Age Concern York

Age Concern York In Safe Hands Services

Inspection report

70 Walmgate
York
YO1 9TL
Tel: 01904 627995
Website: www.ageuk.org.uk/york

Date of inspection visit: 18 September 2015
Date of publication: 22/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

We inspected this service on 18 September 2015. The inspection was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

In Safe Hands Services is run by Age Concern York and is registered to provide personal care to people in their own homes. The service aims to give people who look after an older person a break from their caring role. At the time of our inspection there were a mixture of paid care workers and volunteers working for In Safe Hands Services; volunteers provided a sitting service (staying with a person in their home whilst their carer went out or had a break), whilst care workers mainly took people out for a period during the day. Support was typically provided to

Summary of findings

people for two to four hours during once weekly visits. At the time of our inspection the service was supporting approximately 80 people, although not all received support with personal care.

The service was last inspected in September 2013 when it was compliant with all of the regulations we assessed.

The registered provider is required to have a registered manager in post and on the day of our inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care workers and volunteers we spoke with understood the types of abuse they might see and knew how to respond to protect people from harm. People's needs were assessed and risk assessments put in place. Care workers and volunteers understood people's needs and were proactive in providing support to minimise risks and prevent avoidable harm. The service had a safe recruitment process and a system to ensure that they had sufficient care workers and volunteers to meet people's needs.

However, we found that the service was not taking sufficient steps to ensure that medication was managed and administered safely.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We found that the registered manager did not sign off accident or incident reports to ensure that these had been dealt with appropriately, meaning there was no analysis for patterns or reoccurring issues. These concerns could place people who use the service at risk. We have made a recommendation about improving the management, recording and analysis of accidents and incidents in the full version of this report.

We saw that the service had an effective recruitment and induction process. Care workers and volunteers we spoke with told us they felt supported in their work and that advice and guidance was always available when needed.

However, the service did not have a robust system to ensure and evidence that all care workers and volunteers had the right training to meet people's needs effectively.

This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We saw that people were supported to make decision; however, the service did not document mental capacity assessments or best interest decisions when seeking consent to support provided. This meant we could not be certain that people's rights were protected in line with the Mental Capacity Act 2005. We have made a recommendation about following best practice relating to the Mental Capacity Act 2005 in the full version of this report.

People using the service had positive caring relationships with their care workers and volunteers. People were matched to one care worker or volunteer and this consistency helped people to develop meaningful caring relationship. People told us that care workers and volunteers treated them with dignity and respect and we could see that people were supported to be actively involved in decisions about their care and support.

People received responsive person centred care and support from familiar care workers or volunteers who understood their needs. People had long-term support from one person meaning that care workers and volunteers knew how best to support that person.

The service completed surveys to collect people's views. People felt able to raise issues or concerns with the registered manager or staff in the office and were confident that their comments would be listened to.

People using the service, care workers and volunteers were positive about the management of the service and felt it was well-led. The service provided a supportive

Summary of findings

environment for care workers and volunteers and there was a positive culture. However, the service did not have robust systems in place to monitor the quality of the care and support provided.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Care workers and volunteers understood the types of abuse they might see and knew how to respond to keep people using the service safe.

People's needs were assessed and proportionate risk assessments put in place to minimise risks and prevent avoidable harm.

The service supported one person to take medication. However, the care worker had not had training on managing medication from In Safe Hands Services. The registered manager did not complete competency checks of their practice or audits of Medication Administration Records. This meant there were insufficient checks in place to ensure medication was administered safely and in-line with best practice.

There was no analysis of accidents and incidents. This meant that the service was not monitoring and ensuring appropriate action was taken to minimise future risks.

Is the service effective?

Requires improvement

The service was not always effective.

The service did not have a robust system to ensure and evidence that care workers had appropriate training to meet the needs of the people they were supporting.

The service did not document mental capacity assessments or best interest decisions when seeking consent to support provided.

People were supported to eat and drink and care workers and volunteers were aware of individual dietary requirements.

Is the service caring?

Good

The service was caring.

People using the service had developed meaningful and positive caring relationships with the care workers and volunteers from In Safe Hands Services.

Care workers and volunteers supported people using the service to be actively involved in making decisions about the support they received.

People using the service consistently told us that care workers and volunteers treated them with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's care plans were personalised. Care workers and volunteers understood the needs of the people they were supporting and used this familiarity to provide responsive person centred care.

The service had a system to collect feedback about the support provided and to respond to compliments and complaints.

Is the service well-led?

Requires improvement

The service was not always well-led.

People using the service felt the service was well organised and well-run.

We observed a positive culture within the service and care workers and volunteers told us they felt supported in their role.

However, there were not adequate systems in place to monitor the quality of the care and support provided so we could not be confident that if problems did arise, that these would be swiftly identified.

Age Concern York In Safe Hands Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 18 September 2015 and was announced. The registered provider was given 48 hours' notice because the location provided a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

The inspection was carried out by one Adult Social Care Inspector. Before our visit we looked at information we held about the service. We also contacted City of York Council's safeguarding and commissioning teams to ask if they had any relevant information to share. They told us that they did not have any information of concern about In Safe Hands Services at the time of our inspection.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with two people using the service and six relatives who were also the main carer. We spoke with five care workers, two volunteers, two care coordinators, the registered manager and the chief officer. We visited the registered provider's office and looked at seven care plans, six care workers and volunteer recruitment and training files and a selection of records used to monitor the quality of the service

Requires improvement

Is the service safe?

Our findings

People told us they felt safe with the support provided by In Safe Hands Services' care workers and volunteers. Comments included "I absolutely feel safe, I know [the care worker] is very aware of safety issues - that comes across in conversations" and "I do feel safe they seem to know just what to do if anything crops up."

The registered manager told us there had been no safeguarding concerns in the last year. Despite this, care workers and volunteers we spoke with understood the types of abuse they might see and described what action they would take if they had concerns. Comments included "I would report it to the manager and safeguarding lead. We would discuss any concerns and liaise and work with social services" and "If I thought abuse was happening I would report it." The registered provider had a safeguarding policy, offered training on safeguarding and had a lead safeguarding officer who was responsible for managing safeguarding alerts and providing advice and guidance. Care workers and volunteers we spoke with knew who the lead safeguarding officer was and understood their role. This showed us that there was a system in place to identify and respond to signs of abuse to keep people safe.

We reviewed people's care plans and saw that people's needs were assessed and risks identified. Risk assessments were put in place before care workers or volunteers started providing support. We saw that risk assessments were proportionate to people's needs and provided details of how risks, such as those associated with moving and handling, problems with medication and unexpected illness would be managed. Care workers and volunteers described how they had been introduced to new people using the service and any risks or concerns were handed over verbally by the care coordinator and documented in the care plans and risk assessment they received.

We asked care workers and volunteers how they kept people using the service safe. One volunteer told us "The care plan is paramount as to what we should or shouldn't do with clients." Care workers and volunteers explained how they had to be aware of people's needs and potential risks. One care worker told us how the person they supported could be unsteady when walking, increasing the risk of falls. By being aware of this risk, the care worker explained that they could make sure they visited accessible places, that the person had their walking stick with them and that they avoided walking long distances as this could cause fatigue and increase the risk of falls. This showed us that there was a system in place to identify and record risks and that care workers and volunteers provided proactive support to keep people safe.

We spoke with two of the care coordinators working for In Safe Hands Services. They assessed people's needs and set up new packages of care - described by the service as a new 'arrangement'. This involved matching a new person to the right care worker or volunteer, agreeing dates and times for the arrangement and creating the care plans and risk assessments. The care coordinators told us that they had a waiting list of people referred to them. We saw that new arrangements were only made with people from the waiting list when there were care workers or volunteers available at the times needed. This ensured that the service had enough care workers and volunteers to meet the needs of all the people they were supporting.

We saw that one care worker or volunteer was usually matched to each person using the service. We found that, this care worker or volunteer provided all of that person's support. People using the service told us their care worker or volunteer arrived on time and rarely missed an arrangement. Comments included "They always come on time" and "I like people who are punctual and they [my care worker's] both are." The care coordinators told us that they tried to find other care workers or volunteers who may be familiar with a person to cover planned absences; however, the service did not routinely cover sicknesses or other unplanned absences. The registered manager explained that the service was designed to provide extra support, they described this as "The icing on the cake" to people's existing support networks so people were not placed at risk if arrangements got cancelled at short notice. Although this could be disappointing for people, it did not put people at risk of harm because of the nature of the support provided and because this was communicated to the person and their family or carer in advance.

People using the service consistently told us that their care workers or volunteers were reliable and rarely or never missed an arrangement. A number of people told us that their arrangements had been running for several years and

Requires improvement

Is the service safe?

their worker had never missed a session. Whilst other people we spoke with said "If the person is unable to come they contact me and we negotiate a different date and time."

We reviewed recruitment files. We saw that prospective new staff completed an application form and had an interview. The service obtained references and Disclosure and Barring Service (DBS) checks were completed before care workers and volunteers started any caring work. DBS checks return information about spent and unspent criminal convictions, cautions, reprimands and final warnings. DBS checks help employers make safer recruitment decisions and prevent people known to pose a risk from working with vulnerable groups. By conducting interviews, seeking references and completing DBS checks, we could see that the service was taking reasonable precautions to ensure that new care workers and volunteers had the right skills and experience for their role.

As we had found that some DBS checks were completed several years ago we spoke with the registered manager and chief officer. They told us that the service had recently started a process of completing new DBS checks for care workers and volunteers in groups of ten to spread the cost of new applications across the year. This is good practice as it keeps this information up to date and helps to protect people using the service.

The service had a medication policy and this was provided to care workers and volunteers as part of their induction. We saw that any medication administered by care workers or volunteers had to be available in the original packaging from the pharmacist clearly showing the person's name, the medication and the dosage required. At the time of our inspection one person using the service needed support from In Safe Hands Services to take their medication during a weekly visit. We found this had been documented in the care plan and an agreement signed with the care worker and the person's relative.

The care worker responsible for administering medication had not received medication training from In Safe Hands Services. We also noted that the registered manager did not complete medication competency checks of this care worker's practice. Training and competency checks are important to ensure that medication is administered safely and in line with up-to-date guidance on best practice. We reviewed the Medication Administration Record (MAR) chart, which was used by the care worker to record medications given. We felt this record was unclear and made it difficult to consistently account for what medication had or had not been given. We discussed this with the registered manager who showed us a new MAR chart they would introduce immediately to address this concern. We could see that the new MAR chart was clearer and easier to use.

We found that the service had not completed audits of MAR charts returned to the office. The registered manager told us that the care worker who supported with administering medication had significant experience and they had no concerns. Although we found no evidence to suggest a medication error had occurred, we felt that the records kept were unclear and that the service was not taking sufficient steps to monitor and ensure that medication was administered safely and in line with best practice.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been three accidents and incidents reported in the last year. We found that in each case staff working for In Safe Hands Services had gathered more information and taken appropriate action where necessary to prevent further risk of harm. In one example, a person using the service displayed inappropriate behaviour towards a care worker. This was investigated and appropriately responded to. However, the registered manager did not document that they had reviewed and signed off accident and incident forms to say that they were satisfied that the service had responded appropriately. This also meant that there was no analysis of accidents and incidents, to look at whether there were any trends or patterns.

We recommend that the service seek advice and guidance from a reputable source about the management, recording and analysis of accidents and incidents.

Requires improvement

Is the service effective?

Our findings

People we spoke with told us "The person who comes in is very knowledgeable" and "The carers seems to be experienced in what they do." Other people we spoke with confirmed that care workers and volunteers were skilled and knowledgeable with comments including, "I've every confidence in them" and "They are mature people who have been doing it for many years."

The registered manager told us that the all new starters completed a two stage induction; part one was a general induction to Age Concern York and part two was a role specific induction to the In Safe Hands Services. This provided training which included safeguarding vulnerable adults and health and safety. Care workers and volunteers we spoke with told us that they felt supported in their roles and that they were confident with what was expected of them by the time they met their first client.

In addition to the induction training, the service provided what they called 'essential' training on moving and handling, safeguarding and dementia awareness and first aid. Care workers and volunteers also had access to 'bite-size' training courses on a wide range of topics which included Parkinson's, Bereavement, Fraud Awareness, Partial Sightedness and Epilepsy. Care workers and volunteers we spoke with felt that they had enough training to carry out their roles effectively. Comments included "I've never had so much training, I love it" and "There are always several dates offered for training if you cannot make one."

We spoke with the registered manager and chief officer about training. They told us that induction training was mandatory, but both the 'essential' training and 'bitesize' training were non-mandatory with carer workers and volunteers encouraged, but not required to complete this. We reviewed the service's training matrix which showed gaps in this essential training. We saw that 46 out of 62 staff had completed moving and handling training, 32 staff had completed safeguarding and dementia awareness and 29 staff had received first aid training.

The registered manager and chief officer told us that where specific needs were identified care workers or volunteers would be required to complete specific relevant training courses. For example where mobility was an identified concern, that person's care worker or volunteer would be required to complete moving and handling training.

However, there was no documentation to evidence this process; whilst a care worker responsible for administering medication had not received training on managing medication from In Safe Hands Services. This showed us that this system was not always effective in ensuring that care workers and volunteers had appropriate training for the support they were providing. We concluded that the service needed a more robust system to ensure that staff had the right training to meet people's needs safely and to evidence that they had considered the risks associated with meeting a person's needs against the training requirements of the care worker or volunteer supporting them.

This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider's supervision and appraisal policy required care workers to have supervision every two months and yearly appraisals. The registered manager told us that care workers and office staff had formal supervision and appraisals, whilst volunteers had regular informal supervision and support from the office staff. Some care workers we spoke with told us they had supervision every two months, however, some care workers were unsure about whether they had had supervision.

We reviewed three supervision records and saw that the care workers had received regular supervision and discussed workload, their cases and training. The registered manager showed us how they diarised supervision dates so they knew when supervisions were due. Meanwhile, care workers we spoke with told us that the office rang them to ask for updates and to find out how they were. We saw that the service held regular team meetings for care workers and volunteers and that minutes for these were produced and distributed. Meanwhile, care workers and volunteers were positive about the supporting environment within the service, one worker told us "There's so much support from the manager it's brilliant." This showed us that the service was supporting care workers and volunteers in their role through formal and informal supervision.

We saw that care plans were signed by the people using the service or their representatives. However, where a person might not be unable to make decisions for themselves (where they lacked mental capacity), the service did not document mental capacity assessments or a best interest

Requires improvement

Is the service effective?

decision to provide care and support. Best Interest Decisions are decisions made on a person's behalf where they lack capacity and are governed by the Mental Capacity Act 2005. By not documenting mental capacity assessments and best interest decisions we could not be certain that people's rights were protected in line with the Mental Capacity Act 2005. Meanwhile, although we saw family members or a representative had been asked to sign care plans on people's behalf the service did not establish whether they had a valid and applicable Power of Attorney (POA) in place to make these best interest decision. A POA is someone who is nominated to make decisions on a person's behalf. It is important for services to be aware when a POA is in place, so that decisions are made by the right person in line with previous wishes.

We recommend that the service follows best practice relating to the Mental Capacity Act 2005 to ensure that consent to care is sought in line with relevant legislation and guidance.

Although the service did not document mental capacity assessments or best interest decisions, decisions about the support provided, for example, where the care workers would take people during trips out, were made in consultation with the person's family or carer and bearing in mind the person's past and present wishes. We spoke with the care coordinators who were responsible for assessing people's needs and setting up new arrangements. They told us "If someone has capacity we ask them to sign the care plan, we include people wherever possible." Whilst other comments included "We show them the care plan and the carer signs it, if they have capacity they sign it."

Care workers and volunteers we spoke with were aware of the importance of consent when providing care and support. One worker said "I always ask first, what would they like to do." Whilst other workers told us how they supported people to make decisions by offering simple choices.

We saw that care plans contained information about the level of support people needed with preparing meals or drinks during a care worker's or volunteer's visit. The majority of people we spoke with did not receive support with meals and drinks although they might have a meal with the care workers during a trip out. We saw that care plans contained information about people's special dietary requirements and any food allergies. One care plan documented "[Person using the service] is diabetic. Please avoid sugary drinks and food." Whilst another care plan had been amended following a choking episode to alert the volunteer to this risk when supporting the person. We spoke to this volunteer and found that they were knowledgeable about the person's needs, the risk of choking and the types of food that the person may struggle to eat. We saw that this care worker had received training in first aid from In Safe Hands Services in April 2012.

People's medical conditions were documented in their care plan and risk assessments contained information to support care workers and volunteers to respond to medical emergencies. Care plans contained contact details for the person's carer, their G.P as well as other professionals involved in supporting that person such as social service, community psychiatric nurses, district nurses and any occupational therapy or physiotherapists. This was important as it meant that care workers and care coordinators had information on who to contact if there were problems during an arrangement.

Care workers and volunteers we spoke with described how they would discuss any concerns they had about the people they were supporting with the person or their carer. Care workers and volunteers were clear that if they had significant concerns during an arrangement they would call the G.P, the non-emergency 111 number or an ambulance if needed. We saw that on occasions care workers supported people using the service to attend appointments including a visit to the dentist and support to attend a hospital appointment. This showed us that the service was supporting people wherever possible to maintain good health and have access to healthcare services.

Good

Is the service caring?

Our findings

People who used the service were consistently positive about the caring relationships they had developed with their care worker or volunteer. Comments included "Oh yes they are very caring. They take an interest in you, you can tell they care" and "I do genuinely feel they care, it's a genuine connection." Whilst a relative told us "The best thing about it is they get along so well together, my wife looks forward to it."

People using the service and their relatives told us they had talked to the care coordinators about their interests and discussed what support they would like from In Safe Hands Services. The care coordinators described how they used this information to match people to a care worker or volunteer who shared a similar hobby and interest. Once a potential match had been made, care workers and volunteers told us that they read the care plans and spoke to the care coordinator so that they had enough information to start getting to know that person.

Care workers and volunteers were matched to a person using the service and provided all of their support. This consistency helped people using the service and their care worker or volunteer to develop meaningful relationships. Care workers and volunteers we spoke with said "We have a chat; I know them so well now as I have been visiting for three years" and "We build long-term relationships with people." Other comments included "I look after them as I would look after one of my own" and "We have time to get to know people and give bespoke support." This and other comments showed us that care workers and volunteers cared about the people they were supporting and took time to get know them and develop meaningful and positive caring relationships.

We could see that people using the service were encouraged to share information about their likes, dislikes and personal preferences and this information was recorded in people's care plans. We reviewed records of the activities and trips that care workers supported people with and it was evident that people's likes and dislikes were taken into account and support was tailored to suit those preferences. People using the service repeatedly told us that care workers and volunteers encouraged them to make decisions about what they would like to do during each arrangement. Comments included "They say where do you want to go and I tell them" and "They take me out wherever I want to go." Meanwhile a relative told us "It depends how he feels, sometimes they sit up and talk or else he goes back to bed. It is definitely up to him [the person who uses the service] what they do." Meanwhile, care workers explained how they used their knowledge of the person to make suggestions if people were struggling to decide, but were clear that "It's up to them what they want to do." This showed that people were actively involved in deciding how they were supported and that care workers encouraged this.

Care workers and volunteers we spoke with understood the importance of respecting people's privacy and dignity when providing care and support. Care workers and volunteers described how they used their knowledge of people's needs to avoid situations which might impact on their privacy and dignity. Care workers and volunteers we spoke with explained that this was particularly important during trips out where people did not have the privacy of their own home. Care workers told us they often had to be discreet and tactful to avoid drawing attention to the person or making that person feel embarrassed. One care worker gave an example of how they would nod discreetly towards the toilet rather than asking the person in a crowded place if they need the toilet, which could cause embarrassment. Another care worker told us they might walk in front of someone or give them a bag to carry if there had been an issue with incontinence and until they could find a toilet or get back to the car. A relative of someone using the service told us "They provide the right kind of supervision in a tactful way." They explained how care workers and volunteers respected the individuals and made the support they provided a, "Normal event" similar to two friends going out rather than a person being escorted by a care worker. This sentiment was reflected by another person using the service who said "Once or twice we have been back late because we were sat talking and lost track of the time." This showed us that care workers and volunteers treated the people using the service with respect and took steps to maintain people's dignity.

Good

Is the service responsive?

Our findings

We reviewed seven people's care plans and saw that they had been created with the involvement of the person and their main carer. Care plans contained important information about the person's needs as well as personal preferences, likes and dislikes. We saw that care plans were put in place before support started and were reviewed and updated when needed. The care coordinators told us "We meet and get to know them [new people to the service]" and "We have a client information form before the initial visit and then we go and get as much information as possible." We saw that all new people to the service had an introductory meeting with the care coordinator and their care worker or volunteer so that they could get to know them before the arrangement started. One member of care worker told us "They take you to meet the person to make sure you're happy and they're happy with the arrangement." Once a successful match had been made this care worker or volunteer usually provided all of that person's support.

Care workers and volunteers we spoke with told us "I think they [the care coordinators] provide an amazing service. They know their clients really well and take time to get to know people so they can make a detailed care plan" and "The care plans are brilliant…if you find out a bit more you can add to it, but everything is down that you need to know." This meant that care workers and volunteers had access to up-to-date personalised information to enable them to provide responsive support to meet people's needs.

Care workers and volunteers told us they read information in the care plans and had discussions with the care coordinators to understand people's needs and how best to support them. Once an arrangement started, however, care workers and volunteers began to get to know people using the service and it was clear that this familiarity enabled them to provide personalised and responsive care. For example one care worker we spoke with described how the person they supported was unable to decide where to go during their arrangement. However, because they had been with the person during previous outings they knew what type of places that person appeared to enjoy and could use this to plan future visits.

To ensure that care plans and risk assessments were updated to reflect the support provided, we saw care workers and volunteers had to document each visit and these records were then returned to the office at the end of each month. Alongside the support provided, these records also asked care workers and volunteers to document any changes needed to the care plans so that office care workers and volunteers could update the records and send out a new copy. However, care workers and volunteers we spoke with told us that they did not always wait for records to be returned at the end of the month and often called the office if people's needs changed and the support plan or risk assessments needed to be updated sooner. One worker told us "If I feel things are changing I go back to the care manager and we re-look at it [the care plan]." This system ensured that care plans and risk assessments were updated when needed.

We could see that people using the service were supported to pursue their own interests, access their community and engage in a wide range of activities. One care worker we spoke with told us how the person they visited liked to go singing so they regularly took them to a singing for the mind class. We saw that other people were supported to go shopping, to garden centres, to a local airfield and to museums or pubs; whilst one person was supported to visit their allotment. This showed that people using the service received personalised support responsive to their specific needs.

We saw evidence that care coordinators called people using the service to make sure they were happy with the support put in place and that people were matched with a suitable care worker or volunteer. People we spoke with told us they felt able to raise concerns or complain and were confident that any issues or problems would be resolved by the manager. We saw that the service had a complaints procedure in place. The service had received one complaint in the last year. This had been investigated, an incident report produced and a formal apology sent to the person addressing the concerns they raised. This showed us that the service was listening and responding to people's experiences of using In Safe Hands Services.

Requires improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of registration for this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. There was a registered manager in post on the day of our inspection and as such the registered provider was meeting registration conditions.

During the inspection we identified concerns regarding the system in place to monitor and ensure that medication was managed safely, concerns that there was no analysis of accidents and incidents, concerns about training and concerns regarding the lack of mental capacity assessments and best interest decisions. Underlying this were concerns about quality assurance within the service.

We could see that the service was delivering responsive and compassionate support, however, there were insufficient systems in place to monitor the quality of the service provided. This meant that the concerns we found had not been identified and addressed by the registered manager and we could not be certain that, if problems did occur in the future, these would be identified.

The service did not complete spot checks or observations of care workers or volunteers practice. The registered manager told us that they had a regular dialogue with care workers and volunteers as well as with the people who used the service and their carers. The registered manager told us that they used this to monitor the quality of the support provided and to identify any problems or concerns around care workers and volunteers s' practice. However, care workers and volunteers often worked unsupervised and in isolation with vulnerable client groups who may be unable to raise or communicate concerns themselves. Although the service offered a wide range of training, there was limited mandatory training increasing the risk of inexperienced care workers and volunteers working with vulnerable adults. For this reason we felt the service needed a more robust system to monitor the quality of care and support provided to ensure that any concerns would be identified.

There were concerns that the registered manager did not complete competency checks for the care worker who administered medication to people using the service. Competency checks are observations of practice and are designed to ensure that medication is administered safely and that care workers are maintaining their skills over time. Given the lack of training provided on medication management, we felt the service needed to take steps to ensure that medication was administered safely and in line with best practice. This showed us that the registered manager was not taking sufficient steps to monitor the quality of the support provided and meant that issues or concerns with practice may not be swiftly identified.

We saw that care plans and risk assessments did not have a review date. The registered manager told us that the care plans and risk assessments were only reviewed and updated when people's needs changed and that they did not complete routine annual reviews. We saw that whilst some care plans were reviewed and updated regularly we saw other care plans that had not been updated for over a year. The registered manager told us that the person using the service, their carer or care workers and volunteers from In Safe Hands Services contacted the office if updates to the care plans or risk assessments were needed. We saw that the care-coordinators intermittently rang people using the service and care workers and volunteers for updates. The registered manager said that this relationship and two-way communication ensured care plans were kept up to date. However, we felt that there was a risk that gradual changes in people's needs could be missed and that changes would not be reflected in the care plans if the care worker or volunteer forget to report them to the office.

We also found that the service did not complete any audits of care plans, risk assessments or MAR charts. Audits are important to identify any gaps in records or problems with the recording system. Without completing audits we could not be certain that there were adequate systems in place to identify and respond if problems arose in the future. Meanwhile, audits and spot-checks are an important tool to support and encourage care workers and volunteers to develop in their practice, as they provide an opportunity to exemplify good practice, whilst identify and address poor recording or other specific issues. We felt that the registered manager was missing this opportunity to drive improvements within the service by not completing sufficient quality assurance to identify and address where changes were needed.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Despite these concerns people who used the service told us they thought it was well-led; with comments including "From my point of view it is well-led. I am quite happy with everything" and "It seems very well organised, everything runs quite smoothly." One person we spoke with told us "I would recommend it to anybody…I cannot fault the service." We asked care workers and volunteers if they thought the service was well-led. The feedback we received was universally positive with comments including "It's run very well really. If I ever have any problems or anything happens I get straight on to them and it's dealt with" and "I think it is well-led, well run and organised."

Care workers and volunteers told us they felt valued in their role, both by people using the service and by the registered manager and staff in the office. We could see from visiting the service and speaking with care workers and volunteers that there was an open, honest and positive culture within the service. Care workers and volunteers told us that they were asked for their opinions and encouraged to provide feedback if they had any issues or concerns. People we spoke with consistently told us that the registered manager and staff in the office were approachable and available to provide advice, guidance and support if needed. We saw that the service held regular team meetings for care workers and volunteers and that minutes for these were produced and distributed. The registered manager told us that these provided an opportunity for care workers and volunteers to meet each other and meet with the office staff to discuss any issues or concerns.

The registered provider completed a satisfaction survey which involved sending out questionnaires to people who used the service and professionals. We saw that 13 questionnaires had been sent to people using the service and two to professionals between April and September 2015. Results from these questionnaires had been collated and comments recorded. We saw that responses and comments from these questionnaires were consistently positive. The registered manager told us that although they had not received any negative feedback, any concerns raised would be addressed with the person. This showed us that there was a system to collect people's views.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered manager did not ensure the proper and safe management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered manager did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Regulation 12 (2) (c).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered manager did not establish and operate systems or processes to effectively: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated. Regulation 17 (2) (a).