1 Care 4 U Ltd

My Care Direct

Inspection report

394 Palatine Road
Manchester
Lancashire
M22 4FZ

Tel: 01619985590
Website: www.mycaredirect.org

Date of inspection visit:
26 February 2016
02 March 2016

Date of publication:
14 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

The inspection took place over two days, 26 February and 2 March 2016. We announced the first visit a day in advance because this is a small service and we wanted to ensure someone would be present in the office. This was the first inspection of the service.

My Care Direct provides a service to people in their own homes. It has a contract with Trafford Council to provide care for people after they have had re-enablement and/or following a stay in hospital. In most cases the service provides care for a short period of weeks or a few months at most. At the date of this inspection there were 15 people using the service in this way. My Care Direct was supporting a further six people with shopping and cleaning and other related services.

There is a registered manager who has been in post since January 2015. 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.

People told us that they felt safe receiving the service. They told us they could rely on their care workers to arrive on time, or to contact them if they were running late. There were a few examples of late or missed calls, but we received explanations of why these had happened and the actions taken to prevent a recurrence.

Staff received rotas in advance and any changes were notified to them. One member of staff told us that 15 minute calls were not always long enough, for example if they had to make and serve a meal. No person receiving the service told us that the calls were too short. Care workers logged in and out using their own mobile phones, but the system did not currently alert the office if a care worker had not arrived.

All staff were trained in safeguarding and in moving and handling in order to keep people safe. We saw that people's safety and the safety of staff were both high priorities.

Records were kept of medicines for those people where My Care Direct assisted people. The registered manager told us the accuracy of these records was important. Staff had recently received training on medicines administration.

Correct processes were followed to explore the background of new members of staff and ensure they were suitable to work with vulnerable people.

We saw there was a high rate of completion of training in all mandatory topics. New staff had all received induction training in those areas. Staff told us they found the training worthwhile. New staff were also doing the Care Certificate, a new set of standards for care workers. Not all staff had been trained in understanding the Mental Capacity Act 2005.

People using the service gave positive feedback about the standard of training, except in one case where a relative told us the care worker had not been trained to use a particular type of catheter bag.

The fact that some staff had not been trained in the Mental Capacity Act 2005, and the example of a member of staff not having received sufficient training in catheter care, were a breach of the Regulation relating to the appropriate training of staff.

Staff received regular supervision. Spot checks were conducted on new staff. The registered manager was introducing annual appraisals, although most of the staff had worked less than one year.

The registered manager showed a good knowledge of the Mental Capacity Act 2005 but had not conducted any mental capacity assessments. This meant there was a risk that some people's needs might not be assessed. This was a breach of the Regulation relating to the need for obtaining in consent in line with the Mental Capacity Act 2005.

Where care workers prepared food people were satisfied. Care workers recorded food intake when it was important to do so. People told us that their care workers were kind and pleasant. They said that the care workers listened to them and often asked them what needed doing. Usually the same care workers visited the same people, enabling relationships to be built up even in the comparatively short time the service would be delivered.

One person gave an example of how the care workers could be flexible and rearrange the time of their visit to make it more convenient.

We looked at five care records and saw that the care plans provided sufficient information to enable the care workers to deliver care safely. The plans were based on the information supplied by Trafford Council. Because people were with the service for short periods, there was not a great deal of personal history in the plans.

People were not always aware that they had a care plan, and there was scope to involve people more in the creation of their own plans. Care plans were reviewed by the registered manager who visited each person to discuss how the care delivery was going.

A record of complaints was kept and we saw that complaints were dealt with thoroughly and lessons learned from them. We considered that one complaint ought to have been recorded as a formal complaint. Some of the complaints policies on file were inaccurate. These failings were a breach of the Regulation relating to handling complaints.

People receiving the service and staff had a high opinion of the registered manager. A deputy manager had recently been appointed but was not spending much time with My Care Direct. This meant that the registered manager had to fulfil all the office functions. There was no cover immediately available if the registered manager needed to visit or assess someone.

Staff meetings were held which enabled the staff to contribute their ideas. Minutes of meetings were sent to staff who could not attend.

Surveys were sent out but did not reach everyone who had used the service. We have recommended that the provider investigates better ways of obtaining feedback from people who use the service. Policies were available in the office. We saw that medicine administration record sheets were checked each month. The

registered manager told us she conducted audits of care files and staff files, but did not keep a record of those audits.

The registered manager was aware of her duty to notify CQC about significant events.
One of the issues facing My Care Direct was the high turnover of staff, but this was not entirely within the control of the registered manager and provider.

We considered that the governance systems were insufficiently robust and this was a breach of the Regulation relating to good governance.

In relation to the breaches of Regulations you can see what action we told the provider to take at the end 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?

Good

The service was safe.

People received a reliable service with very few late or missed calls. When there was a late or missed call it was investigated and action taken to stop it happening again.

The service ensured that staff knew what calls they were making so that calls would not be missed.

Staff were trained in safeguarding and in assisting people to receive medicines. Proper procedures were followed to recruit suitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received induction training. Not all staff had received training in the Mental Capacity Act 2005. A lack of training in catheter care had caused a problem on one occasion.

The registered manager was not conducting mental capacity assessments which meant the service was not working within the principles of the Mental Capacity Act 2005.

The registered manager conducted spot checks on new staff and regular supervision sessions.

Is the service caring?

Good

The service was caring.

People said they were treated with dignity and respect, and gave positive feedback about the care they had received.

Care workers built up friendly caring relationships with the people receiving the service. They encouraged them to regain independence.

People told us that staff always asked them what they wanted doing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were often based on plans supplied by Trafford Council. They provided adequate information about the care needs of people receiving the service. People were not always involved in the development of their care plans.

Care plans were reviewed by the registered manager who visited each person as part of the review.

A record was kept of complaints and lessons were learned from them. One complaint had not been recorded as a formal complaint but should have been. Some of the complaints policies were incorrect.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager worked without office support. She was able to complete the tasks as the service was small. The office was not manned if the registered manager had to leave it.

There were regular staff meetings which helped to engage staff in the running of the business. Surveys of people using the service did not reach enough people.

The registered manager conducted audits. Care plan audits were recorded on the care files but there was no separate list of which audits had been done or of actions taken as a result. Governance systems needed to be more robust.

My Care Direct

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 26 February and 2 March 2016. We gave notice the day before the first visit to ensure that someone would be in the office.

The inspection was carried out by two inspectors. One adult social care inspector visited the office on Friday 26 February 2016 and again on Wednesday 2 March 2016. Another inspector made phone calls to people using the service on Monday 29 February 2016.

Before the inspection we reviewed the information that we held. The provider had submitted at our request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. It was submitted to us on15 January 2016. Alongside this we considered notifications sent to us by the service and information received about the service.

We contacted the commissioning officer of Trafford Council for information about the council's assessment of My Care Direct's performance.

During the inspection we spent time with the registered manager and viewed files including five care records, staff rotas, four personnel files, policies and procedures, minutes of staff meetings and results of surveys. We spoke with two members of staff. On the second day of the inspection we talked with the registered manager again and with the deputy manager.

On 29 February 2016 we spoke by telephone with seven people using the service, or their relatives, and asked them about the service they were receiving.

Good

Is the service safe?

Our findings

We contacted by telephone seven people who were receiving the service from My Care Direct. We spoke with three people directly. In four cases we spoke with relatives who were at home with the people concerned. They explained that the people receiving the service would not be able to communicate with us. We asked whether people felt safe. People told us they did feel safe. One person said, "I always feel safe when the carers visit, and the carers are kind and helpful."

One relative said both they and the person using the service felt safe when the care workers were there. Everyone else said the same, and no-one expressed any concerns about safety.

People mostly said they could rely on their care workers to arrive on time, or to let them know if they were going to be significantly late. They also said they had the telephone number of the office in case their care worker was late, which they told us was reassuring. One relative, however, described how on one occasion when the care worker had not arrived they had phoned the office only to be told that the care worker had car trouble. The office had not contacted the person using the service or their family to advise that the care worker was going to be late. We discussed this with the registered manager who stated it was their policy always to contact people, if the care worker informed the office that they were running late.

There had been a few examples of late calls early in the history of the service but the registered manager had investigated the causes and learnt from them. No-one else whom we spoke with reported any late calls.

Before the inspection we had been alerted to a missed call which had been reported to Trafford Council in January 2016. The council had concluded that no harm had been sustained. The registered manager told us that on that occasion a family member had left a message in the office. The office staff thought the call had been cancelled, as sometimes happened when the family member was visiting, but on this occasion that had not been the caller's intention. The registered manager told us she had now adopted a policy of double-checking whenever a message was received before cancelling a call.

During the inspection we learnt that there had been two missed calls in August 2015 which had been the subject of a complaint. The registered manager told us that after investigating that complaint since then she had implemented a new procedure. If any changes were made to the rota she would phone the staff, follow up with a text message and staff were asked to confirm receipt of the changes. This minimised the chance of changes going unnoticed, so it was more likely that people would always receive the calls they were supposed to. The registered manager told us she clearly understood that late or missed calls were unsettling for people and could make them feel unsafe or result in harm occurring. The registered manager's effective response by investigating late or missed calls, and acting to minimise the chance of a recurrence, meant that people were protected from such events.

We saw staff rotas which were either sent out by post to staff every Tuesday, or collected from the office. They set out clearly for staff their rota for the following week. Each rota identified the length of each call and who the staff member would be working with if it was a double (or two person) call.

My Care Direct owned a car which some staff were authorised to drive, and could use to travel between calls. This minimised the travelling time between calls compared with using public transport. This helped to ensure that those staff who used the car arrived at their calls on time.

We asked the registered manager what happened if a staff member was sick and unable to work. She said that when this happened she was able to call on other staff to make up the rota, or if necessary she or another member of office staff would make the calls. She said it had never yet happened that she had been unable to provide cover to ensure all the calls were made.

Some of the calls commissioned by Trafford Council were 15 minutes in length. If someone was receiving several calls a day, often the first call would be longer but the lunchtime and teatime calls would be 15 minutes. When we asked one member of staff what was the one thing that they thought would improve the care being delivered, they said longer calls. They added, "If the visit is just to prompt medicines, there's enough time. But some calls are to make the lunch and help the person eat it. 15 minutes just isn't long enough." We mentioned this to the registered manager. None of the people receiving the service told us that the calls were too short to meet their needs.

My Care Direct used a system whereby staff logged in and out of calls using their mobile phones and a tiny electronic chip which was fixed to the wall near the entrance to each person's home. This allowed the registered manager to check that the calls had taken place and their duration. We asked whether staff always remembered to log in and out this way, and we were told this was how their wages were calculated so they had an incentive to do so. This system did not currently generate an alert in the office if the care worker had not arrived after a certain period. We discussed whether this would provide an additional level of confidence in people receiving the service and their relatives, if they knew that the office could take appropriate action if a care worker was late or missing. The registered manager told us this alert function was not technically feasible with the current system, but she would investigate the possibility of implementing it.

All staff including recent recruits had received training in safeguarding. We asked one member of staff what they understood safeguarding meant, and they were able to explain the various types of abuse that might occur and how to report if they witnessed or suspected anything. They added they had not come across any abuse of any kind while working for My Care Direct.

All staff had also received practical training in moving and handling techniques, which meant they had a good understanding of how to move people safely. We saw an example of this on the first day of our inspection. Two staff reported that a person who had just started using the service was less able to support their own weight than the care plan supplied by Trafford Council suggested. They thought this might have been because the person had just come out of hospital. They reported that it was unsafe to attempt to move them without a hoist, which was not available and would take a few days to obtain. The registered manager contacted the person's GP and considered all the options, one of which was to transfer the person back to hospital. The registered manager decided the only way to ensure the person's safety was to do a home visit themselves. It turned out that the person's mobility had improved during the day, and they were able to stay at home. We saw that the registered manager's primary concern was for the safety of the person receiving the service, while she was also concerned that the staff would not be put at risk by moving someone in an unsafe way.

We saw detailed risk assessments in people's care plans which showed that people's safety was considered when planning care. We saw that medicine administration records (MAR sheets) were used when people were assisted with taking medicines. Most of the people using the service and relatives we spoke with told us

that people did not have assistance with their medicines. When they did, the MAR sheet was completed and every four weeks brought back to the office where it was checked. We saw that several staff had been reminded at supervisions of the need to complete MAR sheets accurately. One member of staff had written on her supervision record in November 2015, "I only have some problems with the medication but we are looking forward to the medication training." We saw that the deputy manager had delivered two sessions of face to face training at the end of January 2016, attended by all the care staff. This was adapted from the National Institute of Clinical Excellence (NICE) guidelines on the administration of medicines and staff described it as very helpful. All staff including the most recent recruits had also completed e-learning training in medication. This level of training was designed to ensure that staff had the knowledge to give or prompt medicines safely.

We looked at the personnel files of four recently recruited members of staff. We saw that all the necessary checks of job applicants' identity and employment record had been carried out. A special form was completed at interview to fill in any gaps in the employment history. Staff had been checked with the Disclosure and Barring Service (DBS) before they started work at the service. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. In each of the files we found two references from previous employers had been requested. A record was kept of the answers given at interview, although we noticed that there was not a record of the questions on all files, because standard questions were used. We were satisfied that the necessary checks were made to ensure that staff were suitable to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

We asked one member of staff about their training while they had been working for My Care Direct, and they told us they felt very well trained. The registered manager confirmed that training was a high priority, for both new and established staff.

We looked at the training record which recorded both 'mandatory' and 'non-mandatory' training. Mandatory topics were health and safety, food hygiene, infection control, moving and handling, safeguarding, fire awareness, first aid and medication. There was an almost 100% completion rate of this training, although for one person three topics had gone past their annual renewal date by a few months. We saw that even the newest member of staff who had started on 11 February 2016, had completed all the mandatory learning. This meant that all staff had completed induction training. The training was done by e-learning on the computer. Staff told us that they found this an enjoyable and effective way of learning. Manual handling training was done face to face in the office. There was a bed made up in the office which was used to teach techniques such as how to use a hoist to lift someone in or out of bed. There had also been classroom training on medication recently.

All the staff had undertaken the training in dementia care and continence care. Only eight staff out of 13 had undertaken the training module on the Mental Capacity Act 2005. We discussed this with the registered manager, who acknowledged it was important for all staff to have a basic understanding of mental capacity and the legislation in that area.

New staff who had started since August 2015 were required to complete the Care Certificate, a set of minimum standards designed for the induction training of new care workers. We saw workbooks and a training plan in use by the most recent recruits. This meant that new staff, especially those without prior experience, would be trained to a basic standard in delivering safe and compassionate care. All staff could also attend training sessions arranged in two care homes owned by the same provider. One member of staff told us that these were useful.

We asked people receiving the service and their relatives whether they thought the care workers were well trained. One person told us they thought the care workers were knowledgeable. When we asked another person if the care workers had the right knowledge and skills they responded by saying, "Well I don't know but what they do for me is satisfactory." One relative said that they thought staff knew what they were doing and had the skills and knowledge to provide the support required.

One relative gave positive feedback about the care staff but said there had been one exception: "Lovely, lovely girls but do not always seem to know what they are doing". The exception had been when one care worker had put a catheter bag on the wrong way round. The relative said they had spoken to the office and was told there were lots of different types of catheter bags. The relative questioned why care workers had not been provided with the correct instructions for the particular catheter bag that was in use. We asked the registered manager about this. She said that the incident had occurred at the start of the care provision for the person concerned when they came out of hospital. The care worker did have experience with catheter

bags, but not the particular type that was supplied by the hospital. There had been no further problems, and the relative had confirmed this was a one-off event.

Nevertheless, the lack of knowledge of catheter care on that occasion had created a risk to the person using the service. This example of insufficient training in catheter care, coupled with the five staff who had not completed training on the Mental Capacity Act 2005, meant there was a breach in Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This Regulation relates to staff receiving appropriate training to enable them to carry out their duties.

Staff received supervision from the registered manager every three months. We saw records of these sessions. The registered manager used the opportunity to inform staff about important messages. For example a reminder about the need to complete MAR charts was on the supervision record for several staff in January 2016. The registered manager told us this did not necessarily mean those staff had been leaving gaps in MAR charts, just that she had wanted to ensure everyone got the message. The supervision records showed that individual concerns raised by staff were also discussed. This meant that staff were being supported to share any issues that might affect their work, and were encouraged to think about improving their practice.

All except two of the current members of staff had started within the past 12 months, which meant they had not yet had an annual appraisal. The registered manager was planning to introduce annual appraisals. The registered manager carried out a spot check on new staff within the first three months. This meant they would turn up unexpectedly and observe the call taking place. They also asked the person receiving the service about their experience. This not only checked the service but ensured the care worker was supported in any areas of improvement needed. We did not see any evidence that these spot checks were repeated on a regular basis, which would be best practice.

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 in order to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. The registered manager and the deputy manager demonstrated a good knowledge of the Mental Capacity Act 2005. They understood that family members, unless they have a relevant power of attorney, cannot give consent for treatment or care on behalf of someone who lacks the capacity to do so themselves. We saw that in most cases care plans were agreed with the person concerned. But there were some people living with dementia who possibly would lack capacity. The registered manager told us that she did not carry out mental capacity assessments if they had not already been carried out. This risked people who may have lacked capacity to make decisions about their care and treatment not being identified. Even though My Care Direct provided the service to people only for weeks or a few months, the staff ought to be alert to notice changes in people's mental capacity and the registered manager should carry out mental capacity assessments when appropriate.

Because she did not carry out any mental capacity assessments the registered manager was unable to demonstrate that the service was applying the principles of the MCA. This was a breach of Regulation 11(3)

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff except one had completed training in food hygiene. Some people were helped with their food needs. We learnt from speaking with people and relatives that this involved preparation of breakfast and making sandwiches. One person had lunch and tea made for them. They told us, "They have a set programme, I provide the food and they cook it. That is alright for me." Most of the people we spoke with did not receive assistance with food preparation except at breakfast.

We saw on one care plan that staff were using a food monitoring chart for one person where there was a concern about their food intake. This was done in consultation with the person's GP. In another case a relative raised a concern with us about the recording of food. They said that during the morning visit the care workers made a sandwich for lunch and left it in the fridge. The relative had asked that staff record everything the person receiving the service ate and check that they had eaten the sandwich left in the fridge, and record the outcome, but this had not happened straightaway. They added they had spoken with the registered manager about this who said she would ensure staff recorded the information. The relative added that this was still early days as the service had started only two weeks earlier, and they would be keeping an eye on the recording of food intake.

We saw evidence that staff were trained to call an ambulance at once in the event of a medical emergency, and had done so recently. They reported other medical concerns to the registered manager who then contacted the person's GP.

Good

Is the service caring?

Our findings

People receiving the service said that the care workers respected their privacy and dignity. One person said, "They do not intrude at all." Another person said that the care workers were respectful and never made them feel uncomfortable.

Another person said that the care workers were respectful, caring, and encouraged them to retain their independence. They added that they were in more pain some mornings than others however in the main they could mostly manage to dress themselves but had trouble with some items of clothing. When they were in more pain the care worker gave more assistance to the level they required or wanted. They added, "These girls are very respectful, it has never been a problem."

We asked one person receiving the service what was good about the service and they replied, "They are very caring and kind and anything I ask they will help me with." Another person said, "They work long hours, it is not a nice job. But they are always pleasant. To sum it up they are good girls, I am happy with them."

We received only positive responses from people when we asked about the care they received.
Another person described their care workers as caring and kind with a positive and helpful attitude. They said they were listened to by the care workers and felt they could influence decisions regarding their own care.

One person said that staff listened to them, were caring and respected what they said. We asked about what happened if they needed help with expressing any of their needs, and they informed us that their family would advocate on their behalf. When asked what the service could improve on, one person said, "No, nothing really, they do try and do what I ask them to do." They added that, "It would be nice if the care workers just stood back when they had finished and said, 'Are you happy with everything?' They know I am otherwise I would say so, but I have no complaint, none whatsoever."

The minutes of a staff meeting in January 2016 stated, "Nobody is assigned to an individual client. All staff are to share the workload by attending a variety of clients." However, usually the same staff were assigned to visit the same people on a regular basis. The registered manager showed us the staff rota which confirmed this was the case. This enabled staff and people receiving the service to build up a relationship and meant that staff could gain knowledge of each person's needs and preferences. This was important even if the service would be delivered for a relatively short period of time. We asked one relative whether the staff were respectful and they replied, "They are just like friends. We all have a good laugh, they are fine, we get on well with them." This showed that within the six weeks since the service had started the care workers had managed to establish a friendly caring relationship with the person using the service.

Several people told us that the care workers involved them by asking them what they wanted doing. They said that staff responded to the amount of help they needed each day. One person said the care workers asked every day "What do you want me to do this morning?" Another person said that they told the care workers at each visit what they wanted doing, namely making the bed, and emptying the commode. They

added, "I ask them the same thing every day and they do it. They will also do other things I have not asked them to do such as washing up and putting things away."

Another person was trying to regain the ability to walk independently. Their relative told us that the care workers assisted them in helping the person and encouraging them to walk. The relative also gave an example of the care workers being flexible. Because they (the relative) had a doctor's appointment in the afternoon, the care workers had offered to make the teatime call later than usual so that the relative could be home in time to be there. The relative was very grateful for this and described the care workers as compassionate.

In the office we found that people's care plans and personal documentation was stored securely in locked cabinets so that confidentiality was protected. Confidentiality had also been discussed at a staff meeting in November 2015, when the registered manager reminded staff that all information about a person using the service was confidential.

Requires Improvement

Is the service responsive?

Our findings

We looked at five people's care records in the office. These contained care plans which described the care that each person needed, and included risk assessments. We noted that the care tasks described primarily risks to staff (for example from moving and handling) rather than risks to the people using the service. We saw that there was sufficient information to enable staff to meet people's basic care needs, in a safe manner.

Most people were with the service for a short time, and there was a high turnover. At the date of our visit, ten out of the fourteen people had started receiving the service in the first two months of 2016. This meant that there had not been a great deal of time for staff to get to know the personal history of people. This influenced the amount of personal information that had been gathered. The registered manager told us it was the intention of the service to obtain as full a history of each person as was possible, in order to facilitate person-centred care.

The registered manager explained that when a new care package was commissioned Trafford Council supplied a care plan. In some files we saw that this provided the basis of the My Care Direct care plan. The registered manager explained that sometimes there was not an opportunity to assess the person before they came out of hospital, so that the care had to start before the My Care Direct care plan was written. She said that she tried to assess people as soon as possible. More often My Care Direct took over after a period of re-enablement (which means care outside hospital, helping people recover their abilities) so the transition could be managed more effectively.

The people we spoke with were not sure whether they had a care plan or if so what it contained. One person stated that there was a file in their home that the care workers wrote in every day, but they had not had a look at it. Another person was unaware of a care plan but stated that their relative had arranged things. They reported that they were pleased with the arrangements made and had no complaints. We concluded that there was improvement needed to involve people more in the creation of their own care plans or at least to make them aware of what was in them. Relatives we spoke with were aware there was a care plan and stated that they were happy with its contents.

We asked the registered manager about the review of care plans and how they were updated to reflect any changes. She told us she carried out what she called a "Client QA review" after two weeks. This took the form of a telephone call to the person receiving the service or their relative, and a set of questions. We saw that the questions were fairly detailed. People were given the opportunity to say whether there was anything they wanted done differently. Then after about two months the registered manager conducted a "service review" which was a visit in person, at a separate time from when the care worker was there. A service review could also take place in response to any event or development in the person's care needs. One person told us that they had received two visits from the registered manager and that they had appreciated the visits. They said "It's reassuring, isn't it?" We saw completed service reviews on people's care files.

We saw the record of formal complaints received by the service. Within the past year there had been two

complaints recorded. They related to two missed calls and an incident when a care worker had allegedly left in the middle of delivering care. We saw that the registered manager had investigated these complaints appropriately, taking a statement from the care worker in the second incident, then delivering personally a letter of apology to the person receiving the service. We saw that lessons had been learnt from both complaints with a view to reducing the likelihood of a recurrence.

We noted, however, that one complaint which had been reported to us before the inspection had not been recorded as a complaint. The registered manager stated that a complaint had been made but not in writing. However, a complaint does not need to be made in writing for it to require to be recorded. She added that it had not been substantiated, but again the complaints record should register all complaints whether or not they are valid. The complainant, who had contacted the CQC directly, told us specifically that they had not complained to the service. Nevertheless, the nature of this complaint meant that in our view it should have been recorded as a formal complaint.

Three of the relatives we spoke with were not sure whether there was a complaints policy on the care file. However, all the people we asked knew there was a number they could call if they wanted to make a complaint. We saw there were two different complaints policies included in care records in the office. One of them referred to the Care Quality Commission Inspectorate, and gave its email address. That is the body which operates in Scotland. The policy also stated that the complainant could "take the complaint to the CQC Inspectorate which will then investigate the complaint." This was misleading because the CQC does not investigate individual complaints. We asked the registered manager why there were two different policies. She stated she could not explain, as they had been present when she took up post. When we returned on the second day of the inspection all the incorrect policies referring to the Scottish body had been replaced with the correct policy, within the files in the office.

We considered that the failure to record the verbal complaint, and the confusion over complaints policies, meant there had not been an effective system for identifying, recording and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

One of the people receiving the service, who had received two visits from the registered manager, spoke highly of her. They said, "Most certainly the one in charge she encourages you to keep in touch. The lady who looks after these girls is very helpful and thoughtful; the girls have a good relationship with her." Staff that we spoke with also had a positive view of the registered manager describing her as, "Well-organised." A commissioning officer from Trafford Council told us that the registered manager was, "Very co-operative and responsive to our ethos and approach."

The registered manager was largely running My Care Direct alone; without the support of an administrator or care coordinator, and performing all the management functions. A deputy manager had been appointed in January 2016 but was now largely working elsewhere. When the need arose for an urgent assessment of a person who had just started receiving the service, in order to assess their mobility, the registered manager had to leave the office unattended. We asked who would answer the phone in the office, and were told the phone would divert to the registered manager's hands-free mobile phone in her car. This was, as she acknowledged, not ideal if for example she needed access to a file in order to answer a query. We accepted that this was a small business but nevertheless considered arrangements should be made to ensure the office was manned in office hours. We also considered that there were risks to the continuity of the business and the safety of people using the service if the registered manager became unable to work for any reason.

There were regular staff meetings. We saw the schedule of monthly meetings planned for 2016. Six staff (out of 14 at the time) had been present at the meeting in January 2016 and four at the November 2015 meeting (there had not been a meeting in December 2015). We asked the registered manager how the matters discussed at staff meetings were communicated to staff who did not attend. She told us a copy of the minutes was posted to each member of staff, as well as being fixed to the office wall. We saw from the minutes that reminders were given out about best practice, and information about the service, while also staff had the opportunity to raise issues which affected them. The two directors of the provider were present at the November 2015 meeting, and the registered manager told us they regularly attended staff meetings, which showed they were engaged with the details of the business. These meetings, alongside the supervision sessions, meant that staff could contribute to the management of the service and raise questions appropriately.

There was a thick folder of policies in the office. At one of the staff meetings staff were encouraged to read the policies. The folder had 21 sections, some with multiple policies. We saw that the index was out of date in that it referred to CQC outcomes, which are no longer part of CQC regulation, but in the main text the policies referred to the fundamental standards, introduced in April 2015.

The registered manager checked a sample of completed MAR sheets each month to verify they had been completed correctly. The registered manager had reminded staff in November 2015 about the need to sign the MAR sheets whenever they gave or prompted medicines. An electronic record was kept of these checks.

The registered manager told us she completed audits of all files, including care records and staff files, on a

regular basis, in order to check they contained necessary information. We saw evidence on the care files we looked at that these audits had been done. However, the registered manager told us she kept no records of when these audits were done, therefore could not state which care files had been audited. An effective audit process would maintain a record of which files have been audited and also a record of issues identified during these audits and action taken as a result.

We asked whether there was any external scrutiny of the service, whether by the provider or by someone independent. The registered manager told us that the provider took a keen interest, but there was no record of audits by the provider. This meant the provider could not demonstrate their role in the governance of the service.

Surveys were sent out to all the people using the service in January 2016. Only three surveys had been returned. Given the length of time that people used the service, on average two to three months, we discussed with the registered manager whether there was a better method of capturing feedback from everyone who used the service over the course of a year. We also suggested that the wording of the survey could be revised to make it more accessible to people using the service.

We recommend that the provider investigate ways to improve the use of surveys of people who use the service.

The registered manager was aware of the need to notify the CQC of events which needed to be reported, and had made such notifications in sufficient detail. She had co-operated with an investigation into a safeguarding allegation made by hospital staff regarding a care worker who had been supporting someone in hospital. This showed she understood her role and responsibilities in relation to the safeguarding process.

One of the issues facing My Care Direct was the rapid turnover of staff. Only two staff out of 13 had worked for more than 12 months. Five staff had started within the last four months. This lack of experience was partly compensated for by the high rate of uptake of training, mentioned earlier. Whilst a high rate of turnover of staff is a feature of the home care industry, this rate of change was particularly high. It would make it more difficult to maintain consistently well trained and experienced staff. The registered manager acknowledged that this was an issue, but said that the rates of pay they could offer did not encourage retention of staff. She added that the emphasis on training was something she hoped would attract staff to stay.

We concluded that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The governance and systems for assessing monitoring and improving the quality of the service were insufficiently robust to ensure compliance with the Regulations. The registered manager had sole responsibility for the management functions. She was not able to demonstrate the effectiveness of care plan audits because no record was kept of which files had been audited. The breaches of Regulations relating to training, use of the Mental Capacity Act 2005, and complaints handling, indicated a need to improve quality monitoring. We also considered that the service needed to be able to demonstrate that when it took on care packages from Trafford Council it could ensure the safety and welfare of people using the service.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the provisions of the Mental Capacity Act 2005 Regulation 11(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider was not operating effectively a system for identifying, receiving, recording, handling and responding to complaints Regulation 16(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems to assess, monitor and improve the quality of the service and mitigate risks to service users Regulation 17(1) , (2)(a) and 2(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training to enable them to carry out their duties.

Regulation 18(2)(a)