Manchester Home Care Associates Limited

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Inspection report

31A Petersfield Drive
Baguley
Manchester
Lancashire
M23 9PS

Tel: 01619629786

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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an inspection of Manchester Home Care Associates on 7, 11 and 12 January 2016. The first day of inspection was unannounced.

Manchester Home Care Associates is a domiciliary care service providing personal care and support to people living in their own homes. The service also works closely with healthcare commissioning teams in supporting people who have complex healthcare needs or are at the end of their life. The hours of support vary depending on the assessed needs of people. Services may be required the same day as the referral is received and may only continue for a few days.
At the time of the inspection the service was supporting 137 people within the local community. We last inspected the service on 30 September 2014 where we found the provider was meeting 3 out of 4 standards inspected at that time. The service was non compliant in requirements relating to workers or staffing.

There was a registered manager in post. 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.

People told us they received safe care, which was reliable and consistent on the whole. We were told where there were any problems with care this predominantly occurred duringt weekends. The service had sufficient staff to meet people's needs, and people were given the time they needed to ensure their care needs were met.

We saw that people were protected from avoidable harm. During the inspection we checked to see how the service protected vulnerable people against abuse and if staff knew what to do if they suspected abuse. There was an up to date safeguarding vulnerable adult's policy in place. Risks to people were assessed and risk management plans were in place. We found that the staff we spoke with had a good knowledge of the principles of safeguarding.

Staff were trained and competent to administer medication. Where errors had occurred the provider could evidence that these were quickly identified and appropriate action taken. The provider was not always recording when medication was administered which was contrary to their own internal policy. We identified this as a breach in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014 relating to the management of medicines.

The service was working to the principles of the Mental Capacity Act, 2005 which meant that care staff supported people to make their own choices about their care. Before any care and support was provided and when appropriate, the service obtained consent from the person who used the service. In other circumstances the service would discuss the support package with their relative. We were able to verify this by speaking with people who used the service, checking people's files and speaking to staff.

The service had improved recruitment processes which included the completion of pre-employment checks prior to a new member of staff working at the service. This helped to ensure that staff members employed to support people were suitable and fit to do so. People who used the service could be confident that they were protected from staff that were known to be suitable to work with vulnerable people. Staff knew their roles and responsibilities and were knowledgeable about the risks of abuse and reporting procedures.

We saw evidence of the induction process, and there was appropriate training provided for caring roles and responsibilities, along with the "shadowing" of more experienced colleagues. Staff also signed to confirm they had read policies and procedures and that they were aware of the provider's requirements in respect of data protection and confidentiality. Supervisions were undertaken with some staff but these were inconsistent with timescales and content. We saw that examples of poor practice was identified during audits but there was no evidence that this was relayed to staff so that practice could be improved.

People were supported with a range of services which enabled them to continue to live in their own homes safely. Most of the people we spoke with who used the service and their relatives told us they had been involved in the assessment and planning of the care and support provided and that the service responded to changes in people's needs.

The care records contained information about the support people required but were written in a task-orientated way. The documentation we saw concentrated predominantly on risk however the provider had recognised this and was in the process of implementing new person-centred care plans and risk assessments. The records we saw were complete and up to date.

We found people were receiving care from care staff who were deployed in a way that met people's needs. Some people who used the service lived alone and staff required the use of a key to access their house. We saw that keys were appropriately stored in a 'key safe' outside a number of houses we visited and people receiving a service were satisfied with the way this was managed.

We found from looking at people's care records that the service liaised with health and social care professionals involved in people's care if their health or support needs changed. We saw care plans both at the office in people's homes contained good information and instructions with regards to specialist equipment used by individuals. The service worked alongside other professionals and agencies in order to meet people's care requirements and professionals we contacted were complimentary of the service.

There was an up to date accident/incident policy and procedure in place. Records of accidents and incidents were recorded appropriately within people's care files.

The service had a complaints policy in place and we could see that people using the service were aware of how to make a complaint. Formal complaints were acknowledged and addressed within specified timescales. What wasn't clear however was whether members of staff had been notified if a complaint directly involved them or what investigatory action had been taken if this was warranted.

Staff told us they felt they were able to put their views across to senior staff and to management and we saw examples of this from minutes of meetings and supervision records. The staff we spoke with told us they enjoyed working at the service and said they felt listened to and valued.

The service undertook audits to monitor the quality of service delivery. We saw a number of audits in place including medication audits and logs of spot checks on care staff completing visits. There was no evidence of any follow-up work as a result of bad or poor practice having been identified.

We found the service had up to date policies and procedures in place, which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control.

The overall rating for this service is 'requires improvement'. You can see what action we have 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 were able to describe the action they would take to protect people if they were concerned people were at risk of harm or abuse.

Recruitment processes had improved and were now more robust. All pre-employment checks were undertaken including DBS checks.

Not all medication administered to people was recorded appropriately.

Is the service effective?

Requires Improvement

The service was not always effective

Staff received training to enable them to deliver effective care.

Staff were pro-active and acted in people's best interests to help them access healthcare and maintain good health.

Supervision was not consistent for all staff.

People told us staff asked for their consent before carrying out care duties.

Is the service caring?

Requires Improvement

The service was not always caring

People were encouraged to maintain their independence.

People told us they were supported by staff who understood their needs.

People's dignity was compromised on occasions.

Is the service responsive?

Good

The service was responsive

The provider delivered care that was responsive to people's individual personal preferences and cultural differences. People told us that they were involved in their care plans and reviews.

People told us that staff provided care visits as planned with consistent staff, although staff on weekend calls were sometimes less consistent.

Complaints and concerns had been investigated and resolved to people's satisfaction

Is the service well-led?

Good

The service was well led

People told us that the management of the service were approachable and listened to them.

Staff felt supported by management and were aware of their roles and responsibilities.

Quality systems and audits were in place that helped identify poor practice.

Manchester Home Care Associates Limited

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 7, 11 and 12 January 2016 and the visits were carried out by two inspectors. One day was spent visiting people in their own homes. Another inspector from the Care Quality Commission contacted people by telephone to find out their views of the service. Before the inspection the provider completed a Provider Information Return (PIR) . This is a form that requires the registered manager to give some key information about the service, what the service does well and improvements they plan to make.

Before our inspection we gathered and reviewed the information we held about the service, including the statutory notifications received since our last inspection. A notification is information about important events which the provider is required to send us by law. We spoke with commissioners of the service to gather their views of the care and service and contacted two health care professionals who had had recent involvement with the service.

At the time of the inspection, there were 137 people using the service which employed 130 members of care staff. We spoke to people who used the service, their relatives, and staff. We contacted five people who used the service and also met face to face with five more people and their relatives in their own homes to seek their views about the agency.

During the inspection we spoke with the registered manager, deputy manager, two care managers, a care co-ordinator, an assessor and seven care staff. We looked at 11 people's care records, 5 personnel files, supervision records and staff meeting minutes. We looked at medicine administration records and records in relation to the management of the service such as checks regarding people's health and safety. We also

looked at staff recruitment, training records, compliments, quality assurance and audit records.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe when receiving personal care and support from the service. People told us they did feel safe. "Yes, staff make me feel safe. They are are very reliable and nice people," one person told us. Another person we spoke with told us they felt safe because, "all [the staff] know what they are doing." We spoke with a relative who also confirmed that his relative was kept safe when receiving personal care. "It's the way they handle [person's name.] They are very careful when they handle [person's name]."

We asked staff if they had received training in safeguarding vulnerable adults. Staff we spoke with told us they had received safeguarding training during their induction and some staff had also done on-line refresher training since. The deputy manager told us that he had been involved in safeguarding meetings , knew to report any referrals to the local authority's contact centre, to management and to the Care Quality Commission.

The company's safeguarding policy had been reviewed and updated in March 2015 and included references to the Care Act and the contact deails for the local authority in the event of reporting an alleged safeguarding incident. The service had also received a safeguarding newsletter from the local authority and we saw this on site. It informed the service that new multi- disciplinary safeguarding procedures were due to be launched in the near future and the manager was fully aware of this.

Staff we spoke with were able to outline and describe the types of abuse that may occur. They were all confident that they would report any safeguarding concerns they might have to the manager and that these would be dealt with appropriately. We were confident that systems were in place to enable staff to raise concerns and that staff were able to identify, recognise and respond to symptoms of abuse to ensure the safety of people using the service.

Staff we spoke with were also asked about the company's whistleblowing policy. Staff confirmed they were aware of the policy and had covered this in induction but when asked to describe the procedure some staff were unsure what the whistleblowing policy meant in practice. The provider was currently issuing revised policies and procedures to all staff in waves. We saw that wave 1 was issued to staff in October 2015 but did not include the whistleblowing policy. Staff need to be aware of the whistleblowing policy and procedure so they are comfortable with the process and know what to expect in the event of raising a concern with their employer.

People had care plans which included assessments of risk and how to mitigate them. Prior to any service being delivered to people the service managers undertook a full assessment of the person's needs together with an assessment of any risks posed by the support they required or the environment. Examples of risk assessments on file included those relating to medication, personal care, moving and handling, mobility, property access and pet dogs. Risk assessments were not always signed or dated and there was no clear review schedule in place. This meant that people using the service were potentially in danger of receiving inappropriate care and support especially if the risks had increased or were no longer applicable.

The manager provided us with revised paperwork in relation to risk assessments in the form of a booklet which incorporated risk assessments around falls, medication and the environment. We were told all risk assessments would be covered with new people accessing the service in the future during the pre-assessment interview, prior to the package of care and support starting. The booklet provided thorough information and assessment of all possible risks and will be implemented into the service. We will check on this implementation at the next inspection.

There were sufficient numbers of staff employed by the agency to meet the needs of people who used the service. We saw from the PIR that staff turnover had been high during the previous year however all staff had been replaced and additional staff recruited in line with the business demands. Staff we spoke with told us there were enough staff. "I have enough time to make my visits," one staff member said and another told us, "To be fair I think there is [enough staff]; it seems as if [there is]." One carer commented that things had improved since she had been given set runs but added that she still felt rushed on occasions with travelling between calls.

The manager told us that they had tried to improve the service by allocating staff more effectively geographically to reduce travelling times in peak traffic. When we spoke to people receiving a service they told us: "Yes, things have improved since Christmas;" "Time keeping is a lot better now;" and "It's better now I have the same carers in the week." People who received care and support from the agency told us the staff were mainly on time and they received a reliable service during the week. The feedback we received from people was that weekend care was a little more chaotic. "Weekends are not the same staff; [we are] not getting regular staff at weekends." Another person told us, "Weekends can be difficult. Different carers – [they] can be a little late." This indicated that staffing levels fluctuated at the weekend and people did not receive consistent care.

The registered manager explained that an electronic call monitoring system was in place. Staff were able to use the telephone in people's houses free of charge to log in to indicate arrival and log out when leaving a property. This facility was not being used by all staff we were told and therefore could not be relied upon to help monitor the quality of the service and the safety of people who used the service and the staff. The provider informed us that they planned to issue and use company smart phones in the future and logging in would be monitored more rigorously with this system.

We looked at five personnel files whilst at the office and saw that recruitment processes had improved since our last inspection. The files we looked at contained appropriate paperwork in relation to recruitment, including two references and a medical declaration on file. The service had also recently started using an interview record to ensure the right people were appointed. We saw that the improved recruitment practices were safe and that appropriate checks had been completed prior to staff working unsupervised for the service.

Staff we spoke with confirmed that they had been interviewed and references sought prior to starting work. Disclosure and Barring Service (DBS) checks had been carried out prior to new members of staff starting work. DBS checks consist of a check on people's criminal record and a further check to see if they have been placed on a list of people who are barred from working with vulnerable adults. People who used the service could be confident that they were protected from staff that were known to be unsuitable to work with vulnerable people. The registered manager told us that recruitment was to be centralised and this would add even greater consistency to the process.

We looked at systems in place with regards to the administration of medication. Staff had received training on how to support people to manage their medicines. This support was generally provided by prompting or

reminding individuals to take their medicines and there were packages of care that required staff to administer medication. Company policy stated that where staff administered medicine in tablet form this was done from blister packs prepared by a pharmacist and the person's Medication Administration Record (MAR) chart was then completed and signed by staff. The manager told us that in the event of a person requiring a service who did not have medication in blister packs then if medication administration was a requirement in the care plan this would be done by district nurses for an interim period.

During visits undertaken to people's homes we saw that tablets were in blister packed medications and were either being prompted or administered accordingly. One medication in a person's property however was too large for the blister pack and was being administered by staff in the service which contradicted company policy. The company might want to review it's medication policy to reflect situations that might arise when tablets cannot be blister-packed but can be administered by staff.

We saw in the same property that a tablet was still listed on the MAR template but a relative informed us that this had been stopped by the gp. Staff were not administering this tablet however the MAR should have been updated to reflect this so that people receive the medication that they are prescribed and are safeguarded from harm. We told the manager about this situation who told us a review of the medication would take place immediately and the care plan would be updated to reflect any changes.

In one property the care plan stated that medication was to be administered and we saw from the blister pack stocks on site that it had been administered correctly. However neither a pre-printed MAR chart, nor a medication recording template used by the service, could be located in the house. We saw in another property where a MAR chart was in place this had not been signed by care staff for the two visits immediately prior to our inspection visit. A relative confirmed that these had been administered correctly and medication stocks supported this.

All medications were checked during visits made to people's houses and all had either been prompted or administered according to correct timescales. It was not always clear what recording mechanisms were in place for some administered medications as we could not locate MAR charts.The manager told us that different processes were in place for those people funded by the local Clinical Commissioning Group (CCG) and signed MAR charts were not a requirement of this contract and therefore not in place in care plans. This process of not recording when medication was administered contradicted the provider's own medication policy which stated as medicines are given they should be recorded immediately and signed for by the person responsible immediately following the administration. We were assured that the recording of medications administered to everybody using the service would be implemented with immediate effect.

A record must be kept of all medicines administered to the person the service is caring for. This information is an audit trail and is vital to other care workers who visit the person as they could administer medication incorrectly, causing harm to the person. This process of not recording when medication was administered is also contrary to the provider's own medication policy which stated as medicines are given they should be recorded immediately and signed for by the person responsible immediately following the administration.

This was a breach of Regulation 12(1) with reference to 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed that they had access to personal protective equipment when undertaking visits to people's homes. People we spoke with confirmed that staff wore gloves and aprons when staff carried out personal care. "I've seen [member of staff] wearing gloves and a pinny." We did speak with a member of care staff during the inspection who was wearing long, false, painted nails and was on duty that day. Appropriate

infection control and hand hygiene includes cleaning and trimming fingernails, which may harbor dirt and germs and can contribute to the spread of some infections. Long nails and or/, false nails do not promote good infection control and can also inflict damage to people's skin and should not be worn by staff delivering personal care. This also contradicted the service's expectations of staff which stated under the "General Appearance and Uniform" code that finger nails were to be kept short with no acrylic extensions or false nails.

Requires Improvement

Is the service effective?

Our findings

People who received care from the service told us they thought staff were well trained in their roles and understood how to meet their care needs. People told us some staff were better trained than others and one person added, "My carer is great. [Staff member] has a lot of experience. [She] looks after me well."

A relative told us staff advised them to tell the district nurses about a red mark appearing on a person's back. They were able to inform the health professional about a potential pressure sore. "Staff try and look for other things as well to make sure [person's name] is kept safe and well."
Another relative we spoke with was complimentary of the service. A staff member had told them that their relative was having difficulty swallowing paracetamol tablets and had advised contact with the gp. The family explored alternatives with the gp who prescribed soluble co-codomol. Another time staff had signposted relatives to purchase more suitable continence products. "Carers have helped. They've given us good advice," they told us. This showed us that staff were confident in applying their learnt skills and knowledge to improve the quality of people's lives and be effective in their caring role.

We saw a training matrix which outlined training staff had undertaken to date or indicated when refresher training was due. Mandatory courses were on the matrix and some examples of this included safeguarding adults level 1, medication administration awareness, fire safety, health and safety, moving and handling theory and practical, food hygiene and infection control. A number of staff had also undertaken more bespoke training in order to better support people in their care or for personal development. Examples of these training elements included dying, death and bereavement, convene and penile sheath fitting, emergency first aid, person centred care, hoist and slide sheet practical and consent.

We saw that training was undertaken by staff in a variety of ways. On line training was one method and the service used the website social care tv (SCTV) , an accredited e-learning provider for health and social care providers, to access on line courses. Other courses were class-room based undertaken during the five day induction period and staff told us that this was followed by shadowing staff undertaking visits to people receiving a service. When asked about the induction staff told us it prepared them for their role.

We saw evidence that some care workers received more supervision than others and this was confirmed in speaking with staff. "Yes, [I] have monthly supervision. [I've] had quite a few," one staff member told us. Another referred to having on the job supervision twice, whilst delivering care to different people. A third worker could not recall having a face to face supervision but told us these were done every six months.

We asked what action had been taken with a member of staff in relation to a complaint made about them but nothing had been said and no supervisions had taken place with the individual. Similarly where audits had identified poor practice there was no evidence to support that this had been broached with individuals during supervision sessions. Staff should be informed of any complaints or poor practice that is highlighted so that they can alter their behaviour accordingly, improve practice and the provider can be reassured that this is not being repeated with other people using the service.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Some staff we spoke with were able to demonstrate a basic awareness of the Mental Capacity Act 2005 and it's principles. They told us that this had been covered in induction training. They recognised and respected that people had the right to makes choices but told us they would ask management if they were ever unsure. One member of staff was able to tell us that they had alerted the office when they believed a person was being restrained by a relative and being deprived of their liberty. This was referred to the local authority as a potential safeguarding incident and appropriate action was taken. This showed us that some staff recognised when a person was being deprived of their liberty and were confident in raising concerns where they felt this was warranted.

However, not all staff displayed this knowledge. When asked about their understanding about a deprivation of liberty one member of staff said, "I don't know what that is." Others who were also unsure told us that they would go into the office for guidance. The manager informed us that due to a technical fault with spreadsheets some aspects of refresher training had been missed with certain members of staff. This was in the process of being addressed both before and after the move of premises and progress with this will be checked at the next inspection.

Staff were able to give us examples of when they asked people for consent. "I always check it's ok with [name of person] before I do anything," a member of staff told us. Another person referred to a particular person having a sleep system in place. Consent was gained to turn and operate it at regular intervals. People we spoke with confirmed this. "They ask for my permission, " one person told us. Another told us, "They check it's ok with me."

People who received a service had differing levels of support with eating and drinking. In some cases staff warmed up meals that had been pre-prepared by family members and people were able to eat independently. Others required more help. One person told us, "[My] regular carers cut [my] food up for me." Another person told us she was kept informed about what was in the freezer. "I get a choice [of meals]. They always ask me what I want [to eat]."

People told us that the service was effective in promoting good health and we saw this reflected in care plans. We saw a good care plan in relation to the care of a person with a tracheostomy. Staff had received training on the hospital ward before the person had been discharged home and staff had been assessed as competent to provide the care. Examples of completed competency forms were on file along with detailed instructions for carers what to do if the tracheostomy came out. We noted that there were pictures on the care plan that helped care staff identify, clean and care for the equipment.

A health professional we contacted told us that the company was very responsive to urgent packages of care and offered a good service to people at the end of their life and their families. There had been some issues with staff being late for agreed shifts we were told but this situation improved once highlighted to management.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their relatives spoke extremely positively about the kindness and caring attitude of the staff. One person told us, "They are very caring and have a great sense of humour." People had strong relationships with staff and they felt that some staff did over and above what was required of them. Comments people made to us included, "Mum has built a rapport with carers. It's great," and "Staff are kind, caring. We have a laugh."

One of the visits we made to people's homes was timed to correspond with visits made by care staff. We observed staff undertaking their duties with warmth whilst keeping a professional approach. We heard staff supporting someone with their personal care needs in another room, speaking slowly and gently, informing the person of the tasks they were going to do and asking for consent from the individual before performing the task. Staff asked if the person was okay, reassured them throughout the task and commented on a new hairstyle. We saw afterwards that the person was fully at ease and made comfortable before staff left. A relative told me, "We've never had any carer not 100% kind."

We were told that staff would sometimes undertake additional tasks for people such as washing up or putting rubbish out. One year a carer bought a small Christmas tree for a person a relative told us. We were told that a carer had once hoovered up after a person had their hair cut at home. "They didn't have to do that. It was good of them." This showed us that staff were willing to do over and above what was required of them to help the people using the service.

Two people we spoke with mentioned that they had experienced rudeness from some staff. One person had informed the office when this had happened and things had improved. Another told us that they felt that a member of staff had displayed a bad attitude on one occasion. They had asked for the particular carer not to provide support again and this was acknowledged and acted upon by the service.

Staff we spoke with had a clear understanding of the people's needs and knew them well. A relative told us of the time carers had recognised a person "was not themself." Staff had alerted the family, as per their instructions, and had flagged up the individual was sleepy and not very responsive. As a result of this the person was admitted to hospital as a precautionary measure, their health improved and they were able to return home. This showed us that staff had the person's wellbeing at heart and were quick to raise concerns when they felt this was necessary.

People told us that carers did respect their privacy and treated them with dignity. Care staff knocked on doors and announced their arrival when gaining access via a key safe we were told. We also saw evidence of this whilst out visiting people in their own homes. Staff we spoke with gave us examples of what they did in the caring role to maintain people's dignity. "I always close any doors," one staff member told us and also mentioned closing curtains if providing personal care downstairs. Someone receiving a service added that care staff always treated them with respect and left them comfortable before leaving. "If they don't I have to stay uncomfortable for hours," they told us.

When out visiting people in their own homes we saw that one person had received care and support prior to our arrival. Both the person and a relative present were able to confirm that the visit had taken place although this had not been documented by the staff member. We checked the care plan of the person receiving the service which documented that the person's leg bag should be emptied during every lunch time visit. The relative told us, "Most [care staff] do it," indicating that not all carried out this task. We could see that this had not been done as per the care plan as the leg-bag was over half-full with urine at the time of the visit, which took place around 1.30pm. This did not represent a caring approach and meant that the person's dignity was compromised and could have placed the person's health and wellbeing at risk.

The service could evidence that it responded to the equality and diversity of people using the service. When attending to the needs of a person practising the muslim faith staff were aware not to prepare food themselves but to reheat that already cooked by family, as this had been prepared in line with cultural beliefs and traditions. This showed that the service respected peope's preferences and cultural differences whilst providing care and support.

People we spoke with and their relatives were positive when asked if the service promoted their independence. A person we spoke to was very pleased about the progress of their relative since receiving a service. "Due to staff [person's name] has come on leaps and bounds and is feeding himself now." Another positive comment we received from relatives included, "[They] have done wonders for him." They went on to tell us how their relative couldn't walk prior to the service starting but now was able to. "It's all due to the staff." This highlighted to us the patience and caring attitude of staff wanting to promote independence and encourage people to achieve their goals.

Staff were able to outline to us examples of when they promoted independence for the people they supported. They gave us examples of encouraging people to dress themselves, wash themselves, eat independently after having cut food into smaller pieces and self-medicating.

People we spoke to and their relatives told us that staff were discreet and kept things to themselves. "Staff never talk about other clients," we were told. Another person receiving a service told us, "Staff are confidential. They don't talk about other people in front of me and they don't argue."

Good

Is the service responsive?

Our findings

Staff we spoke with told us that the company was responsive to people's needs. One person provided an excellent example of when they had recognised unmet needs for some people and the company had helped him to achieve new skills to meet these needs. Some men receiving the service were not able to access the community independently and so were not able to visit the barbers to get their hair cut. The member of staff had asked to attend a barbering course which the company had agreed to. At the time of inspection he had qualified successfully and was able to use his new skills to meet the needs of the men wanting their hair to be cut.

We were given other examples of when the provider had been responsive to people's choices and requests. One person had requested that male carers did not provide care and female staff were allocated to all calls. We were shown the system for allocating work for staff on rotas. If people had requested a change of carer for any reason or had declined a particular carer then this was able to be recorded on the system. This meant that any carers "flagged" on the system would not be approached to undertake any regular shifts or cover shifts for particular individuals and showed us that people's personal choices and preferences were respected and upheld.

It was apparent on speaking with people that the service had experienced some staffing issues in the past which were now improved. One person we spoke with told us, "It [the service] didn't get off to a good start. I wasn't happy at the beginning." The person was initially visited by lots of carers. "I had to keep telling them where things were [and] what to do." They went on to tell us that things had vastly improved and staff were more consistent . "I'm very happy with them – two lovely girls."

People told us that care was still a little unreliable at the weekends and not as stable as in the week. People using the service and their relatives understood and appreciated that the service was doing its best.

We looked at care plans kept on site at the office and also those in people's homes. The care plans mapped out what was expected of carers at each visit and included aspects of care in relation to skin integrity; mobility; continence care; medication; eating and drinking.
We asked people if they had been involved in the development and review of their care plans. One person told us, "Yes, [name of person] came from the office with a social worker [to do a review]. It wasn't that long ago." A relative also told us, "Yes, when they call and do a review I have been involved."

We saw that not all documents had been signed by the person receiving the service or by a company representative. People did tell us that they were able to make choices about how their care was provided and delivered and that staff respected their decisions. Care plans we looked at were predominantly task orientated, with identified risks highlighted however we saw, and people told us, that the care being delivered was person-centred.

The service had recognised that care plans needed updating and were in the process of introducing a personal care and support plan in the form of a bound booklet. We were given a copy and saw that the

booklet contained information relating to the person as well as the care and support to be provided. Progress on this will be checked at the next inspection.

There was a process for handling complaints and we were shown the process for dealing with these and saw examples of resolved complaints. One complaint was from a person using the service. They had complained about a particular carer raising her voice, said they had felt frightened and requested that this member of staff did not visit again. The service had acknowledged the complaint, responded to it and removed the carer from visits to the individual.

We spoke with a relative who told us she had made a complaint about a particular member of staff. She had raised the issue with the manager but was not yet aware of the outcome of the complaint. Other than that she spoke very highly of the service. "I am very pleased," she told us.

We saw examples of compliments and thank you cards that the service had received from people using the service and their relatives. Some of these were in email format and had been sent specifically to praise or compliment specific members of staff. One relative was a health worker and emailed the service to thank the carer who had attended to her nan the previous day. The member of staff had gone out and bought fish and mushy peas at the request of the individual as that was, "the meal she fancied at the time." The email stated that, "My nan ate everything and enjoyed it."

Another pair of relatives were very complimentary about both the management and staff. "Over a three year period they were invaluable." They described staff as flexible, caring and supportive adding, "We would recommend them to future clients."

Good

Is the service well-led?

Our findings

People we spoke with were complimentary about the registered manager of Manchester Home Care Associates. This included people using the service, their relatives, staff and other professionals involved with the company. They told us they found the management staff of Manchester Home Care Associates were approachable.

Some people we spoke with had completed a survey and we saw completed questionnaires in the office. In the three responses received during December people were either quite satisfied or very satisfied. "Now mum has regular care workers things have improved considerably," was one comment from a relative. "Everything was ok so no changes [were] needed," one person told us after being involved in a review. Others told us that contact with the office was more verbal. A relative had been asked about their views on the service. "I told them I am very pleased," they said. Another relative had the manager's mobile number and was able to ring if there was anything she wasn't happy with. "If I ring up with a concern it is sorted," she added. Others told us that there had been staffing issues in the past but recognised that, "the manager is doing her best."

We discussed the management structure with the registered manager. The employee-owned company had recently benefitted from becoming a franchise organisation within Care and Share Associates (CASA), a social enterprise company which develops franchise companies in which the workforce are the owners.

We were told that CASA maintained close relationships with Manchester Home Care Associates and during our visits we spoke with two representatives from the CASA company who had called to offer support to the registered manager. We could see that the organisation was introducing structure and consistency into Manchester Home Care Associates in the form of improved care plans, risk assessments and quality assurance audit tools. Representatives from Manchester Home Care Associates now attended CASA's regular quality meetings and the General Council meetings, held four times a year.

At the time of our visit the provider was planning to move to larger premises, still within the local area. We were told that these new premises were purpose-built offices with more space to allow future expansion of the service.

The company offered incentives to staff in the shape of a loyalty card, access to the cycle to work scheme and a Gold Star, awarded to care staff who had demonstrated good practice or improved performance at work. One of the staff members we interviewed wore a gold star pinned to her uniform. She told us she had been awarded it last year for working better and improved attendance. The staff member was proud of her gold star. "It makes me feel like I'm doing a good job," she told us. This showed us that the member of staff felt appreciated and morale was increased as a result of the incentive.

Staff were made fully aware of the expectations of the company with regards to general appearance; etiquette on entering a person's home; communication books; log in system and spot checks. We saw a "What We Expect From You" form pinned up in the reception area of the service which outlined how staff

should look and what they should do when in the community representing the company. Staff we spoke with were aware of management expectations.

When asked if they felt supported and listened to all staff gave us positive replies. "I get on well with the manager." "I would go the the manager [if I had a problem]", and "[the manager is] amazing. She listens to what you have to say," staff told us. The staff we spoke with told us they enjoyed working at the service and felt valued. "I wouldn't be there if they [the management team] weren't good," one person told us.

Staff told us they felt they were able to put their views across to seniors and to management and we saw examples of this from minutes of meetings and supervision records. A member of staff had turned up to provide care for a person who had passed away as this had not been communicated to her. She brought up the need for better communication during a supervision session and felt comfortable in doing this with her line manager.

The service undertook audits to monitor the quality of service delivery. We saw a number of audits in place such as medication audits and spot checks on care staff. These were good tools used by supervisors and we saw that they identified poor practices from some of the staff: tea calls not being logged; electronic call monitoring not being used; medication not being signed for and staff not wearing identification badges.

We found the service had up to date policies and procedures in place, which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control. Revised policies were being emailed out to all staff in waves and we saw an email dated October 2015 that included all Wave 1 policies sent out to staff. Included in the first wave were policies around safeguarding; dementia; confidentiality; privacy and incident reporting.

Everyone receiving a service had been banded A,B or C depending on assessed need and personal circumstances. This banding indicated the priority of calls for people in the event of an emergency, with those in band A identified as being most in need. Checks would be done on those people in the first instance, followed by those in bands B and C respectively and this was reflected in the Business Continuity procedure. This demonstrated that management had planned ahead and staff would be directed to keep people safe in the event of a disruption to the service.

Professionals we contacted for feedback were complimentary of the registered manager and of the service. We were told communication was good and the manager was responsive in assessing packages of care, sometimes within very tight timescales.

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 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 Not all administered medications were being recorded. Records were not updated in a timely manner following changes to people's prescribed medication. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment. Regulation 12 (2)(g)