Inspection Report

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

Caremark (East Riding)

East Riding, 2 Owen Avenue, Priory Park, West, Hessle, HU13 9PD

Tel: 01482579579

Date of Inspections: 02 October 2013
01 October 2013

Date of Publication: November 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Staffing	✓ Met this standard
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Care Precious Limited
Registered Manager	Mr. Daniel Malcolm Rhodes
Overview of the service	Caremark is a domiciliary care service operating from offices on a business park in Hessle. It provides care and support to adults of all ages with a wide range of care needs, including memory impairment, old age, learning disability and physical disability, as well as some needs associated with medical conditions. There are over 600 clients receiving care and support, and around 200 staff working for the service.
Type of service	Domiciliary care service
Regulated activity	Personal care

Contents

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'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 1 October 2013 and 2 October 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other authorities. We talked with other authorities.

What people told us and what we found

We brought forward an inspection of Caremark as a result of concerns raised with us. We found people were only satisfied with some elements of their care. Concerns were raised regarding ability of staff to carry out required tasks, missed calls and calls cut short. Care was not always being delivered in line with care plans. Robust risk assessments were not in place. Comments made to us included "Overall we are happy", "The visits are cut short. This has caused us worry", "Some carers are excellent, others are only okay", "Sometimes carers don't really know how to effectively support X. This has caused me some concern".

There was a deficit in safeguarding training for staff and evidence that safeguarding concerns were not always recognised and responded to appropriately. Staffing levels were appropriate at the current time. Staff did not receive regular supervision and professional development and there was a shortfall in training for staff. This was not monitored effectively. Staff told us they did not always feel supported to carry out their roles effectively.

The service did not have effective quality assurance systems in place and there was a lack of evidence that feedback from service users and staff was acted upon appropriately. There were gaps in records including those for people who used the service.

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 16 November 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning. We will check to make sure that action is taken to meet the essential standards.

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

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate 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

People's needs were not assessed regularly and care and treatment was not always planned and delivered in line with their individual care plan. Care and treatment was not always delivered in a way that was intended to ensure people's safety and welfare.

The scheduled inspection of Caremark was bought forward as a result of concerns raised with us. As part of the inspection we visited people that used the service and relatives. People told us they were happy with some elements of the service they received but dissatisfaction was expressed with areas such as arrival times, length of visits, amount of staff attending and capability of staff. This meant overall people felt there could be improvements made. Comments made to us included "Overall we are happy", "The visits are cut short and sometimes nobody has turned up. This has caused us worry", "Some care staff are excellent but others are only okay", "Sometimes the care staff that come don't really know how to effectively support X. This has caused me some concern". There was general feedback from the people we spoke with that the quality of care could be dependent on the particular carer that had visited and this could be inconsistent. As the service provided support to more than 600 people we are intending to send surveys to a larger proportion of people in order to ensure that a fair picture is built of people's satisfaction with the service.

We spoke with people about the care they required and how this was delivered. All of those we spoke with felt that the basic care provided was satisfactory. However one person we spoke with highlighted issues with some of the specialist care they required. When we spoke with some of the care staff they confirmed they were sometimes sent on calls that required tasks completing they had not been trained for. This meant there had been occasions where care staff were unable or unsure how to deliver appropriate care. We had concerns raised with us prior to the inspection about the quality of care that was

being delivered. We saw during the inspection there was evidence that the service had also received complaints regarding the quality of care staff provided.

We looked at care and support plans for four people who used the service. There was evidence that the care being delivered was not always in line with these plans and that in some cases the plans did not contain the correct information about the care that people required. This could have had an impact on the care that people received. Information received prior to the inspection and evidence seen as part of the inspection showed that the care that people received was not always appropriate to their specific needs.

The plans were task orientated and did not give details about how the person wanted to be supported. There were statements such as "Requires personal care" without any confirmation of what kind of personal care support was required. It was not always clear whether the person's care had been reviewed. We were provided with evidence during the inspection that indicated that 225 were overdue. This meant that the provider could not clarify if the care people received was meeting their current needs.

We found evidence within the files and from further information we held about the service that visits had been missed. This included calls to administer medication, change colostomy bags, get people up and out of bed, assist people to attend to personal care including going to the toilet and refilling peg feeds. This could have meant people were being neglected through not receiving required and necessary care.

When we spoke with people who used the service they told us that visits were often cut short. Comments made to us included "All of our visits are cut short because there is no travel time allocated", "The half hour calls are sometimes cut shorter although the hour visits are usually alright", "We have had problems with care staff arriving late or leaving early although this has been better recently", "Sometimes they only stay for 30 minutes but usually that's okay with me". Several people we spoke with who used the service also highlighted their frustrations and difficulties with lots of different people supporting them. Two of the people we spoke with said this had improved recently and they had more consistency in the last two months than previously. However it was a source of worry and concern for people as they often didn't know the care staff who came to support them and sometimes it would be different people than expected. One person highlighted how this caused issues because newer or unfamiliar staff did not always know how to support their relative appropriately. Another spoke with us about their relatives condition and how new or unfamiliar staff did not always know how to communicate with them effectively. Concerns raised with CQC prior to the inspection also highlighted dignity issues around being supported with personal care by staff people were not familiar with.

One person who used the service and their relative were dissatisfied with the competency of staff in the use of equipment which they felt could have put their relative at risk of harm. They told us "There has been care staff sent who do not know how to carry out the procedure required. We have needed to show them ourselves but this might not always be possible".

Staff were not following the provider's policy and procedure with regard to the reporting of accidents and injuries. There was evidence that appropriate referrals and re-assessments of need were not always happening. This was having an impact on care and in some situations was resulting in people not receiving the assistance or support that they required. We saw evidence in several care files of incidents and accidents recorded in the daily notes. There was no evidence these had been reported to or acted upon by the

supervisors and no separate record was kept anywhere of the incidents that had occurred. Some of the incidents recorded showed both the person who used the service and staff could have been at risk of injury. Some also indicated that the person's current care package may not have been meeting their needs.

Risk assessments within the care files were not robust. When we looked at risk assessments within people's files we found that these were either not present or did not accurately describe the risks and how they were to be managed. Specific needs and risks were discussed with staff who were able to tell us how these would be managed in some cases but not in others. For example one staff member we spoke with told us "I have one service user who displays challenging behaviour. There is no guidance about how to deal with them".

There was a lack of evidence that the care and support being delivered by the service was in line with current good practice guidelines such as the Dementia Strategy. We spoke with staff who were not confident about their knowledge around areas such as dementia or mental health care. There was also little evidence that staff had received training in these areas. This meant that the care packages being delivered may not have been in line with recommended practices. There was no evidence that best practice was monitored with the delivery of care.

We looked at documents regarding business continuity. A business continuity policy did not contain any contingency planning. It was high level and did not contain detail about what would be done and how if there was an event that affected the delivery of services.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

People who used the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. There was a lack of evidence that the provider had responded appropriately to any allegation of abuse.

We looked at the ways the service ensured people were safeguarded against abuse, neglect and discrimination. When we spoke with people who used the service they told us they usually felt safe when being supported by the care staff.

There were a significant number of people supported by the service who had dementia or related conditions, mental health issues and learning disabilities. We found little evidence that staff had received sufficient training to meet these specific needs and protect people from abuse. Safeguarding training was included as part of the induction of new staff and as annual training and was delivered in house. When we checked records we found 41 staff were overdue for refresher training.

The provider was unable to provide us with evidence of the amount of staff that had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty. This may have meant that staff did not understand the issues pertinent to vulnerable groups of people.

The service had a safeguarding policy in place and this had been reviewed in September 2013. The policy was robust and included a flow chart of the actions that should be taken if there was a safeguarding concern. There was also a whistle blowing policy in place and copies were included in the staff handbook for staff to refer to. When we spoke with staff they showed a good understanding of safeguarding and were able to give examples of signs and indicators of concerns. Some staff also told us they had the contact details for the safeguarding team at the local authority.

All the staff we spoke with told us they would usually raise any concerns with their supervisor although most said they didn't know what happened with the information after that and they were not aware if any action was taken to respond to issues raised. We spoke with a supervisor who was able to tell us how they would escalate concerns to the manager or the local authority. They were aware of how the safeguarding process worked. The provider confirmed they were unsure if all the supervisors escalated safeguarding concerns appropriately.

We looked at files for people who had recognised or diagnosed conditions that included displays of challenging behaviour or aggression. These files did not contain clear guidance for staff on how to deal with situations arising or what the responsibility was for reporting and recording the incidents. This may have further added to the risk for both staff and the person who used the service to suffer injury or have inappropriate care delivered and for a lack of appropriate reporting to occur.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

The service allocated calls to care staff using a paper based system and there was not currently a system in place to effectively monitor whether staff had attended visits or stayed for the appropriate length of time. When we spoke with people who used the service some of them told us they had to contact the office themselves to see where the care staff were. The provider told us they were in the process of implementing a new system which would record and give office staff data about where care staff were, how long calls had lasted and when calls were missed or late. This would allow analysis and identification of where calls were not being carried out for the allocated period of time.

Staff told us that they received their rotas regularly and in good time. When we spoke with staff they told us that they usually knew the people they were visiting and felt they had good knowledge of how to meet individual needs. They were also able to tell us how they notified the office when they were unable to work. None of the staff we spoke with felt that they were expected to work an unreasonable amount of hours and stated that they were able to choose how much they worked on top of their normal hours. One member of the care staff told us that they were aware of another staff member being told they had to pick up extra hours or there would be negative consequences but felt this was an isolated incident.

The manager explained visits were allocated by identifying 'teams' of care staff for each person that used the service. Calls were then divided out across the week to each of the care staff in the team. This was done by care co-ordinators in the office. When we spoke with co-ordinators they told us they had knowledge of each person and which staff could support them and this information was used to allocate calls appropriately. The provider may wish to note that this was not recorded anywhere and there was no system currently in place to record this accurately. This meant the information was effectively held 'in people's heads' and would not have been available to refer to if any care co-ordinators were unable to organise the timetables of visits.

When we spoke with the manager about the frequency of missed calls they stated they did not think this happened very often. However, feedback from people who used the service

indicated that it was one of their concerns. When we looked at some of the complaints the manager had received we saw at least two of these referred to missed visits. The manager told us supervisors were responsible for dealing with any missed calls and usually care co-ordinators would be aware of when this had happened. Care co-ordinators also felt there weren't any problems in this area.

A report submitted to the provider from the manager evidenced that there were 408 'unallocated' hours per month. It also showed there was a difference between the number of scheduled hours and the number actually delivered. One month showed more hours delivered than scheduled and another month showed a shortfall. However these discrepancies in the data may have been present due to the unreliabile monitoring system currently being used. The manager felt that the numbers of staff employed provided enough cover for all the calls. When we spoke with the provider they were very keen to put improved systems in place that monitored and highlighted any issues and allowed them to take appropriate action. This planning for this improvement was already underway at the time of our inspection.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate 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

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.

We looked at support systems to enable to staff to carry out their roles effectively. A structure whereby each of the eight areas covered by the service was managed by a supervisor and all care staff were managed directly by one of these supervisors was in place. Four care co-ordinators each had responsibility for two areas. A newly appointed senior supervisor was responsible for management of supervisors. A registered manager was responsible for the overall service. The service was currently employing over 200 care staff. A training manager was responsible for the training and induction of staff. Most training was delivered 'in-house'.

Supervisors were responsible for carrying out supervision and monitoring of care staff. We had received information about the frequency, effectiveness, confidentiality and environment of supervisions prior to our inspection. When we spoke with staff they confirmed supervisions were not held regularly. Supervisors confirmed with us there were not any dedicated available spaces for them to carry out supervision and this made it difficult to ensure these were effective or regular.

We spoke with staff about supervision and support and they told us it felt inconsistent and was sometimes dependent on the supervisor. Comments made to us by staff members included "I haven't had many supervisions and I would prefer to have more. I feel supported in some areas and not in others", "I had a supervision meeting when I first started but haven't had any in the last year. All it covered was visit arrival times. I haven't had the chance to express my opinion", "I haven't had any supervision meetings. I had three spot checks in one day which looked at arrival time and uniform but I wasn't given feedback", "I've had a few supervisions and have found these really useful. I have found my supervisor approachable and helpful".

We looked at five staff files and records of supervision. Two files had no supervision

records at all, two had one record of a supervision meeting and the last file showed three supervisions in the last year. None of the supervision records we saw identified any actions or areas for development.

Staff also had 'spot checks' carried out by supervisors which looked at areas such as arrival time, dress code, greeting, referral to plans, interaction with person and any identified actions. All the files we looked at had at least one record of a spot check being carried out. However these were inconsistent and in some cases there was only one, and in others there had been up to a two year gap between these being carried out. The provider told us these should be carried out on a regular basis. None of these identified any actions and there was no evidence of any feedback being given to the staff member. Staff confirmed when we spoke with them that they did not usually receive any feedback from supervisors after these spot checks had been carried out. This meant staff did not always fully understand what areas of development they required.

The service employed a training manager who was responsible for monitoring, organising and delivering training. The training manager had been in post since February 2013 and explained there was a backlog of training to be completed by staff. They explained there was a rolling programme of training which was based on safeguarding, food hygiene, infection control, fire safety and first aid being repeated annually and medication bi-annually. An electronic system was used to allocate training which showed when training was due although not when training had last been completed. At the time of our inspection the training manager was unable to produce a training matrix that showed all training and all staff.

After the inspection the training manager confirmed numbers of staff overdue for training included 41 for safeguarding, 37 for moving and handling and 17 for medication. Exact numbers were not available for how many staff had completed other mandatory or specialist training such as infection control, fire safety, first aid, dementia, epilepsy, catheter care, diabetes, peg feeding and risk assessments. There was evidence within some staff files that other training subjects had been completed including National Vocational Qualifications (NVQ). The training manager and staff confirmed not all staff had done these. The current system meant confirming which staff had completed certain types of training was not possible.

The provider was aware of issues with getting staff to attend training. The provider had recently revisited people's contracts to ensure staff understood attending training was a requirement of the role. They informed us staff would be unable to continue working until they had attended required training. There had not been any consultation with staff about training issues. The training manager and provider had been looking at ways to improve this and the provider felt this was getting better.

Some of the staff we spoke with felt morale was low and some mentioned situations where they had not felt valued. This was somewhat dependent on the supervisor the staff member had. Comments made to us by staff included "I have specific skills I feel have been ignored when calls are allocated", "There's an emergency call line but I feel I've been discouraged from using it to get advice outside of office hours unless it's an emergency so at times have felt unsupported", "There have been times when I have felt ignored and unsupported", "I have felt very supported by my supervisor although I haven't always been given feedback about my performance". The lack of support experienced by staff was confirmed by them to be having an impact on the delivery of care because they did not always receive support or advice when unsure about the appropriateness of the care they

provided.

Assessing and monitoring the quality of service provision ✖ Action needed

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 have an effective system to regularly assess and monitor the quality of service that people received.

We have judged that this has a moderate 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

The provider did not have an effective system to regularly assess and monitor the quality of service that people received, or to identify, assess and manage risks to the health, safety and welfare of people using the service and others. People who used the service, their representatives and staff were not always asked for their views about their care and treatment and where feedback had been received it had not always been acted on.

The provider had a system in place where supervisors carried out visits to people who used the service every six weeks to check files and every three months to carry out a review of the service. The newly appointed senior supervisor was responsible for monitoring when these visits had been carried out. The supervisors, care staff and senior supervisor confirmed to us these visits did not always happen and that some visits were overdue and we saw evidence of this in files. The senior supervisor had highlighted some issues around the effectiveness of these visits was monitoring and addressing this with supervisors.

Where required changes to paperwork had been highlighted these had not subsequently been completed. There were a large amount of reviews overdue. The senior supervisor provided us with lists of all the people and when they were due for a review or a paperwork check. The lists appeared to evidence that 225 reviews were overdue. It was difficult to ascertain if this was because the review had not taken place or accurate information had not been submitted to the senior supervisor. This meant that people were not having checks of their care carried out and may have been unable to give their views back to the provider. It was therefore not possible for the provider to have a full understanding of the number of people that were dissatisfied with the service, or of any improvements that were needed to service provision.

The manager told us it was the supervisor's responsibility to go through the financial transaction sheets and check for discrepancies. We discussed auditing with the provider they told us supervisors were responsible for auditing medication records, financial

transaction records and daily notes. There were no records available of these checks being carried out. The manager and provider were unsure if these were being completed.

We looked at complaints received by the service. The evidence we looked at and the conversations we had with staff and people who used the service indicated that the provider's policy and procedure with regard to complaints was not being followed by the management team.

When we spoke with staff about complaints all knew how to raise issues or make complaints and all felt confident in supporting people who used the service to make a complaint. We saw people who used the service were given information about how to make a complaint. This included contact details of CQC. Both staff and people who used the service were less clear about whether action would be taken and if issues would be kept confidential. We received evidence of individual situations where details of complaints made had been shared inappropriately with other staff by management and one example within a complaint documented how this had resulted in a negative impact on the person who used the service.

The manager provided us with eight complaints that were dated between July and September 2013. There was evidence that two had been dealt with appropriately although the records indicating the action taken was minimal. The remaining six had little or no evidence of any action taken. One of the responses was a holding letter stating an investigation would be carried out and a response would be sent by the 20th September 2013. There was no evidence of any investigation or further response sent to the complainant. One person who used the service had expressed dissatisfaction with how day to day financial transactions had been carried out. There was no written evidence of any investigation and the manager confirmed that none had been carried out.

We also received information that the local authority had carried out investigations into poor care practices. Recommendations had been made to the provider regarding the service's response to these incidents.

We saw one example of a carer recording some concerns the person who used the service had raised but there was no further evidence this had been acted on. We also saw in some files that care staff had recorded incidents and areas of concern but there was no further evidence of any action being taken.

The supervisors and manager were not carrying out any monitoring of missed, late or shortened visits. With the current paper based system used for allocating and recording visits the provider was unable to reliably monitor this as it was reliant on care staff completing records and supervisors checking these. This would only happen at the end of each month. Discussion with the provider and manager indicated that they did not have an understanding of the extent of any problems and were not always aware that vital visits had been missed.

The provider had chosen to do an audit as part of the quality assurance system in the service. The manager explained the audit was undertaken with the providers on a monthly basis. This audit looked at three examples each of carer, service user, supervisor and care co-ordinator files, service delivery and marketing. A checklist was used identifying whether the appropriate paperwork was in place in each of the files. The service delivery section recorded whether there had been missed calls, incidents, safeguarding alerts and complaints. We looked at September and October audits which recorded there had been

no missed calls or safeguarding alerts and one complaint. However, other evidence seen as part of the inspection indicated this was inaccurate. The manager was unable to clarify the cause of the discrepancies. The audits highlighted a large amount of paperwork missing from staff files, customer files and management files. However there was no associated action plan and no evidence of any action taken to address the issues following either of the audits.

There was little evidence of how staff views were being captured and how the provider was monitoring support given to staff. Supervisors held staff meetings with staff but these were infrequent. We were not able to view any minutes from these meetings. When we spoke with staff they felt meetings were not effective. Comments made to us by staff members included "We don't get paid to attend meetings and we don't get any minutes afterwards but it is good to meet up with other care staff", "I feel that staff meetings are a waste of time as nothing is ever done about the issues raised". This indicated the effectiveness and frequency of meetings may have resulted in staff not being motivated to engage with them. When we spoke with people who used the service some told us that staff were unhappy with elements of the job and would sometimes speak to them about their frustrations because they didn't feel listened to by their supervisors.

No business development plan was in place at the time of our inspection although the provider explained this was something they were currently in the process of developing. They had met with external consultants and the manager and senior supervisor to identify the focus areas although these meetings had not been recorded.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a moderate 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

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had not been maintained.

We looked at the recording and documentation within the service across a wide range of areas. Care plan files and staff files were stored in locked cabinets within the office. These were held securely and were accessible to appropriate staff. The office staff undertook archiving tasks by scanning documents and then shredding them on-site. Daily notes were retained and were indexed and archived by an external archiving company. All confidential documents were shredded and this paperwork was then collected and disposed of by an external company. With regard to electronic data, all computers were password protected and there was a secure external back-up server hosted off-site so that information could be accessed in the event of an emergency.

When we looked at care related documentation we found there were not always detailed care plans available recording people's needs. One of the files we looked at did not contain a care plan. There were discrepancies in some of the files we looked at. One care plan stated the person was independently managing their personal care and then later said the person required assistance with personal care. Some plans had been written in 2011 and had not been altered since. Daily notes were completed by care staff at each visit. The manager confirmed sheets were brought into the office at the end of each month and put in files. There were many sections of notes missing from the files we looked at. One file contained daily notes for May and June 2013 but no previous or subsequent records. When we requested these they could not be located. The provider told us sheets were checked by the supervisors when they were brought in by staff but could not clarify if this always happened.

One person's file showed the person had a review in June 2013 where their care package had been changed. The care plan had not been updated. The supervisor then confirmed that this person's care needs had changed again but nothing was recorded. A check of the file was carried out in August 2013 which confirmed the care plan required updating but

when we visited (in October 2013) the plan still remained unaltered. This could have resulted in the person receiving inappropriate care if support was delivered by staff that were not familiar with the individual.

Within one of the files there was an agreement from the local authority regarding the visits required but daily notes showed that visit times and frequency did not correlate with these. The care plan showed different times again. When we queried this with staff we were told that visits had been altered but the care plan had not been updated.

We looked at care records regarding financial transactions that staff were involved in and found these were inconsistent. In some care files separate sheets recorded all financial transactions and had receipts included. In one file we looked at financial transactions had been recorded within the body of daily notes and was not recorded separately. There were no receipts available.

The care staff recorded time of arrival and departure on daily notes within people's homes. We saw several examples of where these records had been altered and multiple examples of the visit not being the length of time allocated. There were some entries within these records that showed the person who used the service had indicated they did not require any further assistance but others did not indicate the reasons why the visit had been shorter.

There was a lack of records relating to action taken following complaints, concerns, safeguarding events, accidents and incidents. Although in some cases the provider, manager, supervisors and staff were able to provide verbal evidence of follow up action in individual situations, there were no records to confirm this.

This section is primarily information for the provider

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.

Regulated activity	Regulation
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regulation 9.(1) The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving inappropriate or unsafe care by planning and delivery of care in such a way as to meet the service users needs. ensure the welfare and safety of the service user, reflect published guidance in relation to good practice.(2) The registered person did not have effective procedures in place for dealing with emergencies which would affect the provision of services or to mitigate the risks arising from such emergencies to service users.
Regulated activity	Regulation
Personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: Regulation 11.(1) The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse because they had not taken reasonable steps to identify the possibility of abuse and prevent it before it

This section is primarily information for the provider

	occurred or responded appropriately to allegations of abuse.
Regulated activity	Regulation
Personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Regulation 23.(1) The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities as they were not receiving appropriate training, professional development, supervision and appraisal.
Regulated activity	Regulation
Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Regulation 10.(1) The registered person did not protect service users and others who may have been at risk of inappropriate or unsafe care because there was not effective operation of systems designed to regularly assess and monitor the quality of services provided or identify, assess and manage risks relating to health, welfare and safety of service users.(2) The registered person did not have regard to the complaints and comments made by service users, did not where necessary make changes to the care provided in order to reflect information relating to the analysis of incidents that resulted in, or had the potential to result in harm to a service user, did not regularly seek the views of service users and persons employed to enable them to come to an informed view in relation to the standard of care and treatment provided to service users.
Regulated activity	Regulation

This section is primarily information for the provider

Personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Regulation 20.(1) The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care arising from the lack of proper information about them by maintenance of accurate records in respect of each service user as these did not include appropriate information and documents in relation to the care and treatment provided to each service user and such other records were not appropriate in relation to the management of the regulated activity.

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 16 November 2013.

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.

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