Focal Care Ltd

Caremark (Barnsley)

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

We inspected Caremark (Barnsley) on 3 and 9 October 2018. The inspection was announced on both days. Our last inspection took place in October 2016 when we rated the service good. As this inspection we found the evidence that the service required improvement.

Caremark (Barnsley) is a domiciliary care agency operating in the Barnsley area. It provides personal care to people living in their own houses and flats in the community. Not everyone using Caremark (Barnsley) received a regulated activity; CQC only inspects the service being received by people provided with 'personal care:' help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection 134 people were receiving regulated activity support from this provider.

The service did not have a registered manager. The registered manager had left the service in February 2018 and had not completed the application process to de-register with the CQQ. The service had a new care manager in post. This person had started the application process to register with the Care Quality Commission.

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.

People told us they felt safe with the staff who supported them. Staff understood their roles and responsibilities to keep people safe from harm.

Medicines were not always administered safely and records relating to the administration of medicines were not always updated appropriately.

There were risk-specific assessments in place which identified risks to the tasks provided to care and support people. Measures had been put in place to minimise these risks; these also covered the environment in which people were supported.

There were sufficient staff to meet people's needs. However, consistency of staff had been a concern. The new care manager had recently changed how staff were deployed. Staff told us this had improved.

Staff recruitment pre-employment checks had been thoroughly carried out.

People who were supported with medication had not always had this administered safely and staff competencies had not always been checked. There was a detailed action plan to improve this area with demonstrated lessons learnt.

Staff had undertaken training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff were able to describe what this meant. People were supported to have 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.

Care records showed people had consented to care and treatment. Staff told us how they would always ask for consent to care before assisting people.

New staff were supported in their role, which included training and shadowing a more experienced staff member until they felt confident. Staff undertook regular on-going training. Staff received regular supervisions, appraisals, observations and spot checks to assess their competency.

Staff gave examples of how they accessed and worked with relevant healthcare professionals when required.

People we spoke with told us staff were kind and caring. Staff treated them with respect and took appropriate steps to maintain people's dignity and privacy. People's private information was kept confidential.

People had a person-centred care plan in place which showed how they wished their care to be undertaken. Their likes, dislikes, and preferences were also included. This enabled staff to provide the care and support required by each individual.

There was a complaints process in place. People told us they felt confident of what to do if they had any concerns or complaints.

Regular audits had not been undertaken and audits that had taken place had failed to identify required actions.

People told us the service was well led and all talked about how well they knew the registered manager.

They described how they were regularly asked for their input and feedback. Staff gave examples of how the registered manager responded positively to feedback. People spoke highly about the management of the service.

The manager described how the service worked in partnership with other organisations and healthcare professionals.

You can see the action we asked the provider to take at the end of this 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.

The management and administration of medicines was not sufficiently robust. Some risks to people had not been identified and acted on.

Staff demonstrated a good understanding of how to ensure people were safeguarded against abuse and were knowledgeable about the procedure to follow to report incidents.

Recruitment practices were found to be safe. There were sufficient numbers of staff to meet people's care needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The frequency of supervision and appraisal required improvement.

Staff had completed necessary training to ensure they had appropriate skills to perform in their roles and their competencies were checked regularly.

The service was generally meeting the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff had received training in privacy and dignity and knew people well.

People's dignity and privacy was observed at all times and staff were aware of the importance of involving people in the care they provided.

People's choice and independence was encouraged and promoted.

Is the service responsive?

Good

The service was responsive.

The service provided person-centred care and staff ensured needs were reviewed when care and support needs changed.

Staff were aware of the needs of the people they were supporting and were knowledgeable about their individual preferences.

Care plans were comprehensive and people were involved in the assessment of their needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits and checks had not been undertaken regularly. Actions were not always identified from these.

The registered provider and care manager were well-known by people, staff and relatives and responded positively to all feedback. People, staff and relatives felt able to contribute their suggestions and opinions.

Engagement was taking place with a local groups and professionals to improve the service.

Caremark (Barnsley)

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 was a comprehensive inspection. The inspection took place on 3 and 9 October 2018 and was announced. We gave the service 48-hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure a member of the management team would be available to meet with us. The inspection team was made up of one adult social care inspector and one bank adult social care inspector on the first day. An adult social care inspector visited on the second day. An expert by experience spoke with people and their relatives over the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. We contacted commissioners of the service, safeguarding and Healthwatch to find whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

Before the inspection, the registered provider had completed 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.

During the inspection we met with the managing director, the operational director and the care manager, three support workers, one field care supervisor, one care co-ordinator and the alerts co-ordinator. We looked at 12 care plans including risk assessments, nine staff records and other records relating to the management of the service. We spoke on the telephone with ten people who used the service and one relative.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe with the care provided by Caremark (Barnsley) and were able to describe how the care workers made sure they were safe. On person said, "[Name of care worker] is always caring, considerate and makes that extra effort to make sure I'm comfortable." Another person told us they felt safe because the care workers wore name badges. However, one person told us they didn't feel safe when one of their care workers wore a lot of jewellery.

Systems, processes and practices safeguarded people from abuse. Training records showed staff had been trained to recognise signs of abuse and staff were able to give examples and told us they would always discuss concerns with their supervisor. A staff member said, "The carers are really good at picking stuff up. They report to the field care supervisors who will do a welfare visit. The carers report everything, for example, bruises, they document on body maps." Another staff member explained how they use the electronic call tagging system to make sure people received calls on time and were kept safe.

The same staff usually visited the same people so they got to know people well and staff said they would recognise changes in people's mood and emotional state. Staff who handled money for people to buy items they requested told us they always saved receipts and completed finance records detailing the cost for each item to protect people from financial abuse.

The provider told us they were recruiting to 12 care worker vacancies and a staff member said, "Staffing levels are right, we're recruiting to vacancies, it will be better when they're filled." The service had an alerts co-ordinator whose job was to monitor and manage each call, look at whether staff were running late and take action to make sure people are safe. Most people told us they knew their care workers well. However, one person told us they had had so many different carers they were unsure of any of their names.
Records showed a person had called the service to ask for the same carers to support them and three staff were named on the person's care plan. However, of the 35 support calls the person received in August 2018 only one of the named staff attended; this happened for 12 of those calls. In total eight different carers had attended to support the person during that month. The care manager explained the service had recently introduced a new system to ensure people were supported by consistent staff and told us, "We always aim to inform a client if a new carer is attending." Most people we spoke to confirmed this and a staff member told us, "We have an improved rota system. It is better organised…this has helped more consistent call times for [people] and [staff]."

Staff said told us they usually cared for the same people but could be asked to take extra calls at short notice, to cover for sickness and absence. Staff confirmed they were usually given enough time to travel between people's homes. All the staff we spoke with said they had been introduced to all of the people they regularly cared for, before delivering care for them. This is good practice which helps people feel safe when allowing someone into their home.

Recruitment practices were safe and appropriate background checks were in place. We saw evidence of application forms, detailed interview records, full employment histories and evidence of identity being

checked. This included references from previous employment and a satisfactory Disclosure and Baring Check (DBS). The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people.

People's medicines were not always managed in a safe way. Safe protocols were not in place for the administration of topical creams. Some people had been prescribed topical creams and lotions and we did not see records of how these were administered by staff. Most of the topical medicines administration records (TMARs) we saw had minimal information stating only the name of the cream and had no directions about how this should be administered. For example, staff would be directed as to when, where and how to apply creams and lotions.

One person had been prescribed two topical creams. Administration records showed one cream had been signed as applied three times each day and one application of the other cream for only six days in a 14-day period. The TMAR did not show how frequently either should have been applied. For another person the daily log indicated 'creams' had been applied but there was no corresponding record on their TMAR.

Another person was prescribed two creams. A staff member we spoke with knew where and when to apply these creams although this had not been recorded on the TMAR. One person had been prescribed 'eye drops' and staff had signed to show these had been given but the MAR did not specify what the eye drops were called, why or when they should be administered or if they were for both or one eye.

Staff told us they used information supplied by a pharmacist or relatives and wrote this information onto lotion boxes. Some creams had not been signed as checked in by staff when these were received although a staff member told us they always checked and signed the medicines administration record (MAR) for medicines if they administered them.

The registered provider had not undertaken any medication audits during the absence of a care manager and we were not assured people were always administered their prescribed medications safely. However, medication audits had taken place recently by the new manager and field care supervisors and we found evidence action had been taken when issues were identified during these checks.

The service had detailed policies and staff received regular training in relation to medicines administration. Following some recent medicines errors the provider had produced, and was actively working to, a detailed action plan to mitigate risks in relation to medicines administration. All staff had recently undertaken further training on medicines administration and their competency to administer medication had been checked. Staff had received frequent and regular information about medicines administration through staff meetings, individual supervisions and provider bulletins and memos.

The provider had taken reasonable action to address the medication errors including working with the local authority to address concerns and taking immediate action to remedy errors. The action plan outlined each issue separately, the actions taken to resolve the issued and those needed to mitigate further risks. Lessons learnt were identified.

The service managed risks to keep people safe when staff intervened. Risk assessments were carried out when people first agreed to use the service and these were reviewed. People's home environments were assessed covering smoke detectors, lighting, electrical appliances carers might use, and access to the property. Substances potentially hazardous to health (COSHH) available in the home and used by care staff had been listed and reviewed.

Risks associated with personal care such as bathing or showering had also been assessed. When risk of infection, falls or scalds had been identified, safe working plans were in place to help carers keep people safe. When the service had responsibility for administering medicines, risk assessments had been carried out. However, individual person-centred risk assessments were not always in place. Generalised risk of falls had been identified, for example, when people were assisted to shower; however, people who had previous falls, used mobility aids, or had health conditions which made falls more likely had not had these risks assessed. We discussed this with the provider and the registered manager who had plans to introduce more person-specific risk assessments.

People's records were legible and securely stored either in paper files in an office, or electronically on a secure server. Copies of care plans were also maintained at each person's home. Progress logs where carers recorded details of each visit were kept in people's homes and transferred to the offices of the provider at the end of each month.

Staff understood their roles and responsibilities in relation to infection control and hygiene. People we spoke with told us their care workers used appropriate personal protective equipment at all times. A staff member said, "We get training on infection control, there's also spot checks." Staff told us they collected personal protective equipment, such as gloves and aprons, from the offices of the service and there was always an ample supply. They all correctly identified effective handwashing as the primary measure in preventing spread of infection.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found the service required improvement in this key question. This was because people reported they did not always have regular care workers and the timing of their visits was not always reliable. When this was discussed with the registered manager at the time they said they had identified this issue and had made plans and undertaken changes to mitigate these issues. At this inspection we found these changes had been implemented and the new care manager had made further changes to the staffing rota system. However, we still found the service required improvement.

A person said they felt their care worker had a tight time schedule and always seemed to be in a rush to get to the next visit. They told us whenever their regular carer was on holiday another carer arrived and "Didn't even take [their] coat off. Another person told us they were unaware of who their area supervisor was. They had raised this with their care workers who told them they were unaware of who their site supervisor was. However most people we spoke with told us they knew their care workers and records showed each person had named staff to support them.

The care manager told us that more than a third of people received a paper copy of their support rota each week so they knew which care workers would attend on each day. The care manager explained, "We give them a paper rota to let them know which carers are attending to support them. Some people ask for this and others are given one where we've noticed the client is anxious."

People's needs were assessed at the start of the service, which enabled managers to ensure they could meet people's needs, and these were regularly reviewed. The registered provider described the types of ways in which they ensured the service was kept up to date with current legislation and practice, such as reviewing CQC reports and benchmarking against other services. The operational director was also on the Local Authority Health and Wellbeing Board and the Dementia Action Alliance Board in Barnsley.

We looked at whether the service considered and respected peoples human rights and their individuality under the protected characteristics of the Equality Act 2010. The registered provider explained that details were captured during the initial assessment in the 'I Am' booklet. This booklet includes people's preferences, likes, dislikes and social history. We saw this information was used when producing care plans to ensure staff were fully informed about people.

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. We checked whether the service was working within the principles of the MCA.

People or their relatives had signed consent to care plans and were involved in reviewing care regularly. When relatives had signed on behalf of the person using the service, records did not explain why. When records had been audited, it had been noted by a manager, but not acted on as no additional information

had been added. Another record showed a person living with dementia who could not communicate had not had a mental capacity assessment and their record had been noted 'family deal with this'. The person's care plan did not make clear whether the person's family were legally able to do so.

Another person lacked capacity in all areas according to a social worker's assessment of needs. However, the person did not have a care plan in place to guide carers how to support them regarding their decision making and the care records showed the person had signed to consent to their care.

Staff we spoke with showed an understanding about MCA and said they would expect to see details in care plans if people might sometimes lack capacity to make their own decisions. They expected details would be recorded about who could make decisions on people's behalf. However, people's care plans did not always reflect this and this had not been picked up in audits. We discussed this with the care manager and the registered provider who told us they would review this area.

Staff had the skills, knowledge and experience to deliver effective care and support. We spoke with staff who were knowledgeable about caring for people with different needs and described in detail the way different people were supported. These details were not always recorded in care plans. Although the same carers usually visited the same people, and those we spoke with knew people well, records showed different carers sometimes visited people for one or two calls which meant the registered provider could not be assured people received consistent care.

People's care records did not always reflect the care and support they received. For example, people who had difficulty communicating did not have care plans to guide staff in communicating effectively with them. Another person with a urinary catheter did not have a care plan to detail the role of carers relating to this. However, daily records for this person showed regular carers emptied the bag and changed bags each morning and evening. Where people were nutritionally at-risk carers recorded detailed notes of each meal prepared in the person's daily care logs. However, the service had not undertaken a nutritional risk assessment despite one person being at risk of malnutrition. Another person living with diabetes had all meals prepared by carers but no risk assessment had been completed concerning their dietary or health needs. We discussed this with the registered provider and the care manager who had plans to introduce more person-specific risk assessments.

People were supported by staff who had the skills and knowledge to deliver effective care. Staff said they had an induction and received training over four or five days when they first started working for the service and had annual updates. They said they had shadowed another experienced care worker for a week and then worked with a colleague for several weeks before being allocated a schedule of working alone. They said they had been introduced to all of the people they regularly cared for before delivering care for them.

Staff said they had regular supervision meetings with their supervisor who also carried out 'spot checks,' observing them when they delivered care and support in people's homes. However, records showed staff had not received regular supervisions or appraisals during the previous year. The care manager had a supervision and appraisal matrix and we saw some staff had received regular supervisions since the new care manager had started at the service. The registered provider had failed to ensure staff received these in the absence of a manager at the service.

Staff worked well together and office staff and field care supervisors ensured staff were kept informed. A care worker said, "Carers all work together when there's an emergency, everyone is very flexible and will support one another." An office-based staff member said, "I've built up relationships over the phone with carers and clients. I get to meet carers, also attend team meetings so get to meet lots of the carers. Carers are

supportive of the role, they think it's an improvement, I feel like I get on with them all really well."

Where domiciliary care was shared with another organisation, there was no evidence of communication between the service and others. However, a staff member recalled when they had contacted their supervisor about a person and the supervisor had contacted district nurses to ask them to review this person. Office staff we spoke with confirmed this happened routinely, however office documentation did not always reflect this. We discussed this with the care manager and the registered provider who took steps to ensure these discussions were recorded.

Good

Is the service caring?

Our findings

People told us the staff were caring. Comments included, "I'm quite happy with the carers who come to my home," "[I'm] quite happy with the service. I would not swap them for the world," and "All the carers are caring, very good and very chatty." Another person said the staff who supported them were, "caring and very excellent".

We spoke with three staff members and asked them to tell us about the different people they provided care for. They told us details that showed they knew people well, knew their families and what was important to them. They demonstrated knowledge of people as individuals and showed concern for their well-being. One talked of a person who no longer lived at home saying, "I miss her loads, she was lovely." Another staff member said, "All the staff are really friendly and caring."

A staff member explained how they supported people emotionally by talking with them and listening. They discussed how elderly people living alone are often lonely and described their role in mitigating this when they visited people to deliver personal care.

Staff told us how they protected people's privacy and dignity at all times and particularly when helping people to bathe or shower. One staff member said, "Some people haven't got a lot, so protecting their privacy and dignity is something we can do to reassure them." Another staff member told us, "Even though we get in a routine with [people], we still always ask questions and give choices." Staff said they always asked people their wishes before delivering care and before preparing food or drinks.

We saw people or their relatives had signed consent to the care plans they agreed with the service managers and to reviews of these care plans.

People's likes and dislikes, their preferences, their hobbies and life history were recorded in a document called 'I Am'. It was evident from discussions with the registered provider and care manager they knew the people the service supported well and ensured the service offered was personalised.

Information about advocacy was given to people with their care plans in a handbook and information about people's advocates was also kept in their care plan. This showed people's choices were in line with current legislation.

The registered provider and the care manager knew about the Accessible Information Standard and had made sure people had information in their care plans, which included the 'I Am' booklet about their communication needs, hearing, eyesight and communication.

Good

Is the service responsive?

Our findings

We spoke with people, their relatives and staff to find out how the service responded to their needs. One person told us they had not been given choices for the times of their calls and another said they had phoned the office because their night call was too early and this had been dealt with. Another person told us they had asked for one care worker not to support them anymore and the service had ensured this was request was respected.

Staff explained if they were given a new schedule or a new person and they found they had not been allocated sufficient time to travel between locations they told their supervisor and it was always changed to a realistic timeframe. Staff told us if people's needs changed and they needed more time to complete planned care, they informed their supervisor who discussed the concern with the person or relatives, and reviewed and improved the plan to meet people's needs. Staff gave an example of how flexibly timed calls had been introduced for one person to accommodate their needs. This meant if the person did not need as much support during the morning and were able to receive more support in the afternoon. However, this was not recorded in the care file kept in the office so it was unclear if this was an informal arrangement between the person and their regular carers or had been agreed with the care manager.

People's needs were actively noticed and recorded by staff and care plans had been changed in response to people's changing needs or circumstances. This meant the service was responsive to people's individual needs. Although staff were not involved in care reviews, those we spoke with said they always spoke to their supervisor if a person's care needs changed. One staff member explained they had recently done this for a person whose health had deteriorated. A re-assessment of the person's needs had been undertaken and the person had been found to need 24-hour care and unable to remain in their own home.

Care plan documentation titled 'I Am' prompted assessors and reviewers to consider people's social history, communication needs, hobbies, preferences and characteristics protected under the Equality Act such as gender, religion, sexual orientation and disability. Staff we spoke with had read the documents and described how the information informed the way the spoke with people and delivered care, however we did not see evidence the information had impacted on care plans.

The service kept detailed documents relating to complaints, concerns and compliments. The registered provider analysed these on a monthly basis and used the information to make improvements to the service. The care manager responded to complaints within their policy timeframes and there was evidence of continued communication with complainants to ensure the service sustained the improvements.

At the time of our inspection there was no one using the service who received end of life care. The care manager explained the service would ordinarily be notified of this by health professionals or relatives and the service would work alongside these to provide suitable end of life care.
Documentation showed that some people's end of life care had been discussed but this hadn't been completed in all instances. The care manager had plans to discuss how this could be improved with the local hospice or Macmillan Nurses.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was not a registered manager in post. The registered manager had left the service in February 2018 and had not completed the application process to de-register with the CQQ. The registered provider had appointed a new care manager who had applied to become the registered manager. 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 person have legal responsibility for meeting the requirements in the Health and Social Care act 2008 and associated Regulations about how the service is run.

The service had a clear vision which was shared with people, relatives and staff. People and relatives received this in a handbook they received when their support started, along with details of the complaints procedure and useful contact numbers for the service and other organisations. Staff members explained about the importance of the quality of the care and the service provided. Staff said they could always contact a member of senior staff. They described an on-call system which meant calls would divert automatically to an on-call supervisor or enable them to leave a message and said they felt supported by this.

Staff spoke very highly of the senior management team and explained how approachable managers were and how they felt they could easily discuss any concerns or issues. One staff member said, "We're very much supported by the manager, who works alongside us. We're able to ask questions throughout the day and get their opinion." Another said, "I'm very supported, I couldn't ask for a better boss than [care manager]. Both [the directors] are very supportive." Another told us, "I really like [care manager], you can go to [them] with anything, [care manager] is supportive. I see [registered providers] every day when I come in, they're really supportive, I'm happy to go to them." One staff member described how supportive the manager had been during a bereavement. Another staff member described how they had been supported to change their job role to enable them to meet family needs.

The registered provider told us about a number of staff benefits available to staff, such as small interest free loans to support them in unexpected emergencies and the service's two pool vehicles which can be loaned to staff if their car had broken down.

The service undertook quality audits over the telephone to seek feedback from people who use the service and their relatives. Records showed office staff routinely called people to ask if they were happy with the service they received or if they had concerns or issues. One call record included the comments 'the service is excellent,' 'carers are friendly,' '[Person's name] has taken to them all [staff],' and 'carers are always punctual and in uniform.' We asked the care manager what happened if comments were negative. The care manager explained all comments were reviewed by them and they contacted people to discuss any concerns. The care manager explained, "I discuss with the field care supervisors if there are any issues and they would do a review. I also look at the good stuff too, for example, thank-you cards." The care manager provided an example of a relative who had expressed concerns about the lack of consistency with carers. The care manager had reviewed the staffing rota, had provided a written response, and agreed to speak with

the relative every month to ensure they were happy with the service. They told us they wanted the service to get better at recording people's views to make the information gathered more meaningful and said, "I don't want it to be a 'tick box' exercise." The registered provider explained how they had previously identified people's concerns about the permanency of regular carers from overhearing these calls and had personally responded to people and issued letters of apologies.

We saw the provider undertook an annual paper survey to people, relatives and staff. The provider explained they used this information to look at trends and learn from these. The Customer Annual Survey 2018 had been undertaken in July 2018 and 28 responses had been received but analysis on these responses was not evident. The registered provider explained the database had become corrupt so they had been unable to do this. The Care and Support Worker Annual Survey had similarly been undertaken in September 2018 with only two responses received at the time of the inspection so no analysis had been completed. Each survey result included resolutions and actions to be completed by managers.

The registered provider explained the process for auditing the service's systems and for monitoring the quality of all aspects of the service being delivered. This involved checks being undertaken on a total of 60% of records each month and the involvement of four levels of checks: field care supervisors, office staff, the care manager, and the registered provider. A field care supervisor told us, "We log book audit 30% of clients, we're always auditing when we go out to see clients. We pick things up and bring back to have a better look." The care manager explained how spot checks on staff competencies are also undertaken at these visits and described the process if staff failed these checks.

The new care manager had started to implement a series of robust quality assurance checks for people's care plans and daily records, identifying issues and concerns and taking action on these. Records showed quality assurance checklists had been completed to audit records and were filed in care records but we did not always see evidence to show proposed actions had always taken place. For example, discrepancies in the recording of topical creams had not been identified.

Although a full audit had been undertaken by Caremark's regional development manager in March 2018 we found the registered provider had not undertaken any regular quality audits before the new care manager had been in post. This meant the registered provider could not be assured care provided was safe and consistent.
We concluded the above examples constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes had not been established and operated effectively to enable the registered provider to ensure quality and safety of the service.

Staff meeting minutes contained outcomes from reviews and opportunity was given to staff to suggest improvements and changes to how the service was run. Staff explained how these took place regularly. A staff member said, "We're very informed about what's happening, team briefings every morning are very good, we all know where we are and what's happening." Another staff member said, "There are lots of team meetings and [staff] are keeping us up to date, we find out what's happening, it's really good."

The service recorded and regularly reviewed accidents, incidents and near misses. The registered provider explained how they learn and improve. A detailed and robust action plan had been developed from the errors made in medicine administration. This showed learning from these issues and included additional training and competency checks, working with the local authority, and robust quality assurance. Staff described some of the improvements made. One said, "The care plans are all on the system everyone can access these, we're able to know how dependent clients are, for example, if they need timed meds or at high

risk."

The service demonstrated how they worked in partnership with other organisations, such as health professionals, and how some of these had provided specialist training for staff in areas such as sensory impairment, falls prevention and motor-neuron disease.

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 Audits had not been undertaken regularly to support safe medication, person-centred reviews and risk management. Audits did not always identify actions needed.