We Care Solutions Manchester Limited

Chorlton

Inspection report

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Date of inspection visit:
07 December 2016
12 December 2016

Date of publication:
03 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over three days. On 7 December 2016 we visited the office. We gave 24 hours' notice of this visit in order to ensure the registered manager and other staff would be present. On 9 December 2016 we made telephone calls to people using the service and their relatives. On 12 December 2016 we returned to the office to complete the inspection and give feedback.

This was the first inspection of this service. There had been a previous service run by the same provider since July 2014, which had moved offices in January 2016 and become registered as 'Chorlton' in March 2016.

'We Care Solutions Manchester Limited' is the name of the provider and is the name by which the service is generally known. 'Chorlton' is the name of the service registered with the Care Quality Commission (CQC), and therefore is the name used in this report. We discussed with the provider changing the registered name to reflect what the service is usually called.

The service is a domiciliary care agency providing care and support to people living in their own homes. Their office is in Chorlton in south west Manchester and they provide the service around the Chorlton area and also in Wythenshawe. At the date of this inspection they had approximately 30 people using the service in the Chorlton area and 20 people in Wythenshawe.

The service had a registered manager who had been registered since March 2016, and had previously been registered with the predecessor service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that some checks of potential employees were made, but that some staff had been allowed to work on their own without a valid Disclosure and Barring Service (DBS) certificate. This was a breach of the regulation relating to employing people of good character.

Staff had been trained to use equipment and the people we spoke with felt safe when they were being moved.

People were told that staff would arrive within a half hour window, and this meant that late visits were rare. There had been one missed visit during 2016 but measures had been taken to prevent a recurrence. Support workers were using a new system to log in and out of calls via their mobile phones. This system had not yet fully bedded in, and was not being used in the Wythenshawe area. We have made a recommendation that the provider installs a reliable system to prevent missed or significantly late calls.

There was usually consistency with the same staff providing support, which provided reassurance to people using the service. Staff had been trained in safeguarding and knew what signs of abuse to look out for. The

provider had reported incidents appropriately. This meant that people were protected from the risk of abuse.

Some people received assistance with medication. Staff were trained in this area and we gained evidence that they recorded the medicines they had given correctly.

Staff had received training in the Mental Capacity Act 2005 (MCA), and the staff sought consent for care interventions. However, if people lacked capacity or might lack capacity to make their own decisions, the service did not carry out coherent mental capacity assessments. This was a breach of the regulation about acting in compliance with the MCA and potentially meant that people could be receiving care or support where consent had not been obtained in the correct way.

There was an induction training package for new recruits which included shadowing existing support workers. Staff then took the Care Certificate. There was also training for experienced staff. There was no overall record which showed what training all the staff had received.

Staff supported people when appropriate to access health services. They were trained in food hygiene in order to assist some people with food preparation.

People receiving the service gave, on the whole, very positive feedback about the staff and the support.

People told us that staff catered for their emotional needs as well as the physical, and sometimes went beyond what they were expected to do. They encouraged people's independence and helped them maintain their hobbies and interests.

We saw from training documents that the staff were taught to treat people with dignity. People we spoke with confirmed they were treated respectfully. Care files were treated as confidential.

We looked at care plans and found them to be very basic, in some cases merely reproducing the information supplied by the council. There was little or no information which would enable staff to deliver person-centred care. Nor was there any evidence on the files that care plans had been reviewed, although some people told us that staff had discussed their plan with them.

The care plan template was not adapted to make it suitable for use. Risk assessments and medication plans were not kept with the care plan so it was difficult to form a complete view of a person's care needs. The deficiencies in care planning were a breach of the regulation relating to meeting people's needs.

The service was responsive to people's preferences to have a support worker who spoke a particular language, where possible.

There was a policy for dealing with complaints, and we saw that these were responded to and recorded. People receiving the service and most staff expressed satisfaction with the management of the service. A local social worker who commissioned care packages was also very positive about how the service was run.

The Chorlton office was well staffed and was using modern technology to improve the quality of the service. The staff in Wythenshawe were managed differently and used less advanced systems, which created the risk of inconsistency in the quality of the service.

The system of care planning audits was defective as there was no accurate record of which files had been

audited, and no record of what the audit involved. The breaches of regulations at this inspection indicated that the quality monitoring of the service required improvement. This was itself a breach of the regulation regarding assessing and monitoring the quality of the service.

A questionnaire had been used in August 2016 to gain people's views about the service, and had resulted in some improvements. Spot checks were used regularly to monitor staff performance.

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

Requires Improvement

The service was not always safe.

Not all required checks on new employees were completed before they started work.

The service was reliable with few late calls reported to us. There had been one missed call but action had been taken to prevent a recurrence.

Staff were equipped to assist people safely if they needed moving, and with their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

There had been some training in the Mental Capacity Act 2005 but staff did not follow its principles when assessing whether people had capacity to consent to their care and support.

There was a programme of induction training and new staff were taking the Care Certificate. There was no overall record of the training received.

Is the service caring?

Good

The service was caring.

People told us they were treated with kindness and respect. This matched the results of a questionnaire from summer 2016. They said that staff met their emotional needs.

People said they were encouraged to remain independent, and involved in interests and hobbies where possible.

Staff respected people's dignity and the service was careful with confidential information.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans lacked detail and did not provide enough information for staff, especially new staff who had not met the person receiving the service.

There was no adequate evidence that care plans were reviewed.

Complaints were dealt with according to the policy. Only one person we spoke with told us they had made a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

We received favourable comments about the management from people using the service and a local social worker. We observed differences between how the service was managed in Chorlton and how it was managed in Wythenshawe.

The audits of care plans were not effective, and there was no record kept of the audits. The audits had not identified the faults in care plans.

Questionnaires were used to assess how people liked the service.

Chorlton

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.

The inspection took place over three days on 7, 9 and 12 December 2016. We gave 24 hours' notice of our first visit because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection was carried out by an adult social care Inspector. On 9 December 2016, an expert by experience made telephone calls to people using the service and their relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert by experience had experience of caring for elderly people.

Before the inspection we reviewed all the information we had about the service. This included notifications sent in by the service, and records of safeguarding meetings we had attended. We contacted a social worker who had experience of arranging care and support provided by the service.

In the office during our inspection visit we talked with the registered manager, the provider, and five other staff including two care staff. We looked at six files containing records of people using the service, including care plans. We looked at seven staff files, policies and procedures, training records, rotas and the computer system, including the process for logging calls.

By telephone we spoke with seven people using the service and nine relatives. We followed up some of the information gathered in the phone calls on our second visit to the office.

Requires Improvement

Is the service safe?

Our findings

We looked at the personnel files of five recently recruited members of staff. We saw that all the necessary checks of job applicants' identity and employment record had been carried out. The application requested job applicants to explain any gaps in their employment history. 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.

We saw on some of the files a record of the Disclosure and Barring Service (DBS) certificate number. 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. However, we saw on some files that the DBS certificate had not yet arrived. The provider and the registered manager assured us that in these circumstances the support worker would not be permitted to work alone with people using the service, but only alongside another support worker. The presence of a second support worker would reduce the risk if concerns were later raised about the staff member's suitability to work with vulnerable people.

However, we found evidence that some support workers were working alone before their DBS certificate had arrived. This evidence was confirmed by information on staff files showing they had not yet received their DBS certificate. This was a breach of Regulation 19(1)(a) and (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people using the service and their relatives whether they felt safe when the support workers came. People told us they felt safe when being provided with care, and that their support workers were competent in using equipment or assisting people to move. There were no reports of accidents or mishaps. 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.

One person told us they needed a hoist to be lifted in and out of bed. They said, "Oh yes, they know what they're doing. I feel quite safe". A relative said, "My wife has Alzheimer's. I watch them use the hoist and it's always done safely and competently; my wife shows no signs of anxiety or distress so I know she is alright."

Some people had keysafes fitted so that support workers could let themselves into the house. Those people who told us about these said, "No problems" and "Everything's fine", and did not report any issues regarding staff accessing their homes in this way.

The provider told us that their usual policy was not to tell people they would arrive at a precise time, but within a half an hour window, for example, "between 8am and 8.30am." This managed people's expectations and meant that people did not report so many late calls. It also meant that staff could stay a little longer at one call if necessary without having to rush off to the next call. People told us that their support workers generally came on time and were only late if there had been traffic problems or an incident at a previous visit. Where delays occurred people told us they were contacted either by the support worker or the office. One relative said, "There's never been any issue with times; they come generally within 20

minutes, and always let me know if they are going to be late." One person did recall one incident when they had arrived an hour late, but nevertheless described them as, "Pretty reliable."

No-one we spoke with could recall any occasion when their support workers had not turned up at all. We asked the provider and registered manager whether they had a record of missed calls. They told us there had been only one in 2016, during the summer months, which they said they had investigated fully. They added they had put in measures to avoid a recurrence.

In the Chorlton area, but not in Wythenshawe, support workers were using a logging in and out system so that the office could know when they had attended a call. This involved staff phoning in using their mobile phones, and the office could detect that they were in the property of the person using the service. This system had only been introduced in October 2016 and was not yet fully operational. We saw from the live screen on the computer that not all staff were using their phones in this way, which made it difficult to identify whether a particular call might have been delayed or missed or it was simply that the support workers had not phoned in.

A further problem with this system was that it did not create an alert if the support worker was late by a defined time or had not turned up at all. It relied on office staff keeping an eye on all the live calls on the screen and identifying any call where they were concerned that the care staff had not turned up. Given that there was no office worker whose task was to monitor the screen, this created a risk that a missed call might go unnoticed, if the person themselves or a relative did not call the office.

The Wythenshawe staff were not using a log in system at all. We were told that the staff all informed a senior care worker at the end of each 'run' or series of calls that they had completed them all. We were assured that there had not been any missed calls in the Wythenshawe area, but there was a risk that if staff missed a call or a series of calls, for whatever reason, the senior care worker and management might not be informed immediately.

There are systems available which raise an alert if the support worker has not arrived by a certain time. The provider told us they were looking at alternative systems. We recommend that the provider install a reliable system which will highlight missed and overdue calls at the earliest opportunity.

People told us the support workers who visited them were usually the same people. One relative said, "I'm very happy with what they do. Four out of the five are the same faces. [My family member] recognises them; they make her smile." Such consistency would cause people to feel more secure if they knew the same support workers were coming regularly.

Staff received training on safeguarding as part of their induction, and received further training including training provided by Manchester City Council. We asked two support workers about their understanding of safeguarding and they were able to describe to us the various forms of abuse that might arise in a domiciliary care setting. They said they would look out for both physical and emotional signs, or changes of mood. They told us they would not hesitate to report any abuse or suspicion of abuse to their managers, or to another authority if necessary. This meant people were kept safe from harm because staff had appropriate knowledge and skills.

We knew from notifications received that the provider understood their responsibility to report safeguarding incidents both to the local authority and to the CQC. There had been two safeguarding investigations during 2016, one of which was still not yet concluded at the date of our inspection. A third safeguarding incident had been raised immediately before the inspection, and the provider was notified of it while we were there.

We asked the provider and registered manager about how they ensured that people who were assisted with medicines received them safely and properly. There was a page on the care plans headed 'Plan of Medication' but this was blank in all six of the care plans we saw. The provider explained that instead they created a list of medicines on the front of every person's file that was kept in their home. We saw this was the case in one care plan in the office. Support workers used this and the instructions on Medicine Administration Records (MARs) to guide them when prompting or administering medicines. Staff received training in medicines as part of their induction. We discussed with the provider the fact that for certain medicines the time at which they are taken is critical, and that therefore those calls especially should be on time.

Most people we spoke with said they or their relatives managed their medication, but where this was supervised by the support workers, we did not pick up any concerns. One person told us, "They stand and make sure I take my tablet, write it down on the daily sheet and if I'm running low they will go to the chemist for me." Another person said they had watched the support workers "writing it down" when they had taken their medication. This showed that support workers were recording medicines on MARs immediately after giving them, which was correct practice.

Staff confirmed that they had access to personal protective equipment (PPE) when undertaking visits to people. People we spoke with confirmed that staff wore gloves and aprons when staff carried out personal care. This meant they were providing protection against the risks of infection.

Requires Improvement

Is the service effective?

Our findings

Several of the people receiving support and care from Chorlton were living with dementia. 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.

We saw from the induction training PowerPoint slides that emphasis was laid on the importance of obtaining consent, where possible. For example, on the slide headed 'healthcare tasks' it stated, "You must always obtain the individual's consent before carrying out healthcare tasks and assisting with medication." People we spoke with confirmed that this happened. One person said, "They always ask first before doing anything." This showed that staff understood the need to obtain consent, where people had the capacity to give consent for their care and support. People also signed a consent form when they commenced receiving the service. The form stated, "I understand and agree the completed assessment of need, and consent to the care." Underneath was a space to record if someone did not have capacity. We saw some care plans where neither part of the form had been completed, so it was unclear whether consent had been obtained or not.

We saw on the files of longer serving staff that they had taken courses in 'MCA awareness'. We asked whether the service had carried out any mental capacity assessments in order to determine whether people could give valid consent and make specific decisions for themselves. The service was using a commercially produced set of forms to assess people's medication needs, and one of these (entitled 'Medication 4: Risk Assessment') included a set of questions which purported to be a mental capacity assessment. The questions did not follow the two stage mental capacity assessment set out in the MCA Code of Practice. The first question was simply "Does the service user lack capacity?" without any guidance as to how the question should be answered. In fact, every test of capacity must relate to a specific decision and should not be put in general terms. A later question was "Does the service user lack capacity to give consent?", again without any explanation or guidance. On one person's form we saw that the member of staff had written "No" in answer to the first question but "Yes" in answer to the second, which was a contradiction.

We raised this issue with senior staff and with the provider. The senior staff said, "If someone needs a mental capacity assessment we put a referral in." Similarly the provider told us "We are not trained to do a mental capacity assessment." This raised the question of the effectiveness of the 'MCA awareness' courses that senior staff had undertaken. We discussed with the provider the legal requirement to presume capacity and the need to undertake mental capacity assessments when there was a question or doubt about a person's capacity. Staff should also be alert to any changes in people's capacity, and react appropriately.

The failure to use appropriate and effective mental capacity assessments when needed meant that the service was not acting in accordance with the MCA. This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they felt their care workers were well trained to do their role. One person said, "I have every confidence in them. They are definitely capable and know what they are doing." There were no adverse comments. We also saw a comment in a questionnaire from August 2016: "The girls are always patient, pleasant and efficient."

We asked the registered manager and provider about the training provided to new recruits. All new staff undertook induction training, and there was a checklist on their files which confirmed they had done it. The registered manager told us she led this training personally, and would usually go through the topics with each person individually, to ensure they understood them. The training included most of the topics relevant to workers in this field, including health and safety, fire safety, infection control, food hygiene, basic life support, medication, moving and handling, the Mental Capacity Act 2005 and safeguarding vulnerable adults. We obtained a copy of the PowerPoint slides used for this induction training. The registered manager said this took a variable amount of time depending on prospective staff's past experience and knowledge. The service did recruit some staff with no prior experience of the care industry, so their induction would take longer. After induction training, staff would shadow an existing support worker (or more than one if they were shadowing a double call). Staff we spoke with confirmed that they had gone through this induction process.

Staff who were new to care then embarked on the Care Certificate. The Care Certificate is a nationally recognised set of standards which form the basis of an induction and development course for new support workers. The provider told us the company had recently moved away from using workbooks for the Care Certificate to an online system. Support workers could come into the office to work on a dedicated training computer in order to complete sections of the Care Certificate.

The provider told us that the service regarded training staff and keeping them up to date as vital. More experienced staff received ongoing and refresher training. For example, some staff had taken training in stoma care in May 2016 because some of the people using the service had a urostomy. We saw certificates were kept on individual staff files. There was a member of the office staff who was tasked to maintain an overview of staff training and remind people when training was due. The computer system had a 'dashboard' which was intended to show when refresher training was required. There was however no overall matrix or spreadsheet to record when each member of staff had last done each training topic, which made it difficult to check that all staff were up to date with all essential topics.

The registered manager carried out most supervisions of staff. Staff told us that these usually followed a spot check, namely a visit to the support worker during a call, carried out by a senior support worker or the registered manager. Records of these supervisions were kept on the staff member's files, and we saw that the supervisions were a two-way conversation. This meant that staff were able to raise issues with the registered manager, and they told us this helped them feel supported in their work. We saw that some supervision records identified needs for additional training which was then put in place. One example was given by a senior support worker who told us that they had considered during a spot check that a support worker needed additional training in moving and handling, and had mentioned this to the registered manager. Relevant training had then been provided. This was a good example of staff's training needs being met for the benefit of people using the service.

We saw some records of annual appraisals although not many of the staff had been employed more than a year, by this service and its predecessor. The form used for appraisals was appropriate as it asked about how the past year had gone and about any career aspirations and training requests.

Health care appointments and health care needs were usually co-ordinated by people themselves or their

relatives. However, we also saw evidence of care staff contacting GPs on behalf of people and the service making referrals to district nurses. The service liaised with health and social care professionals involved in people's care if their health or support needs changed. A member of staff described referring a person to their GP when they had developed a pressure ulcer and we saw a record of this in the person's care plan. One person's relative told us about an incident when the support worker noticed the person receiving the service looked poorly and confused. The support worker stayed with them waiting for the ambulance and was kind and reassuring. The relative said, "The way she talked to mum was out of this world."

Some people received assistance with cooking and/or eating. We saw that the induction training included advice on food hygiene and on encouraging balanced diets. New staff were urged to look out for signs of poor nutrition or hydration and to react appropriately. Staff then undertook the more detailed training on fluids, nutrition and food safety which formed one standard of the Care Certificate. This meant that staff had a good basic knowledge with which to support people who received support with meals from the service.

A few people amongst those we spoke with had their meals and drinks prepared by their support workers. People told us they had choice over their meals and the food and drinks were served hot and nicely presented. In one case a relative told us that staff tried to ensure the person ate their meals. Another relative told us that the person receiving the service was prompted to eat by the support worker. This was evidence that people were supported, when required, to maintain good nutrition and hydration.

Good

Is the service caring?

Our findings

We asked the 16 people we spoke with by telephone about the quality of the care they or their relative were receiving from the service. With one exception, their answers were positive and demonstrated that support workers had built up good relationships and rapport with the people they were supporting. (The exception is described later in this report). One person using the service said, "[Staff are] friendly, kind and gentle; they will do anything for you. They are like one of the family." This was echoed by a relative who said, "Very good. They act like family, so kind to [my spouse]. Before I had been dreading this but I'm glad of them now."

People also told us that the staff offered emotional support and were concerned for people's wellbeing. One person using the service told us they had a health condition which the support workers were aware of and helped them with. "Brilliant, couldn't do without them, very professional, courteous, absolutely wonderful. Sometimes I find it [my health condition] quite difficult. They notice if I am unhappy, and try and bolster me up."

Another person said, "They make me feel comfortable, ask me if I am worried about anything and if there's a problem try and resolve it." One relative said, "Don't know what I would do without them. Cheerful, obliging, have a chat when they have finished." Other comments about the staff and support received were, "Thoroughly satisfied," "The main girl is brilliant, talks to mum forever," and "My angels."

One criticism suggested a lack of interpersonal skills or experience. One relative said the support worker, whilst good at the practical side of the job, was very quiet which made both them and their spouse uncomfortable. They said, "We find it embarrassing if someone is in our home and doesn't talk so we have to generate the conversation ourselves."

On the other hand we found examples where the support workers went beyond their allotted tasks. One person said they always put the laundry in the washing machine even though it was not part of their duties. There were also examples of staff supporting both the people receiving the care and their family carers. One relative said the support workers had helped them to understand the social services benefits system and also to get support from the food bank. They said, "At the beginning it was very difficult; I did not understand, they helped me. Got me food parcels from the food bank." They also said, "They're not just looking after [name] but me as well, we always have a conversation. They are good - 100%."

One relative described how the support workers had boosted their own confidence as well as providing care and support for their spouse, "Before I was desperate, dreading what I would find when I came home. Now I'm managing, I can go out, have a life of my own and I know my [spouse] is being looked after." This was testimony to the reliability of the support workers. Similarly one person had written in a questionnaire, "They help me to have more confidence in myself."

We looked at questionnaire responses received a few months earlier, in August 2016. The responses were uniformly positive. One person had written, "Very happy with my carers. Enjoy seeing them. Very well taken care of." Someone else wrote, "The carers really are caring. Not only do they leave my wife clean and tidy

and comfortable, they leave her smiling – which is important and lovely." A third person had written, "I find [name of support worker] very caring, helpful and understanding. I cannot praise her enough."

The evidence from our phone calls and from the August 2016 questionnaires was that, on the whole, support workers were providing a high standard of care which people appreciated.

We asked people whether their support workers provided privacy and dignity especially when delivering personal care. People told us they felt comfortable and secure. No-one raised any complaints about privacy. We saw in the staff induction folder that detailed instructions were given to staff about carrying out personal care in a dignified way.

Care files were kept in a locked filing cabinet in the office. This meant that people's personal data was kept securely within the office. Personal information was also kept on the care files in people's homes, where security was the responsibility of the person receiving support or their family. However, daily notes and medication administration record forms were removed at the end of each month and brought into the office. This meant that confidential information was not left in people's homes longer than it needed to be.

Requires Improvement

Is the service responsive?

Our findings

When the service commenced a new care package for someone funded by Manchester City Council they received a 'Citizen support plan' which gave a summary of the person's care needs and set out what care was needed to meet those needs. The service then created its own care plan stating how these needs would be met. In some cases when the care was not being funded by the Council the service needed to create its own care plan from scratch.

We looked at six care plans. These were very basic and did not include enough information to enable staff to deliver individualised care that met people's needs. In some cases the wording on the plan was identical or very similar to the Citizen support plan which had been supplied by the Council. We found examples where the information was sparse. It was not inaccurate but did not provide sufficient detail. For example, the first page of the care plan was headed 'About me' but gave only the person's name, age, marital status, telephone number and address. The next page was headed 'Personal Information' and carried the same information as the previous page, followed by contact details of family members and health professionals. There was no information about the person's life history, health history, family, interests or hobbies, which would enable support workers to engage with them in a person-centred way.

We discussed the care plans with the provider and registered manager, who explained that staff got to know the person they were working with and built up a relationship with them gradually. We acknowledged that this would happen, and the feedback we received from our telephone calls indicated that people using the service felt that staff were interested in their emotional wellbeing. However, a new member of staff or a staff member who had not met that particular person before would have no access to information about that person from the care plan.

We discussed the fact that a care plan should be a living document which should be revised regularly and as people's needs changed. Detail was lacking from the main parts of the care plan. On one care plan it stated "Personal care needs to be supported in bed." The care plan gave no indication that this person needed to be assisted out of bed by means of a hoist, or that sometimes the hoist battery was not charged which meant it could not be used. We knew this was the case from conversations with staff. We noted in the care plan there was no guidance as to how this person should be moved safely.

We saw that the care plan template included some sections which were not being used, such as 'Learning at work' and 'Being a parent'. The template had been taken from a commercial supplier and not made relevant to this service. There was a page headed 'Risk assessments' but this was blank in all the care plans we looked at. The provider explained to us that risk assessments were kept in people's houses, and there was also a copy of them in the care files in the office. The same was true with the page 'Plan of medication' which was also blank. Copies of all the care planning information should be together and accessible to all staff. Otherwise there is a risk that people may not receive the care they need safely.

We asked to see one person's care file and we were told it was incomplete, and there was a Post-it note saying the risk assessments had not been done. This person had been receiving the service for about two

months. A senior member of staff told us the risk assessments had been done and were in the person's house, which contradicted the note on the file.

On another person's care file there was no care plan, but instead two copies of the Citizen support plan. The provider could not find the plan on the computer system, and it was clear that one had not been created for this person. This meant that staff supporting this person had no information or guidance about the care needed or associated risks other than what had been supplied in the Citizen support plan. At our second visit to the office the care plan had been written.

We asked people using the service about whether they knew they had a care plan, and we received positive responses. One person said, "It wholly meets my needs." Another person said, "All the girls are thorough and good and conscientious. The care plan works."

Every care plan carried the standard wording 'Agreed review frequency: Every 6 weeks' and underneath was the typed statement "1st review – 6 weeks (yearly). To be confirmed." It was not clear what this meant, whether the review would be after six weeks or after a year. None of the plans we saw contained any evidence that they had been reviewed or any changes made to the care plan. The provider told us that changes were made when people's needs changed, but it did not appear that this was recorded. The provider could not demonstrate that reviews were taking place.

One person using the service did tell us, "Someone from the office contacts me occasionally to check all ok. They told me I can increase the care if needed." However, there were no records to show that people's care needs were being reassessed regularly to help ensure that the care being provided was still appropriate.

The lack of sufficient information in care plans, and the lack of recorded reviews, were a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager explained to us that the service tried where possible to provide support workers who spoke the same language as the people receiving the care. A relative said, "It's always the same carer. Mum has a good rapport, she speaks pure Punjabi like mum and they get on together." They added that the support worker took their relative to a weekly Asian women's group. Another person told us they were encouraged and helped to attend their photography and art group. This was evidence that people were helped to maintain involvement with the community and retain their interest in hobbies.

The registered manager told us that some people only wanted female support workers, often for cultural reasons. The service met these requirements. There had been one person who objected to the support worker's accent, even though they spoke good English. The service had replaced the support worker, but the registered manager discussed with us the difficulty of balancing people's preferences against being influenced by their prejudices.

The provider's statement of purpose – a document that all registered providers are required to produce – stated: "It is the company's policy to welcome comments, complaints and compliments and to look upon them as an opportunity to learn, adapt, improve and provide better services."

There was only one complaint that was mentioned to us by people we spoke with. One person said, "I've no complaints but I am the sort of person who would complain if there was a problem." Another person said that they had contacted the office about some issues but were satisfied with the response, "Phone calls are answered or followed up promptly." Another person said similarly, "Excellent communication within the team. Messages get passed on and dealt with."

There was a complaints log kept in the office which recorded complaints received, what action was taken and the response given to the complainant.

Requires Improvement

Is the service well-led?

Our findings

We asked people using the service about the management and the quality of the service. The responses we received were positive. One person said, "Nothing can be improved because it is so good!" We saw a comment from the August questionnaire: "The standard and reliability of care is excellent."

Staff we spoke with in the office expressed satisfaction with the provider. One who worked in the Chorlton area said, "I am very happy with the company." Another member of staff said, "This company is very fair, and the management is good." However, not all the staff we spoke with were as favourable.

We received very positive feedback from a social worker who had commissioned care and support from the service for a number of people living with young onset dementia. They wrote: "They have been great in providing urgent care at home, enabling people to stay at home as the least restrictive approach, through providing familiar carers [support workers] with skills in working with people with dementia. The feedback that I get from [families] (usually at the point of a six week review once a care package has been put in), is that We Care are very helpful and friendly, and that they are flexible in terms of understanding the fluctuating needs [of people using the service]."

The provider and the registered manager worked together in the Chorlton office alongside three other office staff who had clearly defined roles. The staff who worked in the Chorlton area frequently came into the office, and there was a sense of teamwork and mutual support.

The service was also supporting approximately 20 people in the Wythenshawe area. There was a base in that area, about four miles away from the Chorlton office. This base was described variously as an office or a hub; it was a place where staff could meet in between calls, and collect their PPE (gloves and aprons) and timesheets. There was no fixed computer there. No care records or staff records were kept there; as we saw they were all kept in the Chorlton office. Training was organised from and took place in the Chorlton office.

A senior member of staff, a director of the company, was effectively in charge of the Wythenshawe part of the service. We learnt that there were different working practices in the Wythenshawe area. The staff were separate; in other words staff worked either in the Chorlton area or the Wythenshawe area. They received their rotas in a different way, and the rotas were organised differently; as mentioned earlier in this report, the staff in Wythenshawe did not use mobile phones to log in and out of calls. Although the registered manager had oversight of the whole service, she admitted her knowledge of the people receiving support in Wythenshawe was not as extensive as of those in Chorlton.

There is no requirement in the regulations that all areas of the same service need to be managed in the same way. However, we perceived a risk that inconsistencies could lead to confusion and difficulty in reliably monitoring the quality of the service. We also noted that a recent safeguarding concern, and the complaint by one family member, had arisen in relation to people in the Wythenshawe area. We considered there was a lower level of management monitoring, control and supervision in regards to Wythenshawe than there was for Chorlton. We discussed this with the provider and the registered manager, who

acknowledged that there were discrepancies in the level of monitoring.

The service used a set of policies and templates supplied by a commercial company. Many of the policies referred to CQC outcomes, which are no longer part of CQC regulation, and obsolete regulations. In the employee handbook which was given to all employees it stated that support workers could not do moving and handling "until you have completed a certified moving and handling course at Anonymous Care Ltd." This error indicated that the handbook was taken from a template rather than created specifically by the provider. This also indicated that the handbook and other policies had not been created specifically to meet the needs of this service.

We asked the provider about what audits were done, in particular audits of care plans. Two of the care files we saw had notes attached saying "audited by [the provider]." However, there was no record of the audit on the care file. We asked what the audit would involve, and the provider said they would check that all the necessary documents would be on the care file, including the care plan, questionnaires etc. One of the files which were marked as having been audited was the file which we found had no care plan. This brought into question the effectiveness of the audit. The provider then suggested that the note saying "audited" might have been incorrectly placed on this file. This gave us even less reassurance that the audit system was functional, if some files were carrying a note to say they had been audited when in fact they had not been. 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.

There was also a problem with the storage of documents. We asked to see a person's recent daily notes which had been brought into the office. These were kept in a locked filing cabinet. Initially they could not be found, and eventually they were located inside an envelope with the wrong dates on. This information might prove vital in the event of a query arising about a person's health or the support they have been receiving. So it is important that daily notes are stored in an accessible way.

Questionnaires to people using the service and their relatives had been sent out in August 2016 and we saw the copies that had been returned. We saw that in some cases where the person receiving the service or their relative had raised an issue the registered manager recorded the action taken in response. This showed that the questionnaires were being used both as a way of assessing customer satisfaction and as a means of implementing improvements to the service.

We saw that a different questionnaire had been used on some files. This asked questions about the first day of receiving the service, so was not appropriate for people who had been using the service for a length of time. The provider accepted this, and admitted they had been using one of the template questionnaires without analysing its relevance.

Spot checks of staff took place regularly, conducted either by the registered manager or a senior support worker. Staff confirmed that these took place, and we saw completed spot check forms on staff files. They included checking on the administration of medicines, where applicable. These checks enabled the management to check the quality of care at the point of delivery.

We asked to see minutes of staff meetings, but only saw the agendas. The provider told us that minutes were not written, but that they intended to start writing them now. This meant we could not establish whether the meetings had provided an opportunity for staff to raise issues. The staff in Wythenshawe had their own staff meetings, of which there were also no minutes.

We concluded that there was a breach of Regulation 17(1), (2)(a) and 2(b) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014. There was not an effective audit system, and the storage of documents was unreliable. This meant the systems for assessing monitoring and improving the quality of the service were insufficiently robust to ensure compliance with the regulations. We found breaches of regulations relating to ensuring staff had a valid DBS certificate before working alone, use of the Mental Capacity Act 2005, and ensuring that care plans addressed all the needs of people using the service. These all indicated a need to improve quality monitoring and governance of 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not carrying out adequate assessments of the needs and preferences of service users Regulation 9(1)

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

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were being employed and working alone before a criminal record certificate had been obtained to establish their good character Regulation 19(1)(a) and (3)(a)