Health Care Recruiters Limited

Health Care Recruiters Limited

Inspection report

25 Winckley Square
Preston
Lancashire
PR1 3JJ

Tel: 01772515056
Website: www.kareplus.com

Date of inspection visit:
07 July 2016

Date of publication:
16 September 2016

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 7 July 2016 and was announced.

The registered manager was given 24 hours' notice prior to the inspection, so that we could be sure they would be available to provide us with the information we required.

We last inspected this service in September 2013. The service was judged to be compliant in all the areas we looked at.

Health Care Recruiters provides staff to support families to care for children and young people and adults with complex or life threatening needs in their own home as well as providing staff to work in hospitals and care homes.

At the time of our inspection Health Care Recruiters provided services to five people.
The registered manager of the service was present throughout our inspection. 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.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. People told us the service was reliable.

Staff we spoke with told us they were given enough time with people. People we spoke with told us that staff stayed for the allocated time.

We looked at assessments undertaken for all five people before the agency agreed to provide their domiciliary care package and found that safety checks and risk assessments were undertaken however, the standards were different between the assessments children and adults. We found care plans for children identified risk management in a person centred way however care plans for adults were basic and were not written in a person centred manner.

We looked at how people were protected from bullying, harassment, avoidable harm and abuse. We found that the service followed safeguarding reporting systems, as outlined in its policies and procedures.

We found that the service promoted staff development and staff received training appropriate to their roles and responsibilities. However, this was not consistent as some staff members had not received training. Induction provided for staff who supported children was suitable however we found induction for staff who supported adults was not suitable for people working in community care. This had been designed for workers who worked in hospitals.

Staff told us they felt well supported by management however, there was no evidence to show regular supervisions or meetings had been undertaken. Staff informed us they relied on parents of children they looked after to supervise them and provide guidance rather than management.

We looked at how the service gained people's consent to care and treatment in line with the Mental Capacity Act [MCA]. We looked at people's care records and found no consent, mental capacity assessments, or best interests decisions where required. The mental capacity act is not applicable to children instead; the service had sought adequate consent from the parents.

Some care records held details of joint working with health and social care professionals involved with people, who used the service, however others lacked detail.

We received consistent positive feedback about the staff and about the care that people received. Staff had awareness on how to respect people's privacy, dignity and rights.

The manager advised us that staff were always introduced to service users, prior to any support being provided. Staff had been trained to operate and monitor equipment that people used. Assessment processes were in place, which helped to ensure staff had a good understanding of people's needs before they started to support them however this was not consistent throughout the service.

The service had a complaints procedure which was made available to people they supported. People we spoke with told us they knew how to make a complaint if they had any concerns. We saw evidence of how a compliant was dealt with.
We found concerns regarding leadership and governance. Staff had not been provided with adequate leadership and oversight. At the time of the inspection we found management did not have adequate contact with the staff team and the majority of staff were unaware who their manager was and any developments in the organisation. Staff informed us there were no staff meetings and supervisions had stopped around February 2016.

There were no robust systems to monitor and assess the quality of the service. We found no audits had been undertaken on medication administration and care files. Staff competence had not been undertaken regularly to ensure staff continued to deliver safe care. Competence checks had been left to parents of children supported by staff. We found people were satisfied with the service they received. We found the registered manager receptive to feedback and keen to improve the service. They worked with us in a positive manner providing all the information we requested.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of governance, person centred care, staffing and governance. This also included a breach of Regulation 12 of Care Quality Commission (Registration) Regulations 2009- Statement of purpose. You can see what action we told the provider to take at the back of the full version of this 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

This service was not consistently safe

There was a lack of consistence in the level of assessment details for children and adults.

The provider had procedures in place to protect people from abuse and unsafe care, and people we spoke with said they felt safe.

Assessments of risks to people who used the service and staff had been undertaken. Written plans were in place to manage these risks. Safeguarding incidents had been identified and dealt with.

There were safe recruitments practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent had not been sufficiently considered and staff had not been trained in Mental Capacity.

People had been exposed to risk because staff had not received regular support from managements, there was no staff meetings, no formal supervision and staff competence had not been adequately and regularly checked.

Staff had been provided with induction before they started their role however, induction was focused on staff working in hospitals and not in the community.

People told us staff were knowledgeable and they had confidence in them.

We saw evidence the care staff had worked with other professionals and professional guidance had been followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives were very pleased with the staff who supported them and the care they received.

There was lack of consistence with care planning. Some people's files were well organised however some were poorly developed and lacked detail. We made a recommendation.

There was no end of life training. This is regardless of the provider specialising in complex needs, end of life and people with life threatening conditions.

Staff engaged with people in a person centred way and had developed warm engaging relationships. People told us their loved ones were supported by staff who treated them with dignity and respect.

Is the service responsive?

Requires Improvement

The service was responsive to people's needs.

People told us the service was efficient and responsive. They informed us staff were in tune with their needs and those of their loved ones.

Some people were exposed to risk because the provider relied on assessments done by other providers to guide their own staff. We made a recommendation.

People told us they were happy that they received personalised care and support. Parents had been involved in the recruitment of staff.

Assessments were completed prior to agreement of services and they showed a good standard of person centred detail. Care plans were completed and reviewed in accordance with the person's changing needs. However care plans were not consistently in quality and detail.

There was a complaints procedure and people told us they could raise complaints if they were unhappy.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of management oversight and leadership for staff providing community care. Staff had relied on parents of children to provide them guidance and supervision.

Some people felt the provider did not provide contingency in the event staff went off sick or resigned.

There was no clear line of management and responsibility within the organisation. Staff did not know who their manager was since the last manager left in February 2016.

Leadership did not appear engaged to the service delivery. There was no robust quality monitoring systems in place. Surveys had been done but stopped December 2015.

There were no audits for, care files and Medication administration records (MAR). We found issues that could have been picked by audits. We saw some evidence of partnership working.

Due to the inconsistences that we found in adult care records we recommend the provider to review all care plans and ensure recording is consistent in all files.

Health Care Recruiters 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 visit took place on 07 July 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service we needed to be sure that someone would be available.

The inspection was carried out by two adult social care inspectors, including the lead inspector for the service.

Before this inspection, we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us. We received feedback from nurse professionals and service commissioners. Their feedback is included within this report.

During our inspection, we went to Health Care Recruiters office and spoke with the registered manager and the provider. We spoke with seven care staff members. Due to the complexity of the needs of people supported by the service, it was not appropriate for us to visit people's homes. However we spoke to three parents of children who used the service. This enabled us to determine if people received the care and support they needed and if any identified risks to people's health and wellbeing were being appropriately managed.

We also looked at a wide range of records. These included; five peoples care records, five staff personnel records, a variety of policies and procedures, training records, medicines records and quality monitoring systems.

Requires Improvement

Is the service safe?

Our findings

Parents we spoke with told us they felt their children were safe supported by Health Care Recruiters care staff. One parent told us, "They are very good people, I feel like they are my friends." And: "They have never let us down." Another person said, "They don't put [name removed] at any risk and will keep us informed of any changes in her needs." And: "They always check things with me first if they are unsure."

We looked at how people were protected from bullying, harassment, avoidable harm and abuse. We found the service had procedures in place to minimise the potential risk of abuse or unsafe care. However, records we saw and conversations with staff confirmed some staff had not received safeguarding training. Staff who worked with children had received safeguarding children training. Staff members we spoke with understood what types of abuse and examples of poor care people might experience. The service had a whistleblowing procedure. We spoke with staff who told us they were aware of the procedure. They said they would not hesitate to use this if they had any concerns about their colleagues' care practice or conduct. We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

We found that the service had followed safeguarding reporting systems as outlined in its policies and procedures. We saw one example of a safeguarding concern that had been dealt with appropriately. We found the registered manager had responded to concerns regarding staff. For example, where care staff had been found to be unable to provide the required standards of care. We spoke to the registered manager who informed us they had taken measures to transfer care staff to other parts of the company.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. Prospective employees were asked to undertake checks prior to employment to help ensure they were not a risk to vulnerable people. We reviewed recruitment records of five staff members and found that robust recruitment procedures had been followed.

People told us the service was reliable. They also told us that they saw the same staff unless there was a specific reason for not doing so, such as annual leave or sickness. However, some people told us the service did not have contingency plans to respond to staff sickness promptly. One person told us, "I have had the same faces for a while now; we always know who's coming to support her."

People we spoke to told us that staff stayed for the allocated time and they arrived on time as planned.

Risks management systems were in place however, we found a lack of consistence in the way people's risk had been assessed and managed. There was a significant difference between the records of adults who were supported by the service and the records for the children. We found care records for children contained well written and comprehensive risk assessments however records for adults contained very little in the way of risk assessments. The adults supported had complex needs and were nearing end of their life however there was no risk assessments to guide care staff.

Care records for children contained work place environment risk assessments, which covered areas, such as

the risk of falls, fire, and other risks around people's homes. This recognised that carers could be at risk in people's homes and what precautions they had to take. Further risk assessments were completed on an individual basis and covered personal risks around people and how to minimise these risks. Risks assessments also recognised that carers would occasionally work alone in people's homes.

We found some of the care plans identified risk management in a person centred way. These were children's records as identified above. We looked at three files and we found detailed risk assessments on the various specialist equipment that were used to support people. For example, people who used percutaneous endoscopic gastrostomy (PEG) had risk assessments which identified things that could go wrong with the tube including blockages and kinks; it also provided guidance to staff on how to clean this equipment and what to do in cases where the machine malfunctions. A PEG is a medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

Children's records had adequate moving and handling care plans, which provided detailed guidance and information to staff on how the individuals were to be transferred. For example, it specified what equipment was to be used to assist this person and the checks that staff needed to undertake before undertaking the task. These were very detailed and provided personalised guidance on each person. Risk assessments had been undertaken and included information about action to be taken to minimise the chance of harm occurring to people and staff.

We looked at training records and found that some staff had received training in a number of areas to include safeguarding, child protection, moving and handling, infection control and fire safety. Staff files included staff competency assessments for the administration of medicines. However, we found some staff had not received training in the mandatory areas such as safeguarding and child protection. Regardless of this staff spoke competently regarding safeguarding and how to protect people from abuse.

We recommend the provider follow best practice and guidance in staff training and development.

We looked at the procedures the service had in place for assisting people with their medicines. We found staff had been trained in medication administration however for children; parents were responsible for administering medication.

Some of the staff employed by the service had received medication training during their induction. Discussion with four staff members confirmed they had been trained and assessed as competent to support people to take their medicines. The competence checks had been done however this was not regular. We noted that some staff had received competence checks up to February 2016; however, this had stopped when one of the community care managers had left the organisation. We spoke to the registered manager who informed us they had not been able to undertake these checks since February 2016. This meant that care staff had not been provided with oversight to check whether they continued to observe safe practice.

We looked at how the service minimised the risk of infections. We found staff had undertaken training in infection control and were able to demonstrate ways in which infections could be spread. People we spoke to confirmed that staff observed infection control practice, which included washing their hands and wearing aprons and uniform. One parent told us, "They wear gloves and change uniforms and they don't expose her to infections."

Requires Improvement

Is the service effective?

Our findings

People were supported by care staff who had the necessary skills and knew the people they cared for well. One person told us, "They [staff] are good at their job." And: They come in and they know what to do." The registered manager explained the various programmes in place to support staff in their role. For example, the induction which staff said was up to two weeks shadowing.

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 to 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.

We looked at how the service gained people's consent to care and treatment in line with the MCA. Care records for adults had no evidence of mental capacity assessments, or best interests decisions where needed. Although staff told us they offered choices to people, relevant knowledge about the MCA, including best interest decisions and how they as staff should act in person's best interest was not present. Consent was not demonstrated and relatives had signed on behalf of people without a reason why the adults could not do so themselves. None of the staff had received mental capacity training to develop an understanding of the requirements of the act and its principles.

The registered manager did not have sufficient knowledge about the principles of MCA. They informed us they were not aware of the requirement to ensure that people's consent was considered and added that next of kin would give consent for people. This however was not correct as people's mental capacity needs to be assessed first to determine if they are able to make decisions themselves and if they are unable others should then do this in their best interest.

We judged these shortcomings to be a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014. - Need for consent.

We found sufficient evidence of consent from parents of the children looked after.

Staff and people told us there is good communication between them and management. However, this was not consistent with all staff we spoke with. We found staff lacked knowledge of management changes and the structure of the organisation. Some staff did not know who their manager was or even the fact that the manager had left and there was a new one in place. People who used the service had not been kept informed of the changes which had an impact on the service delivery. Staff spoken with told us meetings were not held. This meant that the provider had not facilitated the staff team to get together and discuss

any areas of interest, challenges or developments within the service in an open forum.

Staff skill and knowledge was adequate to prepare them for their role. However, competence was not adequately checked in various areas of practice. We spoke to the registered manager who informed us care staff would be competence checked by parents of the children they looked after. Parents also confirmed they monitored staff competence. We found no competence checks had been carried out for care staff who supported adults. We also found that all competence checks and spot checks had stopped when the community care manager had left in February 2016.

The registered manager informed us they had not managed to undertake these tasks due to other commitments outside of the registered manager role. We found this had the potential of putting people at risk due to lack of oversight on staff performance.

We found staff had not received formal supervision since the last manager had left. Staff we spoke with informed us supervision was done on the phone and not formally recorded. We spoke to the registered manager who confirmed this. The lack of robust and regular supervision meant that the provider had not adequately supported staff to identify support and developmental needs and ensure they continued to provide safe care.

This was a breach of regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.- Staffing

The induction for staff who were involved with children with complex needs involved staff working alongside professionals in the hospitals where children were due to be discharged. During this period, staff had been trained to use specialist equipment and to get an in depth understanding of children's needs. Staff were had also been provided with training at the office first before going out for their first shift.

One member of staff told us, "I was really well supported with my induction." One person said, "They [staff] do know what they are doing I don't have to tell them what to do." We however found the induction process was suited to care staff who worked in hospitals, there was no separate induction processes for care staff who worked in the community which is a different environment from hospitals.
We found there was a training room which was set up to simulate people's bedrooms. This had moving and handling equipment, which staff could practice on.

We looked at the provider's training matrix, which covered multiple courses including moving and handling, safeguarding, health and safety, fire awareness, and infection control. We found that the service promoted staff development and had a development programme to ensure that staff received training appropriate to their role and responsibilities. However, were commend the provider consider training for areas such as mental capacity and end of life care which was not being completed.

We asked staff if they received training to help them understand their role and responsibilities. Staff told us, "We get a lot of training and this always helps, it's a continuous learning environment." Another member of staff told us, "The induction here was brilliant and really informative."

Parents of children supported by the staff told us, "The staff knows what they are doing and I support then and supervise to ensure they are getting it right." And: "Staff definitely know what they are doing I have no concerns there." And: "The staff are the best at what they do."

We found the service had supported people to have sufficient nutrition and hydration. People had been

assessed and care plans showed associated risk, action plans and people's preferences. We saw staff had documented the meals provided confirming the person's dietary needs had been met. Staff spoken with during our inspection confirmed they had received training in food safety and were aware of safe food handling practices.

Care records held details of joint working with health and social care professionals involved with people who accessed the service. However, this was not consistent throughout the files we checked with adult records lacking detailed information.

We found multiple examples across the care records we looked at of people being referred for external health and social care support and professional advice being followed. The service maintained good working relationships with other professionals and sought guidance when needed.

Requires Improvement

Is the service caring?

Our findings

We received consistent positive feedback about the staff and about the care that people received. Parents we spoke with told us care staff treated their children with kindness and the staff were caring towards them. One parent told us, "I'm absolutely confident with the carers, they are professional and efficient." And: The standards are high."

People benefited from having regular staff who they knew well. One parent said: "We get the same staff unless there is an illness."

Staff we spoke to understood how to respect people's privacy, dignity and rights. Staff described how they would ensure people had their privacy protected. One person told us, "They are respectful and treat our home with respect they know it's our home."

Staff we spoke with showed good awareness of confidentiality, privacy and dignity. Staff told us, "I know I'm in a family home and will ask the parents for anything I want and I know I cannot access every part of the family home only where I need to be."

We were unable to obtain feedback from adults supported by the service and their relatives however parents of children supported by the service told us they were satisfied staff who supported them had up to date information about their needs and this was delivered in the way they wanted. People told us they felt there was a caring ethos. One person we spoke with said, "I'm happy with the carers, they are caring." Another person we spoke with said, "I have no issues with the staff." And: They are professional and patient when providing personal care."

We saw instances where things had not worked well between carers and people they supported. In these instances, we saw evidence to show how the registered manager had attempted to resolve the issues ensuring carers and people were both listened to. For example, there was a mismatch between one carer and a person, consideration was made to change the carers and this appeared to have resolved the issues.

Care plans for adults were of very poor quality and did not have enough detail considering the complex needs of the adults cared for. Information was not arranged in an easy to find manner and in one file there was very minimal information which had been written by another agency. The registered manager informed us they were sharing the care package with another company. However, we expected the provider to have their own assessment to provide guidance to their own staff.

We looked at care plans and checked if people were involved in planning for their care. We found no evidence adults or their relatives had been involved in planning their care. We however acknowledged that the adults who were supported had very complex needs and were towards the end of their life.

Care records for children showed parents had been involved in planning and review of their children's needs. Care records for children which were detailed and person centred.

We found no evidence of end of life care planning or end of life training this is regardless of the fact that the service provides care to people with complex needs in some cases people with terminal illnesses or requiring palliative care.
We recommended the provider to follow best practice in care planning.

Requires Improvement

Is the service responsive?

Our findings

We found assessments had been undertaken to identify people's support needs prior to the service commencing. A person centred care plan had then been developed outlining how these needs were to be met. However, this was not consistent as adults care files lacked detail.

We found there was lack of co-ordinated working. For example, care files for people who required end of life care did not state whether they were on an end of life pathway. We asked the registered manager about the two people we reviewed and they did not know whether these people's care involved any end of life pathway. This meant the service had not put systems in place to ensure people's care was consistent and well-coordinated which could result in poor outcomes for people.

The registered manager advised us that staff were always introduced to service users, prior to any support being provided. This helped to ensure people received their care from staff they were familiar with. We were also advised that the service were very careful to maintain a good level of continuity in respect of carers and this information was supported by our discussions with people who used the service.

We saw some parents of children supported by the service had expressed when, how and by whom they wanted their support provided. For example, some parents had chosen to have support provided after school and some preferred the support to be provided overnight. In some cases parents had choose to manage their children's medication instead of letting staff deal with this. In children's files, objectives and desires had been identified as part of the plan of care. However, we could not find the same level of detail in the files of adults supported by the service. This meant that there was no consistence in the care planning across the services.

We found there was a clear assessment processes in place, which helped to ensure staff had a good understanding of people's needs before they started to support them. We noted that the assessment process always involved a visit to the service user's home and included the views of other professionals involved in their care, as well as input from their relatives. However, there was no consistence, as this was only in relation to children's records and support plans.

We looked at care records of five people. Three of the care records were informative and enabled us to identify how staff supported people with their daily routines and personal care needs. However, some records did not have enough details and guidance for staff. We found in one care record there were records from other care agencies. We were told the service was relying on assessments and care plans devised by other agencies and had not felt it was necessary for to do their own assessments. This meant that people had been exposed to risk as the service had not assessed and provided guidance to its own staff based on their own view of risks against their staff's competence and capability.

People we spoke with during the inspection said the service had responded to their requests for support and they were satisfied with the service they received. We however found people's care had not been routinely reviewed. We spoke to people who told us reviews used to be undertaken by the previous

community care manager however, this had not been done since this person had left the organisation. We spoke to the registered manager who confirmed this. They however advised us they would contact people on the phone and ask how their care was going. This shortcoming meant the provider had failed to ensure people's needs are monitored for changes.

Staff providing support understood people's individual needs and we were told by people that person centred care was central to their support services. One person told us, "They come in and know what to do; we don't have to keep repeating telling them."

We also saw evidence, parents had been involved in the recruitment of staff, this ensured family could consider whether prospective care staff were suitable to work with their children.

The service had a complaints procedure which was made available to people they supported and their family members. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and the Care Quality Commission (CQC) were available.

We saw the service had a system in place for recording incidents/complaints. This included recording the nature of the complaint and the action taken by the service. We saw complaints received had been responded to and the outcome had been recorded. People who used the service told us knew how to make a complaint if they were unhappy about anything. One person said, "We are quite happy with the service but know how to complain if we need to."

Inadequate

Is the service well-led?

Our findings

We checked whether the service was well led. Evidence we found showed there was a lack of management oversight and leadership for care staff. Staff had relied on parents of children to provide them guidance and supervision. Staff consistently told us, "The parents supervise me, if I am not sure or worried I will ask them and they will help." Another person told us, "We are happy with the carers and not with the provider." They told us they felt the provider did not provide contingency in the event staff went off sick or resigned. One person said, "They are reactive rather than proactive." We however spoke to the registered manager who informed us, if a staff member cannot continue they would attempt to cover using staff from other parts of their business.

We found the service had no clear lines of responsibility and accountability. Staff we spoke with did not know who their manager was since the last manager left in February 2016. The registered manager at the time of the inspection left soon after our inspection however when we contacted staff two days later they were unaware the registered manager had left. We spoke to parents of children supported by the organisation and they were unaware of these changes in management. The registered manager informed us they had been managing the other side of the business owned by the provider and admitted they had not provided staff with oversight and supervision they required since February 2016.

The registered manager informed us they had delegated the tasks of managing the registered services to a community manager; however this person had left in February 2016. Staff and people that we spoke with informed us the service used to be managed well before this time however since the departure of the community manager they had not received adequate management oversight. We found leadership of the organisation was not engaged with the delivery of registered activities. We found due to the complexity of the needs of people supported and the risks associated, the service required robust leadership to ensure staff are regularly supervised and monitored.

There were no clear visions around the registered activities and the regulated activities had not been seen as a priority requiring adequate attention. This was demonstrated by lack of leadership and management for the community care staff. We found the policies and procedures that were in force had been devised for staff working in hospitals, this included the induction policy, supervision policy training and staff handbooks.

We looked at how staff worked as a team and how effective communication between staff members was maintained and found that this was not robust. We found no evidence of staff meetings. Staff told us they did not have regular meetings however, they were kept informed through the email. The registered manager informed us that best practice was shared through email for example when new guidance is introduced.

We were informed supervision was done on the phone when staff were sent their rotas, however this was not formally recorded and had stopped in February 2016. We did not find this to be an effective way of supporting staff who were involved in delivery of complex care. The registered manager could not demonstrate how staff were involved in discussions about improving the service and management input

was motivating, to encourage the staff team to provide good standards of care and support.

We found that the service did not have a robust quality auditing system in place. The provider had carried out audits to monitor the quality of the service however, this had stopped in December 2015. The organisation's policy stated that these should be done every 6 months. There were no audits for care files and medication administration records. We found issues that could have been identified by audits.

Spot checks to observe staff's competency had not been carried out on a regular basis. These had stopped in February 2016. The purpose of spot checks is to check whether staff were punctual, stayed for the correct amount of time allocated and people supported were happy with the service. They also help identify if staff had continued to be competent in various care tasks.

These shortfalls in leadership, quality assurance, amounted to a breach of regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

We looked at the statement of purpose and found this was not up to date. It did not reflect the registered services that they were being provided. It is a regulatory requirement that registered providers should ensure their statement of purpose is kept up to date and any changes are communicated with CQC. Providers must notify CQC of any changes to their statement of purpose and ensure it is kept under review, and notify CQC when there are any changes to the information. We spoke to the registered manager who accepted that the statement of purpose did not reflect the services they were providing and that the document was due for review but had not been reviewed.

This was a breach of Regulation 12 of Care Quality Commission (Registration) Regulations 2009- Statement of purpose.

We found the registered manager had some knowledge of the people who used the service and their needs. For example, the registered manager was able to identify people with very complex needs and the risks associated to these individuals. This showed the registered manager took time to understand people as individuals and ensured their needs were met in a person centred way.

We found inconsistences in the care files of adults and children's records. We recommend the provider review their care planning processes and ensure all records consistent for both children and adults.

Some staff told us management were supportive and listened. However, responses were mixed, some staff stated they had not communicated with the office and would communicate with parents and some staff told us they did not know about any developments within the service.

Staff told us, "I quite like working for this company." However, some staff felt that their requests for training had not been responded to appropriately, however this was not widespread.

We found the organisation had maintained links with other organisations such as the local commissioning groups. We found the registered manager receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

The CQC registration certificate was on display, along with a copy of the most recent inspection report. The service worked in a transparent way however, they lacked commitment to keeping people who accessed the service up to date with any changes within the organisation that impacted on how people were cared for.

Following the inspection, the registered manager left the organisation and the provider recruited another manager. They informed us they will be employing a community care manager to provide staff with management oversight.

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 Registration Regulations 2009 (Schedule 3) Statement of purpose Suitable arrangements were not in place to ensure the statement of purpose was reviewed and updated when changes occurred. Regulation 12 (CQC Registration Regulations) 2009- Schedule 3 statement of purpose

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to protect service users from abuse and improper treatment. This is because there were no arrangements to assess people's mental capacity. Regulation 11 (1)(2) Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient systems in place to identify or address issues that affected the quality of the service people received or the risks they were exposed to. There was lack of leadership and oversight on the registered services. Regulation 17 (1) (2)-Good governance

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Suitable arrangements were not in place in order to ensure that persons employed were able to deliver care to people safely and to an appropriate standard. This was because staff had not received regular forma supervision, competence checks or spot checks. Regulation 18 (1) (2)- Staffing