Care Quality Commission

Community Care Direct Limited

Community Care Direct

Inspection report

33 Shakespeare Street
Southport
Merseyside
PR8 5AB
Tel:01704 544460
Website: www.communitycaredirect.co.uk

Date of inspection visit: 14th, 15th and 20th January 2015
Date of publication: 09/03/2015

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?	Good
Is the service well-led?	Requires Improvement

Overall summary

An announced inspection took place on the 14, 15 and 20 January 2015. We informed the provider two days before our visit that we would be inspecting the organisation.

Community Care Direct is a 24 hour domiciliary care provider based on a busy high street close to the centre of Southport. The agency provides domiciliary/in-home care, palliative care [end of life care] and 24 hour live-in service. At the time of our inspection the organisation was providing support to approximately 50 people.

A registered manager was not in post as they had left the service prior the inspection. 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. The service had an acting manager.

Most people were able to tell us they felt safe in the care of the staff. A person told us, "I always feel safe. I have my own little team."

Summary of findings

Staffing levels were determined by the number of people who used the services of the agency. The acting manager informed us they employed sufficient numbers of care staff to meet people's needs at this time.

Staff had received safeguarding training and were knowledgeable regarding the reporting procedures for any concerns they had.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. This included discussion with the acting manager and looked at staff files for evidence of appropriate applications, references and necessary checks that had been carried out. We found the information required was missing or inadequate in some staff files. These did not provide adequate checks to ensure staff suitability to work with vulnerable people.

You can see what action we told the provider to take at the back of the full version of this report.

We looked at how medicines were managed by the agency. We found that people were receiving their medicines and this was confirmed by the people we spoke with. We found there were no systems in place to confirm staff knowledge around medicine administration. We have made a recommendation around developing systems to ensure care staff have the necessary knowledge, skills and competencies relating to managing and administering medicines.

Risk assessments identified individual risks to people and the support people needed to ensure their safety and wellbeing. We saw these in the care files we looked at and care staff were knowledgeable regarding the management of these risks.

Staff we spoke with told us they were now receiving regular training and attending supervision meetings with the acting manager. New care staff had received an induction and staff training was recorded. Staff appraisals had not been given as the acting manager was new in post. We saw there was no current training plan or training needs analysis to support staff induction, training and appraisal though a programme of training was underway for all staff.

A number of care packages included food preparation. Although we did not see care staff supporting people with meals the care plans we saw made reference to the support people needed with food preparation and nutritional support.

With their permission we visited four people in their own home and during the visits some care staff were providing support to people. This was provided in a polite and caring manner.

Care staff had received training in mental capacity to help support people who may not be able to make decisions. This is in relation to the Mental Capacity Act 2005 which is legislation to protect an empower people who may not be able to make their own decisions, particularly about their health care, finances and welfare.

People told us they received good support from the care staff and advice and appointments were made with external health professional at the right time. Care staff had a good knowledge about people's needs and how they supported them to keep well and active. A relative said, "They [the staff] support us to keep [relative] at home, for us they have been a life line, they are very good." A person told us, "I am very happy with my care, the staff are very caring."

Some people reported they did not always receive care from the same carers to ensure continuity of care. The acting manager informed us they were looking at how to best to ensure this took place. They informed us they felt this had improved though they appreciated further work was needed in light of our findings. We also received mixed feedback from people about whether calls by care staff were on time or had been missed. Management discussed with us the actions taken following these incidents. We have made a recommendation about monitoring calls to people in their own home.

People and their relatives told us they were involved in the plan of care and this was reviewed when needed.

A complaints procedure was in place. People and their relatives we spoke with knew how to make a complaint or raise a concern about the service.

There was no formal system in place to get feedback from people so that the service could be developed with

Summary of findings

respect to their needs and wishes. For example a feedback survey. The acting manager informed us that in February 2015, feedback surveys would be sent to people who used the service.

We enquired about quality assurance systems in place to monitor performance and to drive continuous improvement. We saw improvements had been made under the new acting manager's direction.

Quality assurance systems were not however consistently applied or embedded. We found management reactive rather than proactive. For example, during and following the inspection the acting manager took appropriate action in response to the areas we brought to their attention. The areas where we identified needing improvement had not been picked up by the current auditing process.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

Risk assessments identified individual risks to people and the support people needed to ensure their safety and wellbeing.

Care staff understood what abuse was and the procedure to follow should they need to report a concern.

People told us they were supported by the care staff with their medicines. Medicines were safety administered to people. There were no systems in place to make sure care staff had the necessary knowledge, skills and competencies in relation to managing and administering medicines.

A number of people told us the calls to them by the care staff were not always on time and some people reported missed calls. There was no system in place to monitor calls to people in their own home.

Records did not evidence that staff had been checked adequately when they were recruited to ensure they were suitable to work with vulnerable adults.

There were sufficient numbers of staff available to provide care and support to people.

Is the service effective?

Good

The service was effective.

The service worked in accordance with the Mental Capacity Act 2005.

Care staff had training and support through induction, training and supervision. We saw there was no current training plan or training needs analysis to support staff induction, training and appraisal though a programme of training was underway for all staff.

The care staff supported people who used the service with their meals.

Is the service caring?

Good

The service was caring.

People and relatives we spoke with were generally pleased with the standard of care provided and told us they 'formed good relationships' with the staff'.

Most people we spoke told us they felt staff treated them with dignity and respect and staff spoke with them appropriately.

People commented on the lack of continuity of care as they did not always receive the same care staff to support them.

People told us they were involved with developing their plan of care.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People's plan of care was regularly reviewed to ensure it reflected their current needs.

A complaints procedure was in place. People and their relatives we spoke with knew how to make a complaint or raise a concern about the service.

There was no formal system in place to get feedback from people, so that the service could be developed with respect to their needs and wishes.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager for the service at the time of the inspection. The acting manager confirmed they would be applying to become registered in accordance with Care Quality Care [CQC] Regulations.

We saw improvements had been made under the new acting manager's direction but quality assurance systems were not consistently applied or embedded to monitor the service and to assess and manage risk to people who used the service.

Care staff were however aware of how to whistle blow and the procedure they would follow.

Community Care Direct

Detailed findings

Background to this inspection

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

The inspection took place on 14, 15 and 20 January 2015 and was announced. The provider [owner] was given 48 hours notice because the organisation provides a domiciliary care service and we needed to be sure that someone would be available. The inspection was carried out by two adult social care inspectors, a Care Quality Commission [CQC] pharmacy manager and an expert by experience [ExE]. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We had asked the provider to submit a Provider Information Return [PIR] prior to the inspection but we did not receive this. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The acting manager informed us the agency currently had computer problems which needed to be resolved. This meant they were not able to complete and submit the PIR.

Prior to the inspection we reviewed the information we held about the service looked at the notifications the Care Quality Commission had received about the service and contacted the local authority with regard to any information they held about the service. The Local Authority informed they did not hold any information about the service at this time. We spoke with a health care professional who informed us the service provided care and support to people in accordance with their individual need.

As part of the inspection we spoke with 10 people who used the service. The majority of people were contacted by telephone but we also visited four people who had agreed to us calling to their home. We also held a discussion with 12 relatives of people who used the service. We spoke with the acting manager, the provider, two care co-ordinators, administrator and 11 care staff who provided direct support to people in their own home.

We looked at care records for six people, five recruitment files, staff training records, six medicine records and other records relevant to the monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Most people were able to tell us they felt safe in the care of the staff. A person told us, “I always feel safe. I have my own little team.”

The agency had a communications book for recording verbal contact with people who used the services of the agency, relatives and staff. The owner and acting manager informed us contact with people who used the service and staff was picked up daily. However, from our review of the communications book it was hard to establish what actions had been taken. An example of this was a missed call to a person who required a visit at a set time in accordance with their plan of care. The person had a medical condition which meant the time of the call was important; the call not being conducted in accordance with the person's care plan had the potential to affect the person's safety and wellbeing. The owner advised us of the action taken with regards to reviewing the staff rota to minimise the risk of a reoccurrence of missed calls in the future.

We received mixed feedback from people who used the services of the agency and their relatives, which indicated there were times when the care staff were late or early arriving for their visit. People said, “They [the staff] are fairly flexible regarding visits. I was offered options. They are normally on time, they will let me know if they are going to be delayed” and “They [the staff] are usually more or less on time, there have been some hiccups but they ring to let me know. I choose to have an early call but they are pretty flexible.” Relatives reported, “Would say they [the staff] are normally on time but recently the tea time visit has been getting later. I have spoken to the office and we will see if it improves”, “They [the staff] are pretty flexible if we need to get to the hospital early I just let them know and they come to get [relative] up earlier” and "The timing can be a little variable and has got worse since Christmas. They [the staff] don't always always let us know if they are going to be late." The person went on to say they had an early appointment that was met by the staff. We brought this feedback to the attention of the acting manager. They advised us that a lot of work had been undertaken to reduce the risk of missed calls but appreciated this needed to be looked at in more detail. Calls not being conducted in accordance with a person’s care plan had the potential to affect people’s safety.

We recommend that the service considers systems to effectively monitor calls to people in their own home.

Care staff we spoke said they received adult safeguarding training. They told us what constituted abuse and were clear about how to report a concern. A member of the care team said they would have no hesitation in reporting any concern to the acting manager.

At our last inspection in August 2014 we found the provider in breach of regulations as people were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place to manage medicines. The provider sent us an action plan which said medicines would be managed safely. At this inspection we checked on the improvements made.

We looked at six people’s care packages that included support with medicines. We found action was being taken to address the issues identified at our previous visit and this was supported by a management action plan. Information about the support people needed with their medicines was now being recorded within their support plans and new procedures were in place for the recording of medicines that care staff administered.

Written consent was obtained from people that were having their medicines administered by care staff and this included a discussion about what support they required including any help they needed to self-administer their medicines. One person’s wishes regarding the keeping of their care records had been fully respected but the service had not put in place suitable arrangements to make sure the subsequent risks were minimised. The acting manager told us this would be reviewed and appropriate action taken.

We saw examples of how medicines were handled in people’s own homes and how this information was recorded in the care records. We saw medication risk assessments for the six people that we checked and these helped identify the support they needed. However, for one person we found the written medicines assessment did not fully reflect the current risks with their medicines because it had not been promptly reviewed when their needs had changed. The acting manager told us all paperwork was being audited as they had recognised that most of the

Requires Improvement

Is the service safe?

medication care plans had not been properly reviewed in the past. The acting manager also described how care co-ordinators had recently and would continue to take a more active role in reviewing people's care files.

Medicines were only administered by staff that had completed the training package used by the service. This training did not include any observations of staff administering medicines and any on-going checks to make sure care staff were competent.

People we spoke with told us they received their medicine on time and in accordance with their prescription.

The acting manager said they were not aware of any medicine errors and that should a medicine error occur then this would be reported through safeguarding channels.

We recommend that the service considers developing systems to ensure care staff have the necessary knowledge, skills and competencies relating to managing and administering medicines.

Risk assessments identified individual risks to people and the support people needed to ensure their safety and wellbeing. For example, assessments for their mobility with use of aids, hazards in the home and use of a key pad for entering people's homes. We saw these in the care files we looked at and care staff we spoke with were knowledgeable regarding the management of these risks.

Discussions with care staff confirmed their knowledge around how to respond to an emergency situation or an untoward event that affected a person's safety and health. The acting manager informed us there had been no accidents or incidents at this time. A carer told us, "We are provided with mobile phones so we can contact the office or the on-call manager if there are any problems when we arrive."

We saw care staff had received infection control training and had access to gloves and aprons when out in the community supporting people.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. This included discussion with the manager and we looked at five staff files for evidence of appropriate applications, references and necessary checks that had been carried out. The staff files contained a record of a DBS check [Disclosure and Barring Service – the standard check for any criminal record] for staff. We found however some information required was missing or inadequate in some staff files. For example, one staff file did not evidence any references [for example a reference from a past employer]. The acting manager and provider were unaware that references had not been received and the care staff had commenced their employment without this recruitment check. There were also no health declaration forms completed and no record of interview. The documents listed above could not be located over the three days. The service had a recruitment policy this stated that two references must be obtained and a 'format to be in place for each interview for candidates' suitability'. These had not been obtained in line with this policy.

The recruitment checks carried out did not provide adequate checks to ensure staff suitability to work with vulnerable people. We brought this to the attention of the acting manager. On the second day of the inspection were informed references were being sought for the staff concerned.

By not having safe recruitment practices was a breach of Regulation 21(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staffing levels were determined by the number of people who used the services of the agency. The acting manager informed us they employed sufficient numbers of care staff to meet people's needs at this time. The staff rotas showed the numbers of care staff who supported people in accordance with their assessed needs.

Good

Is the service effective?

Our findings

At our last inspection in August 2014 we found the provider in breach of regulations as there was a lack of staff training and support. This meant there was a risk people did not receive safe care and support in accordance with individual need. The provider sent us an action plan which said staff would be trained. At this inspection we checked on the improvements made.

We looked at staff induction, staff training and support. We found a number of actions had been taken to address the issues.

Staff we spoke with told us they were now receiving regular training and this had improved since the last inspection. With regard to the induction staff told us they had received this when they commenced employment. One of the care staff said, "I have only been here since October [2014] but I got a really good induction and completed mandatory training including safeguarding." Care staff comments around training included, "I really enjoy my job and do my best for all the people I support, all been fine up to now" and "I do care about the people I look after and I get well supported to do my job."

Whilst discussing staff training with the acting manager it came to light that one person's training had expired. The person concerned was providing care to people. We brought this to the attention of the acting manager. The acting manager informed us during the inspection that the person would not support people till their training was completed. At the time of our feedback to the acting manager they advised us the person concerned was now undertaking the training they needed.

We looked at two staff files for recently appointed staff. We found a lack of information around what was covered during the induction period. The acting manager advised us however that new staff received an induction and this included training in areas such as moving and handling, infection control, first aid, safeguarding adults, health and safety, mental capacity and dementia care as part of their induction programme. Certificates for these courses attended by the two new staff members were on file. Other staff files we viewed evidenced the care staff had attended this training, as part of their learning and development.

The acting manager informed us they were looking to introduce a more centred care induction for new care staff. We looked at the staffing rota and this evidenced when new care staff 'shadowed' an experienced carer as part of their induction.

The acting manager informed us care staff were provided with a handbook when they commenced employment. A number of care staff we spoke with told us they had not received this as part of their induction. We brought this to the attention of the acting manager.

The organisation supported people with end of life care. For three care staff who carried out this care there was no record on file of them undertaking any training to ensure they supported people effectively. Following the inspection we were informed that eight to 10 care staff were enrolled on a palliative care [care of the dying] course in March 2015. Specific training was also provided to meet the needs of people the service supported. For example, support with bowel care.

We saw evidence that staff supervision meetings were now being held by the acting manager. The acting manager was new in post and therefore they had not been able to conduct a supervision meeting as yet with all the care staff. They informed us that out of the 63 staff employed, 30 had received supervision. Being new in post the acting manager had also not been able to conduct the appraisals. They were aware of the need to organise these.

We saw there was no current training plan or training needs analysis to support staff induction, training and appraisal, though a programme of training was underway for all staff. The acting manager said they were in the process of implementing this.

We asked people who used the service and relatives if they felt confident in the way in which the care staff supported them in their own home. Most people felt the care staff were trained to carry out their role. We received the following comments from relatives, "They [the staff] support us to keep [relative] at home, for us they have been a life line, they are very good", "They [the staff] always treat [relative] well, they don't talk down to [relative] or anything", "They [the staff] seem to be well trained" and "I think they [the staff] are well trained to do what they do, they are really good with [relative]."

Care staff had received training in mental capacity to help support people who may not be able to make decisions.

Good

Is the service effective?

This was in relation to the Mental Capacity Act 2005, which is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, finances and welfare. The acting manager told us they had not been required to hold any 'best interest' meetings to support people in respect of decisions needed about their care and welfare. They told us people who used the service were able to make their own decisions at this time.

We saw evidence of people's consent to care and support and evidence of other external health care professionals being involved with people's plan of care. Care staff told us they would arrange a GP appointment if people needed this. The service was aware of the importance of taking preventative action at the right time to help maintain people's health and wellbeing. A member of the care team said, "When I go out on a call if I think someone needs a doctor I will ask them and ring up. I will also tell the office and complete the care records."

People told us they received good support from the staff and advice and appointments were made with external health professional at the right time. When looking through the care files we saw people had access to health care professionals, such as their GP, the district nurse, chiropodist, dietician or optician to help keep people in the best of health. Care staff had a good knowledge about people's needs and how they supported them to keep well and active.

We spoke with a health care professional who informed us the service provided care and support to people in accordance with their individual need.

A number of care packages included food preparation. Although we did not see staff supporting people with meals the care plans we saw made reference to the support people needed with food preparation and nutritional support.

Good

Is the service caring?

Our findings

People and relatives we spoke with were generally pleased with the standard of care provided and they told us they 'formed good relationships with the staff'. Relatives said the staff were patient, supportive and used their family member's preferred name when speaking with them. Most people we spoke told us they felt care staff treated them with dignity and respect and care staff spoke with them appropriately. A relative informed us the care staff always involved their family member when discussing the care and support they were providing. For example, supporting a person with personal care and offering a choice of a shower or body wash. One of the care staff said, "I always ask the service user [person receiving support] what they want to do. I don't just do things I ask first." People told us doors and curtains were closed whilst care staff carried out a personal care.

With their permission we visited four people in their own home and during the visits some care staff were providing support to people. This was provided in a polite and caring manner.

During our inspection people told us, "Sometimes the carers can be late but overall I cannot fault them – really caring", "They [the staff] always treat me with respect, we have a laugh I think we have a good rapport", "The girls who come here to me are very attentive – they are really nice and I look forward to them coming", "I am very happy with my care, the staff are very caring" and "The staff are always polite, we get on well."

Relatives said, "My [relative] is more than comfortable with the staff, they always treat [relative] well", "Lots of different carers come in which is not good and at times they can be quite late. I have asked for the same carers but they said it is not possible" and "The staff always explain what's happening, they are very careful and don't hurry my [relative]." Most people we spoke with had been receiving support for quite a while and had a core group of care staff that attended to them.

The acting manager informed us they were looking at how best to ensure the same care staff carried out the visits to people they supported to help ensure continuity of care. They informed us they felt this had improved though they appreciated further work was needed in light of our findings.

Most people who used the service said they had a plan of care and that some plans were set up in conjunction with the district nurse documentation. People who used the service and their relatives told us they were involved in the plan of care and this was reviewed when needed. A person said, "Every time the girls come out they complete al the paperwork before they go." Relatives' comments included, "The staff fill in a plan each visit, I think my [relative] signed it. It was reviewed a couple of months ago", and "I have signed the book which they complete at each visit. Someone came about two months back to review the plan."

People told us the care staff provided plenty of encouragement around promoting independence and care document recorded this. People's comments included, "I am really happy with my care. I don't want anyone to try and organise me. I just want support and I have a good little rapport with them all. They [the staff] are supporting me to remain independent" and "The staff are very good, they help me with my exercises, they encourage me to help myself."

Information about a local advocacy organisation were available in the office for staff to refer to should a person they supported wish to speak with an advocate. An advocate is a person who works alongside an individual who may require independent support and encouragement to exercise their rights.

Good

Is the service responsive?

Our findings

At our last inspection in August 2014 we found the provider in breach of regulations as care and treatment was not always planned and delivered in a way that was intended to ensure people's health and welfare. The provider sent us an action plan which said care plans would record this information. At this inspection we checked on the improvements made.

We looked at six people's care files and found improvement had been made. The care documents held information about each person and how they wish to be supported. Care documents included a plan of care, risk assessment and daily report. The care documents provided information about the importance of keeping people independent in their own home with staff support. Care staff kept people's care needs under review to ensure the right level of support was provided.

The acting manager informed us that where possible there was staff cover across geographical areas to cut down on the travelling time and to ensure the calls were 'on time'. No one we spoke with raised any concerns about calls being cut short by care staff. A carer told us how they were responding to a referral that had come in late for a person who required care and support. They told us they were going out first thing to provide this. People told us the service was fairly flexible if a change of time was required by them, for an appointment for instance.

Not everyone we spoke with told us they were offered a choice regarding whether they would prefer a male or female carer to carry out their care. The acting manager told us the assessment form had been changed to ensure this preference was recorded. A person told us they would be happy to phone the office to discuss carer preference.

A complaints procedure was in place. Staff told us they knew what procedure to follow should a person wish to raise a concern. Care staff said, "I would be happy talking to any of the managers if I had a complaint, I find them all approachable and easy to talk to" and "If a service user made a complaint to me I would contact the office straight away and get it recorded and try and get an answer for them." People and their relatives we spoke with knew how to make a complaint or raise a concern about the service. Details of how to raise a complaint were available in people's homes. People said, "If I had a problem or a complaint I would ring the office and speak to one of the supervisors or managers" and "If I had any issues I would phone [the owner] I am sure they would sort things out." A relative said, "I do know who to speak to if I need to." The acting manager informed us they had not received any complaints from people who used the service or relatives since the last inspection.

There was no formal system in place to get feedback from people so that the service could be developed with respect to their needs and wishes. For example, a feedback survey. People told us that generally the service did not contact them for feedback. We saw a communications book in use for recording telephone messages from people who used the service, relatives and staff who contacted the agency. It was however difficult to ascertain what actions had been taken as these had not always been recorded. The acting manager informed us that in February 2015, feedback surveys would be sent to people who used the service.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July August 2014 we found the provider in breach of regulations because an effective system was not in place to identify, assess and manage risks to the health, safety and welfare of people who used the service. The provider sent us an action plan which told us how they were going to monitor the service. On the visit we checked to see if the improvements had been made.

At this inspection the agency did not have a registered manager in post; the agency had not had an active registered manager for approximately two months. We talked to the provider who told us that the acting manager would be applying to be registered following the inspection. The acting manager had previously worked for the service in a supervisory role.

We spoke at length with the acting manager regarding the overall management, development of the service, its aims and objectives and culture. The acting manager advised us they wanted the service to continually improve and to be the best it could be.

We asked the acting manager to tell us about their role and how this related to the provider in terms of areas of work and accountability. The acting manager advised us they currently did not have a job description though they were clear about their role. They told us about their role, responsibilities and the provider's input into the service. Management support was available from the provider [owner], office staff and two care co-ordinators. The care-ordinators were clear about their role. This included staff support and also undertaking checks on the service provision in people's homes. A person told us they could always speak to the managers when put through to the office.

We requested a PIR prior the inspection however this was not completed and returned to us. The acting manager informed us the agency currently had computer problems which needed to be resolved. This meant they were not able to complete and submit the PIR.

We enquired about quality assurance systems in place to monitor performance and to drive continuous improvement.

We could see that some audits [checks] were now being carried out. We saw some audits for the checking of people's medicines that the service was involved with. New checks had been put in place for auditing medicines administration records but these were limited to looking for missing signatures on the records and were not full embedded into practice. Wider audits of medicines handling of the service including reviewing medicines care plans and risk assessments were not carried out and spot checks of staff administering medicines to assess their competency were not in place. Although we saw improvements around auditing medicines, the service still needed to develop a more robust process in place for identifying, reporting, reviewing and learning from medicines errors.

The acting manager had introduced 'house checks' in people's homes to make the care package was in accordance with people's needs. These checks were carried out by the two care co-ordinators. The visits enabled care plans to be reviewed and to talk with people about their care. We saw records of these checks which were now taking place on a regular basis. The acting manager informed us the 'house checks' will include observation of staff when providing care to people and also staff competencies for safe administration of medicines. This will form part of monitoring staff performance. Following the inspection we were informed these checks had commenced.

We saw improvements had been made under the acting manager's direction but quality assurance systems were not as yet consistently applied or embedded. This had the potential to put people at risk. Management appeared to be reactive rather than proactive. For example, during and following the inspection the acting manager took appropriate action in response to the areas we brought to their attention. The areas where we identified concerns had not been picked up by the current auditing process.

A full audit of the service had not been carried out as yet to identify areas that required improvement. For example, seeking formal feedback from people who used the service, missed or late calls to people they supported, staff recruitment, medicines [including staff competencies for administering medicines] and staff support. The acting manager said this that was being done in February 2015. We have asked for a copy of this audit once completed.

Care plans were now being reviewed on a regular basis and this was confirmed by looking at care records and talking with staff, people who used the service and relatives.

Requires Improvement

Is the service well-led?

We were concerned regarding the lack of feedback to the relative who had contacted the agency regarding the missed call for their family member. This had not been recorded and thus difficult to evidence how the incident was managed. The acting manager said in the future feedback would be recorded in the communications book to provide an audit trail.

On the whole we found the management of people's care records to be satisfactory. The acting manager told us how they respected a person's wishes with regard to specific record requirements. We asked the acting manager to look at ways of keeping records for this person to manage any potential risks. The acting manager told us this would be reviewed and appropriate action taken.

Staff meetings were now being held and we saw minutes of meetings held in 2014. These informed staff of issues such as medicines, confidentiality and rotas. Care staff told us the meetings were informative.

Prior to the inspection we had received information of concern around the culture of the service, staff being expected to work excessive hours, poor communication and attitude of management, staff not receiving a job description or contract of employment. We spoke at length with the owner and acting manager regarding this and were given assurances to how this was being addressed and future management plans to ensure the service was open, transparent and inclusive. During our feedback to the acting manager, they informed us that care staff were being provided with a job description and contract. The care co-ordinators reported the general management of the service had improved over the last months since the acting manager had been appointed.

The acting manager informed us another care co-ordinator was being appointed this month to help provide staff support and undertake quality checks on people's care and support.

We looked at a number of policies and procedure for staff to refer to for safe working. These were dated 2003. As part of the development of the service the acting manager informed us that an external company were providing new policies and procedures for the service. A whistle blowing policy could not be located during our inspection. Care staff were however aware of how to whistle blow and the procedure they would follow.

The Care Quality Commission [CQC] had received notifications regarding incidents that have occurred at the service in accordance with our regulations.

By not having robust systems in place to assure the quality of the service was a breach of Regulation 10 (1) (a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **There was a lack of effective recruitment and selection processes in place for staff** **Regulation 21(a) and (b)**

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **We saw improvements had been made under the new acting manager's direction but quality assurance systems were not consistently applied or embedded to monitor the service and to assess and manage risk to people who used the service.** **Regulation 10(1)(a)(b) and (e)**