Next Step Domiciliary Care Ltd

# Next Step Domiciliary Care Ltd

## Inspection report

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08 March 2016
14 March 2016
18 March 2016
22 March 2016

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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

This inspection took place on 8, 14, 18 and 22 March 2016. The provider was given 24 hours' notice of our first visit because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be in.

Next Step Domiciliary Care Limited is a domiciliary care agency registered to provide care for people in their own home. The provider serves Macclesfield, Stockport, Cheshire and the surrounding areas. The agency has a number of services to offer individuals from supported housing, home care services as well as personal assistant services, supported holidays and companionship.

Some of the people who use the service live in group houses where they hold independent tenancies with a private landlord. Their support is provided to them as a group but there are also personal assistants who provide more individualised care. Other people receive the service on an individual basis in their own home. In this report when we have to distinguish between the two groups we have referred to these people as receiving "care at home" whilst those people living in groups are referred to as receiving the "supported living" service. At the time of our inspection there were 13 people living in two group houses and 19 people receiving care at home.

Next Step Domiciliary Care Limited has had a registered manager since it first registered with the Care Quality Commission (CQC) in 2014. A registered manager is a person who has registered with the CQC 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.

Next Step Domiciliary Care Limited provides a service to people living at home which is tailored around their needs and preferences. The service provided is reliable, flexible, consistent and dependable. Staff provide care with dignity and respect and work hard to establish friendly relationships with people who use the service. Staff are prepared to assist with a wide range of tasks including providing personal assistance to people so that they can take part in community and other activities outside their own home.

During our inspection we found that the provider needed to maintain better records of how people were involved in setting up and agreeing their care plans and keep better records of the training that staff had received as well as how they had been recruited.

We have recommended that the provider reviews the availability of safeguarding. We have also recommended that the provider reviews arrangements for medicines including the format of record sheets. Further recommendations include the provision of training in medicines at an appropriate level for the tasks being undertaken as well as in the Mental Capacity Act 2005.

We found that the provider's recruitment procedures did not meet the requirements of the relevant

regulations. We also found that the provider had not notified us about certain events about when they are required by law to do so. You can see what action we 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 because the provider could not evidence that all the necessary checks to make sure that people were safe to work in the service had been completed. Staff needed a higher level of training to allow them to safely carry out some of the tasks they were undertaking in relation to medicines.

People who used the service told us that they felt they were safe from harm. Staff understood the need to be alert to any potential risks of abuse or other harm which could affect people who used the service.

### Is the service effective?

**Requires Improvement**

The service was not always effective. The service had not made arrangements for people who might need protection under the Mental Capacity Act 2005. Staff had received induction training but it was difficult to check what training they had had since they started work.

There were sufficient staff employed to provide care for the people who used the service. Staff received supervision from the provider.

### Is the service caring?

**Good**

The service was caring. People told us that the staff who provided their care were flexible, reliable and were prompt when they visited. People usually knew who would be calling to provide their care and any changes were notified to them and agreed with them.

Staff kept good records of their work which would help other staff to know what was required and so help continuity of care.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive. We could not establish how much people had been involved in making their care plans and risk assessments and reviewing them.

The provider took a person-centred approach to care which

meant that they tried to arrange care around the preferences and requirements of the person rather than the service.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led. The provider had not notified the Care Quality Commission of certain events which it is required to by law.

The manager was well-known throughout the service and was felt to be supportive by people who used the service and by staff. Both the manager and the nominated individual undertook regular audit activity to make sure that they knew about the quality of the service being provided.

# Next Step Domiciliary Care Ltd

**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 was 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 first day of this inspection took place on 8 March 2016. The provider was given 24 hours' notice of our first visit because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be in. On 14 March we visited people who used the service in their own homes. We told the provider we would be returning on 18 March 2016 to continue to review records relating to the management of the service. We also returned to the Next Step Domiciliary Care Limited offices to provide feedback on this inspection to the registered manager as well as our other contact, the nominated individual, on 22 March 2016.

The inspection was undertaken by an adult social care inspector. Before the inspection we wrote to the local authority which commissions services and is also responsible for safeguarding. We took account of their comments during our inspection. We also checked and reviewed the information held by the Care Quality Commission about the provider.

During the inspection we visited and spoke with two people receiving care at home and three people living in the supported living schemes. We looked at the care files kept in their homes with their permission. We spoke with six members of staff as well as the registered manager, the nominated individual and the coordinator based in the office.

We looked at a variety of records including six office versions of care files and nine staff files. We also looked at staff training records, rotas, log files and other audit documents.

Requires Improvement

# Is the service safe?

## Our findings

We asked people if they felt safe when they received a service from Next Step Domiciliary Care Limited. Nobody expressed any concerns and anxieties. One person told us "The staff are kind – if there was a problem I would tell (the registered manager) or (the nominated individual)". Another person told us "I feel safe. If I need any support at all they (the staff) will help me". A third person told us about how because of their particular communication requirements they had been allowed to keep in contact with staff using text messages particularly when they were anxious.

We asked staff if they were familiar with safeguarding and the ways in which adults could be protected from abuse. All of the staff were familiar with the term and two of them described in detail the types of abuse and the measures they would take. Some staff had experience of using these procedures to safeguard people and described these to us. These staff described undertaking safeguarding training as part of their induction but other staff we spoke with could not recall undertaking this training with the provider although one said that they had undertaken it in a previous job role when working somewhere else. We could not verify this however.

We checked the training records for safeguarding for all the staff we spoke with and confirmed that it was recorded that they had all completed it and that it was due for renewal later this year. We saw that one other member of staff's training in this area was overdue and brought this matter to the attention of the registered manager.

We saw that there was no advice about safeguarding procedures for people who used the service in the service user guide they were provided with although we did see guidance in pictorial form on the care plans of people in the supported living service. We saw that the topic had also been covered at recent tenants' meeting for people living in the supported living service.

We also asked staff about whistleblowing. Some understood that whistleblowing is the process whereby anyone can raise a matter of concern if they do not feel that the provider is taking appropriate steps in relation to it. One member of staff said "If I thought for one moment something was wrong I wouldn't think twice about reporting it". The Care Quality Commission is authorised by law to receive such information. However not all staff we spoke with were familiar with the term. We directed them towards the provider's staff handbook. Although this did not refer to safeguarding procedures there was extensive information about whistleblowing. We could not confirm that staff had received training in whistleblowing, however, and brought this to the attention of the registered manager as an area which required attention.

We looked at staff files to see if the provider took appropriate steps to make sure that staff were suitable to work in the service. We saw that the provider had obtained Disclosure and Barring Service checks so that the provider could check if a person had a criminal record and if so whether this made them unsuitable for this type of work. On most of the files that we looked at we found that such a check had been received but on one file there was only evidence of preliminary clearance from the Independent Safeguarding Authority.

We saw instances where staff had declared previous convictions. Although these would not necessarily rule people out of employment in health and social care there was no record that the conviction had been assessed or discussed with the potential employee so that the provider could determine if any special arrangements should be put in place.

The files included records of interviews and health questionnaires. The provider has also obtained separate proofs of identity as well as photographic identity documents so that this could be verified. These checks are all required by the relevant regulations which apply to people working in health and social care.

Not all the other information on the files was complete however. On two files there was either no application form or the form was not completed. Application forms for employment are important because they provide a means of obtaining key information for a prospective employee. In another instance whilst there was an application form the provider had not recorded any reasons given for gaps in a person's employment record. Providers are required to check employment records to see if a person has been employed in health or social care before if so what information this might provide about their suitability for this work. In one instance an applicant had worked for a substantial period of time in a similar role with another employer but there was no record that a reference had been taken from that employer (who was still in existence at the time of our inspection) or the reason why it had not.

References had not always been checked for their authenticity and appropriateness. For example we saw that references had been provided by relatives, friends or work colleagues and sometimes had been received from someone different to that nominated by the applicant on their application form. In another instance the references were undated and were copies rather than originals.

References are a key means by which a provider can check an employee's work history and it is important that their suitability and authenticity is checked and that this is recorded. Where necessary providers should seek alternative references from applicants in order to ensure that they can be satisfied about an applicant's suitability before they work with people who use the service.

These matters relating to recruitment checks were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We raised them with the registered manager who provided explanations about why some had each occurred. The registered manager undertook to ensure that records of staff recruitment were maintained in accordance with the relevant regulations.

People told us that they were satisfied with the way that the provider helped them to take their medicines. The provider told us that all the people who used the service needed assistance in one form or another when taking these. We saw on the care plans that distinctions were drawn between people who needed prompting to take these and people who needed assistance. However we were told that none of the people using the service required their medicines to be administered. Different arrangements including staff training need to be in place depending on the level of help people require with medicines. The provider had trained all the staff to a level where they would be proficient in assisting people with their medicines.

We asked staff to explain what the difference was between prompting and assisting and were satisfied that they understood the distinction. However we found records which showed that in two instances staff were engaged in practices which might be described as medicines administration. We raised this with the provider who told us that in one instance this had been a short-term measure to assist a service user with a short course of eye drops. The registered manager agreed with our concerns and told us that she would arrange for certain staff to be trained to the appropriate level to support providing this assistance to people who used the service.

People in the supported living scheme told us that when required a repeat prescription was sent by their doctor to the pharmacy from which their medicines were supplied mainly in blister packs. Blister packs are a form of monitored dosage system (MDS) where the chemist prepacks the medicines in to the required dosage for each day. In this way MDS can reduce the potential for people to receive either the wrong medicines or the wrong dose or at the wrong time. The registered manager told us that she checked the medicines on receipt from the chemist to make sure that they corresponded with what had been ordered.

People told us told that they had a personal safe in their room in which they could store valuables and that each person's medicines were stored in this safe. We saw that there was a medicines' administration record (MAR) sheet for each person and that this was completed with details of the medicine as provided to them. In one of the supported living houses we visited most of the MAR sheets were pre-printed by the chemist. This ensured that the dosage information was correctly transcribed.

However in another house we saw that the provider had introduced their own MAR sheet. The provider explained that this was necessary where the person's chemist did not operate an MDS system and therefore did not provide a pre-printed MAR sheet. We were concerned that this sheet did not provide space for reconciliation of the levels of medicines stored against those recorded as administered and also offered only choices between "observing" and "administering" medicines with no "assist" option. We brought this to the attention of the registered manager who agreed to review the format of these records.

Staff were involved in handling cash with some of the people who used the service, For example, if they accompanied people to leisure and sports activities people might have to pay fees or meet the costs of taxis. We were told that all the people who received the supported living service had their own appointees. An appointee is someone, often a relative, who manages the financial affairs of someone else on their behalf often because of a person's disability. The registered manager told us that people's benefits and other income were paid to the appointee and a sum was then transferred to an account held by each house for relevant expenses with a further sum held by each person in their safe. We saw that very detailed receipts were kept of all expenditure made so that the provider could account for this money to the appointee.

Staff working for providers like Next Step Domiciliary Care Limited often work alone. We saw that the provider had issued them with personal alarms so that they could summon assistance in an emergency.

We recommend that the provider reviews the availability of safeguarding information to people who use the service.

We recommend that the provider reviews arrangements for medicines including the format of MAR sheets and the provision of training at an appropriate level for the tasks being undertaken.

Requires Improvement

# Is the service effective?

## Our findings

The arrangements for staffing differed between the people receiving supported living service and those receiving care at home. In the supported accommodation one member of staff was on duty in the day from 9.00 am until 5.00 pm. Another member of staff would then continue with waking duty from 5.00 pm and would then "sleep in" (and so be available within the home) from 11.00 pm until the next morning.

In both these houses we saw this was sufficient staffing because of the relative independence of the people living there. We saw that other staff (employed by the provider but known as "personal assistants") called at the home to undertake specific tasks with the people who lived there such as taking them out to attend activities in the community with them. Where people received care at home they received scheduled visits from one carer. None of the people receiving the service required the assistance of two staff for personal care.

Unforeseen staff absence such as through sickness or scheduled absence through leave was managed within the staff group without recourse to external agency staff. Staff we spoke with told us that that they did not find this onerous when it occurred and we saw from staff rotas that it was managed so as not to impact negatively on staff and therefore on the service they provided to people. Because of the small size of the agency people were likely to be familiar with any replacement worker providing them with personal care.

All new staff were required to complete induction training in the first twelve weeks of their employment. The provider told us that this was made up of a combination of DVD training, a day spent with the registered manager looking at policies and procedures, with the new member of staff then shadowing a more experienced member of staff for a minimum of two weeks or until they felt comfortable working alone.

All the staff we spoke with confirmed that they had undergone this process. One told us that the first week of shadowing was spent in observation of another member of staff, the second week was spent completing tasks under the supervision of staff and that they were only expected to work alone once they felt confident to do so. We saw a copy of an archived log which showed that new staff shadowed other staff in this way.

We saw that in each staff file there were certificates showing that mandatory training had been completed and the date it was next due to be undertaken. We saw that staff had completed training in such topics as fire safety, moving and handling, health and safety and effective hand hygiene with medicines training to a level commensurate with staff assisting people with their medication. Most of the training was current and most was not due for renewal for over twelve months. We brought two instances where records showed staff required refresher training more urgently to the attention of the registered manager.

We saw that the provider had introduced arrangements for new staff to study the Care Certificate as part of their induction. This was suggested by the recent Cavendish Review which made recommendations about the training and support of care workers. The provider was trialling a new computer-based system which would provide a centralised system for recording training. This would mean that the registered manager would have a clearer overall picture of the workforce's training and an easier means of ensuring that it was

kept up to date.

We saw records that showed that staff had attended for induction sessions in advance of their start date with the provider. However these documents included a checklist of 56 different policies across a very wide range of topics. In two instances both the registered manager and the employee had signed that they had received and understood these policies although this was in the form of a blanket signature so we could not be sure in what detail each had been covered. In one instance this checklist was unsigned and in another the list appeared to have been signed only selectively meaning that this part of the induction was incomplete.

We saw that there was a note stating that some of the policies would be provided in the staff handbook which staff could keep. However when we looked at the staff handbook we saw that this focused on employment policies and did not include, for example, the awareness of abuse, medicines, Mental Capacity Act and food and nutrition policies which were as relevant to staff providing care to people who used the service.

We looked at the other records of staff training held by the provider. There was no single central register and so we looked through a number of staff files on which training certificates had been placed. These generally confirmed only the components of training which had been provided as part of each member of staff's induction. We saw references to training within supervision records which stated that this had been undertaken in additional areas such as the Mental Capacity Act 2005 but staff could not always confirm that they had completed this. We saw that the provider had identified that training was required by staff in fire safety, safeguarding, health and hygiene safety, moving and handling, medicines and first aid within two months of the date of our inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We were told that only one of the people who used the service required the protection of the Act and that they lived at home and their relative acted on their behalf. The staff we spoke with had a good grasp of the issues covered by the MCA and some identified that lack of capacity might be becoming a matter for consideration for other people who used the service such as because of dementia. We saw no evidence on care files that this matter was considered other than to confirm whether or not people were able to sign time sheets to confirm staff attendance. Because of this, the lack of records and varying accounts from staff we could not be satisfied that the provider was complying with the requirements of the MCA. We brought this matter to the attention of the registered manager who agreed to review the provider's arrangements.

We were told that staff supervision was scheduled to take place every three months. However records of supervision on staff files suggested that this took place six-monthly. The registered manager readily explained that she had had a sudden unforeseen absence from the service in the last few months and that this had interrupted the frequency of this. We saw supervision records which were detailed and included reviews of past performance, training and future targets. Staff were asked to confirm that they had not received any criminal convictions since the last supervision meeting. We saw that the registered manager used the opportunity provided by supervision to offer compliments to her staff.

People who lived in the supported living service told us that the staff helped them to prepare their own meals. We saw staff helping people to use the internet to look for items on a supermarket website making sure that they were aware of any special dietary requirements. Staff took time to talk through options with people such as pointing out if an item might be used for other dishes as well, or if there were special offers which the person might want to take advantage of. One person told us that once the order was complete they would send it off and it would be delivered to the home. Although there was no requirement to do so we were told that people in one house all tended to eat together at the same time. This seemed to reflect the time that they had been living together and their familiarity with each other.

People who were receiving care at home told us that they were happy with the way that the staff prepared their food. This was usually convenience food which could be prepared in a microwave. We noted that the logs completed by staff after each call often confirmed not only that people had eaten a meal but that the staff had washed any dishes, pots and pans and cleared away before they left. People we spoke with confirmed that this was the case.

We recommend that the provider reviews its arrangements for training and induction in order to make sure that it is effective and can easily be kept up to date.

We recommend that the provider makes arrangements to provide staff with support around the implementation of the Mental Capacity Act 2005 particularly given the future needs of the people who use the service.

Good

# Is the service caring?

## Our findings

People told us "I love the staff – they are brilliant. They look after you. My confidence used to be right down there (points to the ground) – now the staff support me and my confidence is right up here (points upwards)". This person told us about how their lack of confidence had affected their life and how this had been improved since they received a service from the provider. Another person told us "The girls are very good".

Some people had had different experiences of other providers. The compared their experience with this provider very favourably. One person told us "The staff (at Next Step) hold no grudges – they are very understanding. There is not one member of staff who I would ask to be replaced". Another person in the supported living service told us they had lived with support in other settings but said "I love being here. I want to stay here for longer".

Throughout our inspection we saw that staff treated people with consideration, concern and kindness. It was evident from the demeanour of both the people who used the service and the staff that there was mutual respect for one another. We heard staff giving explanations to people so as to help them to make choices. We saw that one group in a supported living house had enjoyed foreign holidays together and were discussing plans for the next one including which members of staff would accompany them. We saw photographs of previous holidays that showed that these had been happy occasions for everyone concerned. Although the supported living house was a group home, staff took care not to stay on the premises without consent when the people who lived there were not present. This was on the grounds that it was those people's private home.

People we spoke with praised staff for their flexibility and one told us "They (the staff) are very, very good". One person told us that generally they needed a number of visits spread out through the day. Sometimes, however, there were specific requirements such as laundry when they could ask the provider who would combine the separate slots together to provide a longer visit so that they could get the task completed.

When we asked people they said staff provided care for them in way that preserved their dignity and treated them with respect. One said "The staff are a lovely group of people – they are always respectful and treat me with dignity". They told us that some of the care they needed from staff was quite intimate and very personal but that the provider's staff had never responded negatively to these requests and had always completed these tasks with respect for that person's dignity. Staff confirmed this and told us that one of the ways they showed respect and dignity was by listening to people and providing them with personal care in a way that they chose.

People told us that the service was reliable. One person told us "The girls are very good at coming here". We saw that each person we visited at home had a copy of a rota which told them which member of staff had been allocated to each visit and the times of the visits. The rota had been produced in a large typeface. This meant that it could be read easily and we were told that it would be delivered to people's homes periodically in advance by a member of care staff.

People said that staff were prompt in visiting them at or as close as possible to the time allocated on the rota. We cross-checked one copy of the rota with the logs of visits kept in a person's care file and saw that the variance of actual to planned calls was rarely more than ten minutes. We saw that where a worker had called but the person had decided to go out and had not cancelled the call, there was note left by staff stating what had happened. People told us that if a call was going to be late the provider would make contact with them to explain this.

People told us that they thought that staff tried hard to fulfil the rota. The area served by the provider is quite rural and hilly and one person told us about a time when adverse weather conditions had rendered travel by road impossible. They told us that their care worker had donned a pair of wellingtons and walked through the snow in order to fulfil their appointment with them. We were also told of an incident where much more intensive cover than usual was required by a person at very short notice. Although this had been during a holiday period when staffing could be under the most pressure, the provider had succeeded in providing this care meaning the person did not have to rely on another agency with whom they would be unfamiliar.

We saw also that the same set of relatively few staff names featured on the rotas. This meant that people tended to receive care from a small group of staff who could cover for one another during time off, holidays, sickness, etc. People told us they appreciated this and that they "couldn't be doing" with unforeseen changes of staff or staff visiting them who might be unfamiliar with their requirements. In some instances we saw that staff had been designated to work directly with one person to include activities such as pursuing sports, studies etc. Where this was the case we saw that staff had been matched so that their specific skills and aptitudes matched the person. In these ways people enjoyed a high degree of continuity from the staff who visited them to provide personal care.

People told us that in some instances the arrangements for which staff visited them were long-standing so they knew the workers well. Sometimes though it was necessary to introduce a new member of staff. Two people explained to us that when this had happened the registered manager had contacted them and introduced the new staff. These staff would then attend initially either with the registered manager or with another member of staff who was already familiar with the person. One person told us "(New staff) don't just come – and you don't have to have them visiting if you don't want them".

We looked at a selection of staff rotas to see what the workload for each member of staff was because where staff have to make too many visits with insufficient time between them, the visits can become rushed with staff running progressively late as the day unfolds. We saw that most staff providing care at home were scheduled to undertake around six visits each day. The maximum for one member of staff was twelve visits. The provider told us that they allowed fifteen minutes for staff to get from one visit to another. Staff told us that they felt the workload was manageable and that where we had identified that the rota seemed to allow less than this time between visits, that this was because the people being visited lived in closer proximity to each other, for example, in the same sheltered housing block. This confirmed the experience of people who used the service who had complimented the staff on their promptness as well as what we had seen in the call logs.

We saw that staff completed a number of records. In the supported living schemes there was a contact book. This included general comments about anything that had happened during the shift. These notes were generally positive tending to celebrate people's achievements. Staff told us that they used these records to maintain continuity and pass information between shifts. We saw that the registered manager had reminded staff "Do not write 'nothing to report' as there is always something to report'".

There was also a call log which was completed as an individual record for all the people who used the service by the member of staff who had last provided personal care. This confirmed the tasks which had been completed as well as the mood and feelings of the person who used the service. As these records were kept on people's care files which in turn were retained by them, they were aware of the records which were being made about them.

Requires Improvement

# Is the service responsive?

## Our findings

We looked at the arrangements the provider made for care planning the service that each person received. In the office each person had a file which we were told was a replica of the one kept in the person's home except for daily record sheets. We looked at examples of both files kept in the office and in the person's own home.

In a number of instances detailed information had been provided by the local authority prior to the person starting the service. We saw that the provider also used its own assessment, care plan, risk assessment and reviewing documents. These were person-centred in that they were written from and reflected the point of view of the person who used the service rather than the needs of the service.

We saw that the provider's own form of assessment was comprehensive and included a document "All about me" which provided a one page at a glance profile of the person as well as information about matters such as communication, mobility, eating and drinking and cultural interests. The assessment also included general risk assessments such as relating to the environment, household hazards and whether the person smoked.

Care plans were similarly detailed but not always dated and signed or otherwise acknowledged by the person who used the service. It was not clear from some of the records in the office when the care plans had last been reviewed. Two of the records stated that there had been reviews within the last couple of months but no amendments had been made. Since in both instances this was the first sign of a review since the care plans had been established in 2011, then in the absence of confirmation that the person had agreed to this conclusion, we found it difficult to accept that there had been no change to the needs of the two younger adult persons concerned in this period.

We looked at the care plans in people's homes with their agreement. All the people who used the service knew that they had a care plan. The provider told us that they regarded the care plan as belonging to the person rather than the service and that this might account for any irregularities in them.

Some of the support plans had been produced in a pictorial format. We asked the person whose care plan was in this format if this helped them to understand the plans and they told us it did. In another example there was no care plan from the agency although local authority documentation showed that the person had consented to the original plan for them to use the service. In a third instance there was an agency care plan which had been completed when the person had been admitted but it was neither dated nor signed by the person.

People who used the service were aware of their care plans and one person told us "I go through my (care) folder quite a lot – I know all about my care file". We saw that another person had made their own entries into the care plan. Staff told us that people kept the care files in their own rooms. However people could not always confirm that they had been involved in creating them or in their review and the care plans themselves did not always provide this information.

Although we had been told that most of the people using the service had mental capacity and therefore could take decisions about their care, we found that there was not always evidence that they had actively been involved in or consented to their care package and the plans contained in these documents. Only two of the care plans and risk assessments we saw in the office were signed by the people to whom they related.

It was clear when we met with people that they were content with the service being provided and therefore it could be taken that their consent was implied. However because there was no reference to them being present or otherwise consulted in the compilation of some of these documents it was not possible to identify what level of involvement they had in them.

We saw that there were risk assessments headed "self-risk assessment". These were detailed and related to each person on an individual level identifying specific risks they might encounter. The plans detailed the risk, the level of risk, the implications of the risk if unmanaged for the person, staff and the wider public and the action to be taken to minimise the risk.

However of the four risk assessments we saw in the office, only one was dated and signed by the person to whom it related. When we visited people in their homes we found that one risk assessment had been signed by the person to whom it related, one had not and in another there was no risk assessment at all. In the last two instances we became aware during our visits that there were risks which had not been recorded and therefore there was no way of assessing them or identifying how staff should respond to them.

Because the management of risks can sometimes involve staff in taking action contrary to the person's immediate wishes it is important that the agreement of the person is recorded with a date so that the plan can also be reviewed. As there were no dates on some of the risk assessments we could not be assured that they had been reviewed and were up to date.

We saw that staff supported many of the people who used the service to undertake a wide range of activities. One person alone listed ladies football, visits to the local leisure centre/gym, attending a slimming club, going 10-pin bowling, going to the cinema as well as visiting a local farm. They told us "We are really busy". We saw from the daily records that other people enjoyed a similar varied leisure time. We also met one person who had recently secured a new job. One person who received care at home told us about how the provider's staff would help them to visit former acquaintances or accompany them in the car if they needed to go out because they no longer felt confident doing so alone

We saw that on the care files there were notes of visits to and from as well as the involvement of other health and social care professionals. During our inspection we saw that a member of staff was visiting from the local NHS Trust and we received responses from local authority staff that confirmed that they were involved with people who used the service. The provider told us that it had become more difficult to secure advocacy services recently and that there was now a waiting list but during our inspection we saw that the registered manager was in contact with the local centre for independent living in this regard.

We saw that the service user guide included information about how people could make complaints. In the first instance this advised that these should be directed towards the provider but also suggested that people could contact their social worker if they wished. However although there was a space left for the address of the local social services team this had not been completed. We saw that the provider maintained a log of complaints but that there had only been one made in the last twelve months. The provider had responded speedily to this and made changes to the service provided in order to address to it.

We recommend that the provider considers the inclusion of information about how people who use the service have been involved in their care plans, reviews and risk assessments.

We recommend that the provider ensures that complete information about how to make complaints is made available to people who use the service.

Requires Improvement

# Is the service well-led?

## Our findings

People talked about the registered manager in positive terms and it was clear to us that she was highly visible and well-known to both her staff and the people who used the service. One person told us "I can always get hold of (the registered manager)". Another person told us that they had a contact number for the registered manager and were confident they could contact her at any time. When the registered manager had been away from work they had been provided with contact details for the nominated individual for the provider. People told us that the registered manager would sometimes help them in person to attend appointments when it was not appropriate for other members of staff to do so.

Staff were similarly complimentary about the management arrangements. One told us "(The registered manager) does a pretty good job – she's approachable. She's good with (the people who use the service) – they think she's approachable too". During our inspection we saw that the registered manager was readily available in the office where staff and people who used the service called. People who used the service told us that the registered manager visited them and we saw from their records that she had checked these from time to time.The current registered manager registered with the Care Quality Commission (CQC) in 2014 when the current company was established.

We saw that the provider had a comprehensive set of policies and procedures. These were of a standardised format but had been customised with local information and contact details which were relevant to the provider. The policies were comprehensive and included topics such as infection control, relationships with service users, risk assessment, person-centred care and health and safety topics such as lone working and moving and handling. There was a record that the policies had been reviewed in March 2015 and were due for review a year later at the time of our inspection.

On each person's care plan we saw that there was a quality assurance assessment which had been conducted annually. People were invited to respond to questions such as whether workers arrived promptly and stayed the full time allocated. It also asked about staff attitudes and behaviour towards people who used the service, whether any complaints were dealt with promptly and whether people wanted any changes in their care provision. Other questions included about whether people knew who to speak to in the provider's office if they needed to and if they knew how to make a complaint. All the assessments we saw had been carried out in the last year and were overwhelmingly positive in their responses although one person reported that they did not know how to make a complaint. We have made a recommendation about complaints in the "responsive" section of this report.

The provider told us that there was no separate form of appraisal with staff. This was partly because they had found it unnecessary to separate out supervision from appraisal. The registered manager pointed out that as a small service with a correspondingly small staff group, informal contacts between care staff and the registered manager were frequent enough to provide the required support to staff in between formal supervision sessions.

Next Step Domiciliary Care Limited operates from offices in a single room attached to one of the houses

which is supported by the service. The registered manager explained that this and the size of the service precluded holding staff meetings very easily. However the registered manager demonstrated the use of a closed group on Facebook through which she could not only brief staff as required but could receive confirmation that they had seen this briefing. During our inspection we saw one example of where instructions regarding medicines were sent to staff in this way.

The use of this and other proposed systems meant that staff were using their own personal mobile phones to receive this information. We were concerned that this might mean confidential information being retained on a personal phone and the control the provider had over this for example when a staff member left the employment of the agency. We raised this with the registered manager who was alert to the issue and assured us that each phone was registered uniquely on the system and could therefore be deregistered, denying further access. Staff access to the information could therefore be controlled and no personal data would remain on the phone itself. All the staff we spoke with about this system were comfortable with their phone being used in this way and found these systems helpful.

The registered manager provided us with records of various audits she undertook. These included audits of care files which showed that the office files had been reviewed within the last three months but that the versions of these kept in people's homes was now overdue for an annual review. These audits however had not identified some of the deficiencies we have commented elsewhere in the report such as the absence of evidence of involvement of people who used the service and use of the Mental Capacity Act 2005. We brought this to the attention of the registered manager who told us this would be reviewed immediately.

We reviewed the provider's safeguarding records. Providers should arrange for any allegation of abuse or alleged or possible abuse to be investigated even if these prove to be unfounded so that any lessons can be learned. We saw that there had been four incidents which had been investigated over the twelve months before our inspection. We saw that these had all been referred to the local authority with responsibility for safeguarding. Where appropriate, action had been taken to reduce any risk. We spoke with the local authority who told us that they were satisfied with the way that the registered manager had investigated one of these allegations.

Registered providers such as Next Step Domiciliary Care Limited are required to notify the Care Quality Commission (CQC) about certain events which may affect people who use their service. This helps the CQC to discharge its statutory responsibilities to protect and promote the health, safety and welfare of people who use health and social care services. When we checked our records we saw that none of these incidents had been reported to the CQC. We brought this to the attention of the registered manager who told us this would be corrected immediately. This was a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

During our inspection we were told that the provider was actively considering transferring the manual recording systems to electronic systems which between them would manage scheduling of rotas, staff training and other management systems. The registered manager told us that she hoped to resolve some of the concerns we expressed during our inspection by the use of such systems.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered person did not notify the Commission without delay of incidents specified in the relevant regulation. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The registered person did not ensure that the information specified in Schedule 3 of the Regulations was available in respect of each person employed. |