Care Link Northern Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Care Link Northern Ltd provides personal care and support to people living in their own homes. At the time of our inspection there were 45 people using the service including four people who live in a supported living setting who require 24 hour care.

This inspection took place on 17 August 2016 and was unannounced. We last inspected this service in February 2014, at which time we found them to be compliant against all the regulations that we inspected.

The service had a registered manager in post who was also the registered provider. 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.

We found the safety of staff recruitment was not robust. Personnel records were missing essential evidence which would verify a person was suitable to work with vulnerable adults. We discussed this with the office manager who told us she would arrange for the collection of the necessary documentation.

The service had risk assessed aspects of people's daily living to ensure their safety, but some wider aspects, such as behaviours which may challenge the staff and people accessing the community, had not been considered. We have made a recommendation about this. The company policies and procedures had been recently reviewed and updated. We discussed the implementation of additional policies with the office manager to ensure the service was more robust in areas such as recruitment, social media and use of mobile phones.

Medicines were administered safely and in line with safe working practices. People and relatives told us they had no issues with medicine support and care workers told us they felt competent with this task, we found that formal medicine competency checks were not being carried out with care workers. The office manager told us she would ensure these checks took place in future.

Staff received an induction and had been trained upon commencement of employment; we found that refresher training was not up to date. For example, two of the four staff files we examined belonged to staff who had been employed for a long time. There was no evidence of refresher training for these two care workers.

The service had supervision and appraisal policies in place but staff told us and records confirmed that formal supervision sessions had not taken place for over 12 months. The office manager told us staff often visited the office to discuss and resolve any issues they may have although these had not been formally recorded as supervision sessions. There was also no appraisal documentation in two files of long standing employees. The registered manager told us she monitored staff competence daily by working with the care

workers and had no concerns about them. We have made a recommendation about this.

The office manager maintained a diary to record actions to take, however formal audits of the quality and safety of the service were not being undertaken. Formal observational quality checks of staff practice had not been completed since March 2015.

The registered manager told us that she regularly worked shifts as a care worker which enabled her to have oversight of the service. People and staff told us they had a good relationship with the registered manager and were able to approach her with any feedback.

People told us they felt safe living at home with support from their care workers. Staff understood their responsibilities to report any safeguarding concerns to the office manager or registered manager. People and staff told us they felt there were enough staff employed to provide a reliable and consistent service. We confirmed this through records.

There had been a low number of accidents and incidents; these were recorded as appropriate. There was evidence to demonstrate that regular reviews of people needs were carried out and information was passed onto the care workers and other health and social care professionals as necessary.

Evidence showed the registered manager and staff had an understanding of the Mental Capacity Act (MCA) and their own responsibilities. The service used the local authority's mental capacity assessments within their records. Care records showed that wherever possible people had been involved in making some decisions, but significant decisions regarding people's care were made in people's best interests and had been taken appropriately with other professionals and relatives involved.

People told us they were respected and their dignity and privacy were maintained. All of the staff displayed kind and caring attitudes and through discussion, care workers demonstrated to us how they respected privacy and dignity. People's care needs were recorded in detail and reviewed by the management with input from people, their families and healthcare professionals. The office manager told us people's care records had been updated with new personalised documentation which had been recently introduced.

People told us they were offered a choice in all aspects of the support they received and care workers told us they gained verbal consent before providing any support. The service encouraged and promoted social inclusion and supported people to maintain links with family and friends. People and their relatives told us they had nothing to complain about but they knew how to complain and would feel confident to do so if necessary.

All of the staff told us they worked very well as a team. Care workers felt supported by the registered manager, office manager and supervisors who they said were approachable, caring and made them feel like a valued member of the team. People, relatives and staff all described the service as "a family run business" with "family values".

The last annual customer survey had been carried out in 2014. People told the service they had found these surveys difficult to complete so no further surveys had been issued. The service had also tried to gather feedback by telephone courtesy calls in 2014 but this had also been a failed attempt. We discussed the need to formally gather opinion of the service from customers with the office manager who told us they would try courtesy calls again. The feedback we gathered as part of the inspection was excellent from each person and relative we contacted.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment processes were not robust. Pre-employment vetting checks were either missing or had not been obtained.

Risk assessments were in place for general aspects of daily living, but risks associated with individual needs had not always been considered.

Safeguarding policies and procedures were in place and people told us they felt very safe with support from the care workers who visited them.

Is the service effective?

Requires Improvement

The service was not always effective.

Training records did not contain evidence of regular refresher training or competency checks to ensure staff remained skilled and competent in their role.

Formal supervision and appraisal meetings were not regularly taking place to demonstrate care workers were supported in their role. Staff told us they felt supported and valued at work.

Mental Capacity Act (2008) training had not been undertaken by staff to ensure they are aware of the principals and their responsibilities, although there was evidence that some decisions had been made in people's best interests.

Is the service caring?

Good

The service was caring.

People told us they were supported by "fantastic" and "marvellous" care workers who were respectful. Relatives echoed this opinion.

The service was very flexible and adapted to meet people's needs. Privacy and dignity was maintained.

The staff we spoke with demonstrated kind and caring attitudes and knew the people they supported well.

People had received relevant information and explanations to help them understand the service.

Is the service responsive?

Good

The service was responsive.

Person-centred records had been introduced. They were very detailed and contained personalised information including likes, dislikes and preferences.

A pre-assessment and in-depth assessment of care needs were carried out to ensure the staff could deliver a service as expected.

People's care plans and assessments were regularly reviewed and updated as necessary.

There had been no complaints made about the service. A complaints procedure was in place and people were aware of it.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although a registered manager was in place, she had spent a lot of her time undertaking care work. This had impacted on the governance of the service.

Formal records were not retained in aspects of the service to demonstrate the registered manager/provider had oversight.

Audits and checks on the safety and quality of the service were not routinely carried out to ensure compliance with the regulations.

Feedback had not been sought from people who currently used the service.

People, relatives and staff all felt the service was well managed and described it as "a family run business with family values."

Care Link Northern 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 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 the 17 August 2016 and was unannounced. The inspection was conducted by one adult social care inspector at the provider's registered office.

Prior to the inspection we reviewed all of the information we held about Care Link Northern Ltd, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

As part of the inspection we contacted three people who used the service by telephone to gather their opinions. We also spoke with and emailed five relatives to gain feedback about the service. We spoke with six members of staff, including the office manager, a senior supervisor, three care workers and the registered manager/provider. We reviewed a range of care records and the records relating to the quality and safety management of the service. This included looking at four people's care records and four staff files.

Additionally, we contacted local authority contract monitoring team and adult safeguarding team to obtain their feedback about the service. On this occasion, we asked for a Provider Information Return (PIR) prior to the inspection. The PIR 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. All of this information informed our planning of the inspection.

Requires Improvement

Is the service safe?

Our findings

The recruitment procedures were not robust to ensure staff were suitable to work with vulnerable adults. The service did not have a recruitment policy in place which meant the office staff did not have sufficient guidance to recruit safely. The staff files we examined lacked the required evidence of Schedule 3 of the Health and Social Care Act 2008 (the Act) which would demonstrate staff had been properly vetted prior to employment. The provider had carried out some pre-employment vetting checks including gaining references from previous employers, completing interview documentation and obtaining an enhanced Disclosure and Barring Service (DBS) check for each employee. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are employed.

Two of the four files we examined contained no evidence of an enhanced DBS check. One file did not contain any references and one file only contained one character reference. The provider had failed to verify the identification of employees in three files. None of the files contained proof of an employee's national insurance number which would ensure people had the right to work in this country. The office manager told us these four employees had been recruited through word of mouth and were already either known to the registered manager/provider or other members of staff. They assumed this may be the reason why stricter pre-employment vetting checks had not been completed.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 19: Fit and proper persons employed.

People's care needs had been risk assessed and detailed risk assessments were drafted to support staff with their duty of care. We saw that risks to aspects of people's health, wellbeing and daily living such as medicine, mobility and ensuring homes were secure at night, along with domestic risks had been assessed and were reviewed monthly. Risk assessment documentation detailed the possible hazards, any contributing factors and strategies to prevent incidents. We noted that some specific needs of people had not been considered such as behaviours which may challenge the staff and risks associated with people accessing the community. We discussed this with the office manager who told us they would ensure a broader risk assessment was carried out. We recommended the provider seek advice and guidance from a reputable source in order to ensure the wider risks people faced were monitored.

We checked how the service managed people's medicine needs. The office manager told us, "Care workers are mostly verbally prompting people to take their medicine." There was strict guidance in place for the staff to follow with regards to the ordering, receipt, storage and disposal of any medicine. The service had ensured people's medicines were stored safely in 'dosette boxes' filled by a pharmacist. We were told this "made people feel empowered." This meant more people could access their own medicine independently without fear of getting their tablets mixed up. Medicine risk assessments were in place as necessary and documented the level of assistance people required. Care workers signed a Medicine Administration Record (MAR) to show when support had been given. We reviewed some MAR's and saw they were legible and well maintained. People told us they received their medicine in a safe and timely manner and relatives confirmed

this. MAR's were audited by office staff on a monthly basis. The office manager told us any discrepancies would be reported to them immediately. There had been no issues with medicine management and no concerns or errors had been reported.

We noted that care workers had not undertaken medicine refresher training for over 12 months and found no evidence that competency based checks were being carried out. The office manager told us the registered manager regularly worked alongside care workers and had not raised any concerns about their practice. Due to the lack of records we were unable to ascertain whether staff remained suitably trained and competent to safely administer medicines. The office manager told us they would ensure competency checks were formally recorded in future.

We asked people who received a service at home if they felt safe with support from their care team. Comments received included, "Yes, [I feel] very safe" and "We definitely feel safe." We asked relatives if they felt their relations were safe and they told us they were.

Safeguarding policies and procedures were in place for staff to follow in order to protect people from harm or improper treatment. The office manager told us there had been no accidents or incidents of a safeguarding nature within the service. Staff had completed a safeguarding awareness session as part of a 'Principals of Care' training course and were able to describe their responsibilities to report safeguarding matters. Staff told us they were not worried or concerned about anyone they looked after. Staff said they understood all of the policies and procedures in place and that they would have no hesitation to report any issues to the management.

The service operated a 'high risk' text service. This meant people who were assessed as being at high risk due to frailty or vulnerability were further protected because care workers were instructed to text the office on arrival at their home. This ensured visits were not missed to people who were not able to call the office or a relative themselves if they were concerned about a care worker not arriving on time.

People and relatives told us there were enough staff employed by the service to meet their needs with reliable and consistent staff. Comments included, "I only ever get (care worker 1), (care worker 2) and (care worker 3). They are my team" and "It's [the service] very consistent." We reviewed the staff rotas for the previous four weeks and saw care workers were allocated regular shifts with the same people to visit each day/week. There were gaps in the rotas for care workers to have breaks. The care workers we spoke with also confirmed the service had enough staff and they did not feel hurried in their duties.

Requires Improvement

Is the service effective?

Our findings

We saw in two of the care worker files we examined, staff had undergone an induction into the company. The office manager told us that more recently all new staff were completing the 'Care Certificate' induction process. The Care Certificate is a benchmark for the induction of staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. The care worker files did not contain evidence of a shadowing period to show new staff had accompanied experienced staff to home visits; however the care workers we spoke with told us they had undertaken this.

Training had been delivered to care workers in topics such as moving and handling, health and safety, food hygiene and infection control upon commencement of employment. On-line training was used to make care workers aware of other key topics such as safeguarding and dementia. Two of the four files we examined were of care workers who had gained qualifications in health and social care. External professionals such as nurses had delivered training on invasive care procedures, such as percutaneous endoscopic gastrostomy (PEG) feeding. PEG feeding is commonly used when oral intake is not adequate. The care worker files we examined demonstrated that they had not received refresher training and formal observations of their competency had not been carried out.

Evidence showed that formal supervision and appraisal had not taken place recently or regularly, despite a company policy being in place. One care worker (employed for nine months) said, "One-to-one's are going to happen, but I haven't had one yet." We discussed this with the office manager who confirmed formal supervisions or appraisals had not taken place since 2014/2015 but care workers often visited the office on a regular basis and spoke on the telephone with the registered manager and office staff. These 'informal sessions' had not been documented as supervision. This meant the service could not demonstrate to us that care workers had received periodic supervision to ensure their competence was maintained.

We spoke with the registered manager about embedding their supervision and appraisal policy into working practice.

The care workers we spoke with told us they felt fully supported in their role and confirmed that that had undertaken training when they started working for the company. One care worker told us, "The [registered] manager is always available and pops into the office often, we can ring or speak to her anytime, she's very approachable." Another said, "You can go to them [office staff] if you have any problems…I completed shadowing and done training, I feel confident." They added, "You can ring on-call at any time or ring the [registered] manager."

Care worker team meetings did not take place. We were told this was due to the logistics of getting the care workers altogether in one place. The office manager told us they had regular meetings with the supervisors and they spoke daily with the registered manager about issues, updates and actions taken to manage the service. However there were no written records of these meetings to demonstrate they had taken place and what was discussed. The office manager told us they would ensure meeting were recorded in future and relevant information would be cascaded to the care workers. The office manager did produce a weekly

newsletter for care workers informing them of relevant information about people who received a service.

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. The service relied upon the local authority's community mental health care team to provide capacity assessments and inform them of people's mental health needs. We saw evidence that where people lacked the mental capacity to make particular decisions they had been supported by care workers, their relatives, and external health and social care professionals to make decisions in their best interests. There was no evidence that office staff or care workers had received training in the principals of the MCA.

We discussed how the service ensured people had the capacity to consent to their care and treatment. We were told that the service would refer a person to the community mental health team if there were any doubt about the mental capacity of someone they supported. The office manager told us some people's relatives had Lasting Power of Attorney (LPA), although they were unsure if this arrangement was for health and welfare, finances or both. The office manager told us in future she would ask relatives if they would provide a copy of the LPA documentation to evidence relatives had the right to make decisions on people's behalf. Some people's finances were managed by the local authority under Court of Protection. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at the time because they may lack capacity to do so. In this situation, the service liaised with the local authority to ensure people had enough food, clothing and bills were paid.

The service was supporting people to maintain good nutrition and hydration. The people we spoke with and their relatives had no concerns about the support they received with this. We saw evidence in care records that the service had assessed people's nutrition and hydration needs and the daily notes demonstrated staff supported people to eat healthy, well balanced meals. There was additional evidence that where there was a risk to someone's health and well-being, food and fluid charts were completed by staff in order for intake to be monitored by external professionals such as GP's, nurses and dieticians.

Care records showed the service involved external health and social care professionals when people's needs changed. The records indicated that staff had made referrals to GP's, a consultant, district nurses, physiotherapists and dieticians. Records were made of the communication and any progress or outcomes were recorded. Relatives confirmed they were kept abreast of any communication between or involvement of external professionals. One relative said, "They've [staff] never had to refer on or get a professional involved but I know I could rely on them to do so if necessary."

Good

Is the service caring?

Our findings

People and relatives used terms such as "The best I've ever had", "fantastic" and "marvellous" to describe the care workers who visited them at home. It was apparent from the conversations we had; people had an excellent relationship with their care workers, some of whom they had known for many years. People told us, "I can't praise them enough" and "They are absolutely wonderful people – lovely girls, very caring." Relatives added, "They put your mind at rest" and "They have got a gift – they can do more with [my wife] than I can – they have a dance with her and she is smiling."

The service was very accommodating of the people's needs. We saw evidence in office records and through discussion that the service adapted to suit people's needs. Visits were re-arranged to make it more convenient for people who had appointments and certain care workers were allocated certain visits because people preferred those care workers or had specifically asked for them. People told us they received a good service from "genuinely caring" staff. A relative told us, "It's an excellent service; I wouldn't go anywhere else now I've had these care workers in, they are flexible and they understand what is expected."

The staff we spoke with demonstrated kind and caring attitudes as they described people's care needs, their role and the tasks they supported people with. Care workers promoted independence and they told us about encouraging people to do some tasks for themselves supporting them only when necessary.

Discussions with the management and care workers revealed that people who used the service did not have any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this.

Care records showed people and their relatives had been involved in the care planning process. They had contributed to the information recorded about themselves such as likes, dislikes, interests and hobbies. People or relatives had been asked to sign the documentation to consent to the agreed care and support.

We reviewed a 'Service User Guide' and an up to date 'Statement of Purpose' which the service had produced and shared with people who used the service. These documents contained information about the company's values and the limitations of service. They explained what the 'service user' can expect from the company and how the service will be delivered. They provided information on quality assurance, complaints and useful contacts. Some of the company's policies were also included for people's information such as staff conduct, health and safety and confidentiality.

At the time of the inspection nobody who used the service required an advocate. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. The office manager told us that informally, relatives usually acted in this role and sometimes the registered manager or a care worker did. The office manager told us they were aware of how to involve an independent advocate from a local service if they thought it was necessary.

Care records which contained people's sensitive information were kept locked away at the office and copies were available in people's homes for care workers to access. The care workers we spoke with were aware of the importance of maintaining confidentiality and privacy. Care workers told us how they would maintain dignity and gave us examples such as closing the blinds and keeping the body covered up during intimate personal care tasks. People and relatives confirmed this and said care workers did treat them and their homes with respect. Although care workers hadn't completed training in privacy, dignity and respect, the office manager told us it was on the list of on-line training courses which the care workers would complete in the near future.

Nobody who used the service was receiving end of life care at the time of the inspection. However the service had supported people in the past and were prepared to deliver this kind of service should anyone require it. Care workers were able to complete an on-line training session in palliative care and there were enough staff to provide 24 hour care to people who may need this level of care and support.

Good

Is the service responsive?

Our findings

A relative told us, "It has been a great relief to find a care-provider in Carelink which puts the client at the centre of their care." We found care records were person-centred. New personalised records had been introduced in January 2016 and people's records had been recently reviewed and transferred to the new documentation. These were all thoroughly completed to a good standard with detailed information.

A pre-assessment was carried out with people when they first enquired about receiving a service. A supervisor visited the person at home to explain about the company and gather information about the level of support required, preferences, routines, likes, dislikes and allergies. An initial safety check on the property was also conducted. Once agreed, a more in-depth assessment was undertaken.

The assessment records contained information about people's care needs including physical, mental, mobility, continence, communication and dietary needs as well as needs associated with a specific conditions such as MS (Multiple Sclerosis) or Parkinson's. The service took a holistic approach to care planning by considering people's wider needs such as social, religious and cultural when devising a plan of support. A copy of the local authority social services document called "All about me" was included in some people's files.

The care plan records contained detailed instructions for the care workers to follow which informed them of people's preferences, routine and abilities. The service has listed person specific outcomes within these records to measure how well the service was meeting people's needs. For example, outcomes included a certain level of independence with personal care that a person could achieve, how comfortable a person was with their hygiene and well-being and how much social involvement they had.

Care workers were provided with a basic information sheet and the management spoke with them prior to attending the first visit to give as much information as possible about the person.

The management were responsible for reviewing and updating care plans and assessments, and there was evidence that people, their relatives and external professionals all had input into this. Review meetings were held in people's homes to ensure people who used the service were involved in the process and they could invite whoever they wished to attend the meeting. We saw evidence of joint reviews taking place with the local authority social services department, with outcomes and action recorded. Some actions included involving specialists such as occupational therapists to provide advice and guidance on the best use of equipment when people are unwilling to cooperate with safe working practice.

The registered manager told us about the importance of people maintaining a relationship with their family and friends. The registered manager was very proactive in encouraging people to be socially included within their community. She told us about organising an annual trip to Blackpool for the people who lived in the supported living setting, and each year the trip had become more popular with people who lived in their own homes being invited to join in. Care workers also gave up their own time to facilitate the short break and they booked the same hotel each year which had the facilities to meet people's needs. The registered

manager told us the staff at the hotel were fantastic and had got to know people well over the years. This made the trip more enjoyable for people who looked forward to visiting "their friends" in Blackpool.

The service had received no complaints. The office manager told us they dealt with issues immediately which could be resolved easily over the telephone or by sending a supervisor to visit the person. The office manager did escalate some issues to the registered manager who usually visited people in person to resolve any problems. A complaints policy and procedure was in place and had been made available to the people who used the service.

The people and relatives we contacted after the inspection had no complaints about the service, the care workers or the management. In fact they were all very complimentary about the service. They said, "I have no concerns at all and I'm confident if I did they would deal with issues properly", "Its excellent – I think it's because it's a family run business, they all know each other and what is expected" and "We cannot fault them."

Requires Improvement

Is the service well-led?

Our findings

Policies and procedures were in place, some had been last reviewed in April 2016 with a view to an annual update. The medicine policy was last reviewed in April 2015 and contained out of date information such as reference to old regulations. The service did not have a recruitment policy drafted and we raised this with the office manager due to the implications of the unsafe procedures we identified when we examined the staff personnel records. We also highlighted other relevant policies which had not been considered such as 'social networking rules' and 'The use of mobile phones – photography and confidentiality'. Other policies and procedures such as the supervision and appraisal policy were in place but were not being adhered to.

Audits and formal checks on the safety and quality of the service were not being carried out. We asked the office manager to provide us with the quality assurance information to review. We were told there wasn't any. This meant we were unable to ascertain whether effective monitoring systems and processes were established to ensure compliance with the regulations. Due to the lack of audits the registered manager was not able to formally assess, monitor and improve the service. Accidents, incidents and safeguarding matters where recorded but they were not being formally monitored for patterns or trends to enable the registered manager to devise strategies or implement control measures to prevent any future recurrences.

As there was no audit of service user records, the registered manager had not identified the shortfalls we highlighted in risk assessment documentation such as the omission of risk assessments for people's specific needs such as challenging behaviour and accessing the community.

As there were no audits of staff personnel files, the registered manager had not been able to assure themselves that new employees were of good character and were suitable to work with vulnerable people. The lack of refresher training and care worker competency checks meant that the registered manager was not able to evidence that care workers remained skilled and competent to carry out their role.

We found that the amount of hours the registered manager had undertaken as a care worker had severely impacted on her ability to have oversight of the service. The lack of audits meant that concerns we raised regarding the safety and quality of the service whilst examining management records during the inspection had not been previously identified by the service themselves and most likely would not have been if it was not for the inspection taking place.

The only information we were given which related to quality assurance was a customer survey conducted in 2014. No further customer surveys had been carried out because some people who used the service in 2014 informed the registered manager that the surveys were too complicated. Therefore no further surveys were developed or implemented. Surveys had also not been sent to relatives or external professionals for an overall opinion of the service. Eight courtesy calls had been attempted in 2014 which we were also told was a failed effort at gathering feedback. We discussed the need to gather feedback from people, relatives and external professionals in order to develop the service and drive through improvements. The office manager told us they would re-start the courtesy calls.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good governance.

The provider/registered managed had been formally registered with the Care Quality Commission (CQC) since January 2011. The service had a history of compliance with the regulations associated with the Health and Social Care Act 2008. A previous inspection by CQC in February 2014 found the service was fully complaint with all of the outcomes we inspected. The registered manager was present for two hours during this inspection but left to undertake care work. The office manager and senior supervisor assisted us throughout the inspection and liaised with care workers and the people who used the service on our behalf.

The registered manager had an extensive history of working with adults in a domiciliary care setting. She had experience of working in the industry before setting up her own company. The registered manager was very knowledgeable about the people who used the service and she regularly worked as a care worker providing personal care and support to people.

There was a clear staffing structure in place, which included the provider/ registered manager, an office manager, a senior supervisor, two supervisors and 30 care workers. The whole team were aware of their responsibilities and what they were accountable for. The care workers worked regular shifts which were consistent for both them and the people who used the service. The care workers we spoke with told us they had no issues with the management of the service.

The culture of the service was open and transparent. The people, relatives and staff we spoke with described it as "A family run business" and told us the management had "family values". People told us they thought the service was well managed and made comments such as, "(Registered manager) is amazing", "She [registered manager] will do anything for you." A relative told us, "I haven't met the overall manager but the office manager has been excellent since the first point of contact."

We asked two care workers if they enjoyed their job. One said, "It's lovely, it's so good, really brilliant" and the other said, "I enjoy it – there is good management, if you've got any problems you can go to them." Both care workers told us they felt supported and valued at work.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always established or effective enough to ensure compliance with the regulations. The service failed to assess, monitor and improve the safety and quality of the service. The service did not always maintain accurate, complete and contemporaneous records and they did not seek feedback from their stakeholders. Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Robust processes were not in place to ensure evidence was collected which would confirm a new employee was of good character and suitable to work with vulnerable adults. Regulation 19 (1) (a) (2)