Kids

Kids Smile Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: KIDS Smile Centre is a short breaks service for children and young people with disabilities up to the age of 25. This involves supporting them in activities in their home or within the community and with some personal care. At the time of the inspection the service was supporting 12 children or young people.

People's experience of using this service:
People did not always receive a service that provided them with safe, effective and high-quality care and were not always provided with support that was personalised to them. Despite this, parents of children and young people were happy being supported by KIDS Smile Centre and parents told us they felt their child or young person was safe. People were supported by staff who were kind and caring.

The provider lacked effective governance systems to identify concerns in the service and drive the necessary improvement. At times there was a lack of clear and accurate records regarding people's support and any potential risks to them. Accidents and incidents were not always analysed sufficiently to ensure risks were reduced for people.

Parents of children and young people felt able to speak to the management team if they had any concerns. Young people's human rights were upheld, and care staff understood the principles of the Mental Capacity Act 2005.

Staff were not always supported with regular supervision or appraisal however, staff told us they felt well supported by the registered manager and had enough training to undertake their roles effectively.

Parents of children and young people felt they did not know the registered manager and felt communication with the office could sometimes be difficult.

The acting manager demonstrated a willingness to make improvements.
Rating at last inspection: Good (Report published 30 December 2016)

Why we inspected: This was a planned inspection based on our last rating.

Follow up:
We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made three recommendations.

We will request an action plan from the registered provider about how they plan to improve the rating to good and in addition, we will monitor all information received about the service to understand any risks that may arise and to ensure the next planned inspection is scheduled accordingly.

You can see what action we told the provider to take at the back of the full version of the report.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Kids Smile Centre

Detailed findings

Background to this inspection

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

Inspection team:
One inspector and one expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance for children and young people.

Service and service type:
KIDS Smile Centre is a domiciliary care agency. It provides personal care to children and young people using the service. Not everyone using KIDS Smile Centre receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service did not have a manager registered with the Care Quality Commission. A registered manager is legally responsible for how the service is run and for the quality and safety of the care provided. An acting manager was in post who told us they would be applying to become the registered manager.

Notice of inspection:
This inspection was announced. We gave the provider 24 hours' notice of the inspection site visit to ensure that the registered manager would be present, and to ensure people's consent was gained for us to contact them for their feedback.

Inspection site visit activity started on 29 April 2019 and ended on 30 April 2019. We visited the office location to see the manager and office staff; and to review care records and policies and procedures.

What we did:

Prior to the inspection we reviewed all the information we held about the service including notifications received by the Commission. A notification is information about important events which the service is required to tell us about by law. We reviewed the last provider information return. This is information we request to provide some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with one young person and seven parents. We spoke with the acting manager, a care coordinator and two members of staff.

We reviewed records related to the care of four people. We reviewed recruitment files for four staff. We looked at records relating to the management of the service, policies and procedures, quality assurance documentation and supervision documentation.

We asked for further information following the inspection including an updated statement of purpose and a copy of a support plan and risk assessment both of which were received.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety.
There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Parents told us that they felt the provision and delivery of care was safe. Parents comments included, "They make sure our son is safe all the time", "I've been with Kids for four years. I'm happy with the care my daughter receives, and I know they are safe with the carer" and, "They are completely safe. I think it's who they are. I've had two carers for 10 years they fit in and are like the family. I know I am fortunate."
- However, risks to people had not always been assessed, monitored or mitigated effectively. One person's care plan identified that they had epilepsy and that there was a syringe preloaded with medicine. This information implied that they were at risk of seizures. There was no detail of when to administer this medicine and in what circumstance. The provider had failed to implement a risk assessment and their care plan failed to provide guidance on how to manage and mitigate the risk of seizures. Therefore, guidance was not available to care workers on how to manage the risks associated epilepsy. Care staff told us they would look in young people's care plans to identify risks to people or discuss with the young people's parents.
- The risks associated with eating and drinking for some young people had not been robustly assessed or mitigated. One person had an eating and drinking risk assessment in place however, this did not refer to speech and language therapy (SLT) guidelines therefore it was difficult to establish where the specific feeding instructions had come from. The acting manager told us they would review the risk assessments and contact SLT. Another young person had a care plan in place which identified 'food may need chopping up' and that they must not skip any meals however, there was no information about what food may need chopping up, to what consistency and under what circumstances. This meant that this person may be at risk of choking if food was not managed effectively and guidance was not available for staff on how to manage the risks associated with choking.
- Where young people lived with specific health conditions, such as Cystic Fibrosis, risk assessments were not in place to guide care workers on how to provide safe care and support. For example, one young person's care plan stated, 'uses positive expiratory therapy' and, 'must have good nutrition and avoid cross contamination' however, their care plan did not contain enough information to say how to assist this person or how to mitigate the risks associated with their condition.
- The system to record accidents and incidents was not always effective. Although there was a system in place, staff were not always aware of it. For example, a care coordinator told us that staff have a paper accident/incident form to complete which then goes to the relevant care coordinator. However, a staff member told us they didn't know how they would report an incident, they told us, "I would inform [young person's parents], then report to KIDS, I don't know how I would report it because I have never had to, could be telephone or email." Documents demonstrated that when an incident was reported there was nowhere on the form to record the next steps or action taken following the accident or incident. This meant that accidents or incidents may not be reported appropriately, and the appropriate follow up action was not easily accessible and therefore difficult to monitor and review to prevent a reoccurrence.

The failure to assess and mitigate risks to the health and safety of service users using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Most young people's medicines were managed by their parents, although care workers did administer or support some people with their medicines. Where this was the case, care plans lacked guidance on the level and type of support required. This meant that care staff were not provided with enough information to be able to administer medicines safely. For example, one young person's care plan stated that Paracetamol could be given as required however, there was no information detailing the dose and no guidance around how pain was identified for this young person. This was a common theme throughout the care plans we looked at. This meant that if an unfamiliar or new care workers were asked to carry out support they would have very little idea of the specific needs of people, which could put them at risk. However, it was unlikely that this would occur because agency staff were not used and in emergency situations the provider cancelled the support visit. We spoke to the acting manager who told us that to date audits of care plans had not been undertaken however this is something they plan to do when resources allow.

● Staff had received training in the administration of medicines however there was no evidence that medicines competency assessments were undertaken. A care coordinator told us, "Families are responsible for medicines although some carers do administer medication. We are planning to do observations of staff giving medication, the last spot check we did was over a year ago." This meant that the provider could not be assured that the staff were competent to administer medicines. Despite this we did not see any evidence of medicine errors. A care coordinator told us that they had already identified this as an area for improvement. The care coordinator told us they had recently spoken with the community nurse team who have agreed to competency assess staff.

The failure to provide proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Learning lessons when things go wrong

● The provider had a system in place to record accidents and incidents. The acting manager told us, "We explore any examples of changes made because of complaints/incidents/feedback as a company. Locally we discuss at monthly managers meetings. It is also done through Yammer (an online discussion forum)." However, an analysis of accidents and incidents had not taken place, to identify themes and patterns and put preventative measures in place.

Staffing and recruitment

● The provider had not always followed safe recruitment practices. Although all staff checked had two references and a DBS in place, new staffs complete work history had not always been thoroughly checked. For example, one person's work history just covered years of employment, for example, 2015 to 2017, 2017 – 2018, there were no start or end dates recorded which meant the provider was unable to identify if there were any gaps in employment and was therefore unable to be assured that safe recruitment practices had taken place. A care coordinator told us, "We will make sure we do this in future." All other recruitment checks were in place.

● Staff had the competence and skills to care for people safely. We received mixed feedback about the availability and consistency of staff at times, we have reported on this in responsive.

Systems and processes to safeguard people from the risk of abuse

● A detailed 'safeguarding adults' policy and procedure' was in place. Care staff could tell us about their responsibilities to safeguard adults and children. A staff member told us, "I would go to my line manager

with any concerns, I feel confident they would deal with it. They would act on information quite quickly."

● We talked to the management team about how they ensure care staff are aware of abuse and how to report it, the acting manager told us that as part of care staffs' induction, care workers are encouraged to report concerns. They told us, "We have safeguarding policies, staff induction, the safeguarding national advice line and our on-call line. We use case scenarios as part of our annual review." This meant that children and young people were safeguarded against abuse.

Preventing and controlling infection

● Parents of young person's told us care workers practiced good infection control measures and records showed staff had been suitably trained. The acting manager told us, "We provide gloves, aprons, body spillage kits, tops and uniforms are available depending on family preference."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

Staff support: induction, training, skills and experience

● Parents of young people told us that care workers were competent, knowledgeable and carried out their roles effectively. One parent told us, "All the carers are good. One carer is doing teaching training and has a good idea about communication" and another said, "The carers are absolutely fantastic. I can't fault them."

● Staff had completed an induction. This included training and shadowing more experienced staff. The acting manager described the induction process which included e-learning, training to meet people's individual needs and shadowing experienced staff for as long as required within the first six months. They also told us, "We encourage staff to request additional training and the virtual online college helps. I did want to avoid a reliance on online learning because it is not everyone's style. We will be recruiting a trainer, funding has been agreed." Documents demonstrated that staff undertook a range of e-learning including, the MCA, manual handling, fire safety, safeguarding, health and safety and medication administration to name a few. We saw documentation which confirmed that care staff also completed a range of bespoke training, for example, 'Care of gastrostomy and jejunostomy tubes' and, 'Oxygen therapy, SATs monitoring and nebuliser.'

● Staff had not been receiving regular supervisions or appraisal and records demonstrated that the last staff meeting was in February 2018. This meant that staff did not receive ongoing support and development in their role and had limited opportunity to review their past and current performance. Despite this care staff told us, "Whenever I speak to [care coordinator] she is supportive." Another care staff member told us that management listen and respond appropriately. The acting manager told us that plans were in place to ensure they were carried out more frequently.

Supporting people to eat and drink enough to maintain a balanced diet

● Where people needed support with their nutrition and hydration needs, this was provided. Some care workers supported children and young people to prepare and cook meals and checked people were having enough nutrition and fluids when they were with them. However guidance was not always available for staff to follow to ensure peoples' meals were prepared correctly to prevent the risk of choking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Parents were responsible for their child having access to a range of health and social care professionals when required. We saw from the care plans and daily support notes that a range of professionals were involved in providing additional care and support to young people and this information had been shared

with the provider.
● When asked how they monitor that young people were having their healthcare needs met, the acting manager told us, "If there is a child in need, healthcare professionals would share that information. Coordinators would identify things that weren't being addressed."
● A care coordinator told us, "We work with the social work team and community nurses. We have started to do joint working with Solent Health and Continuing Care. We have come together to get the best outcome for the young people." A care coordinator told us about a young person who required complex medicines, they told us how they worked with a joint care provider to ensure this person was supported appropriately. Care staff were confused by the medicines, so they invited the other care provider to give training to staff on how to use the complex medicines form. They told us the family were really pleased that they had built a positive relationship with the joint provider.

Ensuring consent to care and treatment in line with law and guidance
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 young 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.

● Staff told us they had received training in the MCA and documents demonstrated this. The acting manager told us, "Parents act on children's behalf until they are 14 years old. Any concerns re; the ability of the next of kin then we would ask for a case review. Mental capacity assessments and best interests' meetings would be arranged."
● Parents of young people felt the carers took the time to explain things to their child, so the young person felt involved and understood what they were going to do. Their comments included, "They explain to [person] what they are going to do but [person] is non-verbal", "They talk to [person] about time to do tummy medicine and dinner. How much [person] understands we're not sure but they do talk to [person]" and, "My [child] likes to be told everything that is going on. [Person] will let her [staff] know if they don't want to do something."
● Care plans had been completed with the involvement of parents, their comments included, "My husband and I are involved in his care planning. On a day to day basis our son is choosy about the programmes he watches, and the staff will give him a choice of which to watch. So, he can pick and choose in that way", "The care plan was written with me. It's literally everything I've said" and, "I am mostly involved and where my daughter can have an input she is invited to." This meant that young people and where appropriate their parents could consent to their care and treatment.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care
● Staff recognised what was important to people and respected this. One parent told us, "They do support [person] with their decision making."
● Documents demonstrated that staff supported young people to express their views and develop their independence.
● Parents and young people were supported to be involved in care planning; relatives and documents confirmed this. The acting manager said they promote people's independence. They told us, "We have all the theoretical training in induction, we always discuss privacy and dignity, we work with families, it is the largest area where the public will ring us…I encourage care staff to prompt young people without embarrassing them."
● The Accessible Information Standard (AIS) is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Some consideration had been given to writing letters in an accessible format. A care coordinator told us, "We use accessible letters that include smiley faces, we do not have policies or leaflets in an accessible format." A care worker told us they hadn't heard of the AIS.

We recommend that the provider reviews reputable guidance to ensure they provide people with information which is accessible.

Ensuring people are well treated and supported; respecting equality and diversity
● Parents of young people were consistently positive about the support their children received from the care staff. Parents comments included, "They treat her with respect. I can't fault them", "They give him hugs, reassurance when they are doing things. They are always positive and chatting to him… They are very receptive to our son's individual needs" and, "I think the carer treats my daughter very well because she has to balance what needs to be done with my daughters' consent. So, the carer pitches how she provides her care and support while still having fun."
• The Equalities Act 2010 was designed to ensure people's diverse needs in relation to disability, gender, marital status, race, religion and sexual orientation are met. The care planning process included information divulged by parents of young people with regards to some of the protected characteristics, for example, disability and religion. This demonstrated that staff considered some of the characteristics defined under the Act. The acting manager told us, "We have a number of children from different ethnic backgrounds, we encourage staff to engage with family to find out about their cultural and religious beliefs." The acting manager gave us three examples of supporting people with regard to their protected characteristics. Parents of young people confirmed they were treated in line with their preferences.

Respecting and promoting people's privacy, dignity and independence

● Parents of young people told us how staff protected their children's privacy and gave examples such as closing doors and curtains when assisting with personal care. One parent of a young person told us, "They are very good about ensuring their privacy and dignity. If they need a pad changing they give them the privacy. Close curtains and close doors. If they've been sick they will ensure they have privacy from people around them." Another parent told us, "If [carer] has taken them to the park and they need changing she brings them home."

● Parents consistently told us that they and their children were treated with respect. One parent told us, "[Carer] explains when she's changing their nappy, giving choice." A staff member told us, "I support one young person who as they have got older needs less support, so I don't go into the toilet with them now, if they go and get changed and need help they ask for it, I help when they need it."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Young people's likes, dislikes and preferences were documented in their care plans however, care plans did not always contain sufficient detail to ensure people received personalised care.

● There were not always enough care workers to provide the care as planned, there was only one permanent staff member and several bank staff. The bank staff were working regular shifts with children and young people and parents viewed them as part of the regular team. There were no additional bank staff who picked up hours on an ad hoc basis. The views of parents were mixed, comments included, "We have two regular carers. It would be nice when they're off if they could find people to cover", "They don't have a bank of carers so if a carer goes on holiday/ill they don't have someone to take their place" and, "One carer left and gave notice, but we are frequently left with gaps and the hours are not made up. If we have [A new staff member] we have lots of hours but there is no consistency." Despite this some parents told us they were happy with the staffing arrangements and liked the flexibility that their care staff offered. One parent told us, "I am happy with one carer. Because I am able to have a flexible approach when the carer is away I am happy to wait till our carer is available. Once they weren't able to provide cover, so we were just happy to wait. My daughter doesn't do well with not knowing what to expect" and, another parent told us, "I'm very happy with the care we receive. I have had the same carer for a long time. I tend not to use another carer to cover when my carer is unwell or on holiday because it's to unsettling for the children and what has been done takes too long to explain. The carer we have is fantastic and we know each other well and have a good relationship." The acting manager told us, "We try and match people with the right person. We don't use agency workers anymore. In an emergency we would cancel the service."

● Children and young people received person centred care and staff were able to describe person centred care. Parents of children and young people told us their children were encouraged to make their views known about their care, treatment and support. Their comments included, "'They ask him if he wants to go out. As long as he has a choice of two things he is able to make a decision", "It can be difficult to know what she wants but everyone works hard to figure out what she wants" and, "I think if the activities were too different it would upset him. The carer has suggested different activities, but I have said he wouldn't cope."

● KIDS Smile Centre used an electronic system for managing children and young people's short breaks. The provider received confirmation from commissioners that hours were available before providing support. Parents were also able to log on to the system and could book short breaks on-line and access and review their information their children.

● Children and young people had their needs assessed prior to receiving care and support. The assessment was used to gather personal information about the child or young person to help staff understand their needs. It covered areas including cognition, communication, personal care, mobility and nutrition. Information gathered in pre-assessments was used to create care plans for the child or young person with the involvement of parents. Parents told us they felt involved in the planning and on-going review of their children's support.

Improving care quality in response to complaints or concerns

● Some parents of children and young people told us they knew how to make a complaint; A parent told us, "I have sent an email to the manager because my child took their iPad into the bath and it was damaged. It was dealt with and they replaced it, but it wasn't really a complaint. If it was a complaint I know I can go to Kids, CQC or social workers" and another relative told us, "I have been given information about how to make a complaint, but I've not had to, I would know the avenues to go down to do so." However, other parents' comments included, "I have not been given information about how to make a complaint about KIDS", and, "I have not had to make a complaint, but I would phone or email the office. I also speak to the carers. I don't think I have been given information about how to make a complaint." Complaint information was not available in an accessible format for young people.

● The acting manager told us they had not had to deal with a complaint, they told us if they received one, "We would investigate, by a trained investigating officer who was not part of the service, be specific in writing telephone interviews. One person does fact finding and the outcome goes to regional manager level, we would follow investigation and disciplinary process." This meant they were aware of the policy and the procedure to follow in the event of a complaint.

We recommend that the provider reviews arrangements for informing people of the complaints policy ensuring it meets with accessible information standards.

End of life care and support

● The acting manager informed us no one was receiving end of life care at the time of our inspection, however, told us, that this is something that could occur in the future.

● The provider did not have a policy, based on national guidance, in place to provide support to staff about the actions to be considered when a person was approaching the end of their life.

● Staff had not received training in end of life care. The service was not supporting anyone with end of life care at the time of the inspection.

● The acting manager told us that they would access training for staff when it was required.

We recommend that the provider seeks reputable guidance to introduce an end of life policy and to give consideration to staff skills in this area.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had some systems in place to monitor and assess the safety and quality of the service. These included monitoring training and viewing incidents and accidents. However, they were not effective and did not pick up on the issues identified during our inspection. These included concerns with records: risk management, governance and oversight.
- The care staff that we spoke with did not know the acting manager, one told us, "I have no opinion because I have never met him" and the other care staff member told us, "I have only met him once at my induction." The acting manager told us that supervisions were not as regular as their policy dictated and that care coordinators would be monitoring their frequency going forward. They told us, "The head of quality does a mock CQC or Ofsted audit every two years." Quality checks were not in place for supervisions and this was confirmed by the acting manager. Plans were in place to ensure that supervisions were carried out more frequently. Everyone we spoke to told us that supervisions should be every six weeks however, the supervision policy states 'Formal supervision takes place at regular intervals (it is recommended once monthly).' The lack of oversight of supervision meant that staff had limited formal opportunities to feedback to the provider.
- A care coordinator told us, "We have now booked supervision and induction for care staff for the year, one problem is only one member of staff is substantive, all of the others are bank staff. We have asked them all to commit to two group supervisions a year." When asked if staff have the opportunity to attend individual supervision a care coordinator told us, "We try to do telephone supervision and a face to face one. Pinning staff down to commit to do that with us is difficult." Although documents demonstrated that supervision had been planned for the year we could not be assured that these would always take place.
- There was no monthly service audit. This meant that there was no way of monitoring ongoing themes or identifying improvements required.
- The acting manager and care coordinator told us that they will be starting to do medicines audits to improve this and will be implementing audits.
- There was a risk that providers were unable to monitor progress against plans to improve the quality and safety of services and would be unable to take appropriate action without delay where progress was not achieved as expected.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● It was a condition of the provider's registration to have a registered manager in post. Kids Smile Centre had a registered manager until they deregistered in May 2019 however this person had not been in post since October 2015. Another manager was in post and was registered between 18 October 2015 and 1 October 2018. At the time of our inspection there has been an acting manager in post for approximately six months, they told us they were waiting until their six-month probation period passed before applying to be the registered manager. However, following the inspection we were informed that the acting manager is no longer employed by the service. A registered manager from one of their other services will oversee the service while the recruitment process takes place.

● The provider did not have effective systems and processes in place to ensure they had a good oversight of the service. There were no quality assurance audits and no action plans to demonstrate how they planned to improve the service. We found the quality assurance processes that were in place to be ineffective and had not identified the issues we found during our inspection. These included concerns with records: risk management, medicine management and a lack of person-centred care. Care plan audits were not in place. The acting manager told us, "I haven't done any audits yet other than baseline stuff. No audits and oversight. I am based in the office so hear what is going on and do informal auditing."

● The provider had not ensured that there were effective systems in place to monitor and assess the quality of the service, to drive improvements and to ensure compliance with the Regulations. Risks to people had not always been fully assessed or planned for. Throughout this report, we have made several references to records relating to peoples care and support which were not always sufficiently detailed to support staff to meet people's individual needs.

● There was a failure to maintain detailed fit for purpose care records. These included missing or incomplete information in the care profile and care plans and risk assessments that were not sufficiently detailed. There was a risk, if accurate and contemporaneous records were not in place, that this could negatively impact on people's health, safety and well-being.

The failure to maintain detailed fit for purpose care records was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We spoke to the acting manager and management team about the areas for development we had noted such as monitoring care records, incidents and accidents, audit processes and risk management most of which the provider did not have adequate oversight of. The acting manager told us that they will start to do audits to improve this and to check that the care coordinators audits are taking place.

● Staff understood the whistle blowing policy and how to escalate concerns if they needed to, via their management team, the local authority, or CQC. Records demonstrated that whistleblowing concerns were appropriately investigated and responded to where relevant.

● Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider was working in accordance with this regulation within their practice.

● Records confirmed the registered manager reported concerns to the relevant local authority and they told us they would undertake investigations where these were required. Services that provide health and social care to people are required to inform CQC of important events that happen at their location in the form of a notification. Important events include accidents, incidents or allegations of abuse. We use this information to monitor the service and to check how events have been handled. There had been no incidents that were required to be reported to CQC. The acting manager was able to talk confidently about situations when a notification would be required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The acting manager told us some examples of how they had worked with other agencies to meet young people's needs. For example, they told us they worked with, social workers, schools and community nurses among others.

● Some parents told us they had been positively engaged by the provider. One parent told us, "The carer we have is fantastic and we know each other well and have a good relationship. I don't know people in the office well, but I have met with them. I have a meeting with someone next week. Communication with the office is good." Other parents were concerned about communication regarding changes, their comments included, "I don't have much to do with the agency. The management is changing but we are not 100% sure who they are. We don't know them well enough yet", "I think communication is difficult. If I try to contact them about hours or work - it has been in the past difficult to get in touch and get a reply back. Or they say they have tried to contact me, but I have no records of missed calls, so I do find it difficult" and, "The administrative side is difficult. My response is positive for the carers not for the administration side."

● Surveys to gain feedback about the service had been completed in 2018. Feedback from parents of children and young people was positive. The summary of the annual parent survey had an action plan included which listed who was responsible, the deadline, the status of the action which had been acted on, and any comments.

Continuous learning and improving care

● The provider failed to improve care and demonstrate continuous learning. We noted several areas for development such as record keeping, monitoring care plans, audit processes and risk management most of which the provider did not have any oversight of. There was no evidence that incidents prompted learning to improve care. Not all staff were aware how to report incidents. A care coordinator told us, "When inputting incidents on a regular basis we notice trends, care staff can raise a flag when writing their notes which goes straight through to the relevant coordinator." There were no actions identified due to the lack of audits which meant required improvements were difficult to monitor.

● Despite these comments a care coordinator told us that the service had improved since the acting manager had joined the team. They told us, "He is brilliant, one of the best managers we have ever had… He understands our frustrations and we as a coordinator team feel very supported by him." They told us he goes out to see young people and visits their families and is not distanced from staff on the ground. They said, "He has come in and made significant changes."

● The acting manager told us, "I am proud of turning the boat around, this was a failing service when I came in, they had four managers in three years. I feel I have given them the leadership and confidence and am seeing a turn around. We have lost some staff, but the culture is improving, they now talk about success instead of issues. I am transparent and open."

● The acting manager acknowledged the improvements that were required and felt confident that the service will continue to improve.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to provide proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to assess and mitigate risks to the health and safety of service users using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 12 (1) 12 (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to have effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a risk, if accurate and contemporaneous records were not in place, that this could negatively impact on people's health, safety and well-being. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 17 (1) 17 (2)(a) (b) (c)