United Response

United Response - Cornish Close DCA

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 27th July and 3rd August 2016.

Cornish Close Domiciliary Care Agency was last inspected in November 2013 when it was found to be meeting all of the five standards reviewed.

Cornish Close Domiciliary Care Agency is registered to provide personal care and support to people with physical and learning disabilities along with associated mental health needs. People receiving the service live in one of the five bungalows in the grounds of a larger unit.

We were aware that the provider was in the process of changing the registered manager and an application had been made to this effect. The service had been without a registered manager for over a year. We had not been notified of this until May 2016. 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. The provider had put interim measures in place in the absence of the registered manager.

Some people we spoke with had limited verbal communication. However, everyone clearly indicated they felt safe, were happy with the service and liked the staff.

Staff had received training in safeguarding vulnerable adults and could clearly describe the action they would take if they suspected any abuse had taken place. There was a safeguarding booklet in an easy-read format, available for people using the service. The booklet signposted people to organisations implementing equal rights for people with learning disabilities.

We saw that a number of incidents had occurred in the service during the last year. A number of medicines errors and a financial error had been reported to the local authority as safeguarding concerns but these had not been notified to the CQC. These incidents and some poor practices indicated that the service were not always safe.

Staff received training in the administration of medicines and recorded this on pre printed documentation supplied by the pharmacist.

The bungalows were clean and tidy and free from odour. There were effective health and safety checks in place. Staff had access to personal protective equipment (PPE) such as gloves and aprons and used them when undertaking personal care tasks and administering medicines.

The service had a safe system in place for the recruitment of new staff. There was a reliance on using agency staff at the service; however, the provider tried to use the same people for consistency. The company also

had their own pool of bank staff to cover for regular staff absences.

An induction programme was in place for new staff to complete required training courses and shadow existing staff. Staff confirmed that they had completed training courses relevant to their role and felt confident in their role

People's care records and risk assessments contained personalised information about their needs. The support plans we looked at included risk assessments, which identified any risks associated with people's care and had been devised to help support people to be as independent as possible.

If people's needs changed a system was in place to liaise with the person, their family and other professionals to update care plans and risk assessments. Where required people's health and medical needs were met, with access to GPs and other health professionals.

We found that the service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. Staff could describe to us how their practices met the requirements of the MCA as they always sought people's consent before they provided care and support. They followed instructions and guidance issued by health professionals and acted in the best interests of the person.

During our inspection we saw that staff were kind and caring. People were given time to do things at their own pace and offered encouragement from staff. We saw that staff knew the people they were supporting well.

People and their relatives were involved in the assessment and review of their care. Staff supported people to access the community and participate in activities that were important to them. Outside spaces had been developed by staff in front of people's bungalows.

Staff told us that the upper management structure wasn't clear given the absence of a long term registered manager and the further pending changes in management, but they felt supported by individual team managers of the bungalows. Team meetings were held and staff were able to raise any issues or concerns.

A system was in place for responding to complaints. We were told by relatives and staff that team managers were approachable and would listen to their concerns.

There was evidence of some audits and competencies of staff being undertaken at the service but we identified that overall, the systems in place to assess, monitor and improve the quality and safety of the service were not sufficiently robust.

During this inspection we found two breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. 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.

People were not always protected from abuse. Security in some of the bungalows was lax especially around the storage of safe keys and medicine cabinet keys.

The service used agency staff. They tried to use the same agency staff for continuity of care but this was not always possible.

Staff had received training in safeguarding vulnerable adults and knew the correct action to take if they witness or suspect abuse.

Support plans included information about the risks people may face and guidelines for staff in how to minimise or eliminate the risks.

Is the service effective?

Good

The service was effective

Staff received training and an induction to meet the needs of people using the service. Team leaders were starting to address supervisions.

The service was meeting the legal requirements relating to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

The service responded to input and suggestions from healthcare professionals, acting in the best interests of people.

Is the service caring?

Good

The service was caring

People we spoke with said staff were caring. People were happy staying at the service.

We saw that staff were patient and respected people's choices.

Staff described how they promoted people's privacy and were

aware to preserve people's dignity when providing support.

Staff described how they tried to promote people's independence by encouraging them to do as much as they could themselves.

Is the service responsive?

Good

The service was responsive.

People's support plans were reviewed and changes in support needs were documented accordingly.

Personalised support plans and guidance for staff were in place.
People received care that was based on their needs and preferences.
People were supported to take part in a range of activities based upon their personal preferences.

People and their relatives were aware of how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications to the Care Quality Commission had not always been made as required by law.

People who used the service, relatives and staff told us that team mangers were approachable and would act on any concerns that they raised.

Staff told us that they enjoyed working in the service.

The service did not have effective systems in place to monitor and assess the quality of the service.

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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 27 July and 3 August 2016 and the first day was unannounced. The inspection team consisted of one inspector.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any incidents which put people at risk of harm. We refer to these as notifications. A notification is information about important events which the service is required to send us by law.

We contacted other health and social care professionals for feedback about the service, including commissioners of care and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We visited the Cornish Close site on two occasions where we spoke with the with the interim service manager, the divisional director, three team leaders and six care staff. We visited three bungalows on the larger site, observed the way people were supported in their accommodation and looked at records relating to the service. We spoke with five people using the service and three of their relatives.

We spent some time looking at documents and records related to people's care and support and the management of the service. These included five care records, daily record notes, five medication administration records (MAR), maintenance records, audits on health and safety, records of accidents and

incidents, policies and procedures and quality assurance records. We also reviewed the provider's recruitment process and looked at staff files.

Requires Improvement

Is the service safe?

Our findings

We asked if people felt safe and they told us they did. One person we spoke to using the service told us, "They look after you well. I like it here." Another person told us they liked to have a bath. When asked if they felt safe with staff when having a bath they told us, "Yes, I do." Relatives we spoke with also agreed and comments we received included, "Safe? Yes I think [person's name] is safe there," and "If I thought someone was taking advantage I would say something."

Some staff we spoke with told us that they considered the service was not always safe. They told us that the usage of agency staff was sometimes high and this impacted on regular staff, especially as agency staff were not competent to administer medicines. If an agency worker was on duty in one of the bungalows then a regular member of staff would have to take time out to administer medicines. They told us this detracted from the time they had to spend supporting people in their own bungalow.

The provider did try to use the same agency staff to assist with continuity of care but this was not always possible. A member of staff we spoke with told us, "Some don't want to come back. We have to repeat the whole process of showing someone what to do."

Following a recent check undertaken on people's money held in the safe in one of the bungalows it had been identified that one person's balance was incorrect and an amount of money was missing. At the time of our inspection this had been reported to police, a safeguarding referral had been made to the local authority and the incident was being investigated internally. We saw that previous financial checks had been done in February 2016 in this particular bungalow, highlighting a gap of nearly five months since finances were last checked.

We spent time in the offices of the bungalows looking at records and support plans. We saw that on one occasion in one bungalow the keys to the safe were stored in the lock with no staff present, allowing full access to the safe. We saw that a previous registered manager was still signatory on some of the household accounts . Although this person was still employed by the company they did not work at Cornish Close and the process of obtaining signatures on cheques was difficult for staff as this took time and often involved posting cheques out. This was not sound financial practice.

Similarly in two of the bungalows it was common practice to keep keys to the medicines cabinet on top of the cabinets, allowing anyone the opportunity to access all medicines stored in cabinets. This lax attitude to security meant people were not kept safe from potential abuse and their safety was compromised.

The above practices constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 13 (2).

Staff we spoke with, told us they had received training in safeguarding vulnerable adults and that this was repeated annually. Training records we saw supported this. Support staff provided us with examples of types of abuse and the action they would take if they had concerns about a person's safety. Staff were clear

they would report any concerns initially to their particular line manager and then on to higher management if this was warranted. A member of staff stated, "If there's anything that bothers me I need to report that." Staff were confident any concerns they raised would be acted upon. The staff members we spoke with confirmed the service had policies and procedures in place to protect people and staff were expected to familiarise themselves with these policies as part of their induction training.

We saw a safeguarding booklet in an easy-read format, available for people using the service. Pictures were used to outline the types of abuse and how this might occur and the booklet signposted people to organisations implementing equal rights for people with learning disabilities.

Staff we spoke with were also aware of the whistleblowing policy. Whistleblowing is one way in which a worker can report suspected wrong doing at work, by telling someone they trust about their concerns. No staff we spoke with had needed to use the policy whilst working for the provider.

Support plans we looked at included risk assessments, which identified any risks associated with people's care. Support plans were person-centred, detailed and contained relevant assessments of risk, both generic and tailored to individual's specific needs. For each area of identified risk staff were provided with guidance on the actions they must take to protect the person they supported and how to manage and minimise these risks.

The service had a call system in place in all five bungalows so that people could call for assistance if this was required. A relative we spoke with told us about the nurse call system and that it was 'always within [person's name] reach' when they visited the service. Bedrooms and bathrooms were equipped with facilities to support people with a range of needs, including the availability of track hoists in some rooms.

We looked at five recruitment files and saw the process was robust and that personnel files were in good order. Paperwork on file in relation to the recruitment process for staff included the original application form, two or more references, proof of identity and a health check. Two people participated in the interview process and we saw a clear audit trail of notes taken during interviews. Reasons for leaving previous job roles and any gaps in employment were also explored with the person during the interview and responses were noted.

The service also had a pool of bank, or relief, staff that the bungalows could utilise to cover in the absence of permanent staff. We spoke with a member of bank staff employed at the service during the inspection. This person had received all mandatory training and a corporate induction to the company in the same way that a permanent member of staff would.

Disclosure and Barring Service (DBS) checks were in place for those employed by the service. DBS checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services.

We looked at how the service managed people's medicine. Medicines were stored securely within each bungalow with each person having an allocated space within a metal cabinet.

We saw that records were kept of medicines received and disposed of. Staff performed a daily stocktake of medicines to ensure that stocks balanced and there were adequate supplies for people. This meant that people were kept safe and protected from harm as the risk of the service running out of any medication was minimalised.

Staff only administered medication after they had received proper training and been assessed as competent therefore agency staff did not administer medicines. There were clear protocols for staff to follow when people were prescribed 'as and when' medicines which people take when they feel they need them or have certain symptoms. Staff used a medication administration record to confirm they had given people's medicines as prescribed. We checked a sample of these and found they had been completed accurately. We were assured that aspects of medicines administration for people using the service were dealt with safely and appropriately.

We saw that health and safety checks on the buildings were up to date, including checks to portable fire fighting equipment, emergency lights and smoke alarms. Fire risk assessments and portable appliance testing records reflected that both had been undertaken in September and October 2015 respectively.

Good

Is the service effective?

Our findings

The service was effective. One of the people using the service told us, "I won't move anywhere else. I like it here." Relatives we spoke with also told us that staff were professional and treated people with respect. They told us, "[My relative] loves it there. I'm very happy. The staff are lovely." Another relative was very complimentary of the service stating that their relative had come on 'leaps and bounds' since moving into a bungalow at Cornish Close and receiving support. They also thought that staff were adequately trained to meet people's needs.

Staff had access to training and we saw that there was a system in place to remind the provider when staff needed e-learning or practical training updates. Staff were well supported through their induction, which included elements of e learning, classroom training and shadowing other colleagues.

The company had their own pool of bank staff. We spoke with a member of bank staff who had previously worked for the company in a permanent role. Bank work suited their current lifestyle and personal circumstances and it meant people living at Cornish Close were at times supported by staff already familiar to them therefore some continuity of care was maintained.

Staff had received training in mandatory core subjects. Examples of mandatory training undertaken during the induction included moving & handling, medication awareness, health & safety, safeguarding adults, fire awareness and diet and nutrition. They also attended training sessions specific to the individual needs of people who used the service. One member of staff told us they had requested autism training and had been told this was to be delivered in early 2017. Another considered the training on offer to be 'really good.' We could see that employees were offered plenty of opportunities and support from the company with regards to additional training and personal development .

Staff we spoke with outlined the induction process and confirmed this was held off site. Staff told us they did not start working until induction training had been completed. An in-house induction took place the first day on site and this included an orientation to the place of work. Induction was followed by a period of shadowing more experienced colleagues for a month or until the new recruit was deemed competent and confident.

Following the induction staff were given a handbook that included relevant information for employees, a holiday request form and a self-certificate form to be submitted by staff following a period of sickness. Policies issued to staff after induction included the grievance policy and complaints policy and staff we spoke with confirmed they had received these.

The feedback we received about supervisions was mixed. Supervision sessions give staff the opportunity to discuss their personal and professional development, as well as any concerns. Staff told us they had not received one to one supervision sessions with their line manager for some time. The team leader in one of the bungalows had recently left and their staff had not received supervision. Supervisions by other team leaders had not been done on a regular basis however we saw, and staff told us, that team leaders were

starting to address these. Three members of staff had received a supervision with their new team leader when we returned for the second day of inspection. A member of staff did say, "You can ask for a supervision if you've got a problem and you will get one straight away." Supervision of all members of staff by the team leaders would provide a consistent approach to service delivery and ultimately benefit people using the service.

People had a good, well balanced diet. We saw that people had choices and individual needs were catered for, with diets and weights monitored when necessary. Staff recognised that certain people needed support with making choices and communicating their preferences and used various ways to assist with this. For example pictures were in use on a board and people were physically shown different foodstuffs so they could make a choice.

Staff prepared and cooked meals, sometimes with assistance from people using the service. People who wanted to were encouraged to join in with household chores and we saw one person assisting staff in the kitchen with meal preparation.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The service recognised that some aspects of care provision represented a deprivation of the person's freedoms and were aware to make applications to the Court of Protection in relation to the specific care needs of these individuals.

The support plans we saw included mental capacity assessments. These detailed whether the person had the capacity to make and communicate decisions about their day to day care, along with more complex decisions, such as their health care needs or financial expenditure. The staff we spoke with during our inspection understood the importance of the MCA in protecting people and the need to involve people in making decisions. We were told that all staff had received training in the principles associated with the MCA and DoLS.

We saw that if people did not have the capacity to consent, procedures had been followed to make sure decisions that were made on their behalf were in their best interests. Records in people's files that showed best interest meetings had taken place and decisions made on people's behalf, were made in accordance with the principles of the MCA. We saw a best interest meeting had been held for one person living at Cornish Close in relation to medicines. The panel had considered a peg feed as a possible solution but chose to covertly administer medicines in liquid format, as this was deemed to be the least restrictive option for the individual.

Thorough assessments and support plans were kept relating to all aspects of people's health and well being. The records we saw showed that people's health was monitored, and any changes which required additional support or intervention were responded to.

We saw records of contact with specialists who had been involved in people's care and treatment. These included a range of health care professionals such as specialist nurses, physiotherapists, speech and language therapists (SaLT) and occupational therapists. We saw that one person had struggled to take a particular tablet prescribed for epilepsy. The service had arranged for a SaLT professional to visit who had watched staff administering medicines and had suggested the medicine be in liquid format due to the person's dysphagia. The person was receiving all medicines in liquid formats at the time of our inspection. This showed that referrals were made to health services when people's needs changed and their suggestions were acted upon to benefit the individual.

One relative was extremely complimentary of actions the service had taken to co-ordinate and manage a person's hospital stay and gave us the following feedback; "This required extensive support and planning and Cornish Close managed this very well. I was very happy with the outcome and the staff were commended for their support."

Good

Is the service caring?

Our findings

We observed that staff were caring in their approach and both people using the service and relatives we spoke with confirmed this. One person told us, "I am happy here. It's great." Relatives were complimentary of staff and the rapport they had with people and told us, "They do try their best," ; "They are very caring," and " My [relative] responds well to staff she has a rapport with and likes." A third relative told us that staff had organised a recent birthday party for a person using the service that everyone had attended and enjoyed. This highlighted the caring nature of staff at Cornish Close Domiciliary Care Unit and during our inspection we observed that they put the person first.

Throughout the inspection we spent time observing people receiving support in their homes . We saw that people were respected by staff and treated with kindness. We observed staff treating people affectionately and heard staff speaking in a friendly manner. Staff were patient in their approach, understood the limitations some people had and took time to listen and respond to them.

Staff were trained to use a person-centred approach to support and care for people living at Cornish Close. We observed staff interacting with people, talking about aspects of their daily lives and asking their opinions. For example we heard one person being offered a choice of sandwiches for lunch. Another support worker was discussing trips away and asking the person where they would like to go. A person we spoke with living at Cornish Close told us they had choices and said, "I choose what I want to wear [for the next day] the night before."

Staff understood the importance of involving individuals in decisions about their lives and encouraged people to make their own choices. Personal spaces had been decorated according to the preferences of people living there and reflected their favourite colours. Staff were aware of how to approach people and one member of staff said, "I explain to people why things have to happen. I give them timescales and they are happy with that."

We saw that people's privacy and dignity were respected by support staff. Staff we spoke with told us dignity was an aspect covered in both safeguarding and moving and handling during the induction. They were fully aware of the importance of maintaining a person's dignity when using a hoist and told us what they would do to ensure this happened. When providing personal care staff stressed they would make sure doors were locked and that curtains were drawn thus preserving an individual's dignity.

Staff asked people whether they required assistance and offered help in a sensitive way. People who used the service could access private space if they wished to, in their bedrooms or within other areas of the home. A relative told us that the person was able to access their bedroom during the day if they wanted to rest or lie down. They told us, "[Person] is happy. I can tell."

We asked support staff how they helped to promote people's independence. They told us that people were encouraged to join in with household tasks, for example cleaning and tidying their own bedrooms or helping to wash the pots. We heard one person being involved in preparing a meal whilst we were

undertaking the inspection. A member of staff told us how one person had been fully reliant on staff support when they first moved to the service. With input and encouragement from staff they were now very independent, choosing to access the community and prepare drinks. This showed us that people were encouraged to maintain life skills and be more independent.
We spoke with a six support workers during the inspection. They were each aware of their roles and responsibilities and were able to describe the needs of each individual who used the service. They demonstrated knowledge of dignity and privacy issues and gave examples of how they respected people's rights and wishes. Staff were also aware of the need for confidentiality as one member of staff told us, "We don't say anything about anyone."

We saw that staff had developed the small outside spaces at the front of the bungalows so that people could sit in the open air. Some had small garden areas with flowers planted along with benches or seating areas. During our inspection we saw people enjoying being outside, chatting with staff and each other. One person we spoke with enjoyed sitting outside but told us, "[The] island is an eyesore. [It] could be nicer for people." This small traffic island was visible to all when sat outside the bungalows and was just a patch of soil and grass at the time of our inspection.

Good

Is the service responsive?

Our findings

We saw some good examples of person centred care on support plans. Support plans contained information about the person's personality, likes and dislikes and preferences around communication. There was good guidance for staff regarding aspects of care for individuals, for example in relation to eating and drinking or treating a specific medical condition. One person had a particular condition and the support plan instructed staff to collect a medical bag on top of the medicines cupboard in the dining room, should this be required. We checked that the medical bag was there and contained the necessary medicines and it did. This indicated that staff were able to respond quickly should the person require urgent attention.

Support plans were reviewed on a regular basis, or as and when needs changed, and people and their relatives confirmed they were involved in those reviews. One person told us, "My sister comes as well. [They ask] what would you like to do and how things are going."

Risk assessments were in place and were specific to individuals. We saw a risk assessment on a person's file in relation to their dysphagia dated June 2016. There was a picture of the person on the risk assessment, showing how they liked to wear their clothes protector during meal times. It also instructed staff to use a small, brown plastic spoon when assisting the person to eat to prevent injury to their mouth. This showed us that people had been involved in formulating their own risk assessments and the use of photographs helped identify the person to staff.

People had detailed health action plans, designed to help staff to understand the person's health care needs, including any specific sensory needs. We saw hospital passports on people's files. These are designed to give hospital staff helpful information should the individual attend or be admitted to hospital. For example, passports can include details about what the person likes or dislikes, their favourite types of food and drink and any interests they might have. Information contained in hospital passports help hospital staff know how to make the person feel comfortable in a different environment. One passport we saw outlined that the person liked routine, watching tv and having visitors. There were also instructions on the health action plan with regards to the use of specific equipment as the plan stated, "I have a ventilation mask at night which I need support with." This indicated to us that the person would receive appropriate support during hospital stays.

Support plans outlined how people presented if they were having a good day or a bad day in a detailed one page profile. The service recognised that one person was having a good day if they were with people they knew, going shopping, having a meal and a coffee out as they enjoyed these things. This person was supported by regular, consistent staff as much as possible as they recognised their likes and preferences for an active social life.

Some aspects of the support planning documentation were blank in two of the files we saw. For example we saw a blank financial support plan and a consent form not signed by the individual. Team leaders were aware of this as the service was in the process of transferring to a new format of support plan. We saw completed versions of these documents in other files.

Staff we spoke with were aware of the way each person expressed themselves and were responsive to people's individual needs. We saw coloured signs on doors indicating 'stop' and 'go'. This was to assist one person in particular who understood what these signs meant. We saw a 'stop' sign on a bedroom door which wasn't their bedroom and the person was aware that this room was not to be entered. This showed us that the service explored ways of communicating with individuals that also helped to promote their independence. Another person had a communication board with specific pictures against days of the week. This outlined activities, events and reminders for the week. For example the person showed us that they visited a relative regularly on a particular day, and the picture on the board reminded them of this.

Staff told us about the activities people like to do at Cornish Close and could describe people's individual preferences. A member of staff we spoke recognised that spending time with a person was important in getting to know them, especially if they weren't able to communicate verbally. They told us, "We look after them every day. You tend to know what they like and don't like to do."

Some people using the service accessed the local community for socialising and activities. The service was responsive in ensuring people had access to a variety of activities that they liked to do. A local arts and crafts group was popular with people living at Cornish Close and we saw examples of what people had made there on display in their homes and bedrooms. Some of the things made had been on show in a local exhibition and we could see that some people had a natural talent and enjoyed being creative.

Other activities included a disco outing, Saturday club, attendance at church, meals out, trips out and meeting up with other friends. People who chose not to go out were involved in household chores if they were able to do these. One person enjoyed mopping the floor and drying the pots so staff encouraged these activities. The service had recently planned a birthday party for someone living at Cornish Close and everyone had attended. Staff working at Cornish Close Domiciliary Care Agency understood the importance of promoting and maintaining friendships.

Relatives we spoke with were happy with the activities on offer. One person was really pleased with their relative's busy social life and one commented, "I go down [to visit] once a fortnight when [they] can fit me in." Another said, "Oh yes they do take [them] out to different places." A relative told us that the cost of holidays for people using the service had increased as the council no longer made a contribution towards the costs. We spoke with the interim service manager and divisional director about this who assured us that the company was looking to address matter so it was fair to all concerned.

We looked at the systems in place for managing complaints about the service. We saw that an up to date policy was in place and people and their relatives were provided with information about how to make a complaint. A person we spoke with told us that they knew how to make a complaint and would do this by raising it with their team manager. They told us they had made a complaint in the past but not recently. We asked if the historical complaint had been dealt with to their satisfaction and they told us it had. A relative we spoke with said that they knew how to raise a concern or complaint with the service but had not yet needed to make one. They told us, "I'd be the first to moan [but I have] no complaints at all."

There were mechanisms in place to gather feedback about the service. One person had received an annual satisfaction survey asking for their views on various aspects of the service received by Cornish Close Domiciliary Care Agency. They showed it to us and we saw that this was a thorough document, in an easy read format, with pictorial symbols to assist with completion. The service had no control over these questionnaires as they were distributed and processed by head office. A support worker chatted to the person about the survey and noted that the response date was 24th August 2016. They offered assistance to the person and said, "We'll go through it together if you want?" We heard the person accept the offer of

help.

Requires Improvement

Is the service well-led?

Our findings

We were aware prior to the inspection that an application to change the registered manager had been made. The proposed registered manager was absent at the time of our inspection. At the time of our inspection an interim service manager had been in post for approximately six months but was due to leave. Their remit included oversight of both the domiciliary care agency and the respite service delivered from Cornish Close. Some staff we spoke with described it as an 'unsettling time' due to the pending management changes. We were assured that the post of service manager would be advertised and recruited to promptly.

We saw evidence that a number of incidents had occurred in the bungalows, for example a series of medicines errors in one and financial irregularities in another, but these had not been reported to CQC via the submission of notifications.

Not informing CQC of relevant incidents was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We looked at the audit systems in place to monitor the service. Checks of medication, support plans and health and safety by staff happened on a daily, weekly or monthly basis, however we saw no evidence of any monthly audits from management to verify that these checks were correct. Finance checks had not been regular and irregularities in one bungalow had been identified prior to the inspection. Due to the lack of management audits this had not been identified in a timely manner. This meant that the provider lacked oversight of the safety and quality of the service. It is the providers responsibility in the absence of the registered manager to ensure the continuity of the service and that the running of the service is not compromised in any way. At the time of our inspection, the service did not have effective systems in place to monitor and assess the safety and quality of the service.

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

The day to day management of the domiciliary care agency, and of the staff working in the five bungalows, was the responsibility of the three team managers, whose contracted week was split to include 22 hours as senior support workers. This meant that management accountability was not clear when team managers were undertaking the senior support worker role or not on duty.

All the staff we spoke with were aware that first line management was handled by the team manager attached to the particular bungalow they worked in. Staff considered team managers to be approachable and fair and felt supported by them. Comments we received from staff included, "Yes, they are good," and, "If you have a problem they are always there." Support staff told us team managers would listen to any concerns and take appropriate action.

We saw that the service supported staff if they identified any errors or poor practice. There were

mechanisms in place to assist staff who were struggling with the role or had made errors. For example we saw staff had been offered additional training and had been observed administering and recording medicines, following a number of identified medicines errors. We saw that the service had taken appropriate action in relation to these incidents, completing reports and obtaining witness statements.

We saw different practices in the bungalows, depending on the team manager responsible. In one bungalow we saw that a recent medicines policy was available for staff, stored in the medicines cupboard. All staff working in that particular bungalow had signed that they had seen and read the revised medicines policy. In another bungalow with a different team manager this was not the case. Good practice was not being shared and adopted across all the service. To do this would benefit the people living at Cornish Close and receiving a service.

A relative we spoke with was also positive about the team manager they dealt with. They told us they would approach the team manager if they had any concerns or complaints and said, "I would go to the high one [in the bungalow] – [team leader's name]." They also recognised that every bungalow was not run the same and said, "I don't know about the other bungalows [but] I couldn't ask for a better service."

Similarly we received mixed feedback about observations and competencies. Some staff indicated that these didn't happen whereas others were getting them. One staff member told us, "My manager doesn't miss a trick." They went on to tell us that if the team manager identified any mistakes when observing then they went through it with everybody so these weren't repeated. In the bungalow where the medicines error had occurred we saw that the team manager at the time had undertaken competencies on all staff working there in September 2015.

Team meetings were undertaken by team managers with their own staff. These had slipped in two bungalows as a team manager had left. The new team manager was new in post and was planning both supervisions and team meetings at the time of our inspection. Team meetings updated staff on practical issues, such as people's care needs and training, and were also a forum for offering support.

We looked at the policies and procedures in place to guide staff at the service. We saw that a set of local policies, including medicines, safeguarding and whistle blowing, were all in date. Staff we spoke with were aware of company policies and procedures and referred to them when appropriate to do so.

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 18 Registration Regulations 2009 Notifications of other incidents Notification of other incidents. A number of notifiable incidents had occurred in the bungalows. These had not been reported to CQC.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established or operated effectively to prevent abuse of people using the service - with reference to 13 (2). A signatory on some household accounts no longer worked at the service. Security regarding access to and the storage of keys was lax in a number of bungalows.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes to assess, monitor and improve the quality and safety of the service were limited - with reference to 17 (2)(a). Management were not undertaking formal audits of the service and observations of staff practices were limited.

Areas for improvement had not been identified.