06 Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of 06 Care Limited took place over two days on 9 and 16 October 2017 at the agency office. Prior to the office visit, we made telephone calls to people using the service and staff between 28 September 2017 and 1 October 2017. The site visits were announced. The service had previously been inspected in April 2016 and was rated requires improvement. There were two breaches of the Health and Social Care Act 2008 and associated Regulations, for safe care and treatment and good governance. We looked at this inspection to see if improvements had been made.

06 Care Limited provides personal care support to 61 people, adults and children, living in their own homes in Bradford and its environs. This support includes day calls and night check visits (for eight people), and the agency also provides a night-sitting service for three people with complex health needs.

There was 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.

Most people told us they felt safe but one person raised concerns about the different staff visiting. We found 06 Care provided staffing through 'runs' which meant staff were told a start time and were given a list of people to visit. This information was not consistently shared with people using the service and staff had unrealistic schedules to follow. Call times were frequently cut short and people were subject to a wide variance in call times.

Medication was not properly managed or safely administered as the provider did not demonstrate an awareness of the NICE Guidelines for domiciliary care agencies which provide clear direction. 06's source of information for most topics was the local authority but this meant they were not always following the relevant legislation.

Staff were trained but this was not always followed up with timely competency checks and more experienced staff had not received regular supervision or appraisal. Staff were also not supported through regular meetings.

Risks in regards to moving and handling, or more complex care packages were managed in a person-centred manner with detailed guidance provided for staff. Staff demonstrated a sound awareness of infection control procedures.

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 practice. We spoke to the registered manager about ensuring the person signed their own record unless physically unable to do so.

People were supported with their nutritional needs and had access to external health and social care support as required.

Staff were spoken of highly by people who told us they were caring, kind and compassionate. We saw some compliments which endorsed this view. People felt they participated in planning their care.

Care records contained sufficient detail so staff knew what support to offer people. Daily notes tended to be task-focused.

The service had not logged any specific complaints as they dealt with issues when they arose. We saw these 'occurrences' were dealt with promptly and investigated well.

The service had detailed quality assurance processes which considered certain aspects of care delivery. However, the more general service delivery was not audited sufficiently well as can be seen by the issues we found with staffing and medication.

This inspection found breaches of the Health and Social Care Act 2008 associated regulations relating to the need for consent, safe care and treatment, good governance and staffing.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not receiving care visits at appropriate times and were not being informed of who was to visit.

Medication was not being properly managed and staff were being supported without sufficient guidance or scrutiny.

Most people said they felt safe and risks in relation to moving and handling were documented clearly.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular supervision or appraisal but spoke positively of the high quality of training which was reflected by people using the service.

06 Care had some understanding the requirements of the Mental Capacity Act 2005.

People were supported with their nutritional and health needs as required.

Is the service caring?

Good

The service was caring.

People spoke highly of the care staff saying they were kind and caring.

We saw people were involved in their care planning needs and these were regularly reviewed.

People said their privacy was respected and their dignity promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although care records reflected people's specific needs the care delivery was not reflective of these in terms of time of call.

Complaints had been acknowledged and responded to but were not always recorded as such.

Is the service well-led?

Inadequate

The service was not well led.

Although the registered manager and directors were present in the service and understood their roles, their auditing system did not identify the issues we found with staffing and medication.

Staff did not receive any formal support through meetings which meant information was not shared in a timely manner.

06 Care Limited

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 checked 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 9 and 16 October 2017 and was announced on both days. The inspection team consisted of three adult social care inspectors (one inspector carried out telephone calls to staff and two inspectors visited the provider's office) 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. Prior to the site visit, the expert by experience carried out telephone calls to people using the service.
Before the inspection we requested a Provider Information Return (PIR) which was returned to us. 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 checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with ten people using the service and six of their carers. In addition, we spoke with fourteen staff including ten care workers, the training and complaints manager, the quality assurance manager, the registered manager and one of the directors.

We looked at 12 care records including risk assessments, 12 staff records including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

Following the previous inspection the service was rated requires improvement in safe as there was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment. The provider was given a requirement notice. During this inspection we found significant concerns with both staffing and medication.

One person told us, "I feel very safe with the carers." Another person said, "There's no back chat from them - 06 are one of the good ones." One relative told us, "We feel very safe with 06 Care staff looking after [name]." Another relative also felt confident with staff saying, "I have no problem with them having the key safe number." A further relative spoke highly of the communication by staff as one person received night care and their relative told us, "They leave a note to let us know how things have been and they will wake us if it's something serious."

However, this view was not endorsed by all people we spoke with as one person told us, "I feel safe with the carers but sometimes it's someone I don't know and I don't feel so safe then." People had different experiences of care staff and rotas. One relative told us, "They keep the same carers which is really important for us." However, they also said there were issues with the timing of call visits "which fluctuate a lot, especially during holiday periods." Another person told us, "They struggle to get staff to cover weekends." A further person said, "They have a lot of calls on their routes so sometimes can be very late, sometimes up to 11pm."

One person was extremely unhappy with the service and told us, "The management are useless and cannot get the basics right. The rotas keep being compressed and they don't tell you times have changed and just turn up without notice." They continued, "Carers just turn up at any time – a morning call can be 2pm with a tea call at 3pm". This was echoed by another person who said, "They organise things to suit themselves – twice this week I've been put to bed at 8pm and not got up until lunchtime." A further person said, "I never know when they will be visiting; calls can vary by 3-4 hours on different days."

Other issues included the length of the actual call time. One person told us, "The carers try but there is not enough time - I should have enough time but they need to go on to the next call." Staff also told us this. One care worker said, "There were quite a few people on the rota for the same time but a few have left now, so it's better." They continued, "Timeliness is generally good but they have had to merge a few runs and people have complained." Another care worker told us, "We could be due to be at someone's for 9.30am but it's more likely to be 10.30am or later. There's a lack of staff and drivers. If a driver calls in sick we have to merge runs." A further care worker said, "Staffing levels have struggled over the last few months due to holidays and sickness. Runs have been merged."

Although people had been asked their preferred call time during the initial assessment, these were not considered in the preparation of the runs. When staff were allocated calls, the times were not consistently shared with people so they had no idea who was turning up or when. Only where people were in receipt of complex care packages were call times shared. We saw continued reference in each care review that "06

Care cannot guarantee the time of the call." We did not see evidence 06 Care allocated people specific times, rather staff were allocated a list of people to visit and they followed this 'run'.

One care worker told us, "Rotas are sent on a Thursday or a Friday for the following week, and I feel they are realistic. Some people want specific times but it's not always possible but we do get there at a consistent time each day." Another care worker said there were no issues with their rota as it remained consistent. However, other care workers discussed the difficulties when runs were merged, especially with double-up calls.

We requested copies of three months' worth of staff rotas up to and including 31 October 2017 and were given records showing the times of the actual calls completed up to 10 October 2017 for specific people. We were not given any subsequent rotas for these people for the rest of the month as we were advised this information was not available. The records highlighted the service did not arrange its call times based on people's choices but around the location and availability of staff.

We looked at seven records in depth and found similar issues. We saw one person was scheduled to receive a 45 minute morning call around 8.30am and a 30 minute evening call around 7.30pm. Between 1 and 10 October 2017, the morning call averaged 30 minutes and the evening call 15 minutes, which meant a shortfall of 15 minutes on each call. When cross referencing these call times to the allocated care worker's 'run', we found their morning calls were scheduled to start at 7.30am and they had four calls to make before attending to this person. Each of the four calls should have lasted 30 minutes. This meant they should not have arrived at this person until 9.30am at the earliest notwithstanding travel time between calls. However, the person had received their morning call between 7.55am and 8.35am.

The records for the same person for September 2017 showed morning calls ranged between 7.40am and 10am (preferred time 8.30am), lasting 30 minutes (none lasted the required 45 minutes) and the evening calls varied between 5.10pm and 8.45pm (preferred time 7.30pm) with a maximum length of 20 minutes, and an average of 10 minutes. We noted this person was allocated one care worker but had been scheduled two on occasion. When we asked one of the directors why this was the case, we were told it was due to staffing issues and needing to merge runs. These examples illustrated the service provision was not consistent and left people with reduced call times.

Another person's record showed call times were more consistent, although these could vary by up to one hour each day. This person had complex needs and required two staff to assist for all care delivery and yet their morning call which was allocated an hour lasted on average for 50 minutes during early October 2017. This was replicated at lunch time where a 30 minute allocated call lasted an average of 24 minutes. When looking at one care worker's rota for 1 October 2017 we saw they were scheduled to start at 6.30am and cover ten calls on the morning run which would have meant arriving at this person at 6.30am and 12.45pm, not allowing for any travel time between calls. However, when we checked against the actual call arrival time, the care worker arrived at 7am and 11.45am which we were later advised by the registered manager was due to other people cancelling their calls. This shortening of call duration was reflected in other rotas we looked at. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as call times were cut short and the arrival time of care staff was too variable.

We looked at staff recruitment files and saw checks had been completed. References were obtained and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. One care worker said, "I attended an interview, part of which was to look at care documentation and complete it as part of a test. References and my DBS were also obtained before I started work." We did note not all gaps in

employment history were investigated.

Staff were able to explain their role in administering medication and spoke well of the training they had received. However, the medication policy for 06 Care did not correlate to the National Institute for Clinical Excellence (NICE) guidelines. The registered manager and provider explained they had sought advice from a pharmacist as they had struggled to obtain Medication Administration Records (MAR) from local pharmacists. 06 Care Limited's medication policy stated, "If medication has been dispensed by a pharmacist or other authorised dispenser in to a dossett (sic) box or blister pack etc no MAR chart is required. Clear documentation in the daily notes, 'medication taken as per the contents of the dosset box' and the time taken." However, NICE guidance states to do this the provider needs a complete, current list of all prescribed medication which was not available for any record we looked at.

When we asked the registered manager for a list of people receiving support with their medication from 06 Care they supplied us with 13 names where medication was administered via dosette boxes. However, when we looked at care records we found care staff were supporting other people with their medication who were not on this list. 06 Care did not perceive the administration of creams as administering medication.

Records were contradictory and staff were unable to follow them correctly. The medication summary sheet and risk assessment contained conflicting information as to 06 Care's role in supporting with medication as they said 'Level 1 assistance' and 'zero assistance' where people were receiving support with the application of creams.

In one person's record we saw a list of medication which corresponded to the date of the person's care review on 30 June 2017. Although it was recorded '06 Care staff to apply creams' there was no guidance for staff to follow. Records did not show where and when to apply creams and to what thickness. It was recorded 'pro-shield cream applied to bottom and zerobase cream to legs when required.' When looking at this person's daily notes for 3 May 2017 and 4 May 2017 it read 'zerobase applied to bottom' showing incorrect administration. These medicines were not recorded on the person's medication record until after the review visit in June 2017 which meant staff had been applying cream without assessment, and with no specific guidance for safe administration.

In another person's daily notes we saw a medication summary sheet dated 8 May 2017, updated on 9 August 2017, which contained no reference to a particular cream which we saw staff had applied on 1, 2, 6 and 7 June 2017. A further cream had been applied by care staff following a hospital visit without any direction from care notes or any discussion with office staff. Notes did not indicate where it was applied or the quantity required meaning the person could have been at risk of harm. This specific cream was applied between 25 and 28 July 2017, and then without any other explanation, a different cream was applied from 29 July 2017 onwards. This was not referenced in the medication summary and although identified by a medication audit this did not happen until 16 October 2017, nearly three months after staff had been applying this cream. This meant 06 Care was not safely administering medicines.

The training manager told us all new staff completed initial training and then were observed delivering care including medication. However they said, "We would wait until they were competent before doing an observation so this may not be immediately". This meant there was a significant risk staff were not competent in administering medication. They said competency checks were conducted annually however they did not have a matrix to show who had received checks or when they were due for renewal. When checking staff files, we found out of a random sample of twelve files, only two staff had been observed administering medication. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not being properly managed or safely administered.

We looked at safeguarding records and found incidents were logged and action taken appropriately in most instances. Detailed logs were kept of all conversations with the relevant authorities showing 06 Care ensured all matters were resolved in full.

The service had had few accidents and these were recorded accurately. There was an analysis of the number and type of accident, and a comparison with the previous year's data.

The service had an overall risk analysis for each person completed at their initial assessment visit which considered personal care, environment, mental health and other significant factors. These highlighted issues such as skin integrity and mobility. There were additional person-specific risk assessments in regards to risks from the environment and mobility. These provided staff with detailed guidance to follow when assisting with more complex moving and handling needs.

All people we spoke with agreed that staff washed their hands and wore protective aprons. One person told us, "They always wash between skin care and personal care - they wear plastic aprons".

Requires Improvement

Is the service effective?

Our findings

One relative was keen to praise staff saying, "I have an excellent relationship with management and they have worked with me to ensure that the carers have a good understanding of my relative's needs which the carers meet excellently." They highlighted the care workers' skills at moving and lifting and said, "They could not be better".

One care worker told us, "I did all my mandatory training and shadowed other workers before starting myself." The training manager told us the induction consisted of two days' classroom-based learning. If needed, staff had additional opportunities to shadow other staff based on the person they were going to support, their own experience and the type of work they would be undertaking. We saw where people were receiving more complex care support, the necessary training had been provided. We also saw photographic guidance for staff when using more specialist equipment such as a percutaneous gastronomy tube (PEG). The service did have a training matrix and this indicated all training was current.

Staff spoke highly of the training they received. One care worker told us, "The company provide good training, especially around more specialist areas such as PEG feeding." Another care worker said, "I had full manual handling training and had to complete a detailed induction book." However, there were no records kept as to when staff were deemed competent in moving and handling or medication administration so it was unclear if all staff had been suitably checked. The registered manager agreed to ensure these records were kept following the inspection.

Some staff told us they had supervision and we saw all new starters had received one session. However, for those working longer with 06 Care the evidence was minimal, with some staff not having had a supervision for over a year, which was concerning as new care staff were shadowing these staff. We asked the training manager about the frequency of supervision and they acknowledged it had lapsed. 06 Care's supervision policy stated staff should receive supervision every 12 weeks. The training manager did not keep a track of who received supervision so it was difficult to ascertain the amount offered. We found one care worker who had been with 06 Care since 2013 had only received four supervisions since they started and another who commenced in 2015 had received only two sessions. A further care worker who had also started in 2015 had received no supervision or appraisal at all and yet were in a senior position. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff had not received appropriate support in relation to their skills and personal development.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. One relative we spoke with felt care staff "look after [name] really well as they know their preferences."

We asked the registered manager if anyone lacked capacity to consent to care and they said not at the current time. We asked what action they would take if they were concerned about a person's ability to make such decisions and they said they would refer them to the local authority for an assessment. They were unaware of their role in assessing a person's capacity. We queried with the registered manager why some of the consent to share forms we saw were signed by relatives or significant others if all people had capacity and they explained it was more likely the person physically was unable to sign. However, this was not evidenced in the records. The registered manager agreed to ensure this was remedied after the inspection. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not obtaining consent from the relevant people.

Two people we spoke with commented that the care workers did not know how to cook. One person said, "They try to put cooked meat under the grill." However, we did not see any further concerns noted about this aspect of care delivery. The registered manager advised if anyone was of concern in relation to their nutritional status care staff would record information on a food and fluid chart which was regularly reviewed.

One person praised care staff for their attention to their skin care, "They keep a close eye for pressure sores." We overheard conversations in the office where concerns had been raised by staff and contact was made with external bodies such as a GP to ascertain further input.

Good

Is the service caring?

Our findings

One person was very complimentary about the care workers, saying "They really pay attention." Another person told us, "Generally, the carers are really good – they're efficient and gentle". A further person said, "They are gentle and kind." One relative said, "The standard of care is fantastic and I can take any issue to management and they sort it out quickly." Another relative told us, "I cannot praise the carers highly enough. They make our life so much better."

Staff were able to explain how they communicated with people who were not able to verbalise their needs as they tended to visit them regularly and got to know them well. Others had an awareness of different cultural heritages and explained some basic principles. The registered manager said they did not send male care workers into some parts of the community as this would not be appropriate and rotas reflected this.

Care records encouraged care staff to promote people's independence. In one record it was noted, "[Name] has lost lots of confidence so staff are to offer guidance and support." We saw in their daily notes where staff had encouraged the person to do as much for themselves as possible.

We saw in a recent quality assurance visit form one person had said, "Carers are very nice. They are polite and respect my dignity. They treat me well and are very kind." In another initial review form it stated, "We are extremely happy with the service. We love [name of care worker] and [name of care worker]. All your staff are a credit to your company." An annual review noted, "Care staff are professional and friendly. They listen and take on board what we say. Thank you to all the staff for their hard work and consistency."

The provider ensured people's preferences and experience of the care delivery in regards to staff conduct was regularly reviewed. The initial assessment involved obtaining detailed information regarding people's needs and wishes and the two and six week subsequent reviews checked these needs were being met.

Requires Improvement

Is the service responsive?

Our findings

One person shared their frustration at the restrictions placed on them by the call times, "Because they put me to bed at 8pm and don't get me up until noon I don't have time to meet anybody. I feel very lonely." We checked this person's records and saw this had happened on 28 and 29 September 2017. A call on 10 September 2017 had similar times; the person had received their morning call at 11am having been supported to bed by 7.10pm the previous evening. This meant the service was not considering individual need and left the person at risk of pressure damage due to the amount of time in bed.

Care records were organised and followed a set format for ease of reading. Details of the initial referral was stored along with the assessment visit which included specifics about people's needs and life history to aid staff in building relationships. People were given a service user guide with key contact information which included agreed outcomes such as building confidence and ensuring quality of life was maintained. This visit generated a person's care plan which identified their support needs along with a summary and related risk assessments. People's reviews were also kept in the file and we saw these were completed on a minimum of an annual basis.

Care plans identified a person's needs, the type of service offered, frequency and the name and address of provider including a start date. Most people we spoke with remembered being involved in care planning to discuss their care needs.

All people and relatives we spoke with knew how to complain, and two people told us they had. One relative said, "There's no need to make a complaint, you can just speak to management." We looked at complaints and saw no official complaints had been logged. However we saw a number of concerns had been raised which had been dealt with promptly.

Concerns were logged as 'occurrences' and were monitored regularly although we noted they had not been audited on a service-wide basis since June 2017. Issues included late calls, missed medication and changes to the care package. Some of these concerns were followed up with visits to people's homes to discuss in more detail. These issues were discussed at the management meeting. Other issues were dealt under this description including being unable to access a property or a person being unwell. We saw appropriate action had been taken in each of these instances to ensure the safety of the individual.

The service had received some compliments. We saw one relative had rung the office to say, "the standard of care provided by staff is excellent" and another relative thanked staff for their kindness when their relation was not well.

Inadequate

Is the service well-led?

Our findings

The previous inspection had rated well led as requires improvement and a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been identified. The service had been issued with a warning notice to ensure compliance. On this inspection we found serious concerns regarding the effectiveness of the auditing processes which had failed to identify the issues we found.

Some people told us they found it difficult to get through to the office. One person said, "They never answer the phone; it can take ages to get through". One relative echoed this, "Sometimes there is a delay answering the phone." However, once people got through they were acknowledged well. One person said, "They are always pleasant on the phone" and a relative told us, "They have always been polite and helpful with me."

Staff expressed similar difficulties getting through to the office, with one care worker saying, "If I ring the office in an emergency, they don't always answer straightaway but they will ring back." Another care worker said they tried calling once over 20 times but there was no answer. A further care worker said, "Management are good but slow to respond. You have to call a few times but they eventually get back to you."

One care worker told us "The company is good to work for but lacks communication at times. For example, if there are cancellations they don't tell us." Another care worker had confidence any concerns raised would be dealt with appropriately. They told us, "06 Care have high standards and staff are sacked if they don't perform to this. I would recommend this service, it's alright." This lack of effective communication meant messages were delayed and resulted in staff attending unnecessary calls, for example if people had gone into hospital.

The provider had a programme of quality assurance measures in place which included a review by telephone two weeks after a care package began, then a visit and questionnaire after six weeks completed by an annual review. The registered manager also explained daily notes were returned to the office and scrutinised to ensure they were being completed properly and there were no other issues.

We looked at the daily notes we found there was an incomplete supply and they did not appear to be returned to the office in a timely manner. On the first day of the inspection we looked for five different people's notes from July 2017, August 2017 and September 2017 respectively but could only find notes for July 2017 for one person and no others, and one set of notes for a person for September 2017 but no other notes. For the other three people there were no notes in the office for this period at all. When we asked the provider where they might be we were told they would not be in the files until audited. The provider did not have a record of which notes had been returned.

Of those notes which had been audited we looked at one set for May 2017 on the first day of the inspection. The audit date was 26 June 2017 which meant the notes had not been looked at for over a month since the provision of care. This meant any issues had not been identified quickly enough. The audit focused on correct completion of the records, whether all calls had been recorded and whether there were any issues of concern. Although this audit identified staff were assisting with creams it had not identified the creams

being applied were not logged in the person's medication or summary of care records. This showed the ineffectiveness of the auditing process. This meant staff were applying creams they had no authority or guidance to do so.

When we checked on the second day of the inspection we found further notes had been returned and three people's notes from August 2017 had been audited on 11 and 12 October 2017, over two months later. The audit did identify creams were being administered and staff had instigated this without any direction from the service. Although the provider had asked for this to be investigated, this was six weeks after the event. We saw other notes had been returned to the office in between the two inspection dates and these had also been audited over two months after the initial care delivery period.

The audit tool did not consider the actual time of the call (apart from checking four hour gaps for medication where applicable) or the duration, it assessed whether all calls had been recorded and the detail of the note taking. We saw the analysis of 'missed calls', based on non-recording of information in the daily notes, focused either on staff misreading the rota or a clerical error where the call had not been added to the rota. In May 2017 one person had six missed calls as staff had not been informed they had returned from hospital. This meant the service was not considering the effectiveness of its service delivery in line with person experience and had missed the issues we identified during the inspection.

We found no evidence staff meetings had been held. One care worker told us no meetings had been held this year but stressed they felt this was needed. This meant staff did not receive the necessary support required to fulfil their roles as most were not receiving supervision or having any other contact with staff. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as governance arrangements were not robust, and the provider was not effectively assessing and monitoring its quality of service delivery, nor appropriately mitigating risks to people.

The provider was looking to implement an electronic record system which would provide real-time data for the staff to ensure calls and records were easily accessible. The registered manager was keen to take the service forward by developing specialisms but was doing this in a gradual manner.