We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Briars Homecare Services Limited

74 Victoria Road East, Thornton Cleveleys, FY5 5HH
Tel: 01253851600

Date of Inspection: 04 September 2014
Date of Publication: October 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
<th>Action needed</th>
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</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
<td></td>
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<tr>
<td>Management of medicines</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>✓</td>
<td></td>
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<tr>
<td>Supporting workers</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✗</td>
<td>Action needed</td>
</tr>
<tr>
<td>Records</td>
<td>✓</td>
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</tbody>
</table>
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Briars Homecare Services Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Manager</td>
<td>Ms Cheryl Holden</td>
</tr>
<tr>
<td>Overview of the service</td>
<td>The Briars Homecare Service offers domiciliary care and support to a range of people in their own homes. The care and support provided is personalised to the specific needs of each person and provided in a way that promotes independence. The service is currently operated from an office base in a residential area of Thornton-Cleveleys that is central to the area that users of the service live.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Domiciliary care service</td>
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<tr>
<td>Regulated activity</td>
<td>Personal care</td>
</tr>
</tbody>
</table>
When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of this inspection:</strong></td>
<td></td>
</tr>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>What we have told the provider to do</td>
<td>6</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>6</td>
</tr>
<tr>
<td><strong>Our judgements for each standard inspected:</strong></td>
<td></td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>7</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>9</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>11</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>12</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>14</td>
</tr>
<tr>
<td>Records</td>
<td>16</td>
</tr>
<tr>
<td><strong>Information primarily for the provider:</strong></td>
<td></td>
</tr>
<tr>
<td>Action we have told the provider to take</td>
<td>18</td>
</tr>
<tr>
<td><strong>About CQC Inspections</strong></td>
<td>19</td>
</tr>
<tr>
<td><strong>How we define our judgements</strong></td>
<td>20</td>
</tr>
<tr>
<td><strong>Glossary of terms we use in this report</strong></td>
<td>22</td>
</tr>
<tr>
<td><strong>Contact us</strong></td>
<td>24</td>
</tr>
</tbody>
</table>

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**Summary of this inspection:**

- Why we carried out this inspection
- How we carried out this inspection
- What people told us and what we found
- What we have told the provider to do
- More information about the provider

**Our judgements for each standard inspected:**

- Care and welfare of people who use services
- Management of medicines
- Requirements relating to workers
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

**Information primarily for the provider:**

- Action we have told the provider to take

**About CQC Inspections**

**How we define our judgements**

**Glossary of terms we use in this report**

**Contact us**
Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Briars Homecare Services Limited had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines
- Requirements relating to workers
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 September 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by other authorities.

What people told us and what we found

This inspection was undertaken to review improvements made by the registered provider following the previous inspection undertaken on 15th April 2014. Areas of non-compliance found at the last inspection included issues relating to the care and welfare of people using the service, the processes in place for the recruitment of new staff and the way staff were supported to undertake their role. Also of concern was the management of medication, the internal assessing and monitoring the quality of the service provided and record keeping.

We asked the registered provider to provide us with an action plan demonstrating what they were doing to address the issues of non-compliance. We received the final action plan in June 2014. This detailed the procedures put in place to address the shortfalls. We used this inspection to see what actions had been taken to address the areas of none compliance.

During the course of this inspection we spoke with four people in their own home that used the service and two relatives of one of the people, who were visiting. We also spoke with the four members of staff that were supporting these people. On another day we spoke by telephone with another three people who used the service, and contacted another four members’ of staff for their views and opinions. This helped us to gather further evidence to establish what improvements had been made.

Generally we noted that although some good improvement had been made in most areas, there were still other areas that required strengthening.
At the last inspection in April 2014, staff did not necessarily have an understanding of the individual needs, wants and wishes of each person they were supporting. This was because there were missing or incomplete records including risk assessments, risk management plans or care plans in peoples' homes. It was also noted that a copy of this important information was not held at the office base. This did not protect people using the service or guide and advise the staff that supported them.

At this inspection we saw that the provider had introduced appropriate measures to improve the information contained in care plans. This provided a holistic account of the individual's assessed needs and wishes in order to guide and direct staff. Care plans, risk assessments and risk management plans were available in each of the homes we visited with a copy of the information also held at the office base.

In April 2014 we concluded that the records relating to the administration of medication were haphazard and incomplete, with many gaps and omissions without explanation. Whilst it seemed probable that the medication had been administered, the drug administration record did not necessarily reflect this. This practice did not ensure that the drug administration record (MAR) for each person was completed accurately, or confirm that the person had received their medication as prescribed. This put people at risk of harm.

At this inspection we noted that improvements had been made. However there still remained evidence of unexplained gaps on the MAR sheet. This meant that either people had not been given, or prompted to take, their medication as prescribed or the MAR record did not give a true account why the medication had not been given/prompted.

At our previous inspection, although the agency's recruitment policy and procedure was robust, this had not necessarily been followed before new members of staff had been allowed to take up their employment at the agency. For example we saw three instances of members of staff starting their employment at the service before all the required references had been received and deemed to be satisfactory. This meant that the personal qualities and attributes of the individual were not necessarily known prior to them working for the agency. This did not help to keep people safe or ensure that only suitable people were employed at the agency.

At this inspection we saw that in respect of recently appointed staff, the home's recruitment policy and procedure had been followed. People had only been appointed when the required references and clearances had been received and deemed satisfactory.

At our last inspection in April 2014 we found that the registered manager did not have suitable arrangements in place to ensure that staff received adequate supervision. This was because the practices in place, did not direct the supervisor to look at all elements of the care workers role and responsibility. This was particularly relevant to maintaining accurate records.

At this inspection we noted that again improvements had been made. The range of topics covered during supervision had been extended. This incorporated in the main, an assessment of the ability of the care worker to follow the policies and procedures of the agency in relation to maintaining complete and accurate records.

A range of systems remained in place to monitor the quality of the service being delivered. Although there was improvement in some areas such as the record used to assess the competency of the care worker, other documents, for example Medication Administration
Records (MAR), remained incomplete. There was also no formal monitoring system in place to audit the medication records or to establish the exact reason for the unaccounted gaps in the MAR sheets. This meant that there was no formal process to check if medication had been administered by staff, as prescribed.

Record keeping at our last inspection, was found to be inadequate. This did not protect people. Although some improvements, particularly in relation to care plans and risk assessments was noted, further improvement was still needed in other areas such as accurate recording on medication administration records.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 28 October 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Standard</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>Met this standard</td>
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<tr>
<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
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Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We last inspected Briars Homecare Service on 15th April 2014. At that inspection we found that people were not being protected against the risks of receiving care that was potentially inappropriate, inconsistent and may not have addressed their assessed needs. This was because in the four homes we visited, records relating to the care and welfare of people were missing or incomplete. This included care plans, risk assessments and risk management plans. This meant that care workers had no written guidance available, to advise or guide them with regard to the specific care that each person required.

We asked the provider to send us an action plan, a final version of which was received in June 2014. This stated that a range of actions would be undertaken to meet requirements. At this inspection, on 4th September 2014, we checked to see that this had happened.

We again visited four different users of the service in their own home and looked at the information and guidance made available for staff. We also looked to see if records held at people's homes had been completed properly and in full. In each of the home's we visited there was a care plan detailing the assessed needs of that person. There was also an overview sheet that highlighted the tasks to be completed by care workers at each visit. This meant that staff had the information available to ensure that people could be cared for in a way which was important to them and met their assessed needs.

We saw that a range of risk assessments had been completed that were available in people's home's. For example we saw that risk assessments related to the environment was in place and an assessment of any potential personal risk to the person being supported. This included a manual handling assessment. Safety measures to eliminate or reduce the identified risk, were in place.

The agency used a personal assessment form to clarify the needs and requirements of each person. This consisted of a tick box system to identify more routine requirements, such as assistance with washing or if the person required support with medication, shaving...
or meals. However the provider may find it useful to note that not all the boxes has been completed. This made it was difficult to know if that particular area had ever been assessed or discussed with the person, or whether an assessment had taken place and that element of support was not required.

Good daily records were maintained by care workers that were completed at each visit. This provided a good oversight of the support provided and was a useful tool for highlighting any trends or changes in behaviour. The people we spoke with in their homes' were pleased with the care workers that supported them. We were told that in the main, people were supported by the same group of staff that knew them well. One person told us that when two care workers were required at least one of those people she knew well. This helped to ensure continuity of care without having to explain to an unfamiliar care worker how she, "Liked things to be done". The husband of another person said, "I tell them as it is. They have been very good with us. You have your ups and downs but on the whole, they have been very good".

We also spoke with the care workers during our visits to people's homes. The care workers told us that there was now sufficient written information available in peoples' homes to provide the individual care and support required. The care workers also confirmed that 'spot checks' in people's homes took place at periodic intervals. This was also confirmed by the records seen. During these 'spot check' visits, a reassessment of need was undertaken when necessary. The person was also given opportunity to confirm whether the level of support provided continued to meet their needs. In addition, the competency of the care worker was observed and records checked. This helped to ensure that the policies and procedures of the agency were being followed and that staff completed their tasks to an acceptable standard.

We also saw that a copy of the records, including care plans, risk assessments and risk management strategies was now held at the office base along with a client social profile. This provided additional information that helped inform the care plan of that person, such as any issues relating to mobility or personal preferences. Ensuring that copies of all important records and documents were held at the office base enabled any missing documents to be quickly replaced.
Management of medicines

Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard. Medicines were given to people appropriately.

Reasons for our judgement

When we inspected the service in April 2014 we found that the recording of medication administered was haphazard and incomplete that put people using the service at risk. There was at times no evidence available to confirm that people had been administered their medication as prescribed. Therefore we could not confirm people were protected against the risks associated with the unsafe use and management of medicines.

We noted that improvements with regard to the recording of medication had being made. However, there were still unexplained gaps on the Medication Admission Record (MAR), without explanation. In one instance, when we saw a gap omission on a MAR sheet, we could evidence that the drug(s) had been removed from the medication cassette. The carer we spoke with told us that she had, on that occasion, assisted the person to take their prescribed medication. However she had not recorded this information on the MAR sheet. An entry in the daily diary record for that visit did state that the medication had been given but this was not detailed on the MAR sheet. Another member of staff we spoke with by telephone, said that she sometimes forgot to complete the MAR sheet, but that she routinely recorded on the daily diary when she had assisted with medication. However this practice meant that the MAR sheet was inaccurate and did not reflect the medication administered.

The registered manager gave an account of the reasons why there could be gaps on the MAR sheets. This included people being out for the day or when a visit had been cancelled and the care worker had not assisted with medication administration. Although the MAR sheet did identify four codes that could be used when medication had not been given, this did not cover all the possible causes identified by the registered manager. Therefore if the circumstances did not cover one of the four codes, the MAR record was not completed.

The Action Plan we received from the provider in relation to medication told us that completed MAR sheets would be returned to the office every four weeks. However this was not necessarily the case. In some of the homes we visited we saw completed MAR sheets that were well over four weeks old. We were told that in these instances a check of the MAR sheets would have been made when the 'spot check' visit by a manager took place. However as this was only scheduled to take place four times a year, this meant that
MAR sheets could remain without oversight for some considerable period of time. In addition, if a MAR sheet was seen as having gaps, this would require the person undertaking to 'spot check' to read through each daily diary record to establish if the medication had been given.

There was no evidence available to confirm that when the MAR sheets were returned to the office, there was a formal audit system in place to identify the reason for the gaps. This meant there was no check in place to confirm that medication had been administered/promoted in accordance with the prescription instructions. Whilst there was nothing to suggest that users of the service were not receiving their prescribed medication, it appeared that some staff either failed or forgot to record this on the Medication Administration Record. What was also concerning was that there was no formal audit in place for highlighting these discrepancies. This will be referred to again in Outcome 16: Assessing and monitoring the quality of service provision. The provider may find it useful to note that these practices did not protect people from risk of harm or monitor the performance of staff in maintaining accurate medication records.
Requirements relating to workers | Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by suitability qualified, skilled and experienced staff.

Reasons for our judgement

At our inspection of the service in April 2014 recruitment practices were not robust. People had been allowed to take up their employment at the service before all the necessary references had been obtained and deemed satisfactory. This did not help to protect people or ensure that only suitable people were employed.

Again improvements were noted. Since the last inspection several new members of staff had been appointed. We looked at the recruitment files of four of these people. We saw that appropriate references and clearances had been obtained and deemed to be satisfactory prior to the person taking up their employment with the agency.

Where telephone references had initially been requested, a structured reference form had been completed detailing the questions asked and the responses. The form had been signed and dated by the person requesting the telephone reference. In most cases this had been follow up by a hard copy reference.

We spoke with two of these recently appointed staff. Both confirmed that a full recruitment process had taken place. We saw that an application form had been completed and interview notes kept. A Statement of Particulars of Employment was issued following the 13 week probationary period, if the person was considered suitable for permanent employment.

The provider had developed an employee checklist form to detail when telephone references had been secured, when the hard copy references had been requested and received and the date the DBS clearance had been submitted and received.

These improvements helped to provide a clear audit trail. Recruitment practices were more robust and people now only took up their post at the agency when the registered manager was confident that they were suitable to work with and support the vulnerable people using the service.
Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Met this standard

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

During our inspection in April 2014, we noted that although staff supervision and staff appraisals took place, these were not necessarily effective in determining the competencies of staff. The documents used for supervision and appraisal were limited in content and did not necessarily focus on the abilities of staff to provide a good quality service, their ability to follow the policies and procedures of the agency or complete records appropriately. This meant that although supervision did take place it was not effective in highlighting areas of concern or advising staff in improving their practice.

At this inspection we noted that improvement had been made. The documents used for supervision and appraisal had been revised and extended, meaning that the practices of the care worker was subject to greater scrutiny. This helped to protect people using the service and improve the work practices of the individual worker.

We also looked at this outcome because we had received some concerning information that incomplete training had been provided. We were told that this did not meet the training needs of some members of staff and this practice also put users of the service at risk. The registered manager told us that staff training was considered important to ensure that a good quality of care was delivered. Most members of staff had achieved a nationally recognised qualification in care, some at more advanced levels. At our last inspection, as there was no staff training matrix available, it was difficult to establish what training had been provided to whom, without going through each person's training certificates. A staff training matrix had now been established that was on displayed at the office base. This showed the induction and further training that each member of staff had undertaken.

The registered manager explained that most of the core training modules had been purchased from a recognised, external training provider. The training consisted of DVD based training, followed by completion of a workbook. By completing the work book and submitting for assessment, the registered manager was able to assess whether or not the individual care worker had understood the training provided. This process was supplemented by an assessment of the care worker undertaking their duties during the management 'spot checks' visits to people's homes.
However, when we spoke with staff both face to face and by telephone, we received conflicting information about the way the training was provided. Whilst some people confirmed that they had received the DVD training and completed a workbook, other people we spoke with, did not. Some people told us that they had received the DVD training only, others that they had received the DVD training followed by discussion regarding the topic in question. One person confirmed the DVD training but when asked if this had been followed by anything else, said they could not remember. One person told us that she had never seen her training certificates for the training undertaken. Never the less we had been shown the training certificates at the office base.

We asked the registered manager to show us some of the completed workbook from training that had recently been undertaken. None were available. The registered manager stated that she destroyed the work books once they had been marked. Therefore we could not confirm that staff had received the required core training in full. The provider may find it useful to note that if people had not received each element of the training module, this put users of the service at risk. This also failed to protect the care worker from inadvertently displaying inadequate practice because of incomplete training.

We saw records to confirm that staff supervision and staff appraisals took place at regular intervals. We saw that appraisals now covered a wider range of topics and were more detailed and informative in content. Any actions required were highlighted and suggestions considered. For example, one person had stated that she would like to undertake some specific training, this had been instigated. It had also been suggested that more staff would be useful to work in one specific area. This had been addressed by a care worker agreeing to change her work pattern and now worked specifically in that area. This showed that staff suggestions were listened to and action taken to where ever possible.

Formal staff supervision was now scheduled to take place at the same time as the three monthly 'spot check' visits to the service user's home. The document used to record the supervision had been redesigned and extended to include the maintenance of records held at the person's home. This, along with observations of the care worker undertaking their duties as prescribed in the care plan, gave the supervisor a more holistic account of the capabilities of the care worker. Any comment or recommendation made to the care worker during the visit was recorded, so that progress could be monitored.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not always have an effective system to regularly assess and monitor the quality of service that people received.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Since our last inspection in April 2014, the provider and registered manager attended a meeting with CQC to discuss what action would be taken to ensure compliance. They had also submitted an action plan in June 2014, detailing how they would meet the required standards. At this inspection we asked about how management oversight was ensuring that standards were monitored and maintained by the service.

We were told of a number of measures had been put into place by the registered manager to ensure quality, and we looked at some of these to find out how well they were working in practice.

We noted that there had been improvement in the way Medication Administration Records (MAR) were being completed. There were less gaps and omissions without explanation than at the previous inspection. However gaps were still noted on some of the MAR sheets we looked at. Although the registered manager could give a suggestion as to why the gaps were present, this could not be confirmed. This was because no account, either written or indicated by an identifiable code, was available to cover all of the reasons suggested. Therefore an accurate audit of medication practices and medication record keeping still could not be guaranteed. Also given that not all completed MAR sheets had been returned to the office base on a monthly basis, this meant that oversight of the MAR sheets was limited.

At our last inspection we found that although 'spot checks' at people's home took place, the form used to record the outcome of the spot check relating to staff, mainly focused on whether staff were wearing their uniform correctly, whether they were carrying their ID or if they had changed the time of their visits. There was nothing detailed on the form to direct the supervisor to look at records and whether these had been completed accurately and in line with the company policy. This meant that an evaluation of the ability and commitment of the care worker to complete important records was not assessed.
All the members of staff and most users of the service that we spoke with, confirmed that 'spot checks' in peoples’ home’s continued to take place at regular intervals. We saw that the document used to record outcomes of the 'spot check' had been revised and extended. This now included a check of the records held at the home including care plans and medication records. Also included was a section regarding the general attitude of the care worker and a section to record any other comments. The completed 'spot check' forms we looked at were completed in full and gave a more holistic account of the overall abilities of the care worker, in undertaking their role.

A person using the service told us that during the 'spot check', once the care worker had left, the supervisor always had a chat and asked a number of set questions. This gave the person opportunity to express their views about the care worker and the service provided. We noted that any comment from speaking with the user of the service was recorded, including any general comments made. We also saw that action had been taken when a user of the service had made an adverse comment. In one instance this had resulted in a change of care workers, to care workers’ of the service user’s choice. This meant that comments were valued and action taken to accommodate the preferences of the individual where ever possible.

A record of general comments from the questions asked was held centrally, that help inform the internal quality audit. This system of taking into account people’s views and opinions and acting on them was particularly important given that formal surveys had not proved effective in eliciting people’s views and opinions.

As previously stated in this report in all the home’s we visited there was an up to date completed care plan, completed risk assessments and completed risk management plans, where appropriate. These were routinely reviewed during the 'spot check' visit. At this visit users of the service were given opportunity to confirm or otherwise, that level of care provided remained sufficient to meet their needs. If there was a change of circumstance such as a hospital admission and discharge, care plans were reviewed with the person concerned and amended as required.

Good daily records had been maintained by staff that was completed at each visit.
Records

People’s personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were not protected from the risk of unsafe or inappropriate care and treatment because accurate records were not always maintained.

Reasons for our judgement

We looked at this outcome because when we inspected the service in April 2014 we found concerns in that records were not being completed effectively. In the homes of the people we visited on that occasion, there were no completed records or only partially complete records. This meant essential information relating to the care needs of people using the service were not being provided.

We looked at what action the provider had taken in order to ensure records were accurate and contained information in relation to the care and support people required.

At this inspection, in all the homes we visited, there was a set of completed records including care plans, risk assessments and a risk management plan if required. This meant that clear and comprehensive records of individual needs, wants and wishes and how any identified risks were to be managed, were available. There was evidence regular reviews were taking place and changes made where necessary. This meant staff had the information they needed to ensure peoples care and welfare was being monitored and acted upon.

When we visited the agency in April 2014 we found that medication records were incomplete and did not accurately reflect the medication that had been administered to people using the service. This put people at risk of not receiving their medication as prescribed. At this inspection we saw that improvements had been made that included refresher medication training for staff. This helped to remind staff of their responsibilities to ensure medication was administered and signed for at each administration.

However some of the Medication Administration Records (MAR) sheets we looked at were still not complete. Four codes had been introduced for staff to use to provide a reason why medication had not been administered. However if there was a different reason for the medication not been administered, the MAR sheet was not completed at all. Therefore there were still gaps and omissions without explanation. However the provider may find it useful to note, that as there was no formal audit in place to identify the reason for each gap or omission, the quality of this element of the service provided, could not be measured.
New documentation had been introduced to track recruitment practices. This helped to ensure that newly appointed staff only took up their employment at the agency once all the required clearances and references had been obtained and deemed to be satisfactory. This enabled the registered manager to be sure that the people appointed had the personal qualities and skills to work with vulnerable people.
Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Assessing and monitoring the quality of service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td></td>
</tr>
</tbody>
</table>

How the regulation was not being met:
The provider did not always have an effective system to regularly assess and monitor the quality of service that people received.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 28 October 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✅ **Met this standard**

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

❌ **Action needed**

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

❌ **Enforcement action taken**

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.