Review of compliance

Sunshine Care Limited Plymouth Sunshine Care - Central Offices	
Region:	South West
Location address:	5 Derriford Park Derriford Business Park Plymouth Devon PL6 5QZ
Type of service:	Domiciliary care service Extra Care housing services Supported living service
Date of Publication:	October 2012
Overview of the service:	The service provides care to people in their own homes, being registered to provide personal care and treatment of disease, disorder or injury.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Sunshine Care - Central Offices was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We asked senior staff to provide contact details of service users who had certain care needs. This was so that we could get the views of people with a range of care needs and different support required. Some people had live-in carers or several visits each day from care staff, whilst others did not have visits as often as every day. Care staff also suggested someone who might like to speak with us.

We contacted 23 people or their representative, either at their own homes (with their agreement) or on the telephone. Two people declined to speak with us at length. We also spoke with care staff who supported some of these people, with senior staff who managed the service on a day-to-day basis and with the provider's representative.

When asked what staff did well, someone who used the service replied "Everything". Another replied, "Spotting what my needs are on a day to day basis." Three people compared Sunshine Care with other agencies they or their friends had used and thought that the service was the better one. Others told us they knew they could use another service if they wished, and chose to stay with Sunshine Care. People who told us they had spoken to senior staff when they had a complaint said their complaints had been resolved, without reoccurrence of the problem.

Most people expressed their views and were involved in making decisions about their care, in part through surveys sent to them by the service and through the service's care planning processes. We found some people were unable to complete the surveys and the service told us they would address this to ensure they obtained feedback in other ways about their care. One person told us "We had a lady who came out from Sunshine care...she went through the paperwork with us to see if mother was getting the care she needed."

Each person had a copy of their care plan and most were entirely satisfied with the care provided by staff. One person's representative told us that one of the care staff went out of their way to meet the person's needs. However, we found some people were not given their care plan and other information in a format suited to their particular needs. Some care plans lacked detail, and other records were not always well maintained.

People felt safe with and respected by the care staff. One person commented "They're very supportive and offer reassuring words to my mother as she can get confused". Other comments included "They're kind and gentle, they talk to him…They're very observant", and "Fabulous carers."

When we asked people if staff needed any more training to meet their needs, one person commented "Some of the new staff aren't very sure...They seem a bit lost," with two other people suggesting staff new to them would benefit from more training. However, someone commented, of the staff in general, "They do what they are asked to do well. They seem well trained."

Approximately half of the people we spoke with confirmed that spot checks had been made on staff that supported them, to ensure that they provided good support. People's views were sought about the care staff also. People told us they could ask for a different staff member if they didn't get on with anyone or didn't think they were suitable.

What we found about the standards we reviewed and how well Sunshine Care - Central Offices was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People's privacy, dignity and independence were respected. Their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

The provider was meeting this standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

The provider was meeting this standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

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

The provider was meeting this standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider had effective systems to regularly monitor the quality of service that people received and manage risks to the health, safety and welfare of people using the service and others.

The provider was meeting this standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

People were not always protected from the risks of unsafe or inappropriate care and treatment. This was because appropriate information was not always kept in relation to their care, and other records required in relation to employees and for the management of the service were not always well maintained.

The provider was not compliant with this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People expressed their views and were involved in making decisions about their care. People had their own care plans, produced by the service and kept in a folder in their home, which they or their representative confirmed they had discussed with senior staff from the service. They told us one section was used as a "message board" for communications between the individual and the care staff, so all staff knew where to find requests from the individual. The provider may find it useful to note that some people were not aware of any advocacy services such as might support them in making decisions about their care.

Most people who used the service confirmed they were given sufficient information regarding the service and their care. However, we spoke with one person who had impaired sight who had been given information in standard print and couldn't read it or read it easily. Staff also spoke of two other people they thought would benefit from large print documents. A care plan we read for someone with a learning disability was in a standard format, rather than using an Easy Read style for example, to make it more accessible. When we raised this with the provider, they told us they would take action to be more proactive in checking if people would prefer or require an alternative format. This was to include asking people when first assessing the needs of prospective service users.

People were supported to be independent, and be part of the community. One person told us "They help me do as much as possible for myself. Most staff know me, they know what I can and can't do." Other people also reported that staff enabled them to do what they could or wanted to do. One person confirmed they had opportunities (with staff support) to be a part of the local community, and could choose where they wanted to go with staff.

People told us their privacy was promoted and their preferences regarding the gender of their carers were respected. They felt that care staff respected them and their values. Some people raised issues about responses they got from the service's office-based staff, which they indicated were not always helpful or respectful. When we discussed this with the provider, they told us that a new phone system which was currently being installed would enable monitoring of calls for quality assurance purposes. Also, office staff were to undertake customer care training as a result of similar concerns being brought to the provider's attention.

Other evidence
We discussed with the provider that we observed in one person's home that staff left their worksheets where the names of other people staff went to could be seen, with implications for confidentiality. The provider confirmed that staff should not do this, and told us they would remind them of this.

Our judgement
People's privacy, dignity and independence were respected. Their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

The provider was meeting this standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People's needs were assessed and care was delivered in line with their care plan, which identified the individual's needs and how they were to be met by care staff. Most people were satisfied with the support provided by care staff, confirming they received the personal care and support indicated in their plan. Those we telephoned told us their care plans had been reviewed by senior staff in recent weeks or months, and all but one of the plans we read in people's homes were up to date.

The provider may find it useful to note that some issues were raised in relation to people who had dementia and the skills or flexibility required to meet their particular needs. One person's representative told us that time was allocated on a set day each week for staff to assist the person to have a bath, but staff could not always persuade the person to bathe that day. There was not enough flexibility in care arrangements for the person to have their bath on a later day if the person agreed to it then, so their personal hygiene needs were not always fully met. Staff raised similar concerns about two other people.

Care and treatment was planned and delivered in a way that ensured people's welfare and safety. People reported that the service tried to create a consistent staff team for them. This promoted continuity of care as staff knew the individual's needs and preferences well. In some cases, individuals had spoken to the service provider about the number of different staff visiting them and the service provider then took action to reduce the numbers. We discussed with the provider whether the service could be more proactive in this and they told us it took a minimum of a week to establish a staff team

for someone new to the service but they would be mindful of this matter.

When we asked people if they had had a fall or accident when staff were present, three people said they had. They were unable to tell us when this had happened so that we could follow up on these, with no records of accidents over the last year held at the office, but people were satisfied with how staff had responded to ensure their welfare.

We observed in one home, and were told by another person's representative, that staff wore disposable gloves into kitchen areas after providing personal care. The provider told us they would follow this up to ensure all staff followed correct infection control procedures.

We spoke with the representatives of two people who required two carers each visit to support them (visits described by people as "double ups"). They raised concerns about the punctuality of staff and how it could affect care provided. People were aware they should allow 15 minutes either side of agreed visit times for staff to arrive, but pointed out this meant one carer might be waiting half-an-hour for the other carer. One person reported that both staff would then rush to complete the care and leave at the same time, so support had not been given for the agreed time by both staff. The provider told us they would look into the arrangements around "double ups" in the light of these comments.

Other evidence
Care plans we read contained details of personal care support needed, any nutritional needs, medication management, any infection control issues, moving and handling directions and general comfort and welfare issues. The plans also contained detailed risk assessments that had been completed about the person and their home environment.

There was appropriate information available to care staff to enable them to meet people's needs. Most care staff confirmed they were given sufficient information about service users who were new to them. Care staff told us everyone had care plans when they visited them except people very new to the service. All but one staff reported that in those cases, there were risk assessments in place as a minimum, they could ask the person themselves what support they wanted and they had information from senior staff. Some said they occasionally had to ring senior staff for more information. Live-in staff reported that they remained contactable for a period of time when a new staff member took over from them, so they could provide information or advice to the new carer.

A live-in carer said the service had responded promptly with practical assistance when the carer reported that the person they were supporting had become much more dependent due to illness. This meant that the person's new needs were met safely and in a timely way.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
When we asked people if they felt safe with the staff, one person told us they were anxious that an older staff member would not be able to support them physically. Another person was concerned that a staff member worked so many hours that they might not provide certain care safely and the person therefore avoided asking for that help. All other people reported they felt safe with the staff.

People told us they would speak with their care staff, someone at the office, or their own relatives if they did have concerns about abuse or they felt something was wrong. One person told us a member of staff reported another member of staff who they thought wasn't doing their job properly, to the office staff, and it was dealt with straight away.

The provider may find it useful to note that all but two people told us they had not been given information by the service about abuse or how they could report concerns to other relevant agencies. Such information could help people to know what they should and shouldn't expect from the staff supporting them.

All but one person (who had spoken with the office staff about the problem already) confirmed that staff ensured the security of their home if they had to let themselves in or out. People generally knew which staff to expect as they were given weekly rosters by the service, though two people pointed out gaps in their roster. They told us that staff carried identification badges which they could check.

People reported that staff did not interfere with their private matters or property. Few required staff to do any shopping for them or otherwise handle their money, and those who did were satisfied with how this was done. They told us staff carried receipt books and gave them receipts each time they shopped for them. We spoke with a live-in carer who had to handle someone's monies because their duties included shopping for the person. They described clear procedures and record-keeping for ensuring the person's money was accounted for. We also spoke to the advocate responsible for the person's monies and they were satisfied with staff practice.

One person raised a matter about an item of their property used by staff when providing agreed support. We did not see any information for people who used the service about responsibility should any damage occur, for example. The provider told us that clarification was now included in people's contracts with the service, in line with advice they had recently received form a provider organisation on this subject.

Other evidence
The provider told us they monitored certain risk factors in relation to staff capability such as pregnancy or age of workers (older or younger), they monitored staff working over 50 hours a week, and increased the hours of new staff gradually. This was to ensure people using the service were not placed at risk.

We received information before our visit about one person's situation with regard to their personal monies or property and live-in care arrangements. The provider confirmed that no staff currently managed service users' finances themselves. The provider also told us that reviews were carried out at the homes of people with live-in carers rather than over the phone because this enabled better checks of the live-in arrangement.

Staff told us the receipt books they carried were checked by supervisory staff, to ensure staff were following expected practice. The provider confirmed that copies of the receipts were stored by the service and could be located if anyone had a query about their finances.

We saw that the service's Safeguarding policy gave guidance on "Financial protection" and this included that staff should be mindful of individuals' mental capacity or ability to agree to financial matters. There was also a policy on handling service users' money and valuables, which showed measures that were to be in place before staff were involved in financial transactions for those who used the service.

All staff could describe different types of abuse and were clear about reporting any suspicions. They also knew the signs of possible abuse, and spoke of subtle forms of abuse such as not supporting people to drink enough or not ensuring the security of homes when they left people. They told us they would contact the office if a service user did not answer the door when they went to them at an agreed time, rather than just leave without ensuring the person was safe. They knew the external agencies to who they could report concerns if necessary.

Records showed staff had annual refresher training on safeguarding adults, and had undertaken training on safeguarding children since this was raised at our last inspection. Although no service users were children, children might be present in household visited by staff. The provider was aware of their duty to report poor practice

through the local safeguarding process and if necessary to the Independent Safeguarding Authority (ISA).

Our judgement
People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

The provider was meeting this standard.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
Comments from people, about the staff, were positive. They included "They're kind and gentle, they talk to him…They're very observant", and "Fabulous carers."

When we asked people if staff needed any more training to meet their needs, one person commented "Some of the new staff aren't very sure...They seem a bit lost." They later said, of the staff in general, "They do what they are asked to do well. They seem well trained."

One person's representative thought staff new to them weren't trained well enough, and didn't shadow other staff who knew them for long enough. They and also someone who used the service told us they felt they sometimes had to train the staff to meet their specific needs or requirements. We were told that staff were not paid when they shadowed other staff, which the provider confirmed, by someone concerned that staff would not do many of these shifts as they wished to start earning.

Approximately half of the people we spoke with confirmed that senior staff had made monitoring visits to check that their care staff were providing good support to them. One told us their views had been sought about the staff member concerned, and we saw records which showed other people had similarly been asked about staff supporting them. Another person said they rang the service to tell them what they thought of new staff who came to them anyway. One person told us the service asked them "from time to time" if they were satisfied with the staff supporting them. People told us they could ask for a different staff member if they didn't get on with anyone or didn't think they were suitable.

Other evidence
We looked at six staff files. There were induction records for each, showing staff covered a range of relevant topics in four days. One staff member told us they had to undertake the induction despite their previous experience and qualifications. The number of areas covered in the time was such that in some cases a relatively short amount of time was given to a topic. Feedback comments from staff, about the induction, included "Lot of information to cram into the time."

Senior staff told us that this induction was part of the recruitment process and staff were offered a job only if they successfully completed it. Also, one-to-one supervision sessions for new staff were initially carried out by the training staff, to ensure that they had understood and were using their training.

Staff confirmed they shadowed longer-serving staff when they were new, with the number of shadow shifts varying between individuals. Staff reported that individuals' competency was not always assessed before they worked alone, and we did not see evidence of these assessments. The provider told us they would put in place systems to to formalise feedback from supervisory staff, which at present was only verbal feedback, and routinely obtain service users' views about new staff as part of the assessment of their competency.

One live-in carer confirmed they received weekly calls from the service by way of supervision, with another saying they received such phone calls occasionally, both having occasional face-to-face meetings. They told us these were opportunities to discuss their work, any training needs and whether they needed more supplies such as stationery or disposable gloves and aprons. We queried with the provider that records we looked at, for two live-in care staff, stated "Weekly supervision" yet entries were only monthly. They said they would look into this, as there was supposed to be weekly contact with live-in staff.

Some but not all staff confirmed they had been subject to spot checks by senior staff. The provider told us that 'spot checks' were undertaken as part of the supervision process, to ensure staff used appropriate practices when supporting people. One staff member employed for two years told us they had not had one-to-one supervision, with other staff telling us they received it 3-6 monthly. The provider told us that they aimed to provide formal supervision four times a year for homecare staff, with this sometimes being group supervision. Staff were required to attend three staff meetings a year, in part for this purpose. Staff also had a manual they could refer to.

We read records showing staff had regular refresher training on health and safety topics, dementia, medication management and financial procedures, amongst other subjects. Their understanding had been checked through completion of questionnaires. Staff confirmed they found the updates useful. One who supported someone who had a catheter told us they had been given training about this by the local community nurse.

Care staff supported a small number of people who had a learning disability or sensory impairments. Staff told us they had not had any training about learning disabilities, and training records did not include the topic of sensory impairment. Though people with these needs did not raise issues about the capability of staff, we raised the matter of training with the provider, as they offer a service to people with such needs. The

provider told us an e-learning package on learning disability was being obtained from a nationally recognised training organisation. They told us they would give consideration to more training on sensory impairment, which was currently covered with other training rather than as a specific topic.

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

The provider was meeting this standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People who used the service and their representatives were asked for their views about their care, by the service. People confirmed they had recently received a survey to complete, though some said they chose not to complete it, with one adding they would just ring the service if they had anything to say. A comment by one person summarised the views of other people we spoke with: "The care staff are good, the organisation could be better", going on to talk about the office staff and staff working conditions. People we contacted were generally satisfied with the service overall.

Representatives of two people who had dementia told us that the individuals were not able to complete surveys because of their needs, and surveys were not provided to them as representatives. The provider told us they would, in future, take action to identify if this was likely to be a problem for a service user and make other arrangements to get feedback about the service from people with such needs.

The provider took account of complaints and comments to improve the service. People who told us they had spoken to senior staff when they had a complaint, told us their complaints had been resolved, without reoccurrence of the problem. One person told us "We had two staff come to visit - one shadowing - but X didn't like it as it was too many people around her. I rang up the office and said X didn't like having more than one person, and only one person came after that."

A small number of people told us about events that had upset them, such as staff being late or not changing their bed as was in their care plan. When we asked if they told the

service, they said they had put comments on the recent survey, or told other care staff. Staff told us that if someone made a complaint to them, they would report this to the office staff and advise the person to do the same. We were unable to determine if staff had identified such comments as complaints and thus reported them.

Two people using the service raised concerns with us about the many hours some staff worked or worked without a break if covering for absent colleagues at short notice. We saw agreements in the contracts of live-in carers about working hours and breaks, as well as forms indicating some staff had opted out of regulations that limit working hours. One person queried if staff were insured to work after 11pm when they were running late, which the provider confirmed they were. There was a suggestion that occasionally staff had car accidents because they were rushing between homes, due to insufficient travelling time or running late. We discussed these risks with the provider who identified how these issues might have arisen and described action they would take to ensure staff had breaks and travel time.

The service monitored possible risks to people's wellbeing and took action to manage the risks. It used a phone "ring in" system to monitor that staff had attended people's homes as rostered. A small number of service users and staff expressed difficulties with the practicalities of this, such that it was not used, one telling us the service was aware of the issues. The provider explained to us changes being made (partly through a new phone system) to improve monitoring systems. Two people reported they had cancelled occasional staff visits when staff were very late. The provider told us this was monitored and that of the 5000 visits (approximately) provided by the service each week, 1-2 visits were cancelled each week due to lateness of staff.

As people told us they could request an individual staff member did not support them again, we asked the provider how this was monitored to ensure it was not an employment or training issue rather than just a clash of personalities. They told us such requests were logged for each staff member and would be followed up if a number of such requests were made.

People's care records included risk assessments relevant to them. Where staff were required to use equipment to meet people's needs, people told us the equipment was serviced regularly but such arrangements were not included in their care plan. The provider told us they would review this, so it would be clear what measures were in place to ensure people's equipment was safe to use. Staff told us they checked the general state of equipment and looked for servicing labels on the item before using it. One told us they had contacted office staff about an item that had not been recently serviced.

Other evidence
The service's quality assurance systems included feedback from people who used the service. The organisation was supporting over 600 people at the time of our inspection. We looked at client feedback questionnaires recently sent out by the service, 31 having been returned to the service so far. We saw that 21 had ratings of 'Acceptable' to 'Excellent' in response to the questions asked. Ten people had responded 'poor' to one or more questions.

Senior staff told us the home sent out surveys every three months to everyone using the service, usually with a 30-40% response rate. They also carried out monthly reviews

over the phone for three months when people first started using the service, moving to six-monthly reviews if people were receiving support with their medication and yearly reviews for people whose needs were minimal or not complex.

Monthly staff meetings were held for each care team, when staff views of the service were obtained. The provider may find it useful to note that one staff member pointed out that minutes were not kept such as to monitor that points for action were followed up, to evidence any improvements were made. Some staff felt suggestions were acted on whilst others did not think this was always the case. Live-in staff said there were no staff meetings for their staff group but also that they would be impracticable as they did not work near each other. They felt that they had sufficient opportunity through other contact with the service to give their views if they wished.

Our judgement
The provider had effective systems to regularly monitor the quality of service that people received and manage risks to the health, safety and welfare of people using the service and others.

The provider was meeting this standard.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we rang told us that the care staff made notes about each of their visits, in the records at the person's house, confirming staff made accurate records of the support they had provided.

Some care plans we read included personalised detail, such as that someone wore their socks in winter months only. Others lacked significant detail, though people told us or we could see from daily records that required care was provided. For example, the care plan for someone who used a wheelchair stated "Assist to access community" without including how this was to be achieved or how often. Also, we were told by one person and by senior staff that because of the person's needs, staff opened their post for them. There was nothing in the care plan about this arrangement however. One person described the support they required, and we found their care plan had not been updated from a time when they were more dependent on staff.

Other evidence
We saw that staff wrote their visit notes in monthly books kept at people's homes, with books for the previous month seen at some people's homes. As the service is required to keep such information securely and for a certain period of time, we asked staff what happened to the books no longer in use. They told us that they returned them to the office, where the notes were checked. Senior staff confirmed this was in part to check the quality of the notes made. Some care staff told us they found books still at people's

homes more than a month after they were completed, suggesting there was no effective system for ensuring notes were stored securely in a timely way.

People we spoke with who had made complaints told us they were resolved to their satisfaction. However, we found record-keeping in relation to complaints was not well managed. The complaints book kept by the service was a loose leaf file with unnumbered pages, so pages could be lost from it without this being identifiable. We found records in one person's file of an incident involving a staff member, but this matter was not recorded in the complaints file or on the service's "Complaints log". There was a record of investigations or referral to other agencies with some of the complaints recorded, but not for others. The "Complaint log" form did not include all the complaints in the Complaint book and the service's "Complaint audit" form had not been completed. We discussed these observations with senior staff at the time. When we gave feedback at the end of our inspection, senior staff told us they had addressed most of these issues.

We found that required information about staff was not maintained consistently, with recruitment processes not always evidenced well. In one case, a reference had been obtained from someone not named as a referee on the individual's application form, without information as to why this had been done. Photocopies of individuals' qualifications were in their files without confirmation that the service had seen the original versions. There were records showing police checks had been applied for, but not always that they had been received. The registered manager, who was not present during our visit, has since told us that this information was kept elsewhere. Senior staff who were present told us they were developing a spreadsheet that would show what information had been obtained and thus ensure that anything outstanding was followed up and clearly recorded.

Our judgement
People were not always protected from the risks of unsafe or inappropriate care and treatment. This was because appropriate information was not always kept in relation to their care, and other records required in relation to employees and for the management of the service were not always well maintained.

The provider was not compliant with this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People were not always protected from the risks of unsafe or inappropriate care and treatment. This was because appropriate information was not always kept in relation to their care, and other records required in relation to employees and for the management of the service were not always well maintained.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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 within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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