being addressed.

If a person had experienced previous falls, a falls prevention assessment was to be completed. However we saw for one person it was documented they had experienced several significant falls and sustained extensive injuries; alongside this the person also had vertigo and would be unsteady on their feet. No falls prevention assessment had been completed and it was further documented this person was at no risk of injury from slips or falls. We raised this with the registered manager and managing director who said it would be addressed.

One person's risk assessment documented they did on occasion 'wander outside'. We could find no further details on this in the person's care plan or how staff were to manage this situation. The managing director explained that if staff arrived on a visit and the person was not home, they all knew to follow procedures but agreed this needed documenting in the care plan.

The service had put in place an electronic monitoring form recording if people had safety equipment, such as smoke detectors, carbon monoxide detectors and key safes in their homes. Although the service was not responsible for the maintenance of these, they wanted to be aware in case of a problem, or the information needed passing on to the appropriate authority.

Peoples' medicines were mostly managed and administered safely. However we did see two examples where the documentation relating to protocols was not in place. For one person it was documented they 'Sometimes struggles to swallow tablets'. No information on what staff should do to support this person taking their medicine had been documented, or if the person's GP had been involved to review the format the medicine was given in. Another person had been prescribed medicine to take 'as required' (PRN), but there was no protocols in place to guide staff. The managing director explained this person had capacity and was able to tell staff if they required this medicine. We saw that the new format care plans being put in place for the end of June 2016 contained a form on medicine support that was more detailed and specific to each individual and was clearer on directing staff to follow stated protocols.

One person was on a medicine patch but there was no accompanying rotation chart to guide staff where to

place the patch each time. We raised this with the registered manager who said the paperwork was in place and showed us the document normally used. The registered manager said it was an oversight that it had not been collected and put with the medicine administration record (MAR) and that this would be found and addressed.

Care plans documented that people had been asked if they required assistance with taking their medicines, and if so if this support was preferred by a prompt or full assistance. All staff that completed a MAR chart for a specific person had to sign and clearly print their name on a separate sheet each month, so their signatures could be easily identified and related to the individual staff member should they need to be traced.

New MAR sheets had been put in place that blocked out all other times and days when a person did not take medicine. This made it clearer for staff to recognise when a person needed their medicines and reduced the potential for errors. We saw guidance was in place to support staff in completing a MAR chart. One staff member told us "I have had basic training to ready me for the administration of medication and marked as competent. I have been monitored through our shadowing scheme which every new carer must complete with an experienced carer to observe the provision of care including medication. Also all provision of medication is recorded on a MAR and checked by senior staff on a monthly basis or through random visits to the client's place of residence".

We saw the last serious medicine error had been in March 2015, and the appropriate action had been taken. This included contacting the person's GP on the action to take. The person concerned also received increased visits from the service to check they were well.

People were protected against the risks of potential abuse by staff who had the knowledge and confidence to identify safeguarding concerns, and acted on these to keep people safe. We spoke with 13 people who all said the service was safe, and that they had never experienced any form of bullying or harassment. One person commented "I've had Carewatch for six years and I feel safe".

One member of staff said "I would contact my supervisor, the on-call, or the office to report my concerns and make discreet note of the circumstances and after leaving the call would document what I had seen and pass this to Carewatch. I have not experienced such a situation". Other staff comments included "I wouldn't hesitate to report to the manager or CQC", "If I saw something I wasn't happy with I would raise it, my main concern is the person's safety" and "Any concerns I would report to the manager, and if not being dealt with I would go higher to CQC, or Wiltshire safeguarding".

All people using the service had been given a service user guide which detailed the process staff members have gone through before being employed. This included the checks and references obtained to reassure people only suitable staff would be employed to support them. The guide further detailed what a person should do if they had experienced any form of abuse.

The service had a contingency plan in place in case of an emergency such as staff shortage or adverse weather conditions. We saw 'Customer crisis plans' which categorised the care visits in priority order of who could not have a visit missed, to people who had family nearby that could attend, or if the visit was a domestic visit only. At the initial assessment family were asked what they could possibly cover in a crisis and this was documented in people's care plans. The field care supervisors in the office and the registered manager were also trained in a care role, so they could cover when required.

Personal information was handled in a sensitive manner, this included people's key safe codes which

enabled staff to access a person's property if they were unable to open the door. Key safe numbers were sent to staff securely and were encrypted so they did not identify the person.

People were supported by sufficient levels of staff. We looked at staff rotas which showed people were supported by regular staff who they had got to know. One staff said "I support regular people and have the same rota; we have enough staff and enough time to support people". Another member of staff said "Weekends are a bit short but on the whole it is ok, most staff are willing to cover shifts".

Relative's also commented saying "The carers turn up on time", "Staff turn up on time as much as traffic allows", "We have a regular team of carers", "Calls are always covered, never had a missed call" and "They turn up and have not missed a visit". The regional operations director told us "When a referral comes through we look at the staff base to see if we can take it on safely, we like to leave a buffer in case of sickness".

We looked at four staff files and found the recruitment and selection process to be thorough. The staff files showed that all checks are completed including sourcing two references and a Disclosure and Barring Service checks (DBS). A DBS check helps employers make safer recruitment decisions and prevents unsuitable people working with vulnerable people. The service had ensured that staff had suitable vehicle insurance in place to attend visits and that a health declaration was completed prior to starting employment.

Good

Is the service effective?

Our findings

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. There was mandatory training of core skills for subjects such as manual handling, medicines training, dementia awareness, health and safety and safeguarding adults, and then specialised training available dependent on an individual's specific health needs. We saw in one person's care plan that the regular staff attending care visits had all received specialised training relating to a particular health condition this person had. It was documented that this training only related to this person and could not be transferred to anyone else. These staff members received refresher training on this annually.

A qualified trainer was employed within the service and had previous experience of caring and also continued to attend some care visits. We looked at the training for staff and saw staff were supported to refresh their knowledge regularly. Refresher training was provided face to face, and prior to this a workbook was sent for staff to complete. This allowed the trainer to identify any gaps in a staff member's knowledge so these could be specifically covered in the refresher session. A second workbook was then completed after the training.

One member of staff told us "The moving and handling, Mental Capacity Act and dementia awareness training modules are part of the ongoing training we are given after completing our basic Induction. Where we feel unsure of a procedure we have access to our training manager who will provide one to one training or small groups of carers with similar concerns". Relatives we spoke with felt staff had the necessary skills to support their loved ones saying "Staff are well trained", "They are very experienced carers" and "The carers know what they are doing".

The staff were supported in achieving higher qualifications, and we saw 8 staff members had completed a diploma level 2 in Health and Social Care. The managing director told us a sample group of staff were currently completing their dementia awareness level 3, with the intention to offer it to all remaining staff who would be interested, commenting, "Although we are a small provider, we do offer opportunities to staff when they arise". Once staff had achieved their diploma a higher rate of pay was awarded as an incentive.

The service had purchased videos to go alongside staff training which provided further insight and knowledge. If staff chose to watch these their records were updated to reflect this accreditation. The service also planned to share the videos with people using the service and their relatives who may want to broaden their understanding in a particular area, or are helping to care for someone.

New staff were supported to complete an induction programme before working on their own. This included four days in the office prior to being officially employed completing mandatory training. The managing director said at the end of the four days the potential new employee has an idea of what their role will entail and can walk away at this point if they feel it's not suitable for them. It also allows time for the office management to learn more about the potential new employee.

The Carewatch footsteps programme monitors and supports a new member of staff over their first three months in their role. This includes observations, shadowing and further training. One staff member told us "The induction was informative; it made me confident to do the role". Another staff member said "At the end of shadowing there is always a surprise visit from one's allocated supervisor to monitor your handling of a client care package, and you are either okayed for single visits or recommended for further training as required". We saw staff records contained an induction probation support checklists, of what needed to be achieved during this time. When a person had been observed doing parts of their role and their competency assessed it was ticked off and signed by the senior observing. End of probation reviews were clearly documented.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. The service operated several types of supervisions which included on-site observations, office supervisions and group support supervisions. We saw supervisions had been clearly recorded, and letters in staff files informing the staff when their supervision was due and what type of supervision it would be. Spot checks were also carried out on a regular basis and these looked at things including staff member's arrival time, presentation, if the support plan was checked and if a person was addressed appropriately.

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 legally authorised under the MCA. For people receiving care in their own home, this is as an Order from the Court of Protection. The registered manager confirmed this didn't apply to anyone receiving the service at the time of this inspection.

We saw in one person's care plan it stated staff were to ensure the back door was locked. The front door had a key safe entry. There was no evidence to support a discussion had been held with the person or family to conclude locking the back door was an agreed decision. The managing director explained that this person had fluctuating capacity and when the back door was locked the key remained in the door and staff had no need to touch it. This had been discussed with the person's family and was what they had asked Carewatch to do.

The managing director further said if there were concerns raised about a person lacking capacity a referral would be made to social services or the mental health team, saying "We have not done any best interests decisions yet as the forms were not in place, but this was identified and we now have new forms available to be put in place where needed, that will allow us to document this".

We looked at the new format and saw they asked if a person had appointed someone to oversee their affairs and make decisions when they lacked capacity to do so. There was a form for best interests decisions to be documented and Mental Capacity assessments where required. The managing director said this would "Capture the missing bits, we will implement this at each person's review and tidy up what we already know, and evidence it".

For people that were supported with meal preparation and food purchases, staff were trained to encourage a balanced diet where possible. If concerns were raised about a person's nutritional intake, a food and fluid monitoring chart would be put in place. The service would work alongside community nurses and nutritionist's, documenting the evidence so external professionals could act upon it and where necessary referrals were made.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments from people included "I like my carers and their attitude", "I get on well with them, they come when promised, and are efficient and help when I'm ill", "Have been with them for seven years and am happy, I don't want to change anything", "They are like friends and always chatty" and "The staff are always cheerful and frequently joke with me". The managing director said "We try and build a team of staff to give continuity for people". One member of staff commented "The service does a pretty good job of matching carers with the person who requires care".

Relatives we spoke with felt reassured by the way staff cared for their relatives saying "They show genuine care, they work hard, and try to go as far as they can", "Very friendly carers", "We are happy with the carers, very kind and considerate", "They are here for me" and "They know my relative, they understand him". One staff member told us "I read the care plan and the profile sheets the office provide when you go in to a new person for the first time. I will also spend a little extra time on the first visits to introduce myself and try to gain some knowledge of their background".

We saw people were encouraged to be involved and make decisions about their care. Care plans contained information on how the person felt their needs should be met, and if they could make most of their own choices and decisions or needed support. Consent forms were in place and had been signed by each person to show they agreed with their care plan, and to having information shared with appropriate agencies where required.

People's dignity was respected by staff. Comments from people included "They get me from my bed to chair and back again with dignity and the minimum of fuss", "Staff are very considerate about washing and changing me", "The staff always knock", "My carer is always polite and does what I ask her" and "Whenever I have a shower they sit in the background talking to me". People's relatives told us "Staff ask permission", "They treat my relative with respect and care" and "They ask permission, and draw the curtains". One staff member said "Treat people as you would expect to be treated".

People's personal preferences were respected and upheld by the service. For example if a person chose not to have a staff member in their house this was respected and documented in a request log. Male carers were not permitted to attend female personal care visits, and female service users were notified if a male carer would be attending a call.

Staff told us that people were encouraged to be as independent as possible. One staff member said "I will try and encourage people to do things for themselves". Another staff commented "I give people a choice, and allow them to do as much as they can safely".

For people that had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNAR) in place, the family or person would inform the office and a copy was kept at the office and in the front of the care plan in the person's home. All staff would be made aware this document was in place for that particular person.

The managing director told us it was rare for the service to support a person at the end of their life as they usually moved on to receive treatment from other sources at this time, but commented "If we have an end of life package this is what we want to improve on, staff have had end of life training but have expressed an interest for more training in this area". Staff members that had attended regular visits for a person were given time off to attend the person's funeral if they wished. The managing director said "It's important for staff to have that closure".

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always contain enough detail about a person's background or information relating to specific health needs. For example one person's care plan stated they had dementia. However there was no mention of what support they may need around this diagnosis or how it affected this person on a daily basis. The only reference in the care plan stated 'Carers to be aware of how person is feeling because of Alzheimer's'. Another person who we were told also had dementia, had no reference of this in their care plan. The only statement relating to their dementia was that the person had a 'Poor memory', but no guidance on management or support for this.

We looked at seven care plans and saw generic statements were often used across all of them. For example when recording about people's expected outcomes it was documented 'To maintain current levels and to remain as independent as possible with support at home'. This was not person centred.

We saw that care plans had a section to record people's life stories and information relating to where they were born, their childhood, interests and close networks. However the majority of ones we viewed had not been completed. For one person there was only two sentences and one of these simply stated 'husband passed away'.

For people that were being assisted with the application of prescribed topical medicines, there was no body map in place to show staff what areas to apply this too. We saw it was stated on the MAR chart but did not have this visual document in place. The registered manager told us this would be addressed.

We spoke with regional operations director and registered manager about the lack of information in people's care plans and were told this had been identified by the Carewatch annual audit. The format of care plans had been changed and would be in place by the end of June 2016. We looked at the format and saw it was clear, detailed and more focused on the individual. We looked at the management action plan and saw the lack of information around dementia had been noted and had planned to be addressed through the new care plans.

Care plans were created with the person and then copied back at the office. These were clearly organised into relevant sections. At the front key information was recorded relating to the person's next of kin, GP or any financial representations in place. A support diary detailed what happened at each visit and we saw this correlated with the visit report sheets that staff completed after each visit. Each plan had a review log detailing when a review had taken place and any items discussed that needed action.

People using the service received an annual review of their needs or when required. The registered manager explained this was changing to every six months alongside the new paperwork. We saw examples of reviews that had taken place in people's care plans. The reviews asked the person about the regular staff attending visits and if the person was happy. The care plan was checked to ensure it was still meeting that person's needs and if any care needs had changed. Risk assessments had also been checked to see if they were still relevant.

The managing director said staff would let the office know if anything new had developed, and this would be checked to see if a risk assessment needed to be put in place, commenting "Staff know to communicate things to the office so it can be documented". One person's relative said "They ring and have we have reviews, someone from the office will come out". Another relative also confirmed receiving regular reviews saying "I have met the supervisors; they do a review, check the paperwork, and make sure the care provision is doing what it is supposed to".

People's concerns and complaints were encouraged, investigated and responded to in good time. We viewed the complaints folder and saw actions were taken in line with the provider's complaint procedures. All complaints had been acknowledged and responded to, however an outcome was not always recorded in relation to if a complainant had been satisfied with the response or had pursued the complaint further internally or externally. The managing director told us the service would start recording this information when a complaint had been closed.

Out of the 13 people we spoke with very few had complained and when they had it had been resolved in a timely manner. One person told us "I made a complaint and they were very responsive". People told us they knew how to complain but most had no need to. One relative said "If I do have a concern they try and accommodate me". Another relative commented "If I needed to make a complaint I have all the information in the file on how to do this". The managing director explained "We try and journal all informal concerns on file for that person and share with staff and do something about it if we can, if we think it should be raised as a formal complaint we will".

The service valued people's feedback and acted on their suggestions, sending an annual survey out. This was then looked at and compared to the results from the previous year to identify if improvements had been made or any areas that may have deteriorated. The managing director reviewed all the comments made by people and investigated where needed. The results were then shared with people and staff.

We saw that telephone monitoring calls had been made to people and the conversation was documented. People had been asked questions such as if their regular staff member was reliable, if they were informed of any changes by the office and if staff stayed the required amount of time. A compliments folder was in place which documented positive feedback received from people and their relatives. This was shared with staff and then logged in the folder. We saw cards and emails which praised the service and staff for the care and support shown.

Good

Is the service well-led?

Our findings

During our inspection we saw that a notifiable incidents had not always been reported to the Care Quality Commission (CQC). A notifiable incident for example is if a person had died or had an accident, and this information is used to monitor the service and ensure they responded appropriately to keep people safe. The notification that had not been reported was a notification of abuse or allegation. The service was investigating this concern at the time of our inspection and had reported it to the local authority safeguarding team.

The managing director said this was an oversight and should have been done. On a previous occasion in March 2016 a notification had not been sent in relating to an incident where the police were involved. On both of these occasions when it was raised with the service the notification was immediately sent to CQC. We spoke with the registered manager about what must be notified to CQC and they confirmed this would be addressed going forward. We looked at the providers own safeguarding adults protection policy, which stated a statutory notification must be made to CQC in such an event.

The service had a registered manager in place who demonstrated understanding of their responsibility to provide quality care and support to people. Throughout our inspection the registered manager and managing director were available to speak with. The registered manager had been with the service for 14 years starting as a support worker and progressing through to supervisor and then registered manager. This had given the registered manager a good understanding of how the service operated at each level, and still continued to do some care visits if required.

Staff told us they felt supported by the management team commenting "I think the management can be very supportive and I feel they do value my contribution", "Management are very approachable", "The manager is fair" and "She is a very approachable manager". The managing director said "Staff know they can speak to anyone in the organisation".

People and their relatives felt the service was well managed with one person commenting "I don't want to change from Carewatch". Relative's comments included "Very pleased with the service, can't fault them", "The manager has been around lots as a carer and as a manager", "We are very happy with the service" and "The service meets our needs very well". The registered manager told us "we have an open door policy".

The service had stopped taking on visits that were only 15 minutes long saying this was not a long enough time frame to complete effective care. The 15 minute visits they already had were being honoured, but no personal care was completed at these.

The managing director played an active role in the service and was located at the office for a few days every week. The registered manager told us she felt very supported by senior management. The managing director was also involved in key local organisations such as being a member of the 'Wiltshire Adult Safeguarding Board' representing domiciliary care providers. He was also a member of the 'Swindon Health and Wellbeing Provider Forum'. The service was also part of a group of providers that gave free training to

unpaid carers Wiltshire and Swindon. The managing director commented "We aren't there just to make money but to support the community, being more than a care provider and working within the community".

People and their relatives were kept informed about events relating to the service. On joining the service people received a guide detailing information about what a person could expect from the service, such as regular care reviews. There was also important contacts listed that they may need. Some relatives of people had chosen to have a communication book in place so they could leave information for staff to read if necessary. One relative said "The staff are good at communicating to us; we have a communication log in place too". Another relative commented "They are very good; if they are going to be a bit late they always ring from the office".

The managing director spoke with us about the difficulty for staff trying to take all their annual leave at the end of each holiday year resulting in many staff being off at the same time. The service has now implemented a new system which allocates each staff member with a different holiday year to alleviate the problem. The proposed idea had been put to staff and they had been in agreement.

The service ensured that staff were aware of their responsibilities and accountable for actions taken. A strike system had been put in place for when a signature was not recorded on a person's medicine administration record (MAR). If more than three strikes were obtained by a member of staff disciplinary action would be taken in regard to not recording medicines correctly. We saw examples of letters that had been sent to staff informing them action was to be taken. This was implemented in January 2016 and the registered manager confirmed the service had already seen an improvement in the reduction of missed signatures. For more serious medicine errors disciplinary action was taken immediately.

Quality assurance systems were in place to monitor the quality of the service being delivered. Internal audits had identified some of the shortfalls that we found during our inspection and an action plan had been devised which was in the process of addressing these concerns. The managing director and the registered manager were working through this action plan together. One shortfall that had been identified was that monitoring sheets were not returned to the office for auditing as often as they could be. This included financial transaction sheets, MAR's and visitor report records. Previously they had been collected every two to three months, this had now changed to monthly, and meant anything requiring action was identified sooner.

Auditing of paperwork was completed by the field care supervisors. This was then checked by the registered manager and the managing director would also look over them. We saw that once paperwork had been checked an audit sheet was attached to the top detailing any concerns found, actions required and who was responsible for completing the action.

We looked at the quality assurance master action plan, and saw that it checked items such as complaints, safeguarding, missed visits, staff training and accidents and incidents. A yearly management review took place and looked to identify any trends within the service.

The registered manager was able to keep up with current practice, completing regular training and attending care visits. There was an annual care conference and workshops which gave the registered manager a chance to meet other managers and providers and share knowledge. The managing director told us "Anything the manager wants to do we help her do it".

The service worked in partnership with other providers to try and meet people's needs. If a person was being discharged from hospital the service would liaise with the hospital before a person was discharged into their

care. The managing director commented "We will not take unsafe discharges. The supervisors will assess in hospital if it is a new person or if a person's needs have significantly changed during their time in hospital". He further commented "We try and work with other providers if we can't cover all of a person's visits. We are happy to share it with another provider if it means that someone can come home from hospital sooner".