Creative Support Limited

Creative Support - Tameside Domiciliary Service

Inspection report

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Date of inspection visit:
09 October 2018
10 October 2018
12 October 2018

Date of publication:
05 April 2019

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?	**Requires Improvement**

Summary of findings

Overall summary

The service is a domiciliary care agency. It provides personal care to people living in their own homes. Not everyone using Creative Support – Tameside Domiciliary Care Service receives a regulated activity; The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care' such as help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection, 136 people were using the service. The service provides personal care in people's own homes and support to people living in an extra care housing service. We have referred to both services in this report as the community and the extra care service.

The inspection took place on 9, 10 and 12 October 2018 and was announced. We gave the service 48 hours' notice we were due to inspect to ensure there was someone available in the office and to alert people we may visit them with permission in their own homes. This has been the first inspection since the service re-registered from their new address in September 2017.

At this inspection, we found a number of concerns relating to safety, person centred care, consent, fit and proper persons and good governance. The overall rating for the service is requires improvement.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility to meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people were not fully explored and risk assessments for people in the community were partly completed and did not give guidance to staff for them to be able to safely manage the risk. Moving and handling risk assessments lacked detail to enable people to be moved safely.

Recruitment of staff was not always safe. Staff's employment history has not always been fully explored and one staff member had commenced employment without a valid disclosure and barring check in place.

Support with medicines was not safely managed. There were a number of gaps on the medication administration records. The records did not always have people's names and other personal details written on them and medication details and directions were not always clearly recorded.

Late calls were a common theme from the people being supported by the service. People told us they were not always informed when the staff member would be late. People also told us there was a lack of consistency in staffing and they did not always know who would be visiting to support them. The majority of people we spoke with from the community felt their care was rushed and staff members did not stay for the whole duration of the call.

Staff members had received training in safeguarding vulnerable people from abuse. All staff we spoke with

understood their responsibilities in relation to reporting any alleged abuse and could describe what actions to take should they suspect abuse was occurring.

The service was not acting in accordance with the Mental Capacity Act 2005. People did not have their capacity assessed and consent to care and support was not always recorded. Relatives were consenting to care and support without having the legal right to do so.

Staff received an induction to their job role and appropriate training. Staff received regular supervision and appraisal, but supervision notes lacked content and did not support staff development.

People had their needs assessed prior to being supported by the service. However, the assessment did not always feed into the care plans.

Staff were kind and respectful to the people they supported. People were supported to retain their independence.

Religious or cultural needs were not always recorded in peoples care plans.

Care plans were not reflective of people's assessed needs. Care plans in the community did not fully give guidance to staff to effectively support people and did not highlight important information. People were not always involved in their care planning and reviews. Care plans lacked detail and clarity and were not person centred.

Hospital passports in place to support people with unplanned hospital admissions did not always have the correct information documented in them to alert hospital staff to how each person communicated, managed mobility, nutrition and mental health.

Complaints were responded to and outcomes shared for learning.

There was a lack of oversight of the governance of the service. Internal audits had not highlighted errors in medication administration records or lack of detail in care files. A senior management audit did identify concerns with detail in care files, but action had not been taken in a timely way to improve the information to enable people to be effectively supported.

Actions had been taken to ensure staff understood the values and culture of the organisation. This included the retraining of staff with the organisations own training academy.

Staff felt supported by the registered manager. The registered manager had a support network including senior operations managers and the nominated individual and chief executive officer.

Statutory notifications to the Care Quality Commission were submitted as required.

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.

Medicines were not safely managed. A number of concerns relating to medicines records were noted and we could not be assured people received their medicines as prescribed.

Risk assessments lacked detail and clarity on how people were supported with risk. Risk assessments for people being supported in the community were found to be incomplete.

Late calls to people in the community were a common theme in the feedback received. People said they were not always informed when their call would be late and often did not know which staff member would be visiting them.

Safe recruitment practices were not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not have their capacity assessed and consent was not always recorded as being received. Family members were consenting to care and support without the legal power to do so.

People wishing to be supported by the service had an assessment of needs completed to ensure their needs could be met. The assessments of needs were not always reflected in the care plans.

Staff received an induction to the service and training appropriate to their job role.

Information in care plans lacked detail and clarity on preferences and level of support needed.

Is the service caring?

Requires Improvement

The service was not always caring.

The inconsistency of regular staffing to support people was a

common theme fed back from people being supported by the service.

Staff were respectful and kind to the people they supported.

People were supported to retain their independence.

Religious or cultural needs were not always recorded in peoples care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans in the community were not reflective of people's assessed needs. People were not always involved in their care planning and care plans were not person centred.

Hospital passports did not correctly confirm the support people needed on an unplanned hospital admission.

Complaints were responded to and answered in a timely manner. There was a complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of oversight of governance of the service. Audits of medicines and care plans had not highlighted failings.

Actions had been taken to ensure staff understood the values and culture of the organisation. This included the retraining of staff with the organisations own training academy.

Staff felt supported by the registered manager.

Statutory notifications to the Care Quality Commission were submitted as required.

Creative Support - Tameside Domiciliary Service

Detailed findings

Background to this inspection

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

The inspection took place on 9, 10 and 12 October 2018. We gave the service 48 hours' notice of the visit to ensure someone was available at the office to facilitate the inspection.

Two inspectors attended the registered office on the first day of inspection. On the second day of inspection, one inspector undertook home visits and two experts by experience contacted people by telephone to discuss the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the third day of inspection, two inspectors completed phone calls to staff members.

Before the inspection, we looked at information we held about the service. This included notifications sent to us about the service. A notification is information about important events that occur in the service, which the provider is required to send us by law. Prior to a planned inspection, we use information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We had not requested a PIR for this inspection.

As part of the inspection, we spoke with the registered manager, the nominated individual and the senior operational manager. We spoke with seven staff members, 27 people who used the service and five family

members. We reviewed seven care files and five records relating to supporting people with the safe administration of medication. We looked at four staff recruitment files, training and supervision of staff. The overall management of the service and how the service is monitored.

Requires Improvement

Is the service safe?

Our findings

Recruitment processes were not always safe. Of the four staff personnel files we viewed, we saw all four had gaps of their employment history. There was no evidence of the gaps being explored and explained at interview. One staff member had received a disclosure and barring service check (DBS) three weeks after their start date. A DBS helps prevent unsuitable staff members working with vulnerable groups. The registered manager told us the chief executive officer of the organisation had sanctioned this and a letter in the staff members personnel file confirmed this. There was no evidence the staff member had shadowed more experienced staff members in this time frame. The files did contain two references, but these were not always from the most recent employer and there were no records kept for how the current references had been obtained.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have robust processes in place and make every effort to gather information to confirm applicant's suitability for positions at the organisation.

Medication was not always safely managed, and we could not be assured people received their medicines as prescribed. Medication administration records (MAR) were intermittently signed, for every record we looked at. Charts did not always have the full name, date of birth and allergies recorded of the person and the month recorded for which the chart was in use. Times of medicines being given had not been recorded. Where people received regular paracetamol, there was no indication that people had received the medicine within the correct time frames. This could put people at risk or receiving too much of the prescribed dose. Medicines, their doses and directions were not always clearly written on the MAR.

Monthly audits of the MAR records had only identified where the record hadn't been signed by staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to have safe and effective systems in place for the management of people's medicines.

People who received support with their medicines felt they had the help they needed. People were assessed to ensure the correct help was given to receive prescribed medicines. This could be level one support for prompting or level two support for assistance. There was no mention of this support in care plans or risk assessments and we were told this was determined by the local authority and captured in the local authority care plan.

In the extra care service, people had fully completed medication assessments which determined what help was required with medicines. This was to enable people to stay safe while not taking away their independence.

Staff were trained to administer medicines and underwent a series of competency-based assessments to ensure they understood their role. Staff confirmed they received the training and there was evidence in staff

files of recorded competency checks. Where concerns were raised against staff members competency, we saw they were re-trained.

Risk assessments to support people in the community did not always support people to be assisted with moving and handling safely. People who required support with moving and handling did not always have a fully completed people handling risk assessments. The assessments should describe what needed to be done to support people to be moved. One risk assessment described the weakness a person suffered from after a stroke which was wrongly described in the care plan, which meant staff may not have been supporting the person to be moved safely. A family member told us, they were not confident their relative was being moved safely. In another risk assessment which was largely incomplete, a person who required the use of a hoist did not confirm the persons level of cooperation or if they had any weaknesses.

Combined risk assessments were not always fully completed which meant risks may not be identified. These risk assessments were used to provide an overview of risk to the person, to others, using transport and housing related risks but they were not comprehensive. For example, one person had been identified with requiring support with medication and this was not mentioned in the combined risk assessment.

Bathing and showering risk assessments were not always completed. One person did not have one although they were supported with bathing and showering.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure risk assessments gave the correct guidance to ensure people were supported safely.

The risk assessments in the extra care service were more robust and clearly highlighted risks to people. They were regularly reviewed and gave strategies to the staff to manage risks people presented in support with mobility, eating and drinking, medication, isolation, neglect or health related concerns.

Staff had received training and were aware of how to report concerns about vulnerable adults. Staff felt confident the management team would listen to any concerns they had and could describe in detail signs and symptoms of abuse and who they could contact to report such concerns. Training certificates for staff were held in their personnel files. The service had policies in place in safeguarding vulnerable adults from abuse. Staff told us they were aware of the policies and could describe how to use the whistle blowing policy.

People said they felt safe while being supported by most of the staff team, but the lateness of the calls and the lack of consistent staffing did cause them concerns. The majority of people we spoke with unless they had their regular staff member, they felt rushed and were not informed if their call would be later than planned.

Allocated call times were not always adhered to and calls were being completed in much less than the allocated time. People we spoke with told us, "I have a 15-minute slot but they [staff] only stay a few minutes, I feel lonely after they have gone." Another person said, "The 30-minute slots are only 20 minutes, the girls don't have enough time to get between calls." A third person told us "The staff are kind and gentle, but they have too much work and so my 30-minute morning call is five to ten minutes short." Relatives told us, "They [staff] stay the time unless they have finished what they need to do." Another relative said "Some of them are in a rush.", "The staff don't stay the full quota of time." A third relative said, "Staff don't stay the full length of time, I have to check if they have given him a full wash or used a wipe."

Logs of calls were recorded in people's care files and this reflected that staff did not stay the full allocated time of the call. We raised this with the registered manager and nominated individual who told us staff always completed the tasks required before leaving a call and the local authority had agreed as long as 50% of the call time had been completed, this was okay.

Late calls were a regular theme from people and family members we spoke with. People told us, "Staff are supposed to come at eight, but they are sometimes late and have been two hours late and my [relative] rings them to see what's going on." Another said, "Timing isn't too bad, they can sometimes be five or ten minutes late which isn't a problem." A third person said, "If I don't have my regular carer, the others can be late." A fourth person said, "They are not too bad, but they are late sometimes and I have to ring the office to find out what's going on.". Relatives told us, "They can be late sometimes, say half an hour." A second relative said, "[Staff member] is okay but some of the others have been up to two hours late." A third said, "They are supposed to come at [time of call] but it is 20 or 30 minutes later, and I can't go out until they turn up." And "We have now cancelled the night call as they could turn up any time between 7.30pm and 10.30pm."
Staff members told us they don't get travel time on the rota. We viewed the rotas and saw there was travel time and some properties were in close proximity to each other however comments from staff included, "Sometimes we have to cut short and run,", "Some people have more time allocated than they need.",

Staff accessed some properties by using a key safe. Key safe codes were stored securely and should be given out on a need to know basis. One person told us, "Staff let themselves in via the key safe, but I don't know whose coming as there are lots of different ones [staff]." A relative told us more recently, they found the key safe unlocked and had to close it themselves. This potentially could put the property at risk of being accessed by intruders. The relative had not raised this recent incident with the provider and had not given us permission to disclose their details. However, we did raise this with the registered manager who said this was when they first took over the contract but the relative advised it was more recently.'

People told us staff were always available in the extra care service. The building was managed by another provider and Creative Support – Tameside Domiciliary Service provided support over a 24-hour period. People told us they summoned assistance via an intercom and they had regular staff visiting them to help with personal care tasks. People said they felt safe as they were in a secure, locked building with 24-hour staffing and they always knew who was visiting them.

Staff supporting people in the extra care service used a 'Round book' which gave a brief overview for the care required for each person over the course of the day. This was an 'At a glance' document to guide staff as to where they needed to be at particular times and what support was required.

Accidents and incidents to people were documented and analysed to prevent future occurrences. This information was shared with the team for wider learning.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who use the service and 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.

We checked whether the service was working within the principles of the (MCA) 2005. People told us that staff sought their consent prior to supporting them and we saw this in practice. However, the service did not always ensure consent was recorded and agreed. In one care file, a relative had consented to care for a person who had not had their capacity assessed. Also, it was not clear if the relative had the legal powers to consent however, we felt the relative was consenting in the best interests of the person. In another care file, a combined risk assessment stated that the person lacked capacity. We were unclear on what assessment this has been based on and there was no record of involvement from others. Family members or people's representatives must have 'lasting power of attorney' for health and welfare decisions before they can consent on behalf of the person. In the absence of an LPA, there must be a best interest's decision. The MCA Code of Practice gives advice about how to reach such a decision. The care records we viewed contained no evidence to show this authority was in place, nor that any assessments of mental capacity had taken place.

The registered manager told us that no one being supported by the service had undergone a capacity assessment by Creative Support – Tameside Domiciliary Care Service.

People did not always have their choices recorded. A living well support plan was in place for people being supported in the community. Support plans viewed did not always have recorded if people preferred a male or female carer.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not work within the principles of the Mental Capacity Act 2005.

Staff were inducted into the service and an induction checklist confirmed this. The induction for staff new to care followed the principles in the care certificate. The care certificate identifies a set of standards that health and social care workers should adhere to in their daily working life. Where people did not meet the expected standard at the end of their induction, we saw the probationary period was extended and reviewed to assist in assuring the suitability for the role.

Staff received regular training and told us they found training to be good. A training matrix confirmed the training staff received and there was the opportunity for staff to develop their skills by completing diplomas in health and social care. Two staff had recorded medication competencies, this checked the staff members learning and observations of the practical side of safely administering medicines to people they supported. The other two staff did not have the competency checks in place, but the registered manager told us this was because they did not administer medicines.

Staff told us they received supervision and appraisal, but we found the records lacked content and many of the sections were blank. This meant there was no evidence of continuous staff development. The registered manager acknowledged this and told us they felt the paperwork needed to be reviewed.

People received an assessment of their needs prior to using the service. Staff told us they didn't always get the opportunity to review the information before they went on their first call and would have to phone the office to obtain details. Levels of detail in the assessments depended on the amount of care and support needed for each person. The local authority provided a detailed care plan which included information regarding the person's support needs, medical history and personal history. The document should be used along with the assessment to generate care plans and risk assessments for each person but the level of detail in the document was not what we saw in the Creative Support care plans.

The care plans identified if the person required support from care workers to prepare and/or eat their meals. We saw the care plans indicated the care workers should provide the person with a meal and drink of their choice, but no information was available in the care records on people's specific preferences. Care workers confirmed they had completed food hygiene training which included food preparation, preventing cross contamination between raw and cooked food and infection control to ensure they could engage in meal preparation safely.

We saw the care plan included the contact details for the person's GP and any other healthcare professional involved in their care. The local authority referral provided an overview of the person's medical history and there was a section for information on medical conditions in the assessment which was completed. We noted one person received oxygen therapy and although the service said they did not actively help the person with this task, there was no mention of the therapy in the care plan or to guide staff what to do should they have concerns with the person and the use of oxygen. Additionally, the community care support plan and risk assessment stated the person required help with setting up the oxygen when they were fatigued.

Requires Improvement

Is the service caring?

Our findings

People raised concerns with the consistency of staffing attending their property. People said the regular staff turned up on time, but the staff team wasn't consistent, and people did not always receive a core group of staff members to support them. One person said, "The other day when [regular staff member] was off, I had four different carers come to the house, I know some of them, but I prefer to know whose coming through the door." Another person said, "With some of them, it's very impersonal, if I have a hospital appointment, I need to be ready and I don't know who is coming or if they will be on time." A third person said, "I get different people coming round but I have seen them all before."
We raised this with the registered manager who told us recruitment was on-going to enable people to be provided with a consistent group of staff members.

People being supported in the community told us they felt well cared for when being supported by regular staff members. When speaking with people the same staff members names popped up over and over again and people said they felt these members were very kind. Some of the comments included, "All the staff who come to the house are very nice, I would raise their marks sky high.", "Most of them are alright.", The girls are smashing, I have no complaints." "I have a regular one called [staff members name], she is brilliant.", "You could not get a more caring set of girls."

Relatives were happy with the care of regular staff members and said. "The girls have really built a relationship with my Dad, he smiles when they come through the door."

People being supported in the extra care service told us staff were respectful. They told us, and we saw staff knock on doors, call people by their preferred name, respond promptly to calls for assistance with personal care and provide explanations to people on request. People told us the staff are not rushed and take the time to communicate and get to know them. One person told us, "The staff seem content here, they appear to have job satisfaction.

Staff were seen to be respectful to the people they supported, and people told us, "They [staff] treat me with respect." and "They are very proper with me, I have no problems, they are pleasant, friendly and joke."

There was one staff member who people commented they didn't feel well supported by, we fed this back to the registered manager as a training and supervision concern.

Staff supported people to retain their independence. People told us, "I do my own medication and can shower myself, staff help me when I need it." Another said, "I like to do what I can, staff help me when I need it and sometimes remind me to take my medicines." Staff told us they encouraged people to do as much as they could for themselves to retain their independence.

The care plans did not always identify if the person had any cultural and religious requirements that may impact on the way their care should be provided. The care plans also did not identify if the person was involved in any social organisations and details about their family and friends who were important to them

were limited. Information on people's personal history, links to the local area and any hobbies was also limited.

Requires Improvement

Is the service responsive?

Our findings

People in the community had living well support plans in place. Plans gave a brief overview of the days and times of care and what support was required during the visit to each person. Care plans had limited information contained in them and did not reflect peoples assessed needs and were not person centred. For example, in one care plan, there was no information contained in the persons interests or aspirations and information to support people with their assessed needs did not describe how the person needs should be met. In the staying safe section of the document, there were no guidelines to keep one person safe with moving and handling even though the person had poor mobility and required help with personal care and dressing. For another person, the information of what they could do for themselves was blank and no personal goals were set in any of the care plans we viewed. A person who required support with continence had no mention of this in the care plan in relation to support with personal care.

There was a lack of evidence that people had been involved in their care planning and it was unclear on how reviews of people's care took place. People told us that people visited their property and looked at the file but no one we spoke with could say if they had reviewed their care plan with staff from the service. Staff members we spoke with could describe peoples care and support needs.

A person who was receiving support with personal care did not have documented there was a percutaneous endoscopic gastrostomy (PEG) in situ. A PEG is where a tube is fed into the stomach to provide a means of feeding. Although the service did not actively provide support to manage the PEG, there was no guidance to support staff in caring for the PEG site when delivering personal care. Additionally, the same person was described in their local authority care plan as being 'Nil by mouth'. This information was not recorded within the Creative Support care plan which could potentially put the person at risk should someone offer them food.

One-page profiles for people in the community were not personalised and held limited information. One-page profiles provide 'At a glance' information about what really matters to people.

Hospital passports were used to support people to hospital in an emergency but did not always contain the correct information. Hospital passports gave brief information to alert hospital staff to the immediate needs of people such as communication, cultural, mobility and nutrition. In passports we viewed, someone who was fed by a PEG and did not receive food orally, this was not recorded on the passport. Also, the same person had some difficulties in communication and communication on the passport was documented as good. In another passport which was partly incomplete, there was no record of a persons mobility difficulties they faced.

Local authority assessments confirmed the support people had in place from family, friends or neighbours but we didn't see this recorded in the Creative Support care plan, so we were not clear if these links had been maintained.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. The provider did not ensure care and treatment of people was recorded, factual, relevant, person centred and included the person and their representatives.

Care plans and hospital passports at the extra care service were more person centred and personalised to each person the service supported. The weekly activity plans were very detailed and confirmed what aspects of personal care people required. Care plans had involved people and personal preferences were recorded and information displayed what people wanted the staff to know about them. The identified support needs in care plans were clear for staff to follow and described how each need was to be met.

Complaints were responded to in a timely way and outcomes shared. People told us they generally knew who they could complain to, but some people were not sure who the manager was. All people we spoke with said they would have no hesitation in making a complaint if they felt they needed to. The service had a complaints policy in place which had been regularly reviewed. A log of complaints was kept which confirmed the complaint raise date and response.

We observed a housing meeting at the extra care service where people could raise concerns or compliments about housing or care received. People at the meeting were introduced to the Care Quality Commission (CQC) inspector and we explained our remit and why we were inspecting the service and gave the opportunity for people to speak with the inspector. People told us they enjoyed the meetings as they felt they could share information and meet the management of the service.

People were supported by the service at the end of life. The service worked with health professionals such as district nurses and GP's to provide support to people to keep them at home when the time came.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and the nominated individual told us the service had been commissioned by the local authority to take over a number of packages of care and they had experienced "Call cramming". Call cramming is when several calls are crammed into a shorter time period. This had been identified at the start of the new commissioned contract and actions had been taken to prevent the call cramming continuing.

We saw staff members had been retrained under the organisations training programme and actions taken to ensure staff understood the culture and values of Creative Support. This was to ensure all staff members were trained to the same standards. An analysis of the transition period had been completed after high levels of complaints were received and the analysis showed complaints reduced as the retraining of the staff was completed.

The registered manager nominated senior staff members to complete audits of the service. This included medicines and daily communication logs. We saw that audits of medicines were completed monthly but did not identify errors on the medication administration records (MAR) such as people's name's and allergies not being recorded as well as medicine directions and doses not being clearly recorded.

A lack of care plans audits did not identify where care plans were lacking detail and guidance for staff to effectively support people. People told us someone visited them to look at their care plan, but they didn't actively contribute to it. An internal management audit in November 2017 had highlighted care plans were partially completed with very little detail provided. Missing persons profiles were blank and hospital passports partially completed. From this audit an action plan was generated but it was clear at our inspection, work to improve the care files had not been implemented in a timely way.

We discussed the oversight of the medicines and care plans with the registered manager and senior operations manager who told us senior staff would receive further training to enhance the support planning and risk assessments reviews. The senior staff will also be given auditing training and the medication audits will be redesigned to ensure it picks up the necessary issues. We will review this on our next inspection.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had a lack of oversight of the governance in relation to the auditing of medicines, care plans and risk assessments.

The service had not sought views on what it offers since February 2017. All the questionnaires completed had been handwritten in the same handwriting and the registered manager told us they were completed by telephone. There was no record of who had been contacted and the information received had not been analysed.

We could not be assured people were receiving the correct support for their assessed needs as staff were not staying the allocated amount of time. The registered manager and nominated individual were aware some calls in the community were not taking the full length of allocated time and we saw some people had been

referred to the local authority to have their package of care reviewed. We found some calls were being undertaken in less than 50% of the time allocated. For example, one person who received a 45-minute daily morning call received only 15 minutes care on each visit over three mornings.

At the extra care service, a senior support worker had oversight of how the service was managed. This included the monitoring and updating of care plans and risk assessments and the co-ordinating of staff. People we spoke with were very complimentary of the senior support worker and told us "[Name] has done a brilliant job here."

The registered manager told us the staffing levels and consistency were improving as staff were now beginning to work regular weekends for continuity to people they supported. The plan was to recruit more staff to ensure people received a regular group of staff members supporting them. We will review this at our next inspection.

Staff felt supported by the registered manager and the management team. Staff we spoke with told us, "The manager is good, I can go to them with anything." Another said, "The manager is okay, I don't have much dealings with the office, I just get on with my jobs.", A third member of staff said, "The manager is helpful, but they can only do so much to help us." The registered manager was supported by a senior operations manager, nominated individual and chief executive office and felt well supported.

Staff received regular spot checks from the senior team to ensure they were carrying out their role. Spot checks were unannounced and documented in the staff members personnel file.

We saw that people, staff members and managers were given a copy of the wider organisational document "Code Red." Code Red is a one-page document that sign posts others to raise concerns within the organisation as well as making people aware that they can raise concerns vis the staff team, registered manager, family, professionals, the local authority and the Care Quality Commission. Staff members told us they had been made aware of Code Red via meetings held with the registered manager

A business continuity plan was in place to ensure the service continued to run in the events of adverse weather conditions, fire or flood. This had been successful in ensuring the continuity of calls during the bad weather in the last winter.

Statutory notifications were submitted to the Care Quality Commission as required. We saw safeguarding alerts were analysed for learning and follow ups and outcomes were clearly recorded.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure care and treatment of people was recorded, factual, relevant, person centred and included the person and their representatives.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not work within the principles of the Mental Capacity Act 2005. People did not have their capacity assessed and consent was not always recorded.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust processes in place and make every effort to gather information to confirm applicant's suitability for positions at the organisation.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to have safe and effective systems in place for the management of people's medicines. and The provider did not ensure risk assessments gave the correct guidance to ensure people were supported safely.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had a lack of oversight of the governance in relation to the auditing of medicines, care plans and risk assessments. Actions had not been taken to ensure staff members stayed for the duration of the allocated time to support people with their assessed needs.

The enforcement action we took:

Warning Notice