Community Integrated Care

Community Integrated Care, Northern Regional Office

Inspection report

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15 September 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**

Is the service well-led?

Requires Improvement

Summary of findings

Overall summary

We inspected this service on 16, 17, 19, 24, 25 and 31 August 2016 and was unannounced. We gave feedback about our inspection findings to the regional director and a regional manager on 15 September 2016 when we received further information about the service.

Community Integrated Care is a domiciliary care service that provides personal care and support to people with a range of needs, including learning difficulties, physical disabilities, complex needs (including dual diagnosis), mental health concerns, sensory impairments and autistic spectrum disorders. These people live in their own homes and supported living services. The service is provided across Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland, Middlesbrough, Stockton, County Durham and Northumberland areas.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered 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.
At the time of our inspection the registered manager was absent from the service and one of the regional managers was covering the duties of the registered manager.

At the last inspection in July 2013 we found the registered provider was meeting the regulatory requirements.

Staff had received training in safeguarding. We found staff understood what actions to take if they thought people were unsafe.

There was robust oversight of accidents and incidents by the management team to ensure the risks of any accidents re-occurring would be reduced.

Staff employed by the registered provider had undergone a number of checks to ensure they were suitable to work in the service.

Where people lived with others in joint homes we found the arrangements for fire safety to between the landlord and the registered service to be at times unclear. People had not been able to practice emergency evacuations.

Staff were not always up to date in their medicines training and some assessments of them to determine their competency to give people their medicines were not up to date.

Staff had not received regular support through supervision and training to enable them to care for people. The service had introduced a new system for giving support to people through supervision meetings with

their manager. This had yet to be fully implemented.

The service adhered to the requirements of the Mental Capacity Act. This meant people's capacity to make decisions had been assessed. Where required we found decisions had been made in people's best interests involving their family members and other professionals.

People were able to choose the food they wanted to eat and were supported to eat and drink when required.

The service had introduced a new system for people's care planning. We saw the implementation of the system was at different stages. Staff saw the advantages of the new system.

We found that people's care plans had not always been reviewed in a timely fashion. This meant that any changes to people's care plans identified in the reviews had not been carried out.

People were supported by staff to participate in a range of activities of their own choosing. We saw people had in place regular visits to places where they enjoyed going.

We found regional managers fed back to the registered manager at monthly meetings about the regulated activity and updated the registered manager on events which had taken place in the service.

We found that some staff were unclear about which of the provider's registered office location they were accountable to. The office arrangements were clarified for us and the regional director explained there may be some further review of these to ensure the service is working in the most effective way.

During our inspection we found a number of breaches 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff who were recruited to the service underwent a number of checks to ensure they were safe to work with people using the service.

We could not be reassured people had the appropriate training and updated competency checks in place to give people their medicines.

Fire evacuation procedures had not been practised by some of the services so people had rehearsed leaving the building in an emergency.

Is the service effective?

Requires Improvement

The service not always effective.

Staff had not received sufficient support through supervision and training to enable them to carry out their roles.

We found staff had developed communication techniques with people and were able to understand people's needs.

The service adhered to the principles of the Mental Capacity Act and had assessed with other profession's people's capacity to make decisions.

Is the service caring?

Good

The service was caring.

Relatives we spoke to during the inspection told us they felt staff cared for people using the service and knew their family members well.

We found that staff respected people's homes and treated people with dignity.

We saw the service had used easy ready formats to give people information in ways they could understand.

Is the service responsive?

Requires Improvement

The service was responsive not always responsive.

Reviews of people's care plans had not always been carried out in a timely manner.

People were engaged in a range of activities to suit their individual preferences.

Relatives we spoke to understood there was a complaints process in place, but told us they had no need to make a complaint.

Is the service well-led?

Requires Improvement

The service was well led not always well led.

People's records had not always been reviewed and updated. This meant people's care plans were not always up to date.

We found the registered provider had in place systems for monitoring actions to demonstrate improvements in the service. However we found actions submitted by service leads had not been carried out with the target timescales.

We found that regional manager audits were not being completed consistently across all services and did not routinely identify deficits in the delivery of the service.

Community Integrated Care, Northern Regional Office

Detailed findings

Background to this inspection

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

This inspection took place on 16, 17, 19, 24, 25 and 31 August 2016. The inspection was unannounced. We did not give the provider notice because the visit on 16 August 2016 was to the registered office and there was an expectation this office would be staffed. On 15 September 2016 we fed back the findings of our inspection to the regional director and a regional manager. The regional director provided us with additional information. The inspection team consisted of two adult social care inspectors and two experts-by-experience. The inspection included visits to the office and visits to people's homes across each local authority who commission the service. The experts-by-experience did not accompany inspectors on the inspection but made telephone calls to relatives of people using the service during the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both of the experts by experience involved in this inspection had a background in caring for people with additional learning needs.

Before the inspection we checked the information that we held about Community Integrated Care Northern Regional Office. For example we looked at safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in supporting the people who used the service, including commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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

Community Integrated Care Northern Regional Office is registered with CQC for the regulated activity Personal Care. We visited 11 of the services which provided personal care to people living on their own, in small groups and in larger services within their own flats. The services we visited were located in seven local authority areas.

During the inspection we spoke with 13 people who used the service. We also spoke to 13 of their relatives by telephone. We reviewed 15 people's care files. We carried out observations of the care being delivered to people who were unable to speak for themselves.

We also spoke with 22 staff members including the regional director, three regional managers, service leads, a quality and excellence partner, an administrator and senior care staff. We were not able to speak with the Registered Manager as they were currently absent from the service. During the inspection we spoke with a professional visiting a person who used the service. We spent some time looking at documents and records that related to the management of the service.
We sent out questionnaires to 130 people including to people who used the service, their relatives, staff who worked in the service and other professionals before the inspection and received feedback from 33 people. The feedback was used to help form our judgements about the service.

Requires Improvement

Is the service safe?

Our findings

One relative we spoke with told us, "Oh yes [person] is definitely safe. [Person] has lived there a long time". Another relative told us, "Yes I think [person] is safe there. It takes [person] a while to get to know new staff but everything is fine". Staff we spoke with told us they knew how to report safeguarding concerns and showed us records demonstrating concerns had been dealt with appropriately. Staff and people who used the services had access to a safeguarding policy and procedure; this was also available in an easy read format. People who used the service told us they knew who to speak to if they had any concerns and that they felt confident staff would help them.

We saw there was an electronic system for recording safeguarding concerns; this meant that staff recorded concerns in a standardised way and that the registered provider had oversight of the actions taken. One staff member we spoke with told us they had used the system to report a safeguarding concerns and it was "Easy to use". Safeguarding training was mandatory for all staff. We saw the majority of staff had received safeguarding training and actions had been taken by managers to ensure everyone's training was up to date.

Staff had access to a whistleblowing policy and procedures. Whistle blowing is where a staff member speaks up about their concerns about a service. Posters were displayed in the offices for "Speak out"; this is an internal telephone number for staff to report any whistleblowing concerns. Staff felt confident in approaching senior staff and managers. One staff member told us, "I always feel supported, if I have any problems I can go to the senior or the service lead". Another staff member told us they had expressed concerns about their workload and management had addressed these concerns.

Staff told us they knew how to report accidents and incidents. Accidents and incidents were recorded on a computer system which recorded the actions taken before allowing staff to close the record. Regional Managers and the Quality Team had oversight of all accidents and incidents recorded on the computer system to monitor the outcomes and prevent reoccurrences.

During the inspection we looked at the recruitment policy and 16 staff files that showed us the registered provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, and two previous employer references and a Disclosure and Barring Service check (DBS) which was carried out before staff commenced employment. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

We saw there was a process in place for completing health and safety checks in people's homes. These included personal emergency evacuation plans so staff were aware of the level of support people living in their own home required should they need to be evacuated in an emergency. Health and safety checklists also included infection control and equipment checks. Water temperatures and fridge temperatures were recorded in some people's homes. Services had records of safety certificates arranged by the landlord such

as gas, Portable Appliance Testing (PAT) and legionella checks. Where hoists were in use there was evidence these were being serviced by external maintenance companies however, in one service we saw that bedrails were in use but these were not being assessed to ensure they were safe.

In two of the services we visited fire checks were not being completed by the staff. Staff told us it was unclear what fire checks were being completed by landlords or what checks were required for the type of service. We saw in one service the Registered Provider had stipulated two fire drills were to be carried out each year to ensure people knew how to evacuate their own homes in an emergency. We saw that only one fire drill had been carried out in 2014 and 2015. This meant staff had not done everything possible to make sure people were safe.

There were sufficient numbers of staff available to keep people safe. Relatives told us people using the service received support when they needed it and did not have to wait any length of time for support from care staff. One relative told us, "They have had some cut backs but [person] still gets enough one to one time" and "Yes there always seems plenty of staff there when I visit". Another relative told us, "They do seem to use a lot of agency staff, but I have to say they choose people who know [person] well so it does not disrupt or upset them" and "I think there are enough staff employed by them". Staff explained that regular agency staff had been used in one service for approximately six months but permanent staff had now been recruited. Staff at several services told us that they had not had a service lead in place for several months and there had been interim arrangements. One staff member told us, the service "Had quite a few managers in the interim period". All of the services we visited now had service leads in post.

We saw the storage, administration and disposal of medicines was in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). We saw people's individual medicines records contained their photograph, allergy information, relevant contact numbers, medicine information and people's preferences regarding how they liked to take the medicines. We observed medicines being administered in line with the medication policy, with staff seeking people's consent and clearly explaining what the medicines were. We saw medicine administration records (MARs) and topical medication administration records (TMAR) for recording the administration of topical medicines were completed correctly.

People who used the service and relatives told us they did not have any concerns about the way their medicines were managed. One relative we spoke with told us, "If [person's] medication is changed they let me know straight away" and "The staff are very vigilant when giving medication". We saw that some people were responsible for their own medication, where this happened risk assessments had been completed. In one service we saw that medicines risk assessments were out of date and did not reflect current needs, however people's medicines were being administered safely. We saw that medicines were kept in people's rooms or flats where possible and lockable storage was provided for this.

We looked at medicines which were given to people as and when required (PRN). We saw people had in place PRN plans which gave guidance to staff as and when to give the medicine. Some people who used the service required PRN epilepsy medicine to be administered in the event of a seizure. Protocols were in place explaining when this medication should be administered. We were told that staff had specific training to administer epilepsy medication but we were not able to see evidence of this during our inspection. This meant we could not be assured the service had in place accurate records about staff training

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

In the registered provider's policy we read, "Care staff have the correct level of training and have their competency assessed before giving any medicines. Staff told us they had received training to administer people's medicines. Staff also told us they had been assessed for their on-going competency to administer medications. Service leads told us that training and competency records were stored at the regional office. During our inspection we observed a member of staff tell the senior on duty they were taking a person to their bedroom to give them their medicine. We checked the staff member's file and found a blank medicines' competency assessment. The manager told us they had training for administering medicines arranged in September 2016. This meant staff were administering medicines before they were trained. We found staff were competency assessed on an annual basis and we found some competency assessments were out of date. One staff member told us they had recently been trained to carry out the assessment but had not yet assessed all the staff team. Medicines training certificates were not available in all the staff files we checked.

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

Relatives told us they thought people's homes were kept clean and tidy. One relative told us, "It [the house] is very, very clean indeed. They wash the dishes and spray the benches" and another told us, "[Person] likes helping to clean the house". People who used the service told us they were supported to do housework. In some services people were able to clean their own flat but could choose not to do this. In these cases there was evidence that staff had support plans in place to offer help with cleaning.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they thought staff were well trained, one person said, "Very much so. There always has to be two staff to move my [relative]. There have not been any incidents that we know of." Another relative said, "One hundred per cent. They do more than their job. They really do care for her. Other relatives said, "Yes they are well trained. [Family member] has epilepsy and they recognise the signs and know what to do", and "Staff seem to know what they are doing when I am there."

The registered provider had recently introduced a new system called "You Can" for offering support and supervision to staff. The system provided a framework for conversations to take place about, for example, of what is working well, and what needs to change. Staff told us that this was just being implemented and supervisors showed us how they had begun to use it with staff. Supervisors confirmed that they had received training and staff were expected to meet four times per year with their supervisors to discuss their progress. We looked at the supervision and support to staff prior to the introduction of the new scheme. Staff explained to us that over the last year in addition to the new scheme staff were expected to be supervised every two months. We found there were significant gaps in supervision and people had not been supported by the manager through supervision on a consistent basis.

We looked at staff training and found the provider had in place a course for staff new to the organisation. This course gave staff the basic knowledge and skills required to undertake the work as a part of their induction. Staff confirmed they had received an induction to the service. The registered provider had in place mandatory training for staff, this included health and safety and moving and handling. This meant staff had received support to carry out duties which appertained to all.

We saw there was a training policy in place. The policy required managers in the service to identify training for their staff team where specialist knowledge was required to meet the needs of people using the service. We found a cluster manager who had identified the need, sought training for their staff and awarded certificates. We spoke with staff who told us they had not received relevant training and found staff were caring for people without having had the relevant training. For example we saw staff caring for people with sight loss, epilepsy and dementia where staff had not received training. During our inspection staff spoke to us about a number of people who they believed were on the autistic spectrum but due to their age, previous diagnostic practices and previous care placements they had not been diagnosed. However we found staff had not received specific training to be able to meet these people's observed needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found staff understood the issue of capacity and we found capacity assessments had been carried out on people with other professionals and their family members. Staff we spoke with told us about their discussions with local authorities. Staff were using the least restrictive practices until authorisations from the Court of Protection had been given. Relatives told us they were involved in decision making; one relative said when it comes to decisions staff would inform her about a holiday they wished to take their relative on. They went onto explain their relative did not like crowds.

One relative told us, "The staff are very good. My [relative] can lash out at any time. They see the warning signs and are really good at calming [relative] down." Staff were trained in Managing Actual or Potential Aggression (MAPA). The training was designed to teach staff techniques to intervene and prevent escalating behaviour in a safe manner. During one of our visits to a service we found a person whose behaviour was becoming increasing challenging to staff. Staff talked to us about how restraint was not acceptable and showed us they had agreed with the person's care manager appropriate actions to take. This meant the service was working with other professionals to consider the issue of restraint.

We spoke with relatives about people's eating and drinking needs. One relative said, "My relative likes most things. There is always a nice smell when they go back. The meals are varied such as curries." Another relative told us the staff were very good at including their relative's preferences over meals and that the house was very homely. They told us how their relative enjoyed two Yorkshire puddings and gravy before their dinner.

During our inspection we observed staff offering drinks to people to maintain their hydration. People were supported to plan their own menus, do their own food shopping and cook their own food. We saw people had a choice of meals. Staff explained to us how people were given a choice. In some people's homes we saw staff prepared and cook people's food. We checked people's weights and found where these were recorded people remained at a healthy weight. In one person's care plans we saw there was detailed guidance about the support they required to eat including the use of utensils. In another's person's hospital passport we noted they required additional support to eat but found there was no care plan in place to describe this. Staff were able to tell us what the person liked and there was a list of their preferred foods attached to the fridge door. We found in people's daily notes staff usually documented what people had to eat.

We saw people using the service had in place a tenancy agreement where they rented their accommodation from a range of landlords. People were involved in the decoration and furnishing of their homes which had been adapted to meet their needs, for example some had wheelchair access. We saw people's homes were spacious and the staff ensured people were not at risk of trips. We asked staff about the adaptation of some of the premises to support people to be more independent for example a reduction in stimuli for people on the autistic spectrum or guidance in place for people with sight difficulties and found adaptations had not been made.

We recommend that Community Integrated Care work with people in their homes to consider what steps could be taken to improve their environment and support people's independence.

One relative told us, "My [relative] is able to communicate, though not at a highly skilled level. They listen to

my [relative]. Another relative said, "They have got a board up on the wall and they have pictures on it. They ask what she wants using pictures." Staff supported people to communicate with us and interpreted hand signals." This meant staff had found ways to communicate with people.

In people's homes we saw communication systems in place to enable staff coming on duty to catch up with events in people's homes. Staff showed us communication books and files where pertinent information was held about people and events in the home. Messages were left for staff to carry out tasks. Staff were able to tell us about where they found information on the service and people who used it.

Good

Is the service caring?

Our findings

People who used the service and relatives we spoke to said they felt the service was caring. One relative told us, "It is wonderful care there, the staff are dedicated" and another told us "It is excellent care there". Other relatives told us, "We are extremely happy with [relative's] care", "They are like family and friends there" and "The level of care is very high".

People who used the service told us they had key workers, a named staff member who worked with them. Relatives were also [relative] Person] has a key worker who they choses each week...this gives [person] a variety of carers" and "Yes [person] has a key worker and has one to one attention, they go out and about together". Another relative told us, "[Person] has a very good keyworker; they have just been to Edinburgh and stayed overnight".

People who use the service told us they liked that staff worked with them and had time with staff on their own. One person who used the service told us, "[Person] is the best carer in the world". Relatives told us, "They [staff] are amazing. I couldn't do without them" and "The staff are marvellous". We saw that staff communicated with people who used the service in a way they understood and that there was a good rapport between staff and people who used the service. We saw staff and people who used the service telling jokes and laughing together.

Relatives told us that staff knew their family member well, "Yes they know [person] well, [person's] likes and dislikes", "They are very respectful of [person's] needs", "They know [person's] ins and outs…excellent carers" and "[Person] does not like change and they consider this when employing agency staff, they only have carers who she knows".

People who used the service told us they had been involved in recruitment. One person who used the service told us they had asked interview questions about if staff would take them out on a night-time because this is what they liked to do. At another service a new staff member was being introduced to the person who used the service. The staff member spent time talking to other staff and also the person who used the service prior to them starting working at the service.

Staff told us that services were tenant led. We saw that people who used the service made decisions about what they wanted to do and when. One person who used the service told us, "I can do what I want". We saw staff asking people what they had planned to do on the day of the inspection. In another service records demonstrated that people who use the service had planned to go to Durham but on the day had decided to go to Sunderland. Staff told us that plans often changed depended on people's choices on the day. People who used the service had chosen the decoration of their rooms and had been supported to buy personal items to furnish their houses. Some people had pets, such as tropical fish. This meant people were encouraged and supported to develop their own homes and lifestyles.

Relatives we spoke with said they were involved in care planning. One relative we spoke with told us: "[Person] has a care plan and we are involved in the yearly review". Another relative we spoke with told us:

"[Person] has a care plan and we are involved but [person] has recently said [person] wants more say, so that is fine". Relatives we spoke with told us that the service invited them to meetings but did not always want to attend these.

We saw that some people who used the service were supported to maintain their independence. We saw people had their own door keys and one person told us, "I let myself in the front door". A staff member told us "[Person] has his own post-box outside the front entrance of the flats. [Person] hold his own key to access his mail". This meant people were supported as individuals and encouraged to be independent.

We saw that some people had advocates to speak up for them and that this was documented in their care files.

In some of the services we saw people had been provided information in easy read formats. These included making a complaint and tenancy agreements. We found in some areas the service had adapted their information to meet people's needs. Community Integrated Care had in place publicity to describe to people the nature of their services and their aspirations for people.

We saw that people's privacy and dignity was respected. Support plans stated, for example "Please respect my dignity by covering me up with my dressing down" and "Staff are to ensure that all doors are kept closed during my personal care". We observed staff treating people with dignity and respecting their privacy. One staff member asked a person who used the service if they would like to talk to them in private about some health concerns. Staff knocked on people's doors before entering their rooms or flats. Staff were respectful of people's homes and sought their permission before allowing us to visit people in their own home.

At one service staff told us one person had recently had a bereavement. They told us that they had worked with the other people living in the service to understand this. At another service we found a person who was using the service had lost people closest to them. Staff had checked on their wellbeing and been told by the person they were alright. We found staff in this service had not received End of Life training but had taken actions to help people in the service deal with the loss.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us staff kept in contact with them about their family member. One relative told us; "They [staff] are constantly in touch. [Person] has fits so they let me know when that happens" and "Yes they keep me informed and up to date". Another relative said they received regular updates from staff during their weekly visits to their relative.

During our inspection we saw people had in their files one page profiles, relationship circles and a page entitled. "My day to day life." This meant staff were given information about people in order to understand people's backgrounds, their preference and the people involved in their life.

We found each person had a set of care plans in place which covered for example their nutrition and hydration, personal care, activities, and the treatment of specific diagnosed conditions. We found people's care plans across the service varied in quality. Some care plans gave detailed instructions on how to deliver care and support whilst others contained less detail. We found one person with specific requirements for whom there was no nutrition plan. We pointed this out to the staff member who agreed to put a plan in place.

The registered provider had addressed the need to improve care plans and introduced a new system of care planning. We saw that some services had been quicker to make changes to the care files than others. Staff told us they had received training in the new plans and had begun to write the plans. Staff showed us examples of what they had written up to the point of the inspection. We saw the new plans contained appropriate levels of information and were person centred. This meant the detail in the care plans was specific to each person. One staff member told us they were working with the Local Authority to find out more about the history of a person who used the service so they could make their support plans more person centred.

Staff told us they felt that the new care documentation would be more streamlined and create more consistency between services. Some services had been without a permanent Service Lead, in these services staff told us, "things were in a bit of a mess and needed updating" and that they had identified some "gaps with paperwork". New service leads who had taken over services since a staffing restructure, earlier in the year, told us they were aware of where there were gaps in the paperwork and were trying to address these.

Staff told us that they regularly reviewed the care records and could clearly tell us about people's current needs. Reviews were not always documented and in two services we found that reviews had not been recorded for over a year. Without written evidence of reviews staff could not demonstrate that these had taken place or that care files still reflected current levels of need. In one service a person who used the service had developed dementia and staff agreed this may have impacted on their capacity to make decisions and consent to care. Staff told us they had identified that the care file needed to reflect this person's dementia but had not yet reassessed the person's needs. This meant the service had failed to assess the health and safety risks to the person.

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

The service had begun to introduce a person centred review involving family members and relevant professionals. Family members confirmed they had been invited to meetings. In one service we saw people had been invited to state their preferred date but the reviews had not gone ahead. Staff told us people in the service did not want the reviews. We found the service had yet to find an accessible way to engage people to participate in their person centred reviews.

We saw that there was a comprehensive complaints procedure in place that recorded the response to complaints. People who used the service and relatives told us they knew how to complain. One person who used the service told us if they had any concerns they "Would go to staff". No one we spoke with told us they had made a complaint. One relative told us, "We have never had any major complaints, sometime little niggles but they are sorted out straight away".

We asked staff to tell us about a good thing they did at work. One staff member told us, "The amount of activities we are trying to get people to participate in. We try new things, such as new games, gardens games." We saw that people had activities planners but these were flexible to suit the person who used the service. We saw that people took part in a wide range of activities, education and work. Relatives told us, "[Person] has a job close to the home and lives as an individual in their own separate rooms", "He likes to go out for his own shopping", " [Person] like to go clubs and shopping, sometimes just does jigsaws at home", "[Person] likes pampering sessions and shopping for clothes", "[Person] goes to college and a day centre two days a week" and "[Person] has very personalised care". This meant people made their own choices to be independent.

People were supported to plan holidays. One person used the service told us they had been away on holiday with a staff member because they shared a hobby. Staff explained that this staff member had been matched to this person who used the service and they went out every week to take part in this hobby. Several people we spoke to told us they had been supported to plan birthday parties or to go on holiday to celebrate their birthdays.

At one service we saw that staff made information available on college courses and had supported people living there to access these. Staff in this service were currently promoting a course for activities for young people that helped develop daily living skills. One person who used the service told us staff had supported them to attend a local group to support their specific needs.

We spoke to a professional who was visiting one of the services during our inspection and told us that they were contacted appropriately by staff. They told us that they were supporting a person who used the service with a transition between services and said that "Staff have been very good with support" and "The transfer is going smoothly".

Relatives told us they had no concerns about staff not accessing medical care in a timely manner. We saw people's healthcare needs had been attended to by staff.

We looked at the arrangement the registered provider had in place about the transitions people may make. People had in place hospital passports. This meant that when a person needs to go to hospital there is information readily available to help staff in hospital understand people's needs.

Requires Improvement

Is the service well-led?

Our findings

There was a manager registered with CQC for the service who had been absent from the service for a number of months. We had received a notification from the registered provider that the registered manager was absent from work and the role would be filled by another regional manager.

We found Community Integrated Care had undergone a reorganisation earlier in 2016. Regional managers were responsible for a number of clusters of services grouped together on a geographical basis. Each cluster was managed by a service lead who was responsible for the day to day running of the services in the cluster, some of which delivered the regulated activity of personal care which we were inspecting.

We asked the regional manager currently responsible for the registered service how regional managers were accountable to the registered manager about personal care. They told us regional managers reported to the registered manager at monthly meetings about matters which affected the CQC registration. The registered manager did not have direct contact with, or visit, the services being delivered.

Relatives we spoke with gave us a mixed response when we asked if they knew the registered manager of the service. One person said, "I have never had any problems. There is nothing I've not been happy with. My [relative] always looks clean. The place is well run and the staff work well together. It is a happy family. There is respect for the manager [service lead]." Other people told us they found the service lead of their local service to be approachable.

We looked at the records held by the service. The service had recently introduced new care plan records. Staff told us they were at the early stage of writing them and showed us some examples. We looked at people's current care plans and found there was a broad spectrum of completion. Some people's care plans were accurate and up to date whilst we found people whose reviews had not been updated.

We saw the service had in place a system of audits carried out by the service leads who confirmed to us they had carried out Self Quality Assessment Tools (SQATS). The SQATS were to be carried out on an annual basis and included a list of actions, some with time scales to be completed to improve the service. Regional managers were also expected to carry out Compliance and Excellence Audits. We asked for copies of each of the audits for the services we had visited. We found that audits had not been carried out for every service which provided personal care as the process was still relatively new. We also found the audit tool did not address the deficits we found in the service, such as gaps in training specific to the needs of the people who used the service. This meant the registered provider had not routinely assessed the quality of the service.

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

Some of the staff we spoke with were unclear about which of the provider's registered office locations they were accountable to. In the geographical areas covered by the regional managers we saw the service was delivered in the Teesside area where the registered provider had another service registered with CQC. We

asked to see staff files for the staff working in the Teesside area and were told they were in the Billingham office. The manager acting for the registered manager told us the files were due to be brought across to the Durham office.. We found there was a lack of clarity in management of the regulated activity between the Teesside and Durham offices. We asked the regional director about this and they explained the Teesside services were mainly short domiciliary calls and the Durham services were mainly provided in supported living services. We discussed the breakdown of the services and the regional director advised that they were considering reviewing arrangements in the future.

We saw how the actions from the SQATS and Compliance and Excellence Audits were aggregated onto an action plan for each regional manager to monitor. Regional managers confirmed to us they received regular emails as reminders to ensure actions were carried out. However, whilst we saw some actions had been completed, we saw that where deadlines had been set for training, for example, food hygiene training the deadlines had been missed.

The registered provider also had in place a system for gathering clinical governance information which showed, for example, hospital admissions, unplanned weight loss and pressure sores. This meant the service was able to measure the needs of people they supported.

The service had an up to date statement of purpose, this is a document which tells people and their relatives what they can expect from the service. We saw this was on display in the regional office.

We asked relatives if they had received a survey from the registered provider asking them about the quality of the services. Some relatives told us they had received a survey, others told us they had not received this communication. We saw copies of surveys in people's files and found these had not been aggregated to measure the quality of the whole service.

The local services had in place community links with doctors, community nurses, dentists, chiropodists and opticians. There was clear working in partnership with people's care managers and in particular where people had more complex needs. Staff described to us the contacts and links they had made including with local resources to enable people to access community facilities.

We saw on the registered provider's website the service had in place a vision and values. The values included, "We deliver the best possible outcomes for people we support and the partners we work with", and "We aspire to be the best at what we can do." During our inspection we found examples which supported the values. We also found the registered provider had built systems and processes which they were working to improve their service delivery.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all staff had received up to date training and competency assessments in the administration of people's medicines. People's care needs had not been assessed to enable the registered provider to do all that was reasonably practicable to mitigate risks.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care records were not up to date or accurate. The registered provider had not assessed and monitored the quality and safety of the services provided in the carrying on of the regulated activity. The provider had not maintained records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.