The Human Support Group Limited

Human Support Group Limited - Didsbury

Inspection report

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Date of inspection visit:
09 May 2017
10 May 2017

Date of publication:
27 July 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	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 was an unannounced inspection, which took place on 9, 10 and 12 May 2017. This meant the service did not know we were coming on the first day. We returned to the service's offices for a second day of inspection. On the third day, with prior consent, we visited people in their homes. The service was last inspected in January 2016 and rated 'Requires Improvement'.

Human Support Group – Didsbury, also referred to as Homecare Support, Didsbury (HSG – Didsbury) is a domiciliary care service which provides personal care and support to people in their homes to help them remain independent. The service also offered practical care tasks such as sit-in services, domestic support and sleeping/waking night services. HSG – Didsbury supports people living within the Greater Manchester. Prior to this inspection the service supported people in living in Manchester and Stockport. The care manager told us due to recruitment issues and concerns about the quality of care suffering as a result, the provider made the decision to stop service provision in Stockport from 31 March 2017. The provider facilitated the smooth transfer of 16 people being supported to suitable alternative providers with the support of the Stockport Council. This helped to ensure people supported were not adversely affected. At the time of our inspection, the service supported 109 people.

At the time of this inspection, the service had not had a registered manager since September 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 current care manager had been in post since November 2016 and was in the process of registering with the CQC.

People told us they felt safe with the care and support provided by the service. They told us there was a regular team of care staff who visited them during the week but that this was variable at the weekend. This meant people were not always supported by people who knew their specific care needs.

We noted the provider had systems in place to help ensure suitable candidates. Where adequate references were not collected, we saw no evidence that had potential risks had been considered and appropriate steps taken to mitigate these.

Risk assessments did not always provide clear and specific information to help staff deliver care and support safely. This meant people were potentially at risk of harm.
Staff were aware of safeguarding principles and knew what to do in the event they suspected abuse was taking place. We noted the provider's safeguarding policy referred to outdated legislation which meant staff were potentially referring to documents that were not completely fit for purpose. The care manager showed us they referred to current local authority safeguarding policies and procedures.

People and relatives told us care staff demonstrated good hygiene practices by using personal protective

equipment (PPE) such as gloves and aprons, and washing their hands as required. If used appropriately, this practice should help to prevent cross contamination and the spread of infection.

Where required people and relatives told us they were safely supported to take their medicines. The service used a medication support plan and risk assessment which helped staff to support people in a safe and effective way.

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

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

We checked to see how the service ensured the principles of the Mental Capacity Act 2005 were adhered to. In some people's care plans we saw relatives had signed, consenting to care on their behalf without evidence that they had the legal authority to do so. It is important to note that relatives may, and usually should, be consulted about the proposed care and support, and their views taken into account, but this is not the same as consent. They do not have automatic legal authority to provide permission for the proposed care or treatment.

We advised the provider to record when they had requested information from the local authority about a person's capacity and to record changes to capacity when reviews were done. This should help to ensure people's care and support were delivered in their best interests.

People and their relatives told us care staff always sought their permission before supporting them and that they had the chance to explain to staff how they preferred to be supported.

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

Care staff told us if they observed that people needed healthcare support they would report these concerns to the office and record them in people's daily comments book. In the event of an emergency they said they would telephone the most appropriate agency, for example, the paramedics. People and relatives told us they knew care staff would support them if they needed any medical attention. This showed staff could be proactive in making sure people received the right health care when they needed to.

People and their relatives told us care staff were kind and considerate to them. Staff demonstrated they knew people well and people said they had developed a good relationship with their care staff. This meant people were supported by people who understood their care needs. People said they were treated with dignity and respect and encouraged to maintain their independence depending on their abilities. This helped to promote their continued wellbeing.

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

Each support plan contained personal and medical information about people, their preferences, personal goals and how they wanted to be supported. Plans we looked at contained detailed descriptions of support

provided. Care and support was not consistently provided in a responsive way. Support plans had not been reviewed in accordance with the provider's policy which meant that people's support may not have been appropriate to their current needs.

Everyone we spoke with knew how to raise a complaint and most people were satisfied with how their complaint was managed. There was a robust complaints process in place which meant complaints were managed effectively.

People told us they provided feedback on the service they received through a satisfaction survey sent every six months. We noted the overall response was positive but the number of responses returned was poor, meaning the response was not reflective of all the people receiving care.

We received mixed responses from people and relatives regarding the management of the service. Some people and relatives raised concerns about the continuity of care because two care coordinators were leaving the service. We saw that senior management had addressed this issue and had organised support from other services to assist. A new coordinator had been recruited into the post and was undergoing their induction and the other role had been advertised. This demonstrated the provider was proactive in ensuring people receiving services were not affected as a result.

The provider had quality assurance systems in place to monitor, for example, staff performance, care plans and medication administration. These did not consistently identify areas requiring improvement. This meant the care manager and provider could not be assured that all aspects of the service provision was safe and effective.
Since the appointment of a care manager, staff meetings had resumed. We saw two meetings had been held since their appointment with further meetings scheduled for the rest of the year 2017. This meant care staff had the opportunity to discuss issues relating to their work and ensure they were always kept up to date on matters affecting the service provision.

We made two recommendations that the provider ensures recruitment processes are robust and fit for purpose and operational policies and procedures are reviewed and updated as appropriate.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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

People told us they felt safe with the service and, in the main, they were supported by regular care staff. Staff were aware of safeguarding principles and knew what to do should they suspect abuse was taking place.

People told us care staff did not miss visits but that sometimes they were late. The service had recognised this issue and had put measures in place to help address this failing.

Is the service effective?

Requires Improvement

The service was not always effective.

People had confidence in care staff's abilities and felt they were trained to do their jobs effectively.

We checked to see how the service had embedded the principles of the Mental Capacity Act 2005 into its practice. People's consent was always sought prior to the provision of care and support. Care records were not always signed by people receiving support.

People were satisfactorily supported to maintain healthy diets.

Is the service caring?

Good

The service was caring.

People and relatives told us care staff were kind and caring and demonstrated good knowledge of the people they supported.

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

People and relatives we spoke with said they had been involved

in decisions relating to their care provision. This was reflected in support plans we looked at.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Support plans contained information about people's personal history, preferences and hobbies and detailed description of the care to be provided. These plans had not always been reviewed regularly. There was an action plan in place to ensure reviews were done.

People told us they knew how to make formal complaints. There was a robust complaints process in place.

The service sent out a survey to get people's feedback on the care and support they received. Results were analysed and people were contacted to address any concerns they may have raised.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had appointed a care manager who was in the process of registering with the Care Quality Commission.

Governance systems did not consistently monitor all aspects of the service provision to help ensure people received care and support that was effective and safe.

Staff meetings had been resumed. Minutes of meetings indicated that staff had the opportunity to discuss matters relating to their work with managers and colleagues.

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 on 9 and 10 May 2017 and the first day was unannounced. This meant the service did not know we were coming. On 12 May 2017, by prior arrangement, we visited people in their homes to find out about their experiences with the care and support provided.

The inspection team consisted of two adult social care inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience had experience of caring for someone who used domiciliary care agencies.
Before the inspection, the provider completed 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 Manchester local authority to find out what information they held on the service.

We spoke with 10 people and 14 relatives on the telephone; we visited three people in their home and spoke with them and their relatives. We spoke with seven members of staff including two care assistants, one care coordinator, the care manager, a company director, the quality monitoring officer, and a training officer. We looked at records relating to the service, including eight care records, six staff personnel files, safeguarding records, minutes of meetings, and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe being supported by HSG – Didsbury. Comments included: "I feel safe", "I do feel safe with them no problems" and "We feel safe. One person (office staff) comes and checks our safety."

We looked at eight support plans to see what considerations had been made for assessing risks. Risk assessments should provide clear and person-specific guidance to staff and ensure that control measures are in place to manage the risks an individual may be exposed to. We saw risk assessments for the environment, control of substances hazardous to health (COSHH), moving and handling, mobility equipment and medication.

We noted risk assessments did not consistently provide clear and specific explanations about what should be done to minimise or manage the identified risks safely. In one file, we saw clear directions for repositioning of a person to maintain good skin integrity. We saw that if care staff were required to prepare meals then a nutrition plan was in place and any risks, for example swallowing, were noted. We saw that any specific requirements, for example a small white cup provided by Speech and Language Therapist (SALT) or staff to stay with the person during the meal were noted.

Across all files, we noted moving and handling equipment, for example a hoist, was recorded but there was no detail regarding its use. In one person's home, we saw staff using a turning stand. This is a piece of moving and handling equipment that supports the safe transfer of a person from a seated position to another. In another person's home we saw the turning stand and asked if the care staff used this and they said yes. This equipment was not mentioned in either support plan nor was there any risk assessment around its use. The training officer told us staff received moving and handling training which included use of a hoist and a turning stand and we saw these pieces of equipment were present in the training room. This training would potentially minimise the risk of harm to people but best practice would be for the service to include risk assessments around equipment use.

Another person's plan, we saw an environmental risk (fire/carbon monoxide) rated as high but there was no evidence that a further risk assessment had been done in accordance with the provider's protocol. This additional assessment provides further guidance to staff on how the risk must be handled. In another person's support plan we saw a local authority assessment which stated the person was having difficulty swallowing and had choked on occasions. However we did not see evidence the service had considered the risks involved or put a support plan in place to reflect this. This meant care staff were not adequately equipped to support this person safely. We raised our concerns with the care manager and showed her the documentation. They said they would investigate this concern.

We saw risks were rated low, medium or high but it was not clear if risk levels identified were the original assessment of risk or the residual risk that remained following control measures put in place. We discussed this issue with care manager and quality monitoring officer and suggested risk assessments could identify initial risk followed by the action(s) to be taken to minimise risk and whether or not further action was required to help ensure the person was safe from harm.

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

When looking at support plans we noted records about the servicing of hoists. We noted in two reviews and at a home visit the hoists were overdue their servicing. The care manager told us the service took responsibility for arranging equipment to be serviced. They said staff checked the equipment prior to using it. If equipment needed servicing, they would report this to the care coordinators who would contact the service company. We made a suggestion that a list of all service dates for equipment could be centrally.

We reviewed six staff personnel files to see if the provider's recruitment processes helped to ensure suitable staff were employed. All files we looked at contained a completed application form, photographic identification, interview notes and an initial test for basic mathematics and language skills and confirmation of online Disclosure and Barring Service (DBS) checks. The DBS keeps a record of criminal convictions and cautions which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. We noted one file had gaps in the employment history that had not been fully explained on the application form or in the interview notes. Of the six files we reviewed, four contained two references each. One of the other two files had only one reference but there was a note indicating the attempts made to obtain the second reference. The last file had a record of attempts to obtain both references but these had been unsuccessful. We noted this candidate had worked for HSG - Didsbury up until October 2016 and reapplied in February 2017, so was known to the provider and this branch of the service. We noted that while the provider had adequate systems in place to help ensure suitable candidates were recruited including undertaking risk assessments where appropriate, these were not consistently in place at HSG – Didsbury.

Most people and their relatives told us there was a consistent team of care staff during the week but at weekends this could vary. Comments included: "Same carers most of the time", "I have a regular team of carers; one lady comes two or three times a week and then I get some others (carer staff)", "Generally there is stability during the week; it is more changeable at the weekends" and "At weekends, there are a lot of different carers as a lot don't work on Saturdays or Sundays." This meant people may not always supported by care staff who were familiar with their specific needs. Following our site visit, we spoke with the care manager about this and they said staff availability contributed to the variance at weekends. For example, regular staff may have one weekend off or were unable to work at the weekend. The care manager said to help ensure more continuity they were currently recruiting for staff to work specifically at weekends.

Prior to our site visit we saw, from notifications, there were eight instances of missed visits, none of which resulted in harm to people. We asked what measures were in place to help ensure missed visits were eliminated or reduced. The care manager told us there was a process in place to ensure that visits were not missed. The care manager said they had done a tidying up exercise of historic missed visits and investigated the causes of these. This had shown that the process in place had not been followed and that there had been a breakdown in communication between care coordinators and care staff. They felt significant improvement had been made in this area. Minutes of two team meetings we looked at confirmed there had been discussions about missed visits and reinforcing the process that all staff were to follow to help prevent missed visits.

People we spoke with confirmed that rarely their visits was missed. One person told us over Christmas 2016 they had experienced missed visits. Some people and relatives said one of their main concerns with the service was late visits. In some cases, they said the office contacted them to let them know care staff were running late but that was not always the case. Staff told us and we saw from minutes of the May 2017 staff

meeting one of their concerns was that travel time between visits was not allocated. This, they said, contributed to them being late for visits.

At the last inspection in January 2016, we found care staff did not have enough time to travel from one visit to the next and we made a recommendation that the provider should ensure staff had enough time to travel safely from one place to the next without impacting on the quality of care provided. We spoke with one of the care coordinators and looked at rotas for May 2017. We noted on some days a 10-minute gap between visits had been allocated as travel time. We queried the instances where there was no allocated travel time. The care coordinator said and showed us these locations were close so no extra time had been allocated. The care manager admitted incorporating travel times into rota was an area for improvement which they were currently monitoring. We will check at the next inspection to see how the provider has improved in this area.

Staff told us they knew how to keep people safe and gave us examples, such as ensuring the person's environment was free from hazards, medicines were administered according to the prescription and the keysafe box, if in place, was securely closed on leaving the property. Staff we spoke with had a good understanding of what safeguarding meant, types of abuse and told us they would report suspected abuse to their manager. Care staff we spoke with provided examples of concerns they had reported. The provider had a detailed safeguarding policy in place which included definitions of abuse, clear procedures on actions to take and mandatory training. We noted the policy referred to the "No Secrets Guidance" which was replaced by the Care Act 2014. The Care Act is legislation that sets out how people's care and support needs should be met and introduces the right to an assessment for anyone, including carers and self-funders, in need of support. The act also sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. We spoke with the care manager about the outdated legislation. They said policies and procedures were updated centrally then showed us that on safeguarding matters they also referred to the local authority's current safeguarding policies and procedures. We concluded the service had sufficient information to help ensure people were kept safe from risk of abuse but have made a recommendation that the provider should ensure policies and procedures were up to date.

We checked the safeguarding records which included accidents and incidents. The care manager was aware of their responsibilities to manage and report any safeguarding concerns. We saw CQC had been appropriately notified of incidents relating to the provision of care and support. We noted the provider had a satisfactory system in place for monitoring accidents and incidents across its services. We saw that analyses of incidents took place, appropriate action taken if required, for example, retraining, and lessons learnt shared across the service. There was adequate oversight of these incidents to help reduce the likelihood of them re-occurring.

People and their relatives told us care staff demonstrated good hygiene practices and used personal protective equipment (PPE) such as gloves and aprons appropriately. Staff we spoke with told us how they used PPE and understood their responsibilities regarding infection control prevention. This should help to ensure infection control practices in place effectively kept people safe from harm of infection.

Where help was required, people and relatives we spoke with were satisfied that care staff safely supported them with their medication. One relative told us they had previously had a problem with care staff coming too early and the person did not get their medicines on time. They raised this with the office staff and the problem was rectified. We saw a medication support plan was in place which detailed the support people needed and how they liked to have their medicines and a medication risk assessment which included if medicines were time critical or not. For example, one person wanted to take their medication with

blackcurrant squash. Another person wanted their tablets on a blue saucer so they could see them better. Plans also detailed who was responsible for re-ordering and collecting the medicines. We found there was sufficient information recorded in people's plans to help ensure staff supported them safely.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives if they felt care staff undertook their role in an effective way. In the main, people and relatives responded positively to staff's abilities and told us they found their regular care staff to be well trained, skilled and had a good understanding of their care and support needs. Their responses included the following: "(Care staff) know exactly what they are doing and what I need; they are a good team", "They (Care staff) are trained and know how to deal with dementia…it's not an easy job" and "Some are more competent and willing than others."

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 checked whether the service was working within the principles of the MCA.

We looked at eight support plans and noted in some support plans, consent to care had been signed for by relatives. We did not see evidence that there was appropriate legal authorisation for them to do so, such as lasting power of attorney (LPA). An 'attorney' is a person with delegated responsibility for their relative to act on their behalf. It is important to note that relatives may, and usually should, be consulted about the proposed care and support, and their views taken into account, but this is not the same as consent. They do not have automatic legal authority to provide permission for the proposed care or treatment. We were told copies of documentation would be requested. This meant we could not be sure the appropriate authorisation was in place to help ensure decisions made on behalf of people were lawful.

We noted medication assessments asked relatives to sign if the person was able to give verbal consent but unable or unwilling to sign for themselves and there was a space for the GP to sign if the person was unable to give consent. We discussed the service's responsibility regarding MCA with the care manager and the nominated individual. They told us they expected the local authority to undertake capacity assessments though the local authority care plans we saw in some people's care records had not considered and recorded the person's mental capacity either. We advised the service to record that they had asked the local authority about a person's capacity when they started providing care and to record if capacity changed when reviews or reassessments were done. However in addition the service needed to ensure that after it had been commissioned by the local authority, there were systems in place to undertake and record capacity assessments and, if required, best interest decisions for people using the service should they be assessed as lacking capacity. This should include people who were self-funded.

People and relatives told us care staff always asked people's consent prior to undertaking tasks according to the person's support plan and explained what they were doing. They told us they had the opportunity to discuss with care staff how they wanted to be supported. People said, "They (carers) ask me what I would like" and "The carers ask is there anything else you would like me to do?" One relative said, "They always ask for consent before they do things for [person]; like when they (care staff) give [person] a wash they tell [person] everything they are going to do and [person] tries to talk to them (using) hand gestures."

Care staff told us they received a comprehensive four-day induction and mandatory training which was updated annually or every three years depending on the topic. They told us they shadowed an experienced staff before working unsupervised. On the first day of our inspection, we spoke with a training officer about induction and mandatory training offered. They told us the induction and mandatory training was based around the common induction standards and the Care Certificate. Topic areas included personal care, skin care, medication, food hygiene, infection control, fire awareness, dementia, mental health, MCA, safeguarding and first aid awareness. The Care Certificate, though not mandatory, is a nationally recognised set of standards to be worked towards during the induction training of new care workers. We were satisfied staff received induction and essential training that helped to ensure they had the necessary knowledge and skills needed to support people safely and effectively at the commencement of their employment.

At our inspection in January 2016, staff told us and records we looked at confirmed a lack of ongoing training. At this inspection, we asked the care manager about ongoing training and they told us this was an area requiring improvement. The training matrix we looked at confirmed not all staff had completed the required refresher training according to the provider's policy. For example, we noted 20 percent of staff were overdue for refresher training in moving and handling, 60 percent in fire safety awareness and 26 percent in falls awareness training. We noted gaps in other key areas such as safeguarding and mental capacity awareness. Failure to ensure that all staff undertake ongoing training meant that people were potentially put at risk of harm or injury because staff may not be competent to do their job. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The care manager told us and we saw they had an action plan to address these gaps. We noted a staff meeting held in May 2017, reinforced and reminded staff to update their training where relevant. We will check the progress of these at our next inspection.

We noted the provider had ensured there were formal systems in place to support and develop staff. These included one to one supervision, appraisals and spot checks. The care manager told us when they started at the service they noted appraisals, supervisions, and spot checks were not being done systematically. Staff files we looked at reflected this inconsistent approach. Spot checks are used as an assessment of the staff member while on duty and are an essential part of their quality assurance system they check for example whether staff arrived on time, used personal protective equipment (PPE), followed the correct procedure when administering medicines and communicated with the person they were supporting. Any issues identified were recorded and, if required, supervision would be arranged. We saw the care manager had suitable actions in place to address these gaps and some were in progress. We noted all new staff had had a spot check within six weeks of starting in their role. We will check the progress of these at our next inspection.

The service sometimes assisted people with meals if required. People and their relatives were positive about the way in which care staff supported them with the preparation of drinks, meals and shopping. Everyone we spoke with was happy with the support they received; one person told us a particular care staff could not prepare scrambled eggs. Their comments included: "They do meals for me; I have no complaints", "The carers make a cup of tea. [Person] has their tea in a particular way (and) the carers do this (well)" and "They do meals for me; it's mainly microwave but I have a choice and they do me tea, coffee and I like chocolate."

People also told us that care staff always gave them a choice of what to eat and drink. They said, "The carers ask me what I want for breakfast" and "They know that I like mushrooms with my meals." We concluded care staff satisfactorily encouraged and supported people to maintain good nutrition and hydration.

We asked people and their relatives if care staff had contacted relevant health care professionals on their

behalf or raised concerns around their health. Most people and relatives told us they were confident care staff would be supportive if required. One person told us, "A couple of times they (care staff) have called the doctor when they were worried about me." Relatives we spoke with said care staff would always keep them informed of any observations they made while providing care, for example, skin soreness or a rash. The support plans we looked at confirmed the service worked with health care professionals such as district nurses. From two people's care records we saw care staff provided continuity to the work of the district nurses. For example, care staff helped to ensure a person had a meal following their insulin injection and that another person's pressure sore pads were changed when required. Care staff told us they would record and report to the office any concerns they had about a person's health and in the case of an emergency they would telephone for an ambulance. This meant the service, where possible, was proactive in making sure people received the right health care when they needed to.

Good

Is the service caring?

Our findings

People we spoke with found the service and the care staff to be caring. They said, "They treat me very well; we have a laugh and a joke", "They are very good with me; they do care", "They call me by my name and they are a lifeline for me and keep me motivated" and "The carers are kind and caring."

In the main, people told us and relatives confirmed that care staff's approach was compassionate and that staff listened to what people and their relatives had to say. One person told us, "The carers listen to me and we have a chat about the weather general conversation." Relatives said, "(The care staff) all listen to [person] and like [person]" and "(Care staff) listen to me and tell me little things so we can keep [person] healthy." We had two examples where people found some staff did not always demonstrate a caring approach. They told us, "I'm okay with most of them (care staff) but one (care staff) I don't like (their) attitude; (they) don't speak and moan about how much time (they) have to do on the job" and "(Care staff) rushes and gives me what I call a lick and a promise." We raised these concerns with the care manager who addressed them during our inspection.

Staff we spoke with had a good understanding of people's personalities, preferences and their support needs. They told us they read people's support plans and daily comments book to update themselves on any changes or concerns their colleagues may have recorded. Care staff also said they had regular clients which helped them to support people effectively. This was confirmed by people and relatives we spoke with. One relative said, "[Person] has a very good personal relationship with them (the care staff); they are friendly and [person] is happy with them", "(The care staff have a good laugh with [person] and talk about football, mainly Manchester City" and "Their (care staff) attitude is positive and they are tolerant and patient with [person]. They understand the dementia, his needs and that [person] has a lack of capacity." This meant people were supported by staff who understood how best to support them.

People and relatives stated they were treated with dignity and their privacy was respected. Comments included: "(The carers) respect our home", "The carers treat [person] with respect; they are friendly and don't over step the mark with friendliness. They chat when they are getting [person] dressed and involve (them)" and "They respect his privacy and dignity." The care staff we spoke with gave us examples of how they would maintain people's privacy and dignity. For example, ensuring doors were closed when providing personal care, covering people appropriately and politely asking family members to leave the room when attending to people. We noticed one person we visited had a plastic food protector over their clothes. We asked if it was their choice to wear this and they told us the care staff put this on when they get her dressed in the morning. We found this practice was of more convenience and benefit to care staff rather than the person.

People and their relatives told us they were involved in planning their care and support. They said information about what they required was gathered during their initial assessment. This was confirmed in the care records we reviewed. People we spoke with said if they had any concerns about their care they would telephone the office to discuss them. This meant that people and relatives felt included and were consulted in making decisions about the care they received.

People told us care staff helped them to maintain their independence by encouraging them to undertake tasks on their own and providing help appropriately. We saw examples of tasks recorded in people's support plans. Comments included: "They encourage [person] to do things like make (themselves) a cup of coffee or make Weetabix which (they) like and they (care staff) are there to help if needed" and "I like to wash myself in the shower but may need help washing my lower back." When speaking with staff they gave us examples of how they encouraged people to maintain their independence and provided support to suit the person's abilities.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us and from people's support plans we saw there had been an initial assessment of people's needs. This should help to determine whether or not the service could provide the care and support needed. We looked at eight support plans and we saw they contained good information about people's personal history, likes and dislikes and hobbies or interests. There was a very detailed description of how staff were to support people. We saw people's gender preference for care staff was recorded in their support plan.

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. All support plans we checked had been reviewed within the last 12 months. However we noted some of the older support plans had not been reviewed for up to two years prior to this. We noted one person's care plan had been reviewed by the service in April 2017 but the care plan did not take into account the person's changing needs regarding difficulty with swallowing and choking incidents. These issues had been identified in an assessment done by the local authority in February 2017. This meant that people's needs had not been reassessed to ensure the care provided was still appropriate. We saw the care manager's action plan to address this concern and a schedule of reviews to be undertaken within established time scales. We will check at our next inspection to see what progress has been made.

People and relatives we spoke with said they knew how to make a complaint. Most people told us they had not made formal complaints but had telephoned the office and raised concerns such as late visits or staff rushing to complete tasks. One relative said they had contacted the office to raise a complaint about a care staff and felt satisfied with the way in which the situation had been managed. Two relatives said they had made complaints but had not had a response. We raised these issues with the care manager. They were familiar with one of the complaints and were able to show us documentary evidence that the matter was being handled. The other concern they were not aware of as this one had been raised with one of the care coordinators. They made a record to address this concern immediately.

We looked at the service's record of complaints for January to April 2017. There had been 11 complaints. We noted each was from a different person and concerned missed visits and care staff attending visits too early. The frequency of these incidents indicated a larger scale problem which potentially put people at risk. We noted earlier in this report the care manager had put measures in place to improve on missed and late visits. These measures provided some assurance that the service was addressing this risk. However, we will check at the next inspection to see if these improvements have been maintained to ensure people supported were safe from harm.

Records we looked at provided an overview of complaints received and acknowledged, investigations and conclusions and actions taken, if required. We saw complainants were sent a letter detailing the outcome of the investigation and actions taken. This process was quality assured by the provider's performance team.

Based on this evidence, we concluded the service had an effective and independent system for managing its complaints to ensure people's concerns about the care they received were taken seriously, investigated and

remedied appropriately.

We asked people if they had been asked to give feedback about the care and support they received. Most people we spoke with said they had been asked to complete a satisfaction survey. We saw that surveys were sent to people every six months in July and December 2016. The care manager told us and we saw they contacted everyone who included written comments on their survey form to try and address the concerns raised. They said the main areas of concern were missed calls and new staff not being aware of people's needs. The care manager said they were trying to organise staff to help ensure these concerns were minimised. We saw the performance team analysed the survey results and documented themes and trends. The overall response was positive. However less than 20 percent of the surveys had been returned which meant the overall response was not representative of the entire group of people receiving care. The service may want to consider alternative ways of getting feedback from a larger proportion of people receiving their support.

Requires Improvement

Is the service well-led?

Our findings

At the time of this inspection, the service had been without a registered manager since September 2016. The provider had appointed a care manager who was in the process of registering with the Care Quality Commission. We checked our records which confirmed that they had begun the process.

We asked people and their relatives if the service was well led. Comments included, "I would recommend the service from the care perspective, but I do have concerns about management", "The on-call (out of hours service) are friendly and amenable but the office are a 'What you want? We can't speak now' sort of attitude", "Overall the service is average", "I would say (the service is) good because it takes a lot off me" and "Yes, home care are pretty good."

Five relatives told us their concerns about the care coordinators leaving the service and the impact this could have on the care provision. During our inspection we spoke with the care manager about these imminent departures. They said and we saw from an emergency staff meeting held in May 2017 that staff had been informed and senior management had acted proactively to ensure adequate measures were in place to support the care manager and continuity of business. The service had already recruited one person into the post and they were undergoing their induction at the time of this inspection. The provider was recruiting internally and externally for the other role. We saw that senior management had pledged to support the branch throughout the transition period through using staff from other branches to assist.

We asked the care manager what measures were in place to continually monitor the service's quality. The care manager told us they collated and sent key performance indicator (KPIs) information on a weekly basis to their line manager. KPIs included complaints and staff management issues such as absences and spot checks. We saw the provider had other quality checks in place which included the following measures: staff spot checks, daily comments books and medication administration record checks, and an internal audit, which was done by the performance team and looked at how the service was performing and should identify any areas for improvement. We noted an internal audit had been done in February 2017 and identified several areas for improvement including staff recruitment records, support plan reviews, staff supervisions, spot checks and appraisals. There was an action plan and set targets for completion of work. We saw evidence the care manager had started taking action in these areas.

Although there were quality assurance systems in place, we found these had not always identified the concerns we highlighted at this inspection which compromised the quality of care and support people received. In addition where improvements had been identified these had not been always been remedied. For example, the competency of staff through refresher training had been highlighted at our last inspection in January 2016 and the recurring issue of late and missed visits. These issues constituted a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care manager spoke passionately about working in care services in the community. They said, "I love domiciliary care because it's about promoting people's independence." They said they had the support of senior management which should help to implement the improvements identified. We saw they had an

action plan which identified these improvements and actions required. This plan was reviewed with the operations director on a monthly basis.

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

Staff we spoke with were complimentary about the service and their colleagues and proud of the work they did. They said, "I find this work rewarding; I love my clients and I've been looking after some people for a long time" and "I would recommend (HSG – Didsbury); it's one of the belter companies. Staff have left and wanted to come back."

The care manager told us prior to their appointment staff meetings did not take place regularly. We saw that quarterly meetings had been scheduled for the rest of the year, 2017. The care manager told us staff who were unable to attend meetings would have a copy of the minutes attached to their rotas. We saw minutes of two meetings held since the care manager had been in post, March and May 2017. Staff we spoke with confirmed meetings were now taking place. This meant care staff had the opportunity to discuss issues relating to their work and ensure they were always kept up to date on matters affecting the service provision.

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 12 HSCA RA Regulations 2014 Safe care and treatment Areas of risks to people's health and well-being had not been adequately assessed and planned for so that people were kept safe. Reg 12(2)(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems did not effectively monitor all aspects of the service provision to help ensure people received a quality service that was safe and effective. Reg 17(1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were overdue undertaking ongoing training in key areas of their role. Reg 18(2)(a)