

The Human Support Group Limited

Human Support Group Limited - Sale

Inspection report

59 Cross Street
Sale
Cheshire
M33 7HF

Tel: 01619429490
Website: www.homecaresupport.co.uk






Date of inspection visit:
24 April 2017
25 April 2017

Date of publication:
27 July 2017

Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This was an unannounced inspection, which took place on 24 and 25 April 2017. This meant the service did not know we were coming on the first day. By arrangement, we returned for a second day of inspection. The inspection was prompted by the outcome of a coronial investigation dated December 2016 into the death of a person who had received care and support from this service from February 2014 to January 2016. Coronial investigations (or inquests) are undertaken to determine the cause or manner of a person's death. We also had concerns about missed visits and what systems were in place to prevent reoccurrence, and failure to report notifiable incidents.

Prior to our inspection visit, we contacted the nominated individual to request information on how they had addressed the concerns raised by the coroner. A nominated individual is a person employed as a director, manager or secretary of an organisation with responsibility for supervising the management of the regulated activity. Given the serious nature of the concerns raised by the coroner, we wanted to be sure the service was doing everything possible to mitigate risks to other users of the service. The service was last inspected in November 2016. We identified no breaches in regulation at that time and the service was rated 'Good'.

Human Support Group – Sale (HSG – Sale), also referred to as Homecare Support, is a domiciliary care service which provides personal care and support to people in their homes to help them remain independent. HSG – Sale supports people living within the Trafford borough of Greater Manchester and Salford. There is also a reablement service called SAMS (Stabilise and Make Safe) which provided short intervention care for up to three weeks. The majority of people using this service had been discharged from hospital and the aim of the reablement team was to help them to regain and maximise their previous level of independence. SAMS was only operated within the Trafford area. The service also offered practical care tasks such as shopping, laundry and ironing. HSG – Sale is also registered to provide treatment of disease, disorder or injury but was not currently providing these services. At this inspection, the service supported 220 people, 27 of whom received support from the SAMS service.

At the time of this inspection there was a manager in place who had registered with the Care Quality Commission (CQC) in January 2017, having been in post since November 2016. 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 they felt safe with the care and support provided by the service.

Risk assessments did not always provide clear and specific information to help staff deliver care and support people safely. We noted that support plans did not contain sufficient information about administering particular medication. This meant people were potentially at risk of harm.

Staff were aware of safeguarding principles and told us they would report any concerns in this area to the relevant authorities. We noted the provider's safeguarding policy referred to outdated legislation which meant staff were potentially referring to documents that were not completely fit for purpose.

There were adequate systems in place to help ensure missed and late visits were minimised. People and relatives told us missed calls were infrequent.

People and relatives told us care staff demonstrated good hygiene practices by using personal protective equipment (PPE) such as gloves and aprons, and washing their hands as required. If used appropriately, this practice should help to prevent the spread of infection or cross-contamination. We did receive one piece of negative feedback in relation to the use of PPE and brought this to the registered manager's attention. They told us this would be addressed during spot check visits.

We found the provider's recruitment processes were robust, ensuring that all appropriate checks were done before staff started working with people. This should help ensure suitable staff were recruited.

We noted there was an effective system of reporting and monitoring accidents and incidents that took place within the service. We saw that lessons learnt were shared across the provider's network of services.

People and relatives told us staff were competent in delivering care and support.

The registered manager had a good understanding of Mental Capacity Act 2005 and how this legislation should be used to protect people. The service had systems in place to help ensure people who lacked capacity were helped to make decisions that were in their best interests.

The service had formal systems in place to train and support staff. We noted not all staff had undertaken required refresher training according to the provider's policy. There were gaps in key areas such as moving and handling, falls awareness, and effective communication/record keeping. This meant some care staff were not up to date with the knowledge and skills needed to support people safely and effectively.

People and their relatives told us they knew care staff would support them if they needed any medical attention. Care staff told us if they observed that people needed healthcare support they would report these concerns to the office and record them in people's daily comments book. This showed staff could be proactive in making sure people received the right health care when they needed to.

People and relatives were happy with the quality of care and support they received from HSG –Sale. They told us they thought of the care staff as friends or family. People appreciated they had regular carers because this encouraged relationship building and trust. One relative raised concerns about the weekend staff not always demonstrating caring and compassionate support. Staff told us they had a good understanding and knowledge of the people they cared for. People and relatives we spoke with confirmed this.

People and relatives told us they had been involved in care planning decisions and care plans we looked at confirmed this. They said care staff supported them to maintain their independence according to their abilities. Care staff were able to give us examples of how they did this.

Each support plan contained personal and medical information about people, their preferences, personal goals and how they wanted to be supported. Some care plans we looked at contained detailed descriptions of support provided. However we found examples where the service did not ensure that support and care

provided was responsive to that individual's needs.

There was a robust complaints process in place and everyone we spoke with knew how to raise a complaint. People told us they had opportunities to provide feedback on the service they received through a questionnaire regularly sent out. The registered manager told us actions were taken as appropriate. We saw summarised results of surveys sent out in May 2016 and December 2016 but were not provided with the actual number of people who responded and what action, if any, had been taken to help improve the service provision.

The provider had established a befriending service which was registered as a charity. This service was free of charge and provided a responsive approach to helping to address issues of loneliness and social isolation amongst people using their service but also the wider local community.

People told us they would recommend this service to others and some had done so. They found the office staff were helpful when they had to contact the office. Staff said they felt supported by their managers. The registered manager said they had the support of the senior management team.

We saw various changes and improvements to processes and documentation had been made to help ensure concerns raised in a coronial investigation were addressed. However we were not assured that these had been embedded thoroughly. We will check at our next inspection to see how these changes have been sustained.

The provider had quality assurance systems in place to monitor, for example, staff performance, care plans and medication administration. However these did not consistently identify areas requiring improvement. This meant the registered manager and provider could not be consistently assured all aspects of the service provision was safe and effective.

The registered manager told us staff meetings were held four times a year. Staff meetings give staff the opportunity to discuss their work and share information with managers and colleagues. Some staff told us their team had not had a meeting for some time but that they felt supported by management.

We made a recommendation that the provider ensures operational policies and procedures are reviewed and updated as appropriate.

During this inspection we identified two breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment and person centred care. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

People told us they felt safe with the service and the care staff supporting them were consistent. Recruitment processes were robust and gave strong assurances that appropriate care staff were employed.

Risk assessments did not always contain sufficient details to help care staff support people safely.

Documentation in support plans pertaining to medication did not contain relevant information to guide staff to administer medicines safely.

Is the service effective?

Good 

The service was not always effective.

People told us they had confidence in their care staff's skills and knowledge and they felt they did a good job.

The registered manager had a good knowledge of mental capacity and there were systems in place to ensure the service operated within the principles of the Mental Capacity Act 2005.

The provider had a comprehensive programme of induction and on-going training in place.

Is the service caring?

Good 

The service was caring.

Everyone we spoke with responded positively about their experiences with the care staff. Care staff demonstrated good knowledge of the people they supported.

People told us they were treated with dignity and respect and supported to maintain their independence according to their abilities. Care staff were able to give us examples of how they did this.

People and relatives we spoke with said they had been involved in decisions relating to their care provision. Support plans we looked at confirmed this.

Is the service responsive?

The service was not always responsive.

Support plans did not always provide specific and person centred information about the care they needed.

The service sent out a survey questionnaire to get people's feedback on the service they received. We were provided with the summaries of two recent surveys undertaken but no information about how service used these results to drive improvements.

People told us they knew how to raise concerns and make formal complaints. There was a robust complaints process in place and we saw the provider's complaints procedure was included the service user guide.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

People told us they would recommend this service to others. There was a registered manager in post and staff told us they were approachable and supportive.

Governance systems did not consistently monitor all aspects of the service provision to help ensure risks to people's health, safety and well-being were reduced.

There were policies and procedures in place that covered all areas of work, some of which required updating. We recommended the provider ensures that operational documents were updated and fit for purpose.

Requires Improvement ●

Human Support Group Limited - Sale

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 24 and 25 April 2017 and was unannounced on the first day. This meant the service did not know we were coming. We returned on the second day by arrangement. The inspection was prompted by the outcome of a coronial investigation dated December 2016 into the death of a person who had received care and support from this service between February 2014 and January 2016. We also had concerns about missed visits and what systems were implemented to prevent reoccurrence and failure to report notifiable incidents. Prior to our inspection visit, we contacted the nominated individual to request information on how they had addressed the concerns raised by the coroner. A nominated individual is a person employed as a director, manager or secretary of an organisation with responsibility for supervising the management of the regulated activity. Given the serious nature of the concerns raised by the coroner, we wanted to be sure the service was doing everything possible to mitigate risks to other users of the service. The service was last inspected in November 2016. We identified no breaches in regulation at that time and the service was rated 'Good'.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert was a person who had experience in domiciliary care services.

We reviewed the information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

Following our site visit we contacted the local authorities of Trafford and Salford, and Healthwatch (Trafford) to find out what information they held on the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

During our inspection and by prior arrangement, we spoke with ten people and nine relatives on the telephone and visited one person in their home. We spoke with members of staff including the registered manager, the quality monitoring officer, one care coordinator and three care assistants including one senior care assistant. We looked at records relating to the service, including eight care records, seven staff recruitment files, policies and procedures and quality assurance records.

Is the service safe?

Our findings

We asked people using the service and their relatives if the service was safe. People told us, "Yes, definitely. I was with other ones (care companies) and didn't like them", "I trust them 'cos sometimes I'm in bed" and "Yes, very safe." Relatives told us their family members were safe when in the care of HSG – Sale. One relative said, "[Name] is very safe with them (care staff)." Another told us, "Yes (regarding safety) almost certainly. I would normally intervene if I felt there was anything unsafe or if something's not been done." A third relative said, "Yes, they're very good and [Name] is safe and they're (care staff) absolutely fabulous." A fourth relative told us, "Yes I feel confident that [Name's] safe and if anything wasn't right, I'd say so."

We looked at eight people's support plans to see what considerations had been made for assessing risks. Risk assessments should provide clear and person-specific guidance to staff and ensure that control measures are in place to manage the risks an individual may be exposed to. We saw risk assessments for the environment, control of substances hazardous to health (COSHH), moving and handling, mobility equipment and medication. We noted some risk assessments did not always provide specific and clear explanation about what should be done to minimise or manage the identified risks safely.

For example, one person's moving and handling risk assessment contained information about their risk of pressure ulcers, which they had, and this was rated as medium risk. They were also fitted with a catheter also rated medium risk. We did not see any information about the location of the pressure ulcers nor was there further assessment on how the person's pressure care was to be managed. We advised that the care staff should complete a body map to identify and monitor these pressure areas. We spoke with the registered manager about this and they told us the person's pressure care management was managed by district nurses. Their support plan did not state what support the person required, for example if they needed to be turned when care staff visited. We saw a general risk assessment which referred to falls and the way to manage this risk was to ensure the hoist was serviced. We did not see any information about the person's history of falls nor were there any considerations about them trying to stand and how the person would be made safe.

Another person's support plan identified they needed support while eating or drinking and this was assessed as a medium risk. But we did not see that a risk assessment had been completed. The person's risk around use of a zimmer frame to mobilise was rated as medium and action to be taken to manage this risk was "(person) to be observed at all times using Zimmer frame." We did not see anything further to indicate if this action sufficiently managed the risk of falling. Also, the person was fitted with a catheter but their support plan did not consider any risks that could be associated with this medical equipment.

In a third person's support plan, we saw notes about a condition related to their Parkinson's disease which involved them going into a deep sleep so that staff would have difficulty waking them up. We did not see any actions to guide staff should this occur during a care call.

Another person's support plan review identified changes in the person's medicines to include the use of 'thickeners' in fluids. Thickener medicines are added to drinks, and sometimes to food, for people who have

difficulty swallowing; they may help to prevent a person from choking. We saw the Speech and Language Team (SALT) had assessed the person and there was documentation from SALT within their care records. We noted the care plan did not state that care staff should follow the SALT guidelines. This meant we were not sure care staff would be adequately equipped to support this person safely.

Based on the previous examples we could not be certain staff had sufficient information to guide them on how to reduce or eliminate the risk so people were kept safe from harm. These were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where help was required, people we spoke with said they were supported to take their medication safely. We saw people who needed support taking their medication had a separate support plan to guide staff with what was required. In one person's medical support plan, it identified they took an anticoagulant medicine but there were no details regarding the level of support required, dosage or when required. Anticoagulants are medicines that help prevent blood clots and are prescribed to people at a high risk of getting clots, to reduce their chances of developing serious conditions such as strokes and heart attacks. Following our site visit, we sought clarification from the provider that staff had appropriate guidance to administer these medicines safely. They provided evidence that staff received specific medication training which instructed them to refer to information from district nurses or blood clinics who were responsible for determining the dosages for these medicines. We were satisfied there were safe practices in place to support people to take their medicines.

Staff we spoke with were knowledgeable on how to keep people safe in their homes and told us they read people's support plan as required and previous days' notes in the comments book. Staff said they would call the office, report any concerns they had and also make a record in the person's daily comments book.

Staff gave us examples of how they kept people safe such as making sure the person's environment was free from trip hazards and that doors were closed and locked appropriately. Staff we spoke with had a good understanding of what safeguarding meant, types of abuse and told us they would report suspected abuse to their manager.

The provider had a detailed safeguarding policy in place which included definitions of abuse, clear procedures on actions to take, mandatory training which should be refreshed every two years. Although training was still valid, we noted about 45 percent of staff had not had their training refreshed in line with the provider's policy.

The policy referred to the "No Secrets Guidance" which was replaced by the Care Act 2014. The Care Act is legislation that sets out how people's care and support needs should be met and introduces the right to an assessment for anyone, including carers and self-funders, in need of support. The act also sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

Prior to our inspection in November 2016, we noted there had been several instances of missed calls. At that inspection the area manager told us systems had been improved and the issue of missed visits had been rectified. At this inspection, we asked people and relatives about their experiences of missed or late visits. Most people and relatives told us they had infrequent or no missed visits but that care staff were sometimes late but the office would phone them to let them know. Their comments included: "Sometimes they're a bit late in the evenings but they're on time in the mornings for washing and dressing me", "They missed one (visit) last year but that's very rare", "They're late sometimes if they have an emergency with other people before coming to us" and "They've not missed calls but they did phone once when they were late".

The registered manager said there was now improved communications between care coordinators and their team of care staff. The registered manager told us each morning they and the care coordinators checked the service's response log which recorded all calls coming into the service for example, if care staff were running late, a visit was missed or a complaint. The registered manager told us they monitored these irregularities through regular reporting and took action, where appropriate. We concluded there were adequate systems in place to minimise missed visits.

Most people and their relatives told us care staff demonstrated good hygiene practices by using personal protective equipment (PPE) such as gloves and aprons, and washing their hands as required. Staff we spoke with confirmed how they used PPE and understood the importance of PPE usage in relation to managing infection. One relative told us, "Yes, they always wear gloves and very neat, tidy and clean." However one relative told us, "They wear gloves but no aprons and they use the same gloves (all the time for different tasks)." This practice could increase the risk of harm to people. We spoke with the quality monitoring officer who had been recruited in March 2017. They said staff's hygiene practices were monitored through spot checks. Spot checks are an assessment of a staff member's performance while on duty. This should help to ensure effective infection control practices were in place to keep people safe from harm of infection.

People and their relatives told us they had a consistent team of care staff. They said, "There's a regular team of about 8 to 9 carers. I generally know them", "They're really reliable", "Yes, I've got regular ones (care staff) and they all know me", "Yes, there's the same group of carers" and "I've had six carers with me over the 10 years and they know my moods; they know where everything is, I don't have to repeat everything time and time again. It works for both the client and carer, and helpful for the wellbeing of the client." While the majority of comments made were positive, two relatives felt staff consistency only applied on particular shifts and week days as opposed to weekends. They said, "(The staff) are consistently good during the week days" and "The morning carers are consistent and excellent." This meant people were supported by care staff who were familiar with their specific needs.

We checked the service's recruitment procedure to see if staff employed by the service were suitable to work in the caring industry. We reviewed seven staff personnel files. The files we looked at contained appropriate recruitment documents including a completed application form, interview questions and responses which had been scored, two written references, photographic identification documents and confirmation of Disclosure and Barring Service (DBS) checks. 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. The registered manager told us the provider had a system of undertaking risk assessments if a prospective candidate has a caution on their DBS. This information in addition to the registered manager's recommendation would be considered by company directors before making a final decision. This meant the provider had robust systems in place to help ensure suitable candidates were recruited to provide care and support to people receiving services.

We looked at the provider's process of monitoring accidents and incidents and found these satisfactory. We saw that analyses of incidents took place, appropriate action taken if required, for example, retraining, and lessons learnt shared across the service.

Is the service effective?

Our findings

We asked people and their relatives if they had confidence in the care staff's abilities. They said, "They appear to be well-trained", "They just get on with things and we're in a routine", "Most certainly (staff know what they are doing)", "They're well trained", "You can't fault them at all; they're really good." "They've never over-stepped the mark. They're nice girls" and "Training is mandatory and good but there is nothing like experience."

We looked at what consideration HSG – Sale gave to the Mental Capacity Act 2005 (MCA) and checked whether the service was working within the principles of the MCA. The lack of mental capacity assessments being undertaken or arranged for people who may lack capacity was one of the concerns raised in a coronial investigation done as a result of the death of a person who had been supported by HSG – Sale prior to their death. The 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. In the case of domiciliary care services, applications must be made to the Court of Protection (CoP). The registered manager confirmed that no one receiving services was subject to CoP restrictions.

We spoke with the registered manager about how they ensured that people who lacked capacity were helped to make decisions that were in their best interests. They told us the service did not undertake capacity assessments themselves but would refer these cases to a GP or the local authority. We were provided with evidence of this. The registered manager demonstrated good knowledge and understanding about mental capacity and told us care staff had received training in mental capacity and MCA. The training matrix we reviewed confirmed this. Only two staff members we spoke with were able to demonstrate an awareness of the MCA and how this legislation was important in protecting people's rights. We found staff's awareness and understanding of the MCA needed to be strengthened in order to recognise possible deprivation of liberty, and how to raise concerns within their organisation.

On five support plans we looked at, we saw relatives had signed consent documents on behalf of the person receiving care. This demonstrated relatives had been involved in the care planning process. We asked the registered manager about this and they said the person was asked to sign; when this was not possible the service would ask a representative with lasting power of attorney (LPA) to sign on their behalf. We did not see any examples of this in the care records we looked at but we saw there was provision for this information to be captured. The 'attorney' is a person with delegated responsibility for their relative to act on their behalf. Copies of documentation would be requested. We did not see evidence of LPA in any of the care records we looked at. It is good practice to ensure that the appropriate legal authorisation should the person lack capacity to consent to their care. Staff told us they always asked people's permission prior to

undertaking tasks according to the person's support plan and explained what they were doing. People and relatives we spoke with confirmed this. People and relatives also told us they were involved in the care planning process. One person said, "Yes they do sometimes discuss things with me but they also talk to my PA. They're very good."

Staff told us training opportunities at the company were good. They said they had received an induction, mandatory training and undertaken shadowing shifts with experienced staff before they were allowed to work unsupervised. This was also confirmed in their recruitment records. They also told us there was on-going training. The registered manager said the provider had a corporate training function which delivered training across all of the provider's services. They said induction consisted of a four day programme which included a corporate induction into the company and mandatory training such as health and safety, food hygiene, privacy and dignity, moving and handling and safeguarding. Recruitment records and the service's training matrix we looked at confirmed this.

We noted from seven staff files we looked at, the induction programme was based around the common induction standards and the Care Certificate. The Care Certificate is a nationally recognised set of standards to be worked towards during the induction training of new care workers. It is not mandatory, although services that choose not to use it must demonstrate that their induction of workers new to health and social care delivers similar outcomes. The registered manager told us the provider had aligned its induction provision to the Care Certificate to ensure all mandatory areas were adequately covered. Following our site visit we spoke with one of the trainers and reviewed the training matrix and confirmed this was the case. Induction, mandatory and on-going training should help to ensure staff have the necessary knowledge and skills needed to support people safely and effectively. We reviewed the training matrix and found not all staff had completed the required refresher training according to the provider's policy. We noted gaps in areas such as moving and handling, infection control awareness, falls awareness, effective communication/record keeping and health and safety.

We saw that there were formal systems in place to support and develop staff. These included one to one supervision, appraisals and spot checks. Staff management records we looked at confirmed these were planned for the year 2017 in accordance with the provider's policy.

We asked people and their relatives if care staff had contacted relevant health care professionals on their behalf or raised concerns around their health. People and their relatives told us they felt confident care staff would make appropriate referrals or contact emergency services. One person told us, "I am vocal enough to know when I need medical help. If (care staff) see anything they think I need medical attention for then they'll prompt me to raise with the district nurse." One relative said, "Yes, the carers have done that...they noticed a bad rash on [person's] (body) once and told me (about contacting a nurse or GP)". Another relative told us it was the care staff that, at the initial assessment, identified the likelihood that their relative may be having problems with swallowing and facilitated the appropriate referral to the speech and language therapy (SALT) team. SALT provides assessment of swallowing or communication difficulties for people with medical, neurological and surgical conditions.

One of coroner's findings and concerns raised was that there was no evidence the service had made relevant referrals to the health care professionals as needed. We asked care staff about making relevant referrals to health care agencies including emergency services. Care staff we spoke with told us they would do so as required. One staff member said, "If we start to see a pattern then we'll put measures in. Report it to the office and they'll put it on the system, and document everything – details of how they (the person) were feeling that day, what they refused (e.g. medicines, food) and any reasons given, so that the next carer understands the position of how the person was feeling and we can get an idea of how they were."

Following the outcome of the inquest, we requested information from the provider about the actions they had taken to address the concerns raised. The inquest had identified a lack of reporting incidents to the office and to relevant health agencies, assessing a person's mental capacity and poor recordkeeping. The nominated individual told us the registered manager had met with the care staff involved in supporting the person to discuss the issues raised, reflect on practice and the lessons to be learnt for future. We saw evidence to support these discussions and spot checks of staff performance; these actions helped to ensure staff were recording appropriately in the daily comments books and reporting any issues they may find at a visit. We saw other actions taken by the provider included covering accident and incident reporting at induction training, and recordkeeping and effective communication training. The registered manager told us and we saw evidence that lessons learnt have been shared with other staff via meetings, training, staff spot checks and leaflets. We concluded the service had made improvements in these areas to help ensure effective care and support was delivered to the people they served.

Is the service caring?

Our findings

People we spoke with responded positively to the service being caring and the caring abilities of the care staff. Their comments included: "Yes, they're (care staff) very caring", "The carers are very good; I'm very happy", "In terms of the staff being kind and caring, they are excellent" and "The girls are so caring and understanding."

One relative told us they were very happy with their relative's care staff as "they all know him well and work well together. They all have a good sense of fun and give me a sense that we are all working together."

People and relatives were complimentary and positive about staff's approach to their role and the relationships they had developed with people. People told us staff knew them and what they preferred because they were supported by the same team of care staff. One relative said, "Yes, they know her very well". Another relative told us, "(The care staff are) very patient and very good with [person], always communicating with (them)." However a third relative told us while on the whole care staff were caring those staff who visited on weekends seemed to just "come in and go out".

Staff were knowledgeable about the people they cared for. They had a good understanding of people's personalities, preferences and their support needs. Care staff told us, and "I just got a good connection with my clients." People confirmed this. One person told us, "They know my little quirks and what I like and don't like." Another person said, "It's like friends coming in. I can have a little bit of a laugh with them." This meant that people were supported by staff who understood how best to support them.

People and their relatives told us care staff always provided care and support in a respectful and dignified way. From our conversations with people and relatives we noted that staff followed appropriate protocols such as covering the person with a towel when undertaking personal care, closing curtains and doors as appropriate. One care staff told us, "I make them feel comfortable and secure. I always treat my clients like it's my mum, my dad, or how I'd like someone to treat myself."

We asked if people and their relatives, where appropriate, had been involved in decisions relating to their care and if they had seen their care plans. The majority of people we spoke with told us they had been involved in decision making. All eight support plans we looked at showed that people had been involved in the care planning process.

People and their relatives told us the care staff helped them to maintain their independence by encouraging them to undertake tasks on their own and providing help appropriately. People said, "Yes, they do get me to do things I can do by myself", "I had a stroke a few years ago and it's left me weakened on my left side so they (care staff) do encourage me appropriately" and "Yes, they (care staff) encourage me saying things like 'you did it yesterday, you can do it today.'" Relatives said, "(The care staff) are always talking to [person] and coaxing [person] to do things (on their own)" and "The morning ones (care staff) are very patient with [person] and go the extra mile to help [person] with (their) walking."

Is the service responsive?

Our findings

We looked at eight support plans to see how people's needs were being met. The quality monitoring officer told us they undertook an initial assessment of people's needs. People who use the service and their relatives confirmed this. This should help to determine whether or not the service could provide the care and support needed. In addition to initial assessments, each support plan contained personal and medical information about people, their likes and dislikes, personal goals and outcomes and how best to support that person. We noted that support plans were reviewed annually or when people's circumstances changed and a new support plan was put in place if required.

Some care plans we looked at contained detailed descriptions of the support to be provided. For example, in one person's support plan we saw specifics around the tasks care staff had to undertake including which topical creams to use and where staff would find necessary items such as flannels and bath towels.

We reviewed two support plans which did not contain sufficient information to help staff support people safely. One person's support plan identified they needed continence care and monitoring of pressure ulcers but we did not see any specific information about managing these. Another person's support plan review done at the end of March 2017 identified changes in the person's medication but we did not see an updated care plan in place (end of April 2017) nor was there specific guidance to help staff manage any risk around these changes. These examples were a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not ensure care and support provided was person-centred and responsive to people's needs.

People told us that they knew about the service's complaints procedure and would use it if required. Most people said they would phone the office to discuss any issues they had with the service provided. One person told us that they had used the complaints process in the past and were satisfied with the way in which the service had dealt with the issue. They added if they had any concerns they would contact the care coordinators in the office and discuss these. We noted the service's complaints procedure was included in the service user guide and we saw a copy of this in people's care records.

The registered manager described the provider's complaints process was that all complaints were investigated by the registered manager unless the complaint involved them. In this case the investigation would be undertaken by the performance team. The registered manager told us that the performance team provided quality assurance support which helped to ensure a thorough and unbiased resolution based on the evidence at hand. We saw a record of the most recent complaints received, February to April 2017 and noted that three complaints had been dealt with. We concluded the service had an effective system for managing complaints and we saw evidence that complaints had been investigated and action taken as appropriate.

We asked the registered manager what mechanisms were in place to get feedback from people about the care and support provided. The registered manager told us the service sent out a questionnaire to people every six months. People we spoke with confirmed that they were asked to provide feedback on the care

and support they received. The registered manager said the service also undertook a telephone survey periodically but this was done in a more reactive way. For example, if there had been an issue with someone's care then the care coordinators would follow up with a telephone call to find out if there had been any improvements and what people thought. While we saw summarised results of surveys sent out for both domiciliary care and reablement services in May 2016 and December 2016, we were not provided with the actual number of people who responded and what action, if required, had been taken by the provider to help improve the service provision.

The provider had also established a befriending service which is a registered charity and covers Greater Manchester and Salford. This was a separate and free of charge service which relied on volunteers to visit people in the local community who were lonely or may be feeling socially isolated. We spoke with one of the coordinators who explained how people were matched with befrienders and that volunteers had to undergo DBS checks and an induction prior to joining the service. At the time of this inspection, the befriending service supported 120 people, some of whom were also receiving domiciliary care support from HSG - Sale. This was a good example of how the provider had identified and proactively responded to a need within the local community.

Is the service well-led?

Our findings

Prior to our inspection visit, we contacted the nominated individual to request information on how the provider had addressed the findings of the inquest and coroner's concerns as detailed throughout this report. We also had additional concerns about how the service ensured missed visits were prevented or minimised and whether notifiable incidents were appropriately reported and we asked them about these. They provided us with actions the provider had taken as a result, lessons learnt and further actions and improvements to be made.

We acknowledged the provider had undertaken substantial work to help ensure, where possible, people they provided support to were protected from risk of harm. We saw support plan documentation had been updated to include risk of falls and falls management and that policy development in falls management was being undertaken. The registered manager told us and we saw that care staff had been spoken with regarding their responsibilities through spot checks and staff meetings. We concluded the provider had responded in a satisfactory and proactive manner to the outcomes of the inquest to help ensure care and support provided was safe and effective.

We checked our records to see whether the service met its legal requirements regarding reporting notifiable incidents. We found that the registered manager ensured statutory notifications had been completed where appropriate and sent to Care Quality Commission (CQC) in accordance with legal requirements. Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC.

We identified some areas for improvement such as updating staff's awareness and knowledge of mental capacity and risk assessments. We will check at our next inspection to see if the required improvements have been embedded within the service.

We saw the provider had various quality checks in place to help ensure adequate monitoring of quality and performance of the service. These included staff spot checks, support plan audits, daily comments books, medication administration record checks and audit of staff personal files. The registered manager told us they were supported by the quality monitoring officer in undertaking these audits such as spot checks and auditing customer documentation such as daily comments books.

The registered manager told us part of the audit process involved an internal audit done by the performance team which looked at how the service was performing and should identify any areas for improvement. From an email we saw this annual audit was due to take place on the second day of our inspection and was subsequently postponed. The registered manager told us the performance team monitored and analysed data and tracked trends for key operational areas such as missed calls, safeguarding referrals and complaints.

We saw evidence the registered manager had started doing regular checks of people's support plans to ensure these were up to date and identified appropriate action to rectify such as schedule a review or create a new support plan. However these audits had not identified the issues we had found.

The registered manager told us they collated and sent key performance indicator (KPIs) information on a weekly basis to the senior management team. KPIs included staff management, safeguarding and complaints. When reviewing staff training and supervision records, we noted a small mismatch between the number of staff that appeared on the training matrix and those on the supervision record. We concluded the registered manager and provider may not always have full oversight of those staff members who required professional development. Following our site visit, the provider gave us a satisfactory explanation of why such mismatches would or could occur. For example, new staff who had completed mandatory training but the service had not yet received all necessary pre-employment checks.

We asked people and relatives their views about the management and quality of service provided. People and relatives told us they found the office staff were helpful when they called in. With the exception of one relative, everyone we spoke with said they would recommend this service to others and one relative had done so. Their comments included: "I would (recommend)...without it, I would have been stranded", "I'm reasonably happy with the continuity of care that I'm being given", "Yes (I would recommend them) and I'd say it's because they're caring and they come at the right time and they seem to know what their duties are", "They're trustworthy and good" and "I'm happy with it; they do go that extra mile." One relative while satisfied with the care provided for her relative told us the service potentially lost competent new care staff because of the demands "thrown at them" in relation to the numbers of visits they are allocated.

HSG - Sale had a manager who had been in post since November 2016 but whose registration with Care Quality Commission had been confirmed in January 2017. They told us as registered manager they were responsible for both service provisions – domiciliary care and the reablement services. Prior to this inspection, each service was managed by separate registered managers. The registered manager said there were four care coordinators (one recently recruited) who reported to them. Each coordinator was responsible for a specific geographic area and managed the care staff working in that area. They felt confident there were adequate resources and support in place to help the new care coordinators and the whole team to function more effectively.

The registered manager told us their presence had provided much needed stability to the location. They told us they felt supported by senior management and added that the managing director was "very supportive and I could ring (them) at any time" and they would be provide help as required. They said, "I wouldn't be here if it wasn't for the support of the head office." Staff spoke highly of the organisation and the registered manager. They said, "I feel there is clear, effective leadership", "As an organisation they have been very supportive to me. If I needed anything they would help me out. They would call me to find out if I was okay" and "100% support from [registered manager]."

We saw the provider had comprehensive policies and procedures in all areas of work and human resources to guide staff in their roles. These included medication, mental capacity act and whistleblowing and helping people with finances. It was not clear how often these were reviewed or updated, for example, the safeguarding policy previously mentioned in this report contained outdated legislation. We recommend the provider should ensure operational policies and procedures are reviewed and updated as appropriate to be fit for purpose and effectively support staff.

The registered manager told us team meetings happened across the four coverage areas of the service, namely, Partington, Stretford, Timperley and Sale. The reablement team had separate meetings. The registered manager said meetings were held about four times in a year and the care coordinators chaired them. The registered manager told us they would add items to this agenda or attend as needed. We noted three coverage areas had had staff meetings in September 2016 and October 2016. The reablement team had met in April 2017. We were not provided with meeting minutes for the Sale area. Staff meetings provide

a forum for care staff to discuss issues relating to their work and ensure they are always kept up to date on matters affecting the service provision. Staff working in the Sale area told us though they had not had a staff meeting for some time they felt supported by their managers and could come into the office to speak with a manager.

We saw a variety of compliments received between January 2017 and April 2017 some of which had been forwarded to the service by one of the local authorities. We noted both care staff and the branch in general were complimented for their "friendly and attentive way they cared for people" and staff who went above and beyond their mandate. We saw the service shared compliments with the staff and sent acknowledgements to people and their family.

This section is primarily information for the provider

Action we have told the provider to take

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

| Regulated activity | Regulation |
|--|--|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | Support plans were not responsive to people's specific needs and did not contain detailed information to help care staff support people in a responsive way. Reg 9(1) |

| Regulated activity | Regulation |
|--|--|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | Areas of risks to people's health and well-being had not been adequately assessed and planned for so that people were kept safe. Reg 12(2)(b) |