# O6 Care Limited

# 06 Care Ltd

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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

The inspection tool place on the 19, 20 and 22 April 2016. We announced the inspection 48 hours prior to our arrival in order to ensure someone would be in the office.

During our last inspection which took place between 25 August and 1 September 2015 we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to safe care and treatment, person centred care and good governance. We issued warning notices in relation to the breach of safe care and treatment which had a compliance date of 13 November 2015. The issues identified were around how medicines and potential risks to people's health and safety were being managed. We also issued requirement notices for the breaches relating to person centred care and good governance. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

06 Care Ltd provides support to people living in their own homes in Bradford, Keighley, North Yorkshire and the surrounding areas. Referrals are made from continuing health care, direct payments and private customers. 06 Care Ltd support people with personal care and support to enable them to live in their own homes. At the time of this visit there were approximately 61 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements had been made to how medicines were managed. For example, more robust arrangements were in place for recording the administration of medicines. However, further improvements were required to the documentation and audit processes to ensure people were fully protected from the risks associated with medicines.

Care records needed to be improved to ensure they were accurate, complete and up to date so that care staff had the information they needed to provide effective and consistent care. Care records did not always contain person centred information particularly in areas such as people's preferred visit times, dietary needs and social histories.

We saw evidence staff provided appropriate support to ensure people consumed an appropriate diet and maintained good health. We also saw some good practices in relation to how risks had been assessed. However, further improvements were required to ensure risk assessments were person centred and that staff consistency recorded how they mitigated potential risks to people's health and wellbeing.

People told us they felt safe when staff visited them and we saw staff took effective action to help protect people from the risk of abuse. However full details of the decision making and actions taken to reduce risk

were not always recorded.

Where people provided feedback about the service they told us they felt listened to and staff were responsive in addressing any issues or concerns. People provided positive feedback about care staff and told us staff treated them with dignity and respect.

People told us staff asked their consent before providing support and the staff we spoke with demonstrated they had a good knowledge of the people they supported and their capacity to make decisions.

Staff were recruited in a safe way and there were sufficient numbers of staff to ensure people received the support they needed. Staff had the required skills, knowledge and experience to deliver effective care.

The provider had introduced a system to ensure daily notes were returned to the main office to be checked each month. This enabled the office staff to identify any concerns or issues and ensure people had received the support they needed. However, staff needed to improve the quality of information they recorded within daily notes to ensure they fully evidenced that appropriate care had been provided. We also found the audits of daily notes needed to be more robust to ensure all issues were identified and addressed.

People were usually supported by the same staff each week which helped encourage a consistent approach to care delivery and enabled staff to develop meaningful relationships with the people they supported. People told us they had noticed an improvement in the consistency of care they received but said the timing of their visits could still be unpredictable. Improvements to the rota planning system were required to ensure people received visits at the times they needed and preferred their support to be delivered.

We concluded that the provider and management team were committed to the continuous improvement of the service. They had implemented processes designed to monitor and assess the quality of the service. As part of a robust quality assurance system the registered manager and provider should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for the Commission to identify shortfalls. We concluded that further development of the quality assurance systems was required to ensure areas for improvement were identified and addressed by the provider. There were also areas where robust audits needed to be implemented such as checks of care records.

We identified two breaches of legal requirements. 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.

Improvements had been made to the way medicines were managed. However further improvements were required to ensure people were consistently protected from the risks associated with medicines.

Risk assessments were in place but were not always person centred. Staff needed to improve the level of detail they recorded to demonstrate risks had been mitigated.

People told us they felt safe when staff visited them and we saw staff took action to help protect people from the risk of abuse.

Staff were recruited in a safe and effective way and there were sufficient numbers of staff to ensure people received consistent care.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Care records needed improvement to ensure staff could evidence appropriate support had been provided in relation to people's dietary needs and preferences.

Staff made referrals to professionals to help people maintain good health.

Staff had a good knowledge of the people they supported and their capacity to make decisions.

Effective systems were in place to ensure staff received appropriate training and development.

### Is the service caring?

**Good**

The service was caring.

People were usually supported by regular staff which helped encourage the development of meaningful and caring

relationships.

People provided positive feedback about care staff and told us staff treated them with dignity and respect.

People's views were sought and listened to and people were involved in planning their care.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care records needed improvement to ensure they were complete, detailed, person centred and up to date. The quality of information recorded within daily notes needed improvement.

Overall improvements had been made to the consistency of care people received. However, people's feedback showed further improvements were required to ensure consistent visit times.

Investigations into complaints were effective and the provider recorded and analysed people's feedback. People told us they felt listened to if they raised any concerns.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The management team were committed to continuous improvement. New quality assurance processes had been implemented, however further improvement and development was required to ensure they were fully effective. There were areas where robust audits still needed to be implemented such as checks of care records and provider audits.

Staff told us they felt supported and listened to. They told us communication between office staff and carers was improving but they were still not always kept informed of changes.

People's feedback was sought and their views were used to help improve the quality of care provided.

# 06 Care Ltd

**Detailed findings**

## Background to this inspection

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

This inspection took place between 19 April and 22 April 2016. We visited the office on 19 April and completed phone calls to staff, people who used the service and relatives on 20 and 22 April. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of two adult social care Inspectors, one pharmacy specialist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert by experience had experience of working for and using services for older people and people living with dementia including community based services.

Before the inspection we reviewed the information we held about the service such as reviewing the statutory notifications we had received. We also contacted the local authority commissioning and safeguarding teams. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR had been partially completed with some sections missing.

We spoke with 12 people who used the service and four relatives of people who used the service. We also spoke with five members of care staff, the registered manager and provider, the training and complaints manager, the quality assurance manager, and the operations manager. We reviewed 10 people's care records, medicines administration records and other documentation relating to the management of the service such as policies, procedures and staff files.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection in August 2015 we found people were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. At this inspection we saw improvements had been made to the way medicines were managed. For example, more appropriate arrangements were in place for recording the administration of medicines. Medicines Administration Records (MAR's) were provided for four of the five people we reviewed. During our last inspection MAR's were not being returned to the office for audit by the management team. This meant problems or changes might not have been picked up and addressed in a timely way. On this inspection, we found that most MARs were returned for audit on a monthly basis to check they were correctly completed, although no MARs were available for March 2016 for two of the people we reviewed. This demonstrated further improvements were still required to ensure the new systems were fully embedded and effective.

We saw the provider's medicines policy had been updated two weeks before our inspection. We saw some of the terminology in the policy had not yet been reflected in people's care plans. The provider told us they were in process of updating care plans in light of this new policy.

We saw examples of body maps and topical MAR's in use and these detailed where creams should be applied. This was an improvement from our previous inspection. However, there was not sufficient documented information available to care staff to assist in the administration of 'as needed' creams. For example, there was a lack of information detailing situations where someone may need additional application of pain relief creams along with their regular application. This information was required to help ensure people were given their 'as needed' medicines in a safe, consistent and appropriate way.

People had a medicines risk assessment in their care files, which was an improvement from our last inspection. However these did not include person specific information such as the risks associated with medicines a person was taking that the service did not support them with or specific medical conditions which may have impacted upon the way they took their medicines. For example, the risk assessment for a person with memory impairment did not outline any risks associated with this when supporting this person to take their medicines.

We looked at the daily notes and MAR documentation for two people who were taking medicines containing paracetamol. These medicines need a gap of at least four hours between doses. We found there were occasions where a four hour gap had not been left between visits meaning people were at increased risk of harm from these medicines. Following our visit to the office, when we spoke with staff they informed us that the provider had put actions in place to reduce the risk of this happening in the future. However we were unable to assess the effectiveness of this new system as part of this inspection. This should have been identified and addressed prior to our inspection through the provider's quality assurance processes.

Whilst improvements had been made to some aspects of the way medicines were managed there were still areas which needed to be improved to ensure people were fully protected from the risks associated with medicines. This meant the provider continued to breach Regulation 12 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place which assessed hazards associated with the environment and moving and handling. For example, one person had specific risks associated with moving and handling. A manual handling risk assessment was in place which detailed how staff should safely support them to move and which specific equipment should be used to support them to move in each scenario. We spoke with two staff who supported this person and the information they provided in relation to how they safely moved this person matched what was recorded within the person's care records.

Whilst we saw some good practice in relation to how some risks had been assessed further improvements were required to ensure consistency in the level of detail included across care records. Some risk assessments were not person centred and staff were not always maintaining complete records. For example, entries made within daily notes were inconsistent in relation to the support staff had provided in areas such as positional changes and fluid intakes. This meant further improvements were required to evidence that appropriate action had been taken to mitigate potential risks to people's health and wellbeing.

We saw no evidence of accidents involving people using the service. The operations manager explained this was because there had been none in the past six months. They were able to explain the process they would follow if there was an accident in the future. This included taking appropriate action to reduce the risk of further accidents, reviewing risk assessments and care plans, considering whether a statutory notification to the Commission was required and analysis to ensure any trends or patterns in accidents were identified and acted upon.

People told us they felt safe when staff visited them. The provider had updated their policies for safeguarding and whistleblowing. Our discussions with staff demonstrated they had a practical understanding of safeguarding and were aware of the procedures to follow to report any concerns. The operations manager explained they were usually responsible for making safeguarding alerts and ensuring appropriate action was taken in response to any incidents. They kept a safeguarding log which provided an overview of all incidents and their outcomes. This enabled the operations manager to monitor that appropriate action had been taken such as making alerts and updating care records. We found additional information could have been included to get maximum benefit from keeping this log, such as analysis of the specific incident and the people and staff involved. This would ensure patterns or trends were identified and acted upon. However, we saw no themes in the safeguarding incidents reviewed.

We saw evidence staff had identified and reported three safeguarding incidents in the three months prior to our inspection. The operations manager had reported these incidents to the relevant authorities and put plans in place to reduce risk. However full details of the decision making and actions taken to reduce risk were not always kept. For instance, in two cases staff told us additional monitoring was required to ensure future incidents were reported to the operations manager. However, there was no information within care records about the incidents or the additional monitoring required. The operations manager explained this information was not included in care records because these were kept in the person's home and it would not be appropriate for other people who may have visited to have seen this information. However, they recognised a record should have been kept on the internal 'people planner' system to evidence the actions they had taken. They said they would ensure this happened in the future to ensure a complete audit trail was maintained of all actions taken.

We concluded there were enough staff to ensure safe care. Records we reviewed showed that overall people received visits from regular staff at consistent times each day. This indicated there were enough staff to

ensure the delivery of a reliable service. Care rotas were arranged into set visit runs which were allocated to staff on a regular basis. This helped achieve consistency with regards to the staff who supported people. Some people who used the service told us the time of their visits could vary but most people told us this was something which was improving. We found improvements were needed to the rota planning system to ensure the timing of visits was planned more effectively. From the rota records we saw, with the exception of one person, there was no clear information about time critical calls such as where people required medicines at a specific time. We raised this with the provider and they said they would address this as a priority.

The service was constantly recruiting to further improve the number of staff available to deliver care and support, for example at the time of the inspection there were six additional staff going through induction training. Safe recruitment procedures were in place. New staff were required to complete an application form detailing their work history, attend an interview, have their identity checked, undertake a Disclosure and Barring Service (DBS) check and provide references. We reviewed three staff files which provided evidence these checks were robustly carried out before staff started. This helped ensure staff were of suitable character to work with vulnerable people.

Requires Improvement

# Is the service effective?

## Our findings

People told us they received the support they needed to eat and drink when staff visited them. We found care records required more person centred detail around people's dietary preferences. Staff told us they would usually ask people what they wanted to eat on each visit and because they usually supported the same people each week they were able to suggest things they knew people had enjoyed during previous visits. However, they said additional information within care records would be helpful where they didn't know people well such as when supporting someone new or covering a visit due to holidays or sickness.

The daily notes we reviewed demonstrated staff supported people with meals, drinks and snacks where this was part of the person's assessed care needs. However, in some cases more detailed records were required. For example, one person was being treated for an infection which meant they needed to increase the volume of fluids they consumed. The daily notes showed staff had been advised to encourage the person to drink fluids on each visit. However, staff did not consistently document the amount of fluids the person had consumed during the visit and where the person had been left with a drink they had not documented whether this had been consumed on their next visit. This meant it would have been difficult for health professionals to establish an accurate picture of this person's fluid intake and to monitor the on-going risk of the infection.

Where staff were concerned about people's health or had noted a change we saw they had made referrals to health professionals. Staff discussed people's health with them during care reviews so any changes could be identified and the care provided amended accordingly. This showed us staff supported people to maintain good health.

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. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection. From the records we reviewed and discussions with staff and people who used the service we concluded that the service was working within the principles of the MCA. Staff had an understanding of how these principles applied to their role and the care they provided.

All of the people we spoke with told us staff asked for their consent before providing care and respected their choices. People signed to agree to their plans of care and we saw evidence in daily notes that people were asked for their choices with regards to how they wanted their care and support to be delivered. Where people were unable to sign their plans of care evidence was provided to show how the person had agreed to their plans of care. We saw one example where a formalised capacity assessment would have provided staff

with more robust guidance. However, overall we found care records contained information which may have impacted upon peoples' capacity to make decisions such as specific mental health and communication needs.

An appropriate system was in place to ensure staff were provided with regular training and support to enhance their skills and knowledge. We reviewed staff training records which showed staff received training in subjects such as manual handling, safeguarding and medication. This was all delivered face to face and staff were up-to-date with training. Further plans were in place to provide all staff with dementia training. Staff were encouraged to achieve further qualifications in health and social care. For example most staff were competing or had completed a recognised health and social care qualification at level 2 or 3. Some staff had received specialist training in subjects such as epilepsy, continence products and palliative care. We found the provider needed to advertise this specialist training more widely as some staff members who had worked for the organisation for a long time told us they would benefit from refresher training in specialist areas such as catheter care but did not know whether this was available for them.

New staff had previously completed the Skills for Care Common Induction Standards and were now required to complete the Care Certificate. The Care Certificate provides a framework to help ensure staff receive a consistent and appropriate level of training and support. In addition new staff were inducted to the policies and procedures of the service and required to shadow more experiences staff to become familiar with the practicalities of the role. We spoke with a staff member who had recently completed their induction and they told us this was comprehensive and provided them with the necessary skills to provide effective care. The training manager told us they were committed to supporting new staff in their role to help ensure staff retention and reduce turnover. This was done through a series of meetings with new staff to check progress and developmental needs.

Some people told us staff did not always have "Life experience" and this sometimes impacted upon their ability to provide them with effective care. However, overall people told us care staff had the relevant skills and knowledge to fulfil their role and provide them with the support they needed. The staff we spoke with demonstrated a practical understanding about key topics such as safeguarding and moving and handling. This showed us their training had been effective.

Staff received periodic staff supervision and checks on their competency. In the first instances staff were subject to a spot check on their practice. The results of this were followed up through a supervision meeting to discuss their performance any areas for improvement. This helped improve the quality and effectiveness of care.

Good

# Is the service caring?

## Our findings

Overall people's feedback about the approach of care staff and the standard of care they provided was positive. One relative told us, "We are really happy with things at the moment. We have nothing to complain about and are particularly happy with the positive and caring attitude of our regular care staff." One person who used the service told us the standard of care they received was "Generally excellent", whilst another person told us "As a rule I can't fault the girls, they are kind."

People told us they were usually supported by the same staff each week. Rotas were organised in a way which helped reduce the number of different care workers who visited people. This helped ensure people were provided with consistent visits from familiar faces. Staff told us they usually supported the same people each week so had been able to build strong relationships with them. We asked staff about people they supported and found they had a good understanding of the individual needs and preferences of each person. In each case the information staff provided was reflective of the information within the person's care records.

We saw people had been involved in planning their care. For example, information in one person's file detailed how staff should support the person to ensure their cultural and religious beliefs were respected. The staff we spoke with understood the importance of meeting these needs for this person and their family. They were able to tell us specific information about the specific support they provided to ensure they respected and met their individual needs.

Some people had completed life histories which included information such as past professions, family, social interests and preferred hobbies. The provider explained this was something people and their families were encouraged to complete as part of their initial assessment. Where life histories were not in place people were encouraged to complete them as part of their care review.

All of the people we spoke with told us staff treated them with dignity and respect. Dignity and respect was monitored through a number of different methods. This included the spot check process and through regularly asking people for feedback about the attitude of staff. This ensured management staff could monitor care staff's approach and address any shortfalls. The records we reviewed such as care review meetings and questionnaires showed most people thought they were treated well by staff.

Staff told us they used care plans but were guided by what each person wanted during each visit. They said they would always ask people's views about how they would like their support to be delivered because they recognised this could change from day to day. Communication care plans were in place which detailed people's specific needs. This meant staff were provided with information to ensure they could effectively seek people's views and preferences in relation to how they wanted their care to be delivered.

Requires Improvement

# Is the service responsive?

## Our findings

Care records showed people's needs were assessed prior to starting to use the service and a plan of care was put in place which detailed their care needs at each visit. Some of this information was clear and detailed. However we found some instances where care plan documentation lacked clarity. For example it was not clear from one person's records how many night time visits they required for pressure relief because conflicting information was recorded within their care records. We established from speaking to the operations manager that the person received three night time visits for pressure relief. However the most up-to-date care plan did not make any reference to the time or frequency of the night visits. We raised this with the operations manager who agreed to amend the support plan so that it reflected this person's current needs.

We found the level of detail within care records was not consistent. For example, one person had a detailed care plan in place regarding how staff should provide support with their personal care. However, another person's care records were not as detailed and it was difficult to establish the level of support staff provided with their personal care. Some care records contained information about people's past and current lives, their family, friends, likes, dislikes, interests and hobbies. Whilst other care records did not contain this information. We also identified more person centred information could have been recorded in relation to people's preferred call times and dietary preferences.

The staff we spoke with told us they found care records useful and had noticed the detail within care records was improving. However, staff said they still found the information was not always complete and up to date and this was a concern when they supported new people or covered a visit which was not usually on their visit run. Two staff members told us of recent occasions where they had not been given sufficient information to provide people with the support they needed because care records were not up to date. They said they had to contact other members of care staff to get the information they needed. This risked that staff did not always have up to date and accurate information to provide effective and consistent care.

The provider had introduced a system to ensure daily notes were returned to the main office to be checked each month. This enabled the senior carers and operations manager to identify any concerns or issues and ensure people had received the support they needed. We saw examples where staff had identified potential risks to people's health and wellbeing from the information recorded within daily notes and made referrals to other health and social professionals. However, some people who used the service told us they were concerned that staff's entries within the daily notes did not always accurately reflect the care and support they had received. We also found occasions where the information staff had recorded did not fully evidence appropriate care had been provided. For example, one person was assessed as being at risk of pressure sores and required their position changing on each visit. We reviewed this person's daily notes and saw care staff did not record the support they provided in a consistent way and the exact positional changes were not documented. This meant the records kept did not clearly evidence this person had received appropriate support to reduce the risk of them developing a pressure sore.

We concluded that further improvements were still required to ensure care records and daily notes

contained accurate and complete information. We also found the systems and processes in place to check daily notes and care records required further refinement to ensure they were fully effective. This meant that the provider continued to breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw improvements had been made to the consistency of care people received. The records we reviewed showed people received care at regular times and from regular staff. Most people told us they had noticed an improvement in recent months. For example, one person told us, "I had issues in the past with them not coming on time. Feeling much better as I now get my medicine on time." One relative told us, "I have seen a definite improvement since Christmas. We now have a regular staff team so we usually know who is coming. The times of visits still sometimes vary but things are definitely moving in the right direction and we receive much more consistent care. I can tell my relative is much happier and settled because of that."

The provider had recruited a number of new staff since our last inspection. Care staff told us the staff team was now more "stable" which meant staff were usually allocated the same people to support each week. They told us this approach enabled them to deliver more consistent and person centred care. One staff member told us, "It's much improved, I now support the same people each week so I feel deliver more person centred care because I can get to know people's specific needs." Despite these improvements over half of the people we spoke with told us they did not always get visits at consistent times. For example, one person told us, "They have improved a lot over the past six months…when they are good they are very good. [However] carers rarely turn up on time especially at weekends." Another person told us staff had, "Been late a lot recently" their visit was supposed to be at 9.30am but it had "been nearer to 10" when staff were arriving. The feedback people provided demonstrated further improvements were still required to ensure people received consistent visit times.

A system was in place to record, investigate and respond to complaints. We looked at a number of complaints which had been received and saw they had been investigated appropriately and responded to within reasonable timescales. Complaints were analysed to identify any themes or trends. We saw the number of formal complaints had been reducing which indicated people were now more satisfied with the service provided.

A positive feature of the service was that issues raised by people were recorded in an open and transparent manner. For example, as well as formal complaints, occurrences were also recorded which included minor, informal complaints or incidents. We saw these were appropriately investigated and responded to promptly. These were also analysed on a monthly basis to look for any common trends or themes.

People were provided with multiple opportunities to provide feedback about their experience of using the service. This included a telephone review two weeks after starting to use the service and a care review after six weeks. This provided staff with the opportunity to address any early issues or changes that people needed to make to the care they received. Each person also received an annual care review.

People told us they felt listened to and where they had raised issues or concerns staff had tried to address them. One relative described how they had raised an issue with the office and they felt the operations manager listened to them and took action to ensure the issues were addressed. They also said the operations manager was, "Good at getting back to you with an outcome if you raise something with them." Another relative told us, "They were helpful when I had an issue to deal with. I felt they listened." This showed us staff were responsive to feedback and used it to try and improve people's individual experience of using the service.

Requires Improvement

# Is the service well-led?

## Our findings

Following the previous inspection in August 2015 the management structure had been refined. A new quality assurance manager had been appointed in January 2016. In addition, there was an operations manager and training and complaints manager employed to assess and monitor the quality of the service. The people and staff we spoke with provided positive feedback about the management team and said they had noted a definite improvement since the quality assurance manager had come into post. For example, two people described how they had recently raised issues and felt assured the quality assurance manager had taken action to try and resolve their concerns. During our discussions with the registered manager, provider and management team we concluded they were committed to the continuous improvement of the service and the quality of care provided. Findings from audits undertaken were also discussed at weekly managers meeting for action and to aid continuous improvement of the service.

We saw a number of improvements had been made to the systems designed to assess and monitor the service. Most daily records and medicine administration records (MAR) were returned to the office on a monthly basis for review by management staff. We also saw improvements to the way complaints were analysed so trends and patterns were more effectively identified and addressed. In addition regular spot checks took place on staff practice and numerous reviews of people's care and support packages helped to assess and monitor the quality of the service.

However, whilst areas of improvement were identified we concluded that some systems and processes needed further refinement to ensure they were effective. For example, monthly medicines audits were completed so the provider could ensure they had a record of the medicines that had been administered. Gaps in the medicines administration records (MAR) meant we could not be sure people were always given their prescribed medicines. We saw the audit identified that where there were gaps in documentation on the MAR's and steps were made to establish if the medicines had been taken or not. This was an improvement from our previous visit. However, the audit did not always identify and address all issues with the MAR's. For example an audit for one person stated the allergy box had been completed but when we reviewed the MAR the allergy box was blank. The audit did not cover all aspects of medicines management. For example audits had failed to identify and address the risk of two person receiving doses of medicines containing paracetamol too close together. In addition, the audit did not check the information kept within people's care plans and risk assessments relating to medicines were accurate. We saw this meant care records did not always contain current and complete information relating to people's medicines. For example one person had a medicine listed on their medicines care plan which was not on their previous month's MAR. This demonstrated that a more robust and complete medicines audit was required to ensure issues were promptly identified and addressed.

We identified instances where staff had not recorded details of visits within people's daily records. The operations manager assured us through reviewing timesheets these visits had taken place but they hadn't been recorded within the daily notes. This showed that a complete and accurate record of each person's care was not always kept. For example, one person was missing records of three visits for a period between 15 and 26 March 2016. This meant there was no evidence to demonstrate they had received the support they

required for those visits. Of particular concern was that the daily notes for that period had been audited, with the audit stating the records were complete and no corrective action was needed. We also identified some visit times were not recorded within daily records and there were occasions where staff had not stayed for the full allocated visit time. These had not been investigated and analysed to ensure the visits people received met their current needs. This led us to conclude that although audits of daily notes were now taking place further improvements were required to ensure they were robust and effective.

The provider had systems in place to monitor the number of missed and late visits. The information we saw showed these were reducing and management staff had responded to investigate the reasons behind these and put plans in place to try and address them. However, we concluded the numbers of missed and late visits could have been further reduced by improving the organisation of the visit rotas. For example we looked at some rota's and saw there were up to 20 visits in a row on the rota which were not achievable within the specified times. We spoke with the operations manager about this. They explained the rota's contained some single visits that the staff member would split with the colleague with whom they were working with during the shift. This meant it was not clearly defined which calls each staff member was responsible for and increased the risk of errors. We also identified that in most cases people's visit times were not specified on rotas. This meant staff could change the order of their run and put people at risk of not receiving visits at their preferred time and at the times they really needed the support. This was of particular concern where people required time critical interventions such as positional changes or time specific medicines.

We also identified a number of areas where there were no quality monitoring systems and processes in place. For example, care plan audits were not completed at the time of this inspection. However, the quality assurance manager told us they had plans to start these in the near future. There were also no overall provider audits to assess and monitor the quality of the service against a number of key indicators. As part of a robust quality assurance system the registered manager and provider should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for the Commission to identify shortfalls.

Overall we concluded that the systems in place to monitor, assess and improve the quality of service provided were not sufficiently robust and required further improvement. This meant the provider continued to breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records showed evidence people's views and feedback was regularly sought through a variety of methods. People's views were sought through a telephone review two weeks after starting to use the service and a six week quality questionnaire and review. Each person also then received an annual care review. Six monthly satisfaction surveys were also sent to people who used the service and the results analysed. We reviewed the results of the February 2016 survey. This showed most people were happy with the service provided. For example out of 18 responses, 10 people were 'very' or 'extremely' satisfied, six people were 'quite' satisfied and two people were 'neither satisfied or dissatisfied'. Survey results showed people generally said they were treated well by staff and that staff completed the required tasks at each visit.

Staff told us the communication between the office and front line staff had improved but was still "A bit hit and miss." Staff told us they were not always kept up to date if people went into hospital or respite care and it could sometimes take "A number of weeks" for revised care records to be sent out to the person's home when their needs or support plan changed. However, staff told us they felt supported and when they raised concerns with the operations manager or quality assurance manager they felt listened to and were confident any concerns were promptly acted upon. We saw that staff meetings were held and were used as an opportunity for any quality issues to be discussed with staff. For example, staff told us they had discussed

the last inspection report during team meetings and were aware of the areas that needed to be improved on. This  helped to encourage a culture whereby staff at all levels of the organisation were responsible for driving improvements.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12(1)(2)(g).<br>Care and treatment was not always provided in a safe way for service users because;<br>medicines were not always managed in a safe and proper way. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17(1)(2)(a)(b)(c).<br><br>Systems and processes were not established and operated effectively to ensure the service;<br><br>Assessed monitored and improved the quality and safety of the service provided.<br><br>Maintained securely and accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided. |

**The enforcement action we took:**

We served a warning notice on the registered manager and registered provider. The notice stated that they had to take action to ensure they met this regulation by 25 July 2016.