The Human Support Group Limited

Human Support Group Limited - Didsbury

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 24, 25, 26 and 27 July 2018 with the first day of inspection being unannounced. The inspection was carried out by one adult social care inspector and an expert by experience. On 25 July 2018 we made calls to people who use the service and staff to gain their views and experiences of the service.

Human Support Group – Didsbury, also known as HSG Homecare – Didsbury and referred to as HSG – Didsbury in this report, is a domiciliary care service which provides personal care and support to people in their own homes to help them remain independent. HSG – Didsbury also provides other elements of support such as sit-in services, domestic support and welfare checks.

The service is managed from an office in Didsbury, Greater Manchester with care and support provided for people living in the immediate area and other districts within Greater Manchester, including Burnage, Wythenshawe, Chorlton and Withington. The length of visits for care and support vary depending on the assessed needs of people. At the time of this inspection, 108 people were in receipt of a service. However, not everyone using the service receives regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the inspection of May 2017, we rated the service overall as Requires Improvement. At that inspection, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks were not managed properly. We also identified weaknesses in the provider's recruitment processes as gaps in employment had not been fully explored with applicants and judged that this needed to improve.

At the time of this inspection there was no registered manager in post although an individual had submitted an application to manage this 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. The person applying to assume the role of registered manager was currently a registered manager at another branch. As the Didsbury branch of the Human Support Group was also the company head office there was the presence of staff from all areas of the business on a day to day basis, including senior management, and staff attached to the branch felt fully supported.

Following the inspection, we told the provider to send us an action plan detailing how they would ensure they met the requirement of the regulation. At this inspection, we saw the provider had taken action as identified in their action plan. In addition, they had sustained previous good practice in other key areas. As a result of this inspection, the service has an overall rating of Good.

There were more robust systems in place to ensure that risks to people's safety and wellbeing were identified and addressed. Risk assessments included information for staff about the risk and any measures they should take to minimise the chance of harm occurring to an individual.

Electronic call logging was undertaken by staff. The electronic call monitoring records we looked at reflected that the majority of staff were staying for the full commissioned time with individuals. A missed call checklist centred around ensuring the well being of the person who had potentially not received care and support. One missed call had occurred six months before this inspection. Where people needed support with medicines the systems in place were safe. Practical competency reviews were completed with all staff to ensure best practice was being followed.

A programme of training and supervision enabled them to provide a good quality service to people. The manager and staff understood the principles of the Mental Capacity Act (MCA) 2005 and, worked to ensure people's rights were respected. People had access to healthcare services and received healthcare support, sometimes as a result of intervention or advice from care staff.

People who used the service told us they were treated with dignity and respect. We saw that people received care and support specific to them, for example meals prepared the way a person liked them and items left within easy reach. Staff understood the importance of promoting independence wherever possible and when safe to do so. Staff saw their role as being vital to help people maintain life skills.

People received a service that was based on their personal needs and wishes. Care plans provided clear rationales as to how individual needs would be met and included risk assessments relevant to the person. Changes in people's needs were highlighted by staff and care was reviewed and amended to meet changing needs.

We judged that the service had effective systems in place for the management and resolution of complaints and we were assured that people's concerns about the care they received were taken seriously and investigated appropriately. People benefitted from a service that was now well led. The vision, values and culture of the service were clearly communicated to and understood by staff. The manager awaiting registration was committed to continuous improvement.

The service demonstrated a good understanding of the importance of effective quality assurance systems. There were processes in place to monitor quality and understand the experiences of people who used the service. The service linked in with other agencies and there were good examples of how they alerted other professionals when concerned for people's welfare. There were also links with a local befriending agency and the service referred or signposted people to this.

Initiatives were in place to keep staff better informed about the wider aspects of the service. Staff we spoke with were complimentary about the service and their colleagues and proud of the work they did. Staff felt appreciated and were therefore more engaged.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk assessments included information for staff about the risk and any measures they should take to minimise the chance of harm occurring to an individual.

Where people needed support with medicines the systems in place were safe. Practical competency reviews were completed with all staff.

Staff knew how to keep people safe and were aware of their responsibilities for reporting accidents, incidents or concerns.

Is the service effective?

Good

The service was effective.

A programme of training and supervision enabled the staff to provide a good quality service to people.

The manager and staff understood the principles of the Mental Capacity Act (MCA) 2005 and worked to ensure people's rights were respected.

People had access to healthcare services and received healthcare support, sometimes as a result of intervention or advice from care staff.

Is the service caring?

Good

The service was caring.

People received care and support specific to them. There was a person centred approach to care.

Staff understood the importance of promoting independence wherever possible and when safe to do so. Staff saw their role as being vital to help people maintain life skills.

Equality and diversity was recognised with specific care practices

in place as per people's wishes.

Is the service responsive?

Good

The service was responsive

Care plans provided clear rationales as to how individual needs would be met and included risk assessments relevant to the person.

Changes in people's needs were highlighted by staff and care was reviewed and amended to meet changing needs.

There were effective systems in place for the management and resolution of complaints. People's concerns were taken seriously and investigated appropriately.

Is the service well-led?

Good

The service was well led

The vision, values and culture of the service were clearly communicated to and understood by staff. The manager awaiting registration was committed to continuous improvement.

There were processes in place to monitor quality and understand the experiences of people who used the service.

The service linked in with other agencies and there were good examples of how they alerted other professionals when concerned for people's welfare.

Human Support Group Limited - Didsbury

Detailed findings

Background to this inspection

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

This inspection took place over four days on 24, 25, 26 and 27 July 2018. An expert by experience contacted people using the service by telephone to gain their views on the quality of care provided. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

One adult social care inspector visited four people in their own homes as part of our inspection of this service. These visits included meeting, speaking with and observing staff who were there to provide support for people. We looked at paperwork kept on file in people's homes relating to their care after asking for the individual's permission.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted local authority contracts team and commissioners of the service to gather their views of the service. We received no negative feedback.

During our inspection we spoke with the manager who was awaiting registration, a care co-ordinator, a training and recruitment officer, an administrator, a senior care worker and four care workers. At the time of

our visit the service was providing personal care and support to 108 people. There were 46 members of staff employed at the time of our inspection.

We spent the first and second day of the inspection at the provider's registered office, speaking with staff and looking at records. These included care plans and associated documentation, staff recruitment files, staff training records, supervision records, various policies and procedures and other documents relating to the management of the service.

Good

Is the service safe?

Our findings

People we spoke with and visited as part of this inspection told us they felt safe being supported by HSG – Didsbury. People told us, "I feel perfectly safe", "Definitely - I feel very safe" and "Yes, I have got to know them well and trust them."

The service had improved since the last inspection and now provided a safe service. At the inspection carried out in May 2017 we were not assured that risks posed to people were appropriately assessed, or that staff were provided with enough information to mitigate some risks and we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments should provide clear and person-specific guidance to staff and ensure that control measures are in place to manage the risks an individual may be exposed to. After the inspection of May 2017, the provider sent us an action plan detailing how they would resolve the issues we had identified with set timescales to achieve this. We saw improvements had been made with the assessment and documenting of risks and to the recruitment processes. Gaps in employment were now explored with applicants and all files we reviewed contained two references.

At this inspection we looked to see what considerations had been made for assessing risks. We saw that people's personal safety had been assessed and any risks identified had corresponding plans in place to minimise and mitigate these risks. Risk assessments included information for staff about the risk and any measures they should take to minimise the chance of harm occurring to an individual. For example, people had risk assessments in place due to their restricted mobility and information was provided to care workers about how to support individuals when moving around their home or when transferring in and out of bed. Other identified risks included falls, specific health conditions, eating and drinking, medicines, smoking and the home environment.

Rounds for care staff had been devised based on geographical areas and then split, depending on whether people needed one member of staff or two to assist with personal care. These were known as 'runs' and were scheduled and managed by the care coordinator. It was identified at the initial assessment process where people required two staff to assist with their care and support. Staff on 'double runs' were always assigned a colleague to undertake joint visits together and therefore, staff did not perform any moving and handling on their own. There was no temptation to attempt a double call alone and this meant people who needed two members of staff consistently received this care and support and were kept safe.

We looked at a number of records in relation to call monitoring and saw that electronic call logging was undertaken by staff. The electronic call monitoring records we looked at reflected that the majority of staff were staying for the full commissioned time with individuals. Some call logs evidenced that staff stayed over and above commissioned time on occasions, for example when a person needed longer to get ready or was feeling unwell. We were assured that staff made sure that people were safe before leaving and moving on to their next scheduled call.

Where staff had not logged in electronically we saw there were reasons for this, for example some people

had expressed the wish that staff were not to use their home telephone. This meant that staff were not able to log in and out remotely and so submitted manual timesheets on these occasions. For those visits where staff had not logged in remotely, or were not able to do this, we discussed with the manager the possibility of missed calls. We identified that for those type of calls the service were not able to identify in a timely way if a call had been missed. They were reliant on being notified of this by someone else for example a customer, a relative, a member of staff or another professional. A missed call checklist was in place for office staff to follow in the event they were alerted to a missed visit. This centred around ensuring the well being of the person who had potentially not received care and support. Improvements initiated after the last inspection had been maintained to ensure people supported were safe from harm.

We explored with people we spoke with and visited if they had experienced any missed calls and seven people told us they had not. One person told us, "Once or twice during the six years," and two other people had, due to bad weather. We judged that missed visits were few in number, however the manager took this on board and told us they would look to explore ways in which the service could improve in this respect.

Most of the people we spoke with as part of this inspection either took responsibility to administer their own medicines or had this carried out for them by a family member. We saw that where people did need support with this aspect of personal care the systems in place were safe. This was demonstrated through the service's policies, procedures, records and practices. Practical competency reviews were completed with all staff to ensure best practice was being followed.

During our visits to people in their own homes we noted one gap in a medicines administration record (MAR). We correlated this with the blister pack in the person's home and saw that the tablet had gone. The log book entry comments confirmed that this had been administered and we were assured that the missing signature was an oversight. The manager outlined the audits of MARs and comments books undertaken at the office and we were assured that care workers were reminded of the importance of correctly documenting MARs in supervision sessions and meetings.

We asked people if staff arrived on time and received mixed feedback. People we spoke with confirmed that 'more or less' they did arrive on time. Care workers had a 30 minute window from a scheduled call time in which to arrive and some people we spoke to were aware of this. One person knew about this and gave staff 'some leeway'. Another person told us that timekeeping in the week was 'more or less on time', but at the weekend care staff were sometimes late. Call records we looked at reflected that staff carried out visits to people at times similar to those originally planned. People were aware that at times carers were delayed because of reasons outside their control, for example due to traffic congestion or an emergency elsewhere and staff confirmed they were allocated sufficient travel time.

We evidenced that the service followed safe recruitment procedures and processes had improved with regards to this aspect. Staff did not carry out care and support until the appropriate pre-employment checks had been completed and written references received. Disclosure and Barring Service (DBS) checks had been carried out for all staff on initial employment and were reviewed every three years, as is good practice. A DBS check allows employers to check whether the applicant has had any past convictions that may prevent them from working with vulnerable people.

Staff knew how to keep people safe and were aware of their responsibilities for reporting accidents, incidents or concerns. Records showed us there had been one incident since the last inspection. The record contained details about what had happened and what action had been taken. There was evidence of learning from incidents that took place and appropriate changes were implemented. Audits carried out by the manager and senior staff helped to pinpoint any trends to help ensure further reoccurrences were

prevented.

Staff understood the processes to follow to safeguard people in their care. Policies and procedures were available and training updates were attended to refresh their knowledge and understanding. The service recognised their responsibilities and was proactive in raising safeguarding concerns when they suspected an incident or event that might indicate abuse had occurred. Agencies they notified included the local authority, CQC and the police and the service had access to a copy of the local authority's multi agency safeguarding procedures.

Staff received training and guidance on safe hygiene and infection control procedures during their induction and at regular intervals when undertaking refresher training. Staff were provided with protective equipment such as disposable gloves and aprons and people we spoke with as part of the inspection confirmed these were used by staff.

Good

Is the service effective?

Our findings

At our last inspection in May 2017 we judged that HSG-Didsbury's ability to provide an effective service required improvement. At this inspection we found that this had improved and judged this was now 'good'. People we contacted recognised that staff were going through a new training process and that new care workers needed time to acquire new skills. However most considered that staff did have the right skills and abilities and one person told us, "I definitely believe they are well trained."

We looked at the induction, training and the development of staff to ensure staff had the skills, knowledge and experience to deliver effective care and support. Staff confirmed that the induction and subsequent training they received was effective and considered they were equipped with the necessary skills and knowledge to meet people's needs. The company linked in with Skills for Care and employees new to care were signed up to the Care Certificate, a set of nationally recognised standards covering all elements of care. New staff initially 'shadowed' existing staff and then worked with other care staff throughout the induction process so they could consolidate their learning. Staff did not work alone until they felt confident within the roles they were to perform.

Elements of mandatory training were further enhanced by additional person specific training so that staff were equipped to deal with the packages of care they were assigned to. Some examples of this included training in stroke care, epilepsy, pressure care, obsessive compulsive disorder (OCD) awareness and needle stick injuries. We saw that the service had a company trainer who linked up with a local Skills For Care representative and the local authority for other useful external training opportunities. Staff we spoke with told us they would ask for specific training if relevant to a support package, as it would 'arm them with additional knowledge and insight' into the person's condition, improve their practice and ultimately benefit the individual receiving the care.

Staff supervision provides a framework for managers and staff to share key information, promote good practice and challenge poor practice. We checked to see if staff were receiving regular supervision sessions and saw that they were. The service had templates in place to record supervision conversations with staff and we saw that there was the opportunity for staff to have their say during their supervision. Staff we spoke with told us they found supervision sessions beneficial and appraisals were carried out with staff on an annual basis.

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 make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. HSG-Didsbury provides a service to people within their own home, therefore any decision to deprive a person of their liberty within the community must be legally authorised

by the Court of Protection.

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA). The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack capacity to make some decisions. Information in people's care records showed the service had assessed people in relation to their mental capacity. The service had an understanding of the MCA and their responsibilities and understood how to implement this should someone not have capacity and the need to support best interest decisions. This included those decisions that would require a discussion with family, and possibly other significant people, for example health and social care professionals.

We saw that documentation, for example a safe use of bed rails agreement, reflected that consent had been gained when appropriate to do so and from the right people. This was either the customer or from a relative or representative with the relevant legal documentation, for example a Lasting Power of Attorney (LPA). The service was mindful of helping people to achieve positive outcomes in their daily lives, either directly through the care and support or because of actions taken by care workers. HSG-Didsbury promotes a local befriending service which operates from the same premises. Befriending is a distinct type of support which is different from the practical or functional day to day support operated by paid professionals. We saw some good examples where the service had identified people either potentially at risk of social isolation or in need of social support and had signposted or referred people to the befriending service. Work had been undertaken by the service to try and make sure people received effective personal care whilst also being mindful of people's wider social and holistic needs.

People were supported with the preparation of meals and drinks where this had been identified as a care and support need during the assessment process. The exact level of support a person needed was recorded in the care plan along with any specific dietary needs, for example a soft diet or a culturally specific diet. We saw and people told us that care workers provided a sufficient amount of support to meet nutritional needs in various ways. People were complimentary of the help they received from staff and one person told us their lunch and cup of tea was served 'just how I like it'. Staff reported any concerns they had about a person's food and drink intake to the manager who took appropriate action. The service had been proactive in devising and distributing information and guidance to staff in how to promote and encourage people to drink plenty fluids, given that the country was experiencing a prolonged spell of hot weather at the time of the inspection. We were assured that people were protected from the effects of dehydration.

We looked at records at the office and also those in people's own homes and saw examples of how people's healthcare needs had been met. People told us that care workers had on occasions contacted a GP to carry out a home visit or had encouraged the person to seek advice from their GP. Care plans reflected contact with health and social care professionals involved in people's care if any health or support needs changed. People's care records included evidence that the service had also supported them to access district nurses, dieticians, dentists and other health and social care professionals based on their individual needs. People had access to healthcare services and received healthcare support, sometimes as a result of intervention or advice from care staff.

Good

Is the service caring?

Our findings

People we spoke with as part of the inspection process were complimentary about the care and support received from HSG-Didsbury, especially if they had a number of regular care workers who attended to their needs. People told us staff were patient in their approach. Staff assigned to specific people on a regular basis had developed positive relationships. One person we spoke with told us, "We have a routine. This is what I like about having a regular carer." We spoke with two people who had not been happy with care workers assigned to them. They had raised this with the office and told us that those care workers were no longer sent to support them. This meant that the service listened to people.

People were less positive on the occasions when they did not have a regular care worker or when their regular care worker was off. People told us that staff filling in for regular care workers were sometimes late. The service was aware of the importance of consistency in care for people and we will check on this on our next inspection.

The manager told us that person centred care was a priority at HSG-Didsbury and that care workers adopted a person centred approach when delivering care and support. This was further evidenced by the way care needs were documented and the way that care delivery was recorded. Comments books comments we saw were detailed and based around the person receiving the care. Care plans were written in the first person and contained information about people's histories and past lives. This gave care workers insight into those they were caring for and helped shape the delivery of care.

People and their relatives felt included, informed and involved when making decisions about their care, if they were able to do so. This meant that important information about how they would like their support to be delivered was captured in the care plan for staff to follow. People we spoke with agreed that care workers provided them with choices when supporting them, and we heard some good examples of this during our visits to people in the community.

People told us they were treated with dignity and respect. We saw that people received care and support specific to them, for example meals prepared the way a person liked them, leaving items within easy reach , such as glasses, tissues and a remote control and providing various drinks with which to take medicines, depending on the individual's preference.

Staff morale was high and we could see from the positive attitudes of staff, the comments they made to us and those recorded in supervision sessions, that they were enthusiastic about the service they provided.

The service provided care and support for people living within areas of Manchester, containing a diverse population, representative of different cultures. We spoke with the manager, a coordinator and care workers about equality and diversity and they were able to give examples of how these were recognised when providing care and support. For example, only female staff were provided to women of a particular faith, where this had been expressed as a specific wish. The service was also mindful of the celebrations of different faiths and adapted the rotas in place to suit both clients and staff who wanted to observe or

participate in those celebrations.

The service included in their Provider Information Return (PIR) that they were working on devising policies and procedures in relation to lesbian, gay, bisexual and transgender (LGBT) groups. Through these they would continue to promote equality, diversity and inclusion and ensure those specific protected characteristics were not discriminated against. We will check that these policies are in place on our next inspection.

One care plan we looked at contained the following comment : "Please allow my independence and do the tasks with me." This was reflected in one of the Human Support Group's core principles - "do with and not for" and staff understood the importance of promoting independence wherever possible and when safe to do so. Staff told us that records and support plans informed them of what people were capable of doing and they saw their role as being vital to help people maintain those skills. People also confirmed that staff respected their independence and 'didn't take over'. Results from a recent survey undertaken by HSG-Didsbury in June 2108 reflected that 100% of the respondents considered the care and support on offer maximised their independence.

We visited the office of HSG-Didsbury as part of our inspection. We found that both electronic and paper documentation were stored securely so that people's confidentiality was properly maintained. Staff were aware of the need to maintain confidentiality and told us that private conversations between them and people they supported were not openly discussed with others unless it was something detrimental that might cause them harm. This showed us that staff respected confidentiality but would take action if the information being shared compromised the person's safety.

Good

Is the service responsive?

Our findings

We asked people if they received care and support when they needed it and most told us they did. One person told us, "I do and am happy. It [the care] is changing rapidly due to my needs changing." This showed that the service was responsive and adapted to people's changing needs. People and relatives told us, and we gauged from people's support plans, there had been an initial assessment of people's needs. Assessments carried out before the start of care provision help determine whether or not a service can safely provide the care and support needed. Care plans provided clear rationales as to how individual needs would be met and included risk assessments relevant to the person.

We looked at nine support plans in total, on site and in people's homes and we saw they contained information about people's personal history, likes and dislikes, hobbies and interests. There were good descriptions of how staff were to support people, containing specific details of preferences for care. We saw people's gender preference for care staff was recorded in their support plan. The approach to care was person centred and care plans clearly evidenced that people had been fully involved in developing their plans and how they wanted to be supported.

According to the provider's policy support plans were to be reviewed annually or sooner if needed due to a requested review or change of need. The care plans we checked had been reviewed within company timescales, if not sooner. We saw that people's changing needs were responded to appropriately and the service had improved in this regard since our last inspection. Staff recognised when people were unwell and reported any concerns to a senior or a manger. We saw and heard examples of where staff had helped identify deterioration in people's health, either through conversation, observation or through experience. This included things such as an increase in needs, treatment for infections, review of medicines and the requirement for additional equipment in their homes. Reviews of care sometimes led to the service making referrals to other professionals or organisations, and we saw occasions when GPs, social workers, district nurses and the fire brigade had been contacted following a review.

Reviews of care were sometimes instigated via the supervision route with staff. We saw an example of this from a staff supervision undertaken on 20 April 2018, where the staff member raised concerns about a client and considered that the care plan needed a review, due to increased needs. We asked the manager about this and was presented with a revised care plan dated 24 April 2018. This showed us that management listened to care staff and were responsive in addressing any changes in need.

We noted that the Quality Policy Statement stated that the company welcomed all forms of feedback and both informal concerns and formal complaints were encouraged, as both were seen as being vital to improving the quality of service. A resolved complaint was a positive step. People were provided with information about the company's complaints policy and procedure when they started to use the service, as this was contained in the service user guide. People we spoke with were all very much aware of how to raise a complaint and all felt at ease in doing so.

At our last inspection we noted that complaints contained recurring themes around missed or late calls. The

service had improved in this aspect at this inspection and we saw the last missed call was more than six months before this inspection. A missed call checklist was also in place for office staff to follow in the event they were alerted to a missed visit. This centred around ensuring the well being of the person who had potentially not received care and support. Improvements initiated after the last inspection had been maintained to ensure people supported were safe from harm.

Records we looked at provided an overview of complaints received and acknowledged, details of any investigations along with conclusions and actions taken, where required. We saw complainants were sent a letter detailing the outcome of the investigation, details of the decisions made and a rationale for these decisions. Complainants were provided with the opportunity to raise any further concerns with the quality team if they were not happy with the outcome of their complaint. We judged that the service had effective systems in place for the management and resolution of complaints and we were assured that people's concerns about the care they received were taken seriously and investigated appropriately.

The company received feedback in the shape of compliments from people who used the service or from other family members and these were shared with staff. Staff were thanked for their performance and practice therefore staff told us they felt valued and appreciated.

At this inspection the service could evidence that people had been supported with care whilst at the end of their life. We saw that reviews were carried out when people were identified as needing end of life care, often due to additional equipment in use, changes in medicines or increased needs. We saw one review carried out identified the need for two care workers to provide good quality end of life care and a request was made to the commissioning authority to increase the care package. The service worked in conjunction with other professionals, particularly district nursing teams, to ensure that people received good care whilst approaching the end of life.

Good

Is the service well-led?

Our findings

At our last inspection of HSG-Didsbury in May 2017 we rated the service requires improvement overall and identified that it was not always well led. At that time we had been alerted about the departure of a number of key members of staff. At this inspection we saw that the company was stable and operating effectively, despite the registered manager leaving the company in April 2018.

At this inspection we saw that people now received care and support from a well-led service. There was no registered manager in post at the time of this inspection as they had left the company in April 2018. A registered manager from another branch of Human Support Group was acting as manager and told us they had submitted their application to the Care Quality Commission to add this branch location to their registration. Our records confirmed that they had begun the process. 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'.

As mentioned earlier in this report HSG-Didsbury branch was run from the same premises as the company's head office and therefore staff assigned to the branch had access to colleagues in other company roles, including senior management, if this support was required.

The company promoted its vision and values to staff in a number of ways. In the main office we saw posters and pictures, conveying the company mission and core values for all office staff to see. These were also cascaded down to care staff. We saw examples of communications to staff, called 'colleague feedback', updating care staff about a recent audit and informing them of areas identified that required a focus in the future. This feedback also contained some of the values of the company, including 'we're in it together' and 'getting better every day', so staff were reminded of these in company communications. Staff were also provided with a pocket-sized card that when unfolded listed the mission, vision, values the company strived to achieve and the behaviours expected of staff. Again, this served as a useful reminder for staff about company expectations of employees when delivering care.

At our last inspection we had identified that the governance systems in place did not effectively monitor all aspects of the service provision to help ensure people received a quality service that was safe and effective. We looked at the quality assurance systems in place to ensure people experienced safe and appropriate care and saw that these were more robust. The manager was able to evidence how practice had improved helped the service meet the regulations.

We noted that the Quality Policy Statement stated that the company reviewed practices regularly so we asked the manager what measures were in place to continually monitor the quality of the service provided. The manager demonstrated how they collated and sent key performance indicator (KPIs) information on a weekly basis to their line manager. KPIs included an overview of any complaints and staff management issues, for example any vacancies, absences and performance spot checks. Other quality checks in place included audits of records completed by care workers, for example comments books and medication administration records (MARs) and unannounced staff spot checks carried out in people's homes. Since the

last inspection the company had implemented and appointed to the new role of a Care Experience Assessor. This member of staff had responsibility for checking compliance and quality with regards to the delivery of care. Audits were carried out on aspects of care delivery including health and safety, environmental factors, care documentation, staffing levels, training, medication and staff supervision and appraisal.

The quality assurance records that we saw demonstrated how the manager maintained oversight of the service. We judged that the service was meeting the regulation in relation to good governance. We did discuss the delay in identifying any potentially missed calls with the manager, who told us they would explore ways of doing this in a more timely manner and we will check this on our next inspection.

Customer satisfaction surveys were sent twice a year to people to assist the service in where improvements were required. The most recent results were positive and we saw examples of some lovely feedback and compliments received by the service.

We saw initiatives being used to keep staff better informed about the wider aspects of the service, for example, newsletters from the branch and colleague feedback including any compliments received, training opportunities and staff performance information. Staff attended meetings where they were updated on aspects of care, support and other management functions. Staff saw these meetings as an opportunity to share their knowledge, ideas, views and experiences. Staff we spoke with told us that as they predominantly worked alone it was easy to often feel quite isolated, however recognised and appreciated the mechanisms the provider had in place to keep them informed and up to date. Other incentives for staff included the allocation of raffle tickets to staff when complimented, carrying out best practice or where it was recognised staff had gone over and above for people. A regular draw was held and staff were rewarded. A company pension was also available.

Staff we spoke with were complimentary about the service and their colleagues and proud of the work they did. This came across in the conversations we had and supervision notes we saw. Staff felt more appreciated and were therefore more engaged.

We looked at how the service linked in with other agencies and saw good examples of how they alerted other professionals when concerned for people's welfare. There were links with the local authority, district nurses, GP's and health professionals. A local authority contracts representative had visited the service in May 2018 and on our request shared positive feedback, based on their findings at that time. The manager explained the links with a local befriending agency, based in the same building, and we saw examples of good outcomes for people as a result of a referral or signposting to the befriending agency from HSG-Didsbury.

Providers of regulated services such as HSG-Didsbury are required by law to notify CQC of certain events which occur in the service, with the submission of statutory notifications. We use this information to monitor the service and ensure they respond appropriately to keep people safe and meet their responsibilities as a service provider. Records showed that when an incident had occurred, such as a potential safeguarding incident, or an accident, information had been shared with all relevant bodies, for example the local authority and CQC.