Home Care For You Limited

Homecare For You Oldham

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

Summary of findings

Overall summary

We undertook an announced inspection of Homecare for You Oldham on the 28 and 29 January 2016 and we returned on the 1 February 2016. The inspection was announced 48 hours prior to our visit to ensure that the registered manager or other responsible person would be available to assist with the inspection process.

Homecare for You Oldham provides personal care and support to adults living in their own homes such as social inclusion, shopping and laundry services. At the time of inspection there were 55 people using the service. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the report.

People told us that they did not always feel safe when staff supported them. They told us that this depended upon which staff member was supporting them.

People did not receive their medicines safely. Records did not contain important information about the medicines that people were taking and care plans did not show what support people needed with their medicines. This meant that there was a risk that people might not receive the medicines they needed as prescribed by their doctor and there had been occasions when this had happened.

Initial assessments of people's needs carried out by the local authority detailed information about their care requirements, however this information had not always been transferred when care records had been developed using Homecare for You care plans. This meant there was a risk people might not receive effective care. People's concerns were not being recognised as complaints and were not investigated appropriately.
Risk assessments were in place which set out how to support people in a safe manner in areas such as moving and handling, nutrition and health and safety however we saw no risk assessments identifying hazards in the environment such as working in people's home or when out in the community.

The service had safeguarding and whistleblowing procedures in place. Staff were aware of their responsibilities in these areas.

Staff told us that they sought people's consent prior to providing their care. Where people were assessed not to have the capacity to consent to their care and treatment there was a record of how the care provided had been agreed as required by the Mental Capacity Act 2005.

Care workers were supported through training to help them meet the care needs of people they supported appropriately. They undertook an induction programme when they started work at the service.

People told us that some staff were caring but new staff needed to be more caring and compassionate in their work. Staff we spoke with had a good understanding of how to promote people's dignity however one person told us she needed to remind care staff to ensure dignity was maintained during personal care support.

When people started to use the service a care plan was developed that included details about their care needs and how to meet those needs. Information about peoples likes dislikes and preferences, were included so staff had all of the relevant information to assist them when supporting the person. However the care plans we reviewed were basic and lacked detail of information about the person's needs.

People felt that they were sometimes rushed by care staff. They told us that the care staff did not always communicate with them and spent time talking to each other using their own language which was not always English.

People told us that they completed a questionnaire to provide feedback on the service. However feedback from this questionnaire was not delivered to care staff or people using the service, or used for the development of the service.

Systems were in place for monitoring the quality of care and support provided. These had not been updated regularly and did not reflect all of the checks that had taken place.

The service had a management structure in place. Some staff told us that they found the management approachable and felt that they were listened to however some care staff and office staff found the manager unapproachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us that whether they felt safe depended on which staff supported them.

The service had robust recruitment procedures in place and checks were carried out on staff before they commenced working at the service.

Appropriate records of medication were not kept and maintained and medication record charts were not audited by the registered manager.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought people's consent prior to providing their care. Where people lacked capacity to consent to their care there was a record of how the care provided had been agreed as required by the Mental Capacity Act 2005.

Not all information from local authority assessment of needs had been used to develop record of care needs.

Staff received training that was appropriate for the needs of the people they were working with.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that some staff members were kind and friendly, but some staff made them feel uncomfortable.

Staff we spoke to had a good understanding of the needs of the people they supported regularly.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us that they were provided with care and support that they needed.

A complaints procedure was in place. Concerns were not consistently recorded as complaints and investigated.

Care records were reviewed annually or as required.

Is the service well-led?

Requires Improvement

The service was not always well led.

People told us that the manager did not follow up complaints.

Systems were in place for monitoring the quality of care and support provided but feedback on the outcomes was not cascaded back to care staff and people who use the service.

Some staff felt they were unable to approach the registered manager and felt under pressure.

Homecare For You Oldham

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 January and we returned on 1 February 2016. We contacted the Registered Manager 48 hours before our visit to advise them of our plans to carry out a comprehensive inspection of the service. This was to ensure that the Register Manager and any relevant staff would be available to answer our questions during the inspection process.

The inspection was carried out by two adult social care inspectors.

Before our inspection, we reviewed the Provider Information Return (PIR). The PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service and information we had received about the service from people who contacted us. We contacted the Quality Monitoring Team from Oldham Council to obtain their views about the care provided. The Quality Monitoring Team work with providers to ensure that they are meeting their contractual obligations with the Council. They told us they had no concerns with the provider.

We reviewed a range of records about people's care and how the service was managed. This included five people's plans of care and associated documents including risk assessments. We looked at ten staff personnel files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service and policies and procedures that the provider had in place. We spoke with the registered manager and eleven care workers, a coordinator and the training manager.

We visited five people who used the service in their home environment. We also telephoned and spoke with two people who used the service and two relatives of people who used the service. This was to gain their views about the service they received.

Requires Improvement

Is the service safe?

Our findings

Some of the people we spoke with told us that they felt safe when receiving support from the care staff. One person told us, "I feel safe at home and when I go out with [care staff]." Other comments included, "I have always felt safe with [care staff]" and, "Carers have never been unkind to me." People told us that their care was not always consistent and varied depending on which carer arrived. This caused concern for people. A relative told us, "It all depends on who is coming, [person's name], doesn't feel as safe with some of the new staff as with others."

The registered manager told us that they provided a service to 55 people and employed 32 support workers, who were responsible for the delivery of personal care to these people, in their own homes or accessing the local community. The records we reviewed confirmed this. People and relatives felt that there were enough support workers and they had the skills and knowledge to meet people's individual needs. One relative we spoke with told us the provider was consistent in providing the same care staff and they knew when they were coming to their family member's home; this helped to provide continuity for people and consistency in the care provided.

Care staff administered people's medicines for them. This included removing medicines from a blister pack, placing them in a container and the giving them to people. Some people also required prompting. In these circumstances national guidelines determine that a full record must be kept of all medicines that are administered. The provider was not keeping such records as required and the records that were kept were incomplete and at times inaccurate as prescribed creams had not been documented on Medication Administration Record (MAR) Charts.

The registered manager advised that they had implemented MAR charts, to record the information in more detail and to provide a record of what medicines people had taken. However some of the MAR charts we looked at had gaps in recording. We found no action had been taken by the registered manager when gaps in recording on the MAR charts had been identified.

Risk assessments had been completed in relation to medicines. These considered areas including whether or not a person required supervision, assistance or prompting with medicines as defined in the provider's policy. However the risk assessments did not identify whether the person could open lids, blister packs, swallow tablets and understand instructions on medicine labels. Nor did they detail what action was needed in relation to this or what protocols to follow if there was a medication error, missed medication, or no medication available.

Staff completed training in medicine administration through in house training and had signed up to this course during induction and then as a refresher course annually. There were no competency checks in place to make sure that staff were assessed as competent to administer medicines following the initial competency check during the induction. This posed a risk to people if staff competencies are not maintained. The registered manager told us that they were going to introduce regular six monthly competency checks for checking staff were still competent in administrating medication.

We reviewed three MAR charts in people's homes and found two people required creams to be applied. There was no information about where and what cream to apply in the medication care records, even though care staff had documented this in the daily records, when they had applied the creams.

As the provider was not keeping the required records and staff were not sufficiently supervised in this area there was a risk that people might not receive the medicines they needed as prescribed by their doctor and evidence was available to confirm that this had happened on two occasions in the four weeks prior to our inspection visit.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

Care workers we spoke with had a good understanding of the different types of abuse and about what actions they would take if they had concerns. All the care workers we spoke with told us that they would report suspected abuse immediately to the manager. The provider had a safeguarding policy and the actions the staff described were consistent with the policy. Care workers told us that they had received training about safeguarding adults. The training records showed that 100% of care staff had received this training and this was in date. All the care workers we spoke with told us that they understood what whistleblowing was. There was a procedure in place, which made it clear that people had the right to whistle blow to outside agencies. The registered manager had an understanding of their responsibility for reporting allegations of abuse to the local authority and the Care Quality Commission (CQC).

Staff told us that risk assessments were carried out when people first started to use the service. We saw that risks relating to people's care were assessed and actions had been put in place to help minimise and manage any known risks. These included assessments about moving and handling, nutritional risk, finances and health and safety. However we saw no risk assessments associated with people's homes or for the environment care workers worked in. Risk assessments were reviewed annually unless a change had occurred in the person's circumstances. The risk assessments we looked at had not been reviewed in the last year, this meant that people may be receiving care that is not appropriate to meet their current needs or the methods to minimise risk are not effective and therefore the risk remains. The registered manager told us that they were in the process of reviewing all files.

There were arrangements in place to protect people from the risk of financial abuse. Care staff obtained receipts if they needed to support people with shopping or other financial transactions when supporting them to access the community. However these transactions and receipts were not audited by any senior support worker or manager to check for any discrepancies and to minimise the risk of financial abuse.

The registered manager had reported concerns appropriately to the local authority adult social care team and the concerns had been investigated either internally or by the local authority.

The registered manager told us that all accident and incident forms were checked and signed by a coordinator or the registered manager. They told us that they were developing a graph to monitor incidents and accidents and to help them identify if there were any patterns. We saw that the registered manager reviewed what had happened and recorded actions that had been taken to reduce the possibility of the incident happening again. We saw that the registered manager had taken action, for example a reminder had been sent to staff about the importance of checking medication blister packs following a medication error. This showed that the registered manager was identifying concerns and taking action to address these.

There was a recruitment and selection policy in place that was followed when the service recruited staff. We looked at the staff personnel files of ten care staff and found that all appropriate pre-employment checks had been carried out before they started work. All the files included copies of identification documents, evidence of eligibility to work in the UK, two written work references or character references, application forms and Disclosure and Barring Service check (DBS). A DBS check identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We saw evidence that support workers were not assigned any work until the appropriate clearance from the DBS had been received. Support worker files also included recruitment details, supervision records and training certificates.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us the staff who supported them knew what their care and support needs were and what they wanted to achieve from the support they received. People told us that staff would always respect the choices they made and would support them to undertake activities which they were interested in. One person told us, "The staff that come now are really kind and know how to respect me." A relative commented, "The care staff always asks mum what she wants them to do before they start."
People told us that they thought some staff had received sufficient training to meet their needs. One person told us, "I think they are well-trained. I would recommend [care staff] there is nothing I would like changing." Another person said, "I think that they could improve but they know how to use the equipment." Another person told us, "I have three very good carers, but the other three that come are always rushing." A relative told us, "I do feel that the new staff could do with a little more training, I asked one of the care staff to change the leg bag, and she didn't know how too so I had to guide her and show her how to change the bag."
All new care staff and office staff were expected to undertake mandatory induction training before commencing any work on their own. This included five days classroom based training which covered a range of topics including the Mental Capacity Act 2005 (MCA), safeguarding vulnerable adults, safe administration of medicines, health and safety and first aid. Following this new care staff shadow experienced members of care staff. All care staff were given a copy of the staff handbook. This included key policies and procedures and the fundamental values of the organisation. Care staff signed to say they had received this handbook. This meant that staff had a copy of key policies and procedures available to them at all times.

All care staff we spoke to told us that they had completed their induction and that they'd received enough training to enable them to carry out their roles. Comments included, "I think the induction was very useful and has taught me a lot of new things, even some of the basic care aspects were explained in detail. The trainer was very clear with his training and taught us until I understood." Another new care staff member on induction told us "What I have learnt will be very useful in the future. I've enjoyed every day as we did practical work and theory." One care worker told us new staff were always closely monitored and observed before they were allowed to work independently with people who used the service. One new member of care staff on day four of their induction told us "The training is good quality and there is some 'hands on' training. I feel I have had enough training", and another new member of care staff said, "The training is thorough, a little long if you have worked in this work before."

We looked at the records relating to training. We saw that staff had received training in a number of areas to assist them in their roles and to meet the needs of the people they supported. This included training in specialist areas such as end of life care and supporting people who were living with dementia. There was a training room in the office, which had a hospital bed available so that staff could gain real experience of using equipment, such as slide sheets, and sliding boards.

Care workers we spoke with told us that they had supervision meetings with their manager or a team leader. One person told us, "I have had a few supervisions with the co-ordinators who are approachable and I am

listened to." We looked at the records and saw that supervisions took place every3 months. The registered manager told us that they were working to ensure supervisions were up to date and carried out on a regular basis. The supervision policy identified that each member of staff should have four quarterly supervisions per year. The registered manager told us that the aim was to make sure staff had four face to face supervisions per year with regular spot checks.

A person using the service told us, "They take me out for lunch; it's my choice where we go." We saw from the records we reviewed that where people did receive support with food, details of what had been served were recorded in the daily notes. We also saw that a nutritional risk assessment had been completed for each person that required one. Where a risk such as someone being at risk of malnutrition had been identified it was not clear that appropriate referrals had been made to health professionals in the records. We discussed this with the registered manager who advised that they had made referrals to the General Practitioner (GP) if someone was identified as being at risk of malnutrition. We saw that a detailed plan by a dietician had been developed for one person, but this plan was not incorporated into the care records. We spoke with the staff that were supporting this person with their eating; who told us they were aware of the consistency that the food served had to be as they had been informed of this by the family.

This was a breach of regulation Breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that, where necessary, arrangements were in place to assess and monitor the nutritional needs of people who used the service. In addition staff told us they would always try and support people to make healthy food choices when they accompanied them to do their shopping, although they respected the rights of people to make their own decisions about the food they wanted to eat.

The registered manager told us that one person using the service at the time of the inspection lacked capacity. The registered manager was aware of the need to refer people to the local authority for assessment under the Mental Capacity Act 2005 (MCA) if they appeared to lack capacity. We reviewed this person's care records and appropriate documentation for power of attorney was in place and a current and up to date best interest document was kept in the office file. We asked care staff if they knew how to promote peoples choices and how they gave people choice. One member of care staff told us "I always ask the person what they want to wear, I never assume, as it's their life and their choice."

Care plans contained contact details of people's relative's, GP's or other involved health care professionals so that staff were able to contact them in the event of an emergency. Staff were aware of their responsibility for dealing with illness or injury, telling us they would call an ambulance or the person's GP or district nurse if required and inform the registered manager so that this information could be passed to other staff. One relative told us "[person] was finding it difficult to swallow and we contacted the main office, the staff helped us to organise a nurse to come out and assess [person] swallowing and update [person] plan."
The care records we looked at had basic information for staff to follow on how to support people with their care. There were no goals identified or any agreed outcomes for each support need identified. We looked at five care files, two of which had separate protocols developed for staff to follow, for eating and drinking. These protocols were not reflected in the person's care plans therefore conflicting information was being passed on to care staff. We looked at the assessment carried out by the local authority and found basic care information had not always been transferred when the provider had developed their own care records. This meant there was a risk people might not receive effective care that met their current needs.
This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care

We spoke with one health care professional who told us "The office staff are very proactive and will always call me if [person] needs me to come out and assess any areas of concerns"

Requires Improvement

Is the service caring?

Our findings

People told us that some care staff acted in a caring manner towards them. One person told us, "I have one male care staff who comes regularly; he is great, caring, friendly, always polite and respectful. He always respects my home and my mum." Another person we spoke with told us, "I have the same girl [care staff] during the week who is fine and we have built a good rapport." Another person told us, "They're okay but need to be more caring. I'd like the good ones to come." One relative we spoke with told us, "It depends on who comes really. Some of them are wonderful and caring. They care and will do anything for us especially [care staff]. The young ones can be on the phones texting and don't really care about this job."

Care staff told us that they had regular calls to people using the service and this made it easier to get to know people. One staff member told us, "If you see the same service users, you just know what they like and when something is wrong you can pick that up." Another staff member told us, "I go to the same people all the time and the family help you and tell you what the person likes and dislikes by talking to them." This showed that staff felt that they could develop relationships with people who used the service when they saw the same people on a consistent basis.

The registered manager told us that when they received an enquiry about the service they or senior carer staff would go and visit the person or their relatives. This was to determine if the service was able to meet their needs. The registered manager told us that care plans and risk assessments were developed based upon information provided by the relevant local authority and their assessment of the person's needs during the initial assessment stage. This involved discussions and input from the person and their family where appropriate. This meant that people were involved in planning the care and support that they received and consenting to the care with a signed agreement in all care records we reviewed. .

We saw that the registered manager ensured care staff employed by the service reflected the diversity and culture of the people they supported to ensure that people who used the service could be confident that their support worker had the appropriate skills to match their required needs. We saw in care plans reviewed that support was tailored to meet people's religious and cultural needs, including which was their preferred first language spoken in.

Four people using the service told us that the staff who had been with the service for 'a while' knew their likes and dislikes, but that not all staff knew this information. Care staff we spoke with knew the people they supported well and were able to tell us about their likes and dislikes and describe the care required. They told us that when they visited people on a regular basis it helped them build a relationship with the person and learn how best to support them. We saw that information about people likes and dislikes, what is important to the person and the best way to support the person were recorded within their care records, however this information needed to be in more detail with guidance on how to clearly communicate with the person especially if English was not their first language. This would ensure that care workers have all of the relevant information including how the person wanted their care and support to be provided.

One person told us that they felt uncomfortable with some staff when receiving personal care. They told us,

"They don't always cover me up properly when they are washing me and that I have to ask them to do this." A relative told us that some care staff made the family feel uncomfortable, "Some carers gossip about our lives in the community and we have heard them talk about other people while they care for my grandma. I have told the manager about this and finally it has stopped because those carers no longer come here." We were told by the registered manager that he took action with the care staff however there was nothing recorded to say he had taken action or had followed any disciplinary process.

Staff told us how they promoted people's dignity, including talking to the person throughout and explaining what they were doing, prompting people to do things for themselves, and asking people what they want to do and involving them in their care. One staff member said, "I like to chat to people in their chosen home language, this makes them comfortable especially when you're doing personal care."

Requires Improvement

Is the service responsive?

Our findings

People told us that the service was sometimes responsive to their needs and that some staff had a good understanding of how to support them. One person told us, "I can request a change of time with our calls, but the office can sometimes forget if I call up to do this." Another person told us, "I have made complaints to the co-ordinator and then the registered manager and finally it's been resolved after a few weeks." One relative we spoke with told us, "[care staff] goes above and beyond what is expected. She cares for our grandma the way we do it and I like it." Another relative told us, "When the regular care staff visit, the care is okay but when the care staff are not the regulars then we can have problem."

We found care records were in place for all people receiving care from Homecare for You. Copies of care records were held at the service's office and also at people's own homes. The meant that people who used the service and their care staff were able to consult the care records on each visit. Care records included information about what support people needed. The care records included two sections, one listed tasks that the staff needed to complete. The second included information about how the person wanted their support to be delivered. For example, the care record for one person highlighted that as part of their morning routine the person requires care staff to monitor all pressure areas and report any changes. We saw that the carer had contacted the district nurse as this person's skin was beginning to break. They then supported this person to immediately seek medical help from health care professionals.

Staff told us that they had access to care records that provided them with information. Two members of care staff told us "When I support a new person sometimes the information I've received from the office is not detailed which often can make the person unhappy." One staff member told us, "It is not nice for the people if you go to someone and they don't know you and then you have to ask them what we do for them." Care records not being detailed and outlining clear guidelines can potentially put people at risk of harm and not having their needs fully met.

The registered manager told us that care records were reviewed annually or more frequently if required. We looked at records that contained information about reviews that had taken place and found that all the five care records we looked at had been reviewed either annually or when a change was required in the care record. The registered manager told us that a number of these reviews had taken place over the phone at the request from family members. We saw records that evidenced that phone consultations about the care and support a person required had happened. However we were told by the registered manager risk assessments had been reviewed however there was no evidence to say any of the five risk assessments we reviewed had been reviewed. This posed a risk to people if risks to care needs had changed.

We saw that care record reviews were carried out with people or the relatives and this could be in the form of telephone interviews. The registered manager told us that a number of care plan reviews had been completed. This was to see if people were happy with the service and the support they were receiving or if they had any concerns. We saw records of care plan reviews that had been carried out previously.

One person told us that they did not always know which staff would be coming, they told us "I don't receive a rota, to tell me who is coming; it would be nice to know in advance who is coming. I know somebody's coming but I can't trust who is coming." Another person told us, "You think so and so is coming then somebody else turns up." The co-ordinators told us that people received a rota if they requested one.

People told us that the staff were often on time. One relative said, "Carers mostly turn up on time. Sometimes they ask if they can come a bit earlier than normal times. That's okay with mum and me." Another person told us, "The carers are on time." The staff told us that they visited people on a regular basis and that they were generally on time when they were working with their usual list of home calls. The registered manager told us that the easy tracker system which monitors the planned call time against the actual call time confirmed that care staff were arriving on time, the records we reviewed confirmed this. The registered manager told us that the system would also raise an alert if care staff were more than fifteen minutes late for a time critical call e.g. a person requires support at a specific time to take a medicine, and thirty minutes late for non-time critical calls. The records that we saw showed that, on such occasions, the senior care staff or another carer would make the care call to the person if there was a delay in staff attending a call. The registered manager told us that some carer's had not always been good at informing the service or the person if they were running late for a call, but that this had improved significantly since the computerised system had been introduced.

People told us that they sometimes felt rushed by the staff. One person told us, "There was one occasion when I felt extremely rushed by one care staff." A relative told us, "The younger staff are always too busy to spend time to talk to my relative, they're always rushing." The relative confirmed that these care staff no longer visit and the new carer was less time constrained.

People told us they knew how to make a complaint. A relative told us, "I've made an official complaint, I did phone up about some concerns I had. The office coordinator didn't really resolve the issues so I went straight to the registered manager, finally things have been resolved and the carers are actually doing what they are supposed to be doing." Another relative told us, "I called the office regularly as the carers can't speak English. They often speak their own language."

The service had a complaints procedure in place. This included timescales for responding to any complaints. The registered manager told us that all people were provided with a service user guide that contained a copy of the complaints procedure, and we saw that this was included within the service user guide, however this information was not provided in different languages to cater for the clientele group. The registered manager told us that people were reminded of where the complaints procedure can be found in the service user guide and how to make a complaint. Staff told us that if they received a complaint from a person they would report it to the office.

The registered manager told us that they had received one complaint. We saw from the records that this had been recorded and investigated. The outcomes of the complaint had been communicated to the person who made the complaint. We saw that one person had complained to the on-call staff member about a specific member of staff, and had discussed this on three separate occasions with the on-call manager. The registered manager advised that they had contacted the person who said they did not want to complain. However this was not logged in the complaints file and no outcome was recorded. We reviewed the on-call file and found over a period of two months there had been over eleven complaints which had not been identified as complaints or followed up by the co-ordinator or the registered manager. A relative told us, "I have reported one care staff. I rang the office and insisted on speaking with the manager. He booked to visit me. This appointment was cancelled and has not been rearranged. I don't feel listened to at all." This meant that people's concerns were not being recognised as complaints, investigated appropriately and resolved.

This was a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place; however care staff and people who use the service were not confident in the manager's ability to manage the service and his lack of visibility at the office.

The registered manager was supported by a team of co-ordinators and care staff. One co-ordinator told us "There's too much pressure here with little support from above." Whilst a senior carer told us "I had concerns with how the manager supported me but these have now been resolved and we have a better understanding. I can go to him now if I need to ask him anything." Another co-ordinator told us "It's okay here; the manager will call us daily to see if we are okay."

People told us that they didn't know who the manager of the service was. One person said "I spoke to the manager once, but nothing has really changed." A relative told us, "If I need to ring I will always ask for a co-ordinator because she will always ring me back. She is very good."

Three care staff told us that they could approach the co-ordinators at any time. They told us that they felt that they were listened to and changes would be made if needed. One care worker told us, "I have seen changes made but we don't see the manager. This is the first time we have seen him in eight months." Another care worker told us, "The manager is approachable but If I have a problem I will still go to the staff in the office." All the staff we spoke with told us that they speak directly to office staff regularly but knew they could go to the registered manager if they needed too.

The registered manager told us that they understood their responsibilities to report incidents, accidents and other occurrences to the Care Quality Commission (CQC). The registered provider had systems in place to monitor and review the service being provided by Homecare for You Oldham and to check that people using the service were happy with the service they received. These included spot checks conducted whilst a service was being delivered in a person's home, telephone contact and regular reviews with people using the service. People told us that they had received questionnaires from the service. One person told us, "We received a quality assurance feedback form recently." Another person told us, "I always tell them what I think about the service."

The service had quality assurance and monitoring systems in place, including an annual questionnaire that was sent to people who used the service. This asked people for their feedback on staff, the service and how well they thought the service was doing. People were asked for their views on areas such as the attitude of staff, their reliability and helpfulness, people's experience of contacting the office and the complaints process. There was also a section of the questionnaire where people could provide feedback on other areas of the service. However, the information gathered from any quality monitoring feedback was not analysed or used to identify areas of good practice and areas requiring improvement.

This was a breach of Breach of Regulation 17 (1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Co-ordinators carried out spot checks on care staff whilst they were providing support. These checks were to monitor care staff behaviour and attitude and to check that they displayed the provider's values of treating people with dignity and respect. We saw in the ten staff personnel files we reviewed, that spot checks had been completed on the carers practice. We were told by the registered manager the plan was that these spot checks would take place as often as possible and at least every six months for all care staff.

We looked at daily records for people who used the service. The last records in the office for one person were dated September 2015, for two other people May 2015 and August 2015. The registered manager advised that the daily notes should be brought back to the office monthly and that these would then be audited. This meant that daily notes, which were a source of evidence about the delivery of care, had not been reviewed for several months. There was a risk that any identified concern may not be addressed promptly. The registered manager advised that they would remind the staff to return all records on a monthly basis so that these can be checked and audited. Records of staff meetings showed that there had been discussions about what could be improved with the service delivery. We reviewed the last five months records of staff meetings and looked at topics of discussion that included uniforms, confidentiality, rotas, logging in, not to use mobile phones in peoples' homes, training, and carers speaking languages other than English. The minutes were available for staff to read if they had been unable to attend. Actions following up from staff meeting had been identified to improve service delivery.

One care staff we spoke with told us that they felt valued. He said, "I really enjoy it here, they have respect for me." The registered manager told us that they were introducing an employee of the month scheme and rewards each month as an incentive for all employees.

Home Care for you Oldham values of providing support that focusses on the person to promote their active participation and promote independence were detailed in the staff handbook and service user guide. Three members of care staff we spoke with were able to tell us about the organisations values and aims and how they implemented this in their work practices.

We spoke with one health care professional who told us "The office staff are very proactive and will always call me if [person] needs me to come out and assess any areas of concerns"

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 9 HSCA RA Regulations 2014 Person-centred care Basic information from the local authority assessment had not been transferred across to develop care plans

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive their medicines safely. Records did not contain important information about the medicines that people were taking and care plans did not show what support people needed with their medicines this meant that there was a risk that people might not receive the medicines they needed as prescribed by their doctor

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not identified appropriately and investigated with an outcome. People's concerns were not being recognised as complaints and investigated appropriately.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Assessment carried out by the local authority

found basic care information had not always been highlighted when the care records had been developed. This meant there was a risk people might not receive effective care.

Information gathered from any quality monitoring feedback was not analysed or used to identify areas of good practice and areas requiring improvement.