Angel Home Care Service Private Limited

Wythenshawe

Inspection report

3 Newhey Avenue
Manchester
Lancashire
M22 8LP

Tel: 01616132722

Date of inspection visit:
01 September 2016
06 September 2016

Date of publication:
20 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days on 1 and 6 September 2016. We gave advance notice of the inspection visit on 1 September as this was a small service and we wanted to ensure there was someone in the office. On 5 September we made phone calls to people using the service. On 6 September we completed the inspection and gave feedback to the provider.

The previous inspection took place in June 2013, when we found the service was compliant in the areas we looked at.

The service registered as Wythenshawe refers to itself and is generally known as Angel Home Care. We have raised this with the provider as they need to register in the name of the service that people recognise. It is a small domiciliary care company, providing personal care and support to people living in their own homes. At the date of this inspection there were 22 people receiving the service. All the people it supported lived in Stockport, which is a few miles away from the office in Wythenshawe, south Manchester. Stockport Council funded all but two of the people supported by the service; those two were privately funded.

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 person who was registered manager at the date of this inspection had resigned about ten days earlier, and the provider was in the process of finding a replacement. An acting manager was in post on the first day of our inspection but submitted their resignation four days later. The 'nominated individual' or representative of the provider was actively involved in the management of the business and was present throughout the inspection.

We found that the service had procedures to ensure that potential new staff had background checks done. However, in two cases they had allowed staff to start work before criminal record checks had been completed. This meant that not all necessary precautions had been taken, and was a breach of the regulation relating to safe recruitment of staff.

People receiving a service from Wythenshawe told us they felt safe. They said they had not had any missed calls, and when care workers were going to be late they usually received a message. People told us it was important to them to see the same regular care workers, and they believed Wythenshawe tried to achieve this where possible.

Staff received rotas each week and were notified of any changes. The rotas occasionally included clashes or required care workers to be in two places at the same time. The service used an electronic call monitoring system which provided some assurance that calls would not be missed. No call was shorter than 30 minutes but travelling time was not allocated between calls.

Staff had a variable understanding of safeguarding and the forms of abuse they needed to watch out for. Medicines were recorded when the care workers were involved in administering them.

The service had not carried out any mental capacity assessments to determine people's ability to consent to the care they were receiving. This was a breach of the regulation relating to obtaining consent in accordance with the Mental Capacity Act 2005. The service did sometimes record that people gave consent to the care when they had capacity to do so.

When a new recruit joined they watched four DVDs, spent two days shadowing and then started work. There was a one day training course which both new recruits and existing staff attended. There had been some additional training within the past year. We found there was a breach of the regulation relating to training staff.

Staff had also received supervisions although these were not recorded on staff files.

Some people received support with their meals as part of their care provision. Staff had received basic training in food hygiene. Records of food and drink consumption were kept when needed.

People and their relatives gave examples of how staff were caring and sometimes went beyond what was expected of them. Two people expressed concerns that their care worker did not speak good English, and they could not understand each other. But this did not appear to be a widespread problem.

When people expressed preferences for which care workers would visit, the service tried to accommodate them, except in one case when the then registered manager had told the person they could not meet their wishes.

Confidential documents were kept securely within the office.

Assessments and care plans were sparse and the service tended to rely on the documents provided by Stockport Council. Some parts of the care plans did not assist staff to know what care to deliver. The service relied on verbal instruction. The care plans did not sufficiently record people's preferences. Reviews of care plans had not been done by the dates scheduled on the plans. These deficiencies were a breach of the regulation relating to person-centred care.

Information was given to people about how to make a complaint. We saw that complaints received in the past year had been handled effectively, with one exception. The service sought feedback from people about the quality of the care provided.

The service had experienced significant management changes in the preceding year, including two registered managers and an acting manager. Stockport Council had imposed a limit on how many hours of care the service could provide. The provider was seeking to appoint a new registered manager.

There was insufficient monitoring of the quality of the service. Spot checks were done to observe staff performance and ask people's views, but none had been done since June 2016. There were no audits of care plans. This was a breach of the regulation relating to assessing and improving the quality of the service.

The service had not reported to the CQC two safeguarding incidents which had been reported to Stockport Council. This was a breach of the regulation about reporting events to the CQC.

There was a set of policies and procedures but it was clear staff did not access these very often. However, we saw that important policies were discussed at a recent staff meeting. Staff views had been sought in a recent questionnaire.

Staff in the main enjoyed working with Wythenshawe, but the rate of turnover was high, which affected the continuity of care for people using the service.

The provider used appropriate disciplinary processes and monitored the performance of staff.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the end of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Not all necessary checks had been done to ensure that staff were suitable to work with vulnerable people.

People told us they felt safe. There had been no missed calls, and people were notified if their care worker was going to be late.

Staff did not all have a good understanding of safeguarding.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not acting in compliance with the Mental Capacity Act 2005 when there was doubt about people's ability to consent to the care they were receiving.

New staff received basic training but were not studying for the Care Certificate. The induction and follow up training were limited in scope.

Is the service caring?

Good

The service was caring.

People regarded their staff as caring and kind, and gave examples where staff had gone the extra mile.

Some people expressed concern about the English language skills of their care workers.

The service tried to meet people's wishes regarding which care workers visited them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans were insufficiently detailed and did not give enough assistance to staff to deliver care that met people's

needs. Care plan reviews had not been done recently.

The service had a system for dealing with complaints. The service used spot checks to obtain feedback about the quality of the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems needed to be more systematic and robust to help ensure that the provider could effectively make improvements to the service.

Not all safeguarding incidents had been reported to the CQC.

There were policies and procedures which were discussed with staff. The service had a high turnover of staff which it was trying to address.

Wythenshawe

Detailed findings

Background to this inspection

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

The inspection took place on 1 and 6 September 2016. We gave the service 24 hours' notice of our first visit, to ensure there would be someone in the office to meet us. On 5 September 2016 we made phone calls to people using the service and their relatives. On 6 September 2016 we completed the inspection and gave initial feedback.

This inspection was carried out by one adult social care Inspector. Prior to the inspection we reviewed all the information we held about the service. This included 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 contacted a quality assurance officer at Stockport Council who commented on the Council's recent involvement with the service.

We spoke with three people who were using the service and three relatives by telephone. In the office we spoke with the nominated individual of the provider, an acting manager (on the first day of our inspection), the administrator and three care workers. We looked at four care records, four staff files, safeguarding records, records of complaints and incidents, and policies.

Requires Improvement

Is the service safe?

Our findings

We checked whether Wythenshawe had safe recruitment procedures. We looked at the personnel files of four recently recruited members of staff. We saw that necessary checks of job applicants' identity and employment record had been carried out. The application form did not specifically request applicants to account for any gaps in employment, which would be best practice. In each of the files we found two references had been requested. However not all the references were from former employers; we saw one which had been written by the applicant's sister-in-law. This would be appropriate only if the applicant had no previous work experience and no independent professional referees. We did not find that a detailed record was kept of applicants' answers at interview.

There was a policy that staff should be checked with the Disclosure and Barring Service (DBS) before they started work at the service. 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. On one file we saw that a past conviction for a driving offence had been risk assessed and deemed as not affecting the person's suitability to work in a domiciliary care service. This was a well presented and reasonable decision.

However, we became aware that one recently appointed care worker had been working before their DBS check had been completed. They had been interviewed in June 2016 and signed a contract in August 2016. The provider admitted to us that the care worker had been working including on single calls. They stated that they had spoken with an agency called ukcrbs, which supports customers to process DBS applications. The provider said that the agency had stated that the person was cleared to work, even though the police check of criminal records was not yet complete. The provider did not have a record of when this conversation had taken place or with whom. In any event the agency ought not to have given such an assurance before the DBS certificate was available. We also saw an email from the agency dated 31 August 2016 stating that there had been a query about the person's surname which had caused ongoing delay in processing the DBS check.

We expressed concern that this care worker was being allowed to work independently before the DBS check was completed. There was a risk that they might have a criminal record which might render them unsuitable to work with the people supported by Wythenshawe. The provider immediately agreed to stop the care worker from doing any single calls, but to allow them to continue doing double calls. The presence of a second care worker would reduce the risk if concerns were later raised about the staff member's suitability to work with vulnerable people.

We were made aware of another person who had worked for about six weeks during the summer of 2016, without a valid DBS certificate. They had provided one from a previous employment, but certificates are not transferable. The provider assured us that this person had only ever worked on double calls because they were unable to drive.

A related issue was that the provider was keeping employees' DBS certificates. The correct process is to

record the number on the certificate and return it to the employee or destroy it. When we informed the provider of this they immediately shredded the file.

We were not satisfied that all the necessary checks were made to ensure that staff were suitable to work with vulnerable adults. In particular allowing a person to work alone before the DBS check was complete was a breach of Regulation 19(1)(a) and (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with who were receiving a service from Wythenshawe, and their relatives, all told us they felt the service was reliable and they were confident they were safe when the care workers visited. One person told us, "They are always more or less on time. Usually they contact me if they are going to be late. They have not missed a call. I mostly get the same people, twice a day." They said that having the same care workers was important to them. People told us care workers had good hygiene practices and wore personal protective equipment such as aprons and gloves, when carrying out their duties.

Another person also emphasised how much they wanted the same care workers to come regularly stating, "I would like the same carers. They have tried to put the same carers on. One of them is leaving soon. I do feel safe with them."

One relative told us that their family members had been receiving the service for about a month. They said there had been a few teething troubles right at the beginning, in relation to agreeing the time of the visits (which were twice a day). The teatime visit had originally been scheduled for 5-6pm, but once the care worker had arrived at 6pm which was too late, because the relative had been there and supplied the tea themselves. The relative said that this was the first call by that particular care worker, and since then they had arrived much more punctually at 5pm. This created confidence for the people receiving the service and also for the relative, who was secure in the knowledge that the care workers would turn up even if they were not present themselves. We asked this relative whether their family members felt safe. The relative said, "Yes they feel safe."

One person mentioned they had once phoned the office because their care worker had not turned up at the agreed time. They said the office had sent someone round at once. None of the people we spoke with mentioned any missed calls (which would be where no care worker had arrived at all).. The service used a call monitoring system whereby staff were expected to make a free call from the telephone in the person's house (with permission) to register their arrival and departure times. One person we spoke with confirmed that the care worker used their telephone and they were happy for them to do so. The system was monitored by office staff and provided assurance that if a care worker had not attended a call they would be able to arrange a replacement care worker.

Staff received their rota every Friday which set out the times and duration of their calls for the week commencing on Monday. Staff told us that they usually received the same or similar rotas, so they got to know the same people and knew the length of time it took to get from one call to the next. This was necessary because there were some calls which were timed to be adjacent, with no travelling time between them. However, the shortest call was 30 minutes, which meant, staff told us, that they were able to complete all their care tasks before moving on to the next call. If a change was made to a rota during the week, the care worker was notified by text message and the office administrator would request confirmation from the care worker that they had received notification of the change.

We noticed some anomalies on the rotas. One care worker showed us on their rota two calls listed at exactly the same time. They told us they had queried this with the office and one of the calls had been given to

someone else. Another care worker was scheduled to be with one person from 9.15 to 10.15am, but with the next person from 9.30 to 10.00am. This was clearly impossible. The office administrator told us that when this happened the care worker would contact them, ideally well in advance, to enable them to arrange a substitute. However this laid the onus on individual care workers to check their rotas in advance, in order to avoid the risk of missed or late calls. The office administrator told us they were urging the provider to obtain more sophisticated software which would prevent such clashes appearing on rotas. We did observe during our time in the office that care staff were regularly in touch with the office and this good communication, together with the size of the service, reduced the likelihood of missed calls.

We asked staff about their understanding of safeguarding and found that it was varied. One care worker told us they had not come across the term 'safeguarding', even though it was supposed to form part of their induction training. We were aware it might be an issue of terminology, as the care worker's first language was not English. However, when we explained that safeguarding included watching out for various forms of abuse, they were unsure what types of abuse might be relevant, although they did indicate they would report to the office if they had any concerns. We saw evidence that five members of staff, including the provider and the registered manager at the time, had attended safeguarding training arranged by Stockport Council.

Most of the people using the service and relatives we spoke with told us that people did not have assistance with their medicines. When they did, a medication record form was completed and every four weeks brought back to the office where it was checked. People told us and staff confirmed that they completed record forms. The acting manager told us that they had recently requested the pharmacies to supply Medicine Administration Records (MARs) to replace the medication record forms which they had been using up till then. However, the medication record forms fulfilled the purpose of recording clearly enough the administration of medicines.

Staff told us they would contact the office if there was an incident or accident. We saw the incident file which recorded any significant incidents. There had not been any of these and therefore we did not see any analysis of them.

We saw that there was a 'general risk assessment' relating to people's wellbeing on each care file, which should be used to minimise individual risks for people using the service. In fact the assessment related to "various service user properties" and included identical information for each person, which reduced its usefulness. We also saw the service used four computer-based risk assessments. One of these asked questions which were more relevant to a care home than a domiciliary care service. Another asked 87 questions. In one person's case this had been partially completed, but when we asked what use staff made of it, we were told that staff never accessed the computer, so they never saw this risk assessment. This meant staff who were providing direct care to people did not have access to information to help minimise risks to them.

Requires Improvement

Is the service effective?

Our findings

Several of the people receiving a service from Wythenshawe were living with dementia. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We asked whether the service had carried out any mental capacity assessments in order to determine whether people could make specific decisions for themselves. We were told that they had not, but relied on assessments by Stockport Council. That would not apply to the two people who were privately funded. When we asked staff about their understanding of the MCA they told us they had not received any training in it. This meant that staff were not aware of the provisions of the MCA and were not trained to observe any deterioration in people's mental capacity. The provider was therefore unable to demonstrate they were acting lawfully when supporting people who did not have the capacity to make decisions for themselves in relation to their care and support.

There were two people living with moderate to advanced dementia who had joined the service recently and whose care needs assessments had been completed in August 2016. From the provider's information it was apparent they might not have capacity to consent to their care and support. This was confirmed by a relative we spoke with, who said, "They can't really understand why the care workers are there." Where the provider suspected people did not have capacity to make decisions they had failed to complete a two stage capacity assessment in order to determine the person's capacity or to consider the need for best interest decisions to be recorded in relation to the person's care and support.

We saw that the service did pay some attention to the need to obtain consent. There was a statement in one care plan signed by the person receiving the service, "I am happy for carers to visit me in my own home to help me meet my needs." One person told us, "They always ask for my consent. I usually tell them what I want and how to do it." A new administration of medicine form had been created which included a space for people to sign next to the sentence "I give my consent for Angel Home Care's assistance with my medicines." However, we saw that one person had been asked to sign this form who was self-sufficient in administering their own medicines, which suggested that staff did not fully understand the purpose of the form.

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

We asked people and their relatives if they felt their care workers were competent and trained to do their role. One person said, "I think they do a good job. I don't know how it could be better." Another person by contrast said, "I don't think they're trained. I think they're pushed in at the deep end." A relative said about their regular care worker, "They're well trained. They always ask if there's anything else they can do." They added that their care worker had brought someone else with them on one occasion who was in training.

This confirmed what the provider told us, that new care workers spent time shadowing existing care workers before going out on their own.

We asked the acting manager and provider about the induction training provided to new recruits. We were shown four DVDs which new staff watched on their first day. These covered the basic topics of moving and handling, health and safety, fire safety and food hygiene. They then had two days shadowing existing staff, after which they were judged by the provider able to deliver care on their own. There was then a 'mandatory training course' provided by an external trainer, which covered 12 topics in one day. Staff were sent on this course at the earliest opportunity. The course was also attended by existing staff, and we saw a certificate of attendance. The course included most of the topics relevant to workers in this field, including health and safety, infection control, food hygiene, basic life support, moving and handling, and safeguarding vulnerable adults. It did not include the Mental Capacity Act 2005.

We asked staff about this course. They confirmed they had attended the course but were uncertain what topics had been covered. This indicated that a one day course covering everything was not the most effective form of tuition. We asked the provider whether new staff were following the Care Certificate. The Care Certificate is a nationally recognised set of standards to form the basis of an induction course for new care workers. The purpose is to develop the values, behaviours and skills care workers need to provide high quality and compassionate care. The provider knew about the Care Certificate but it was not being implemented for new staff at Wythenshawe.

We saw there had been some additional specialised training for staff within the last year, in medication, moving and handling, health and safety, fire safety, dignity in care and food hygiene. We saw five questionnaires completed after the medication training in May 2016 gave word for word identical answers. We were told staff had been allowed to use handouts when completing their answers and so had copied them. This called into question the effectiveness of the training. Four staff including the then registered manager had attended safeguarding training at Stockport Council in July 2016. There was a training matrix which recorded all the topics undertaken in the mandatory training courses.

We found that the induction was not thorough enough to equip staff to work alone. The one day course did also not provide staff with sufficient skills and knowledge. The staff's knowledge around safeguarding and lack of training in the MCA also demonstrated the need to improve training. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supervisions had been carried out by the previous registered manager who had left in August 2016. There was a schedule on the office wall showing that all staff would receive a supervision every two or three months. One staff member recalled a supervision a few months earlier. We did not see records of supervisions on staff files, which would be a good way of recording that the supervisions had taken place. We observed that many staff were in contact with the office, either by telephone or by coming in, which meant they had the opportunity to raise any work-related issues on a daily basis. There was no evidence that annual appraisals had taken place.

Staff were trained in food hygiene as part of their annual course. Some people but not all received support with preparing meals. We spoke with the relative of two people who had a daily meal provided by their care worker. The relative commended the care workers on their patience. They said their parent was often reluctant to eat, but the care worker sat with them patiently saying, "Just have another mouthful." They added that on one occasion the care worker had left a sandwich for their parents, and then telephoned to let the relative know and check whether they had eaten it. While we were in the office the administrator telephoned a care worker to ask them to add a call to their rota. The care worker told the administrator they

had not visited that person before, and the administrator gave instructions from the care plan about how to prepare and serve a meal. This showed that the service was careful to ensure that people received the food they needed in the correct way.

On one person's file we saw that the care workers had kept daily food record charts and fluid balance charts (to record how much food and drink had been consumed). Although the care workers were not present all the time, these charts would assist medical professionals to monitor a person's dietary health.

Good

Is the service caring?

Our findings

We asked people receiving the service whether they felt the service was caring and met their needs.

One relative said that they felt confident because the care worker knew how to look after the needs of people living with dementia. They gave an example that when the care workers first came it had taken twenty minutes to help one of her family members get out of bed. The relative said, "They were very patient." But now, they got out of bed straight away because of the trust that had developed between their family member and the care worker. The relative added, "I am happy with the service. The care workers have been brilliant."

We saw a letter from a relative thanking the service after the care worker had gone beyond what was expected and taken their family member to hospital in a taxi. The relative wrote "Please thank [name of care worker] for their kindness." This showed that care workers were willing to go the extra mile when needed to care for the people they were supporting.

Another person had provided written feedback, "I know that Angel Home Care tries hard to provide a good caring service." Another person said their care workers were "pleasant and respectful." A relative said, "They are very nice, but I would like to have the same person every time."

By contrast another person had responded, in answer to the question "Do you feel the care workers understand your needs?" by writing, "Mostly depends on each person's verbal English. Can vary a lot." We were unable to contact this person by telephone, but saw they had made a similar comment during a spot check, which showed their concern had not been dealt with. When assessing these comments we were mindful that several of the care workers we met did not have English as a first language, and in one case had some difficulty communicating with us in English. Wythenshawe's guide for people using the service included a 'Charter of Rights', one of which was the "fundamental right to be cared for by people who are capable of understanding their needs and are competent to meet those needs." A good understanding and use of any person's first language would therefore be essential to enable care to be delivered effectively. One other person told us when speaking about the care staff that, "I can't always understand them." However, although these two people expressed concerns to us about the language skills of the care workers, we saw no evidence that this had been an issue for anyone else.

We saw records of meetings held where people had expressed a preference not to have a particular care worker visit again. The provider told us they tried to accommodate such requests, although it was difficult because of the size of the service and the number of staff available. They added that sometimes people changed their minds, and we saw some examples where this had happened, and the person was now happy with the arrangement.

One person who received a double call told us they had informed the management that they did not want to have two female care workers, because of the personal care they needed. They said the previous manager had promised to send at least one male care worker, and this now happened most times but not every time.

They also mentioned that on one occasion a care worker had caused discomfort, but had stopped as soon as they pointed it out and had not done the same since then. On a positive note, they said the previous registered manager had been out to see them several times, which they saw as very caring and sensitive to their needs.

Wythenshawe stated in its guide for people using the service that one of its aims and objectives was "Ensuring that confidential information is protected at all times and only shared with others strictly in accordance with its policy on confidentiality." We saw that the office was a secure room inside a building with a monitored entrance. Documents were kept in locked filing cabinets inside the office. This meant that people's personal data was kept securely within the office. Personal information was also kept on the care files in people's homes, where security was the responsibility of the householder. However, daily notes and medication record forms were removed at the end of each month and brought into the office. This meant that confidential information was not left in people's homes longer than necessary.

Requires Improvement

Is the service responsive?

Our findings

We saw from people's care records that they had an initial assessment of their needs. This initial document was quite basic and contained minimal details of the person and the support they required. In one case the document did not include the person's name, which was an indication of the care with which it had been completed. Another one did not state who had completed the form. In many cases the initial assessment was filed alongside the information received from Stockport Council, which was often more detailed and included support plans and personal history about the person receiving the service. Whilst this information was useful, it was not a substitute for Wythenshawe creating their own assessments and care plans.

We asked the acting manager and provider about these assessments. They stated that they were sometimes asked to take on new care packages at short notice or even immediately, and then were only able to do their assessment on the day the care started. While that would make it impossible to create detailed assessments and care plans before the care package started, we would expect these care plans to be developed at the earliest opportunity, rather than the service relying on support plans provided by the Council. We also pointed out that willingness to accept packages at such short notice created the risk they might be asked to take on people with complex needs which the staff were not trained to meet. They responded by saying that Stockport Council knew what Wythenshawe, "Were capable of." This did not provide us with any assurances people's needs would always be robustly assessed and their care planned accordingly.

We saw there was a document called the 'Angel Care Plan' but it contained little information. In one case the initial pages were contact details of the person concerned and their family. When it came to planning care needs, it stated what those needs were, but gave no information for staff about how they could address those needs. For example it stated, "I require full support with personal care", but did not describe what those personal care needs were or how the person should be supported. Similarly it stated, "I require support with mobility", but gave no further details. Any member of staff who had not visited that person before would not be informed from this plan as to what care was needed. However, care workers told us they received information verbally about each new person before their first care visit. Although this meant staff know the needs of people they supported the provider was unable to demonstrate how they were meeting these needs. This risked people receiving care that did not meet their assessed needs in the event of them being supported by staff who were not familiar with them.

The care plans did not always reflect people's preferences. For example one person had told us they did not want the care delivered by two female care workers (as was mentioned earlier). They said they had mentioned this to the office several times, and most of the time there was at least one male care worker. When we checked the care plan in the office there was no record of this preference. Although it was known to the provider and the office administrator who organised the rotas, it should have been recorded in the care plan. We raised this with the provider who arranged for the care plan to be amended at once.

Care plans included dates for review either three or four months after completion, but we saw no evidence that reviews had been done on those dates. This meant that people's care needs were not being reassessed regularly to help ensure that the care being provided was still appropriate.

In the Provider Information Return (PIR) the provider had referred to plans to "introduce a comprehensive person centred care plan." While we acknowledged this was the plan, the shortcomings in current care planning were a breach of Regulation 9(1) and 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Wythenshawe set out in its guide for people using the service brief information about people's right to make a complaint and how their complaint would be handled. There was also a complaints handling policy. When we spoke with people they were not sure about how the complaints process worked, but they said they would phone the office if they had to. None of the people we spoke with said they had made a formal complaint, but they stated they could discuss issues with their care worker or with office staff.

The service had received four formal complaints in the preceding 12 months. We saw that these complaints had been recorded and responded to. One complaint involved a person using the service who said they did not want a particular care worker to come again. The then registered manager had visited the person in their home, which was a positive response. However, their note of the meeting stated, "I explained to [name] that I have very limited staff, and if they will restrict my staff how can I manage in future?" This was neither sympathetic nor helpful to the person concerned.

People's feedback was sought about the quality of the service. The spot check forms which were used to assess staff on visits also were used to record the views of people receiving the service. They were asked whether staff delivered the service required, whether they followed the care plan, whether they were flexible, and finally "Are you happy with the current staff?" One person recalled a visit from someone from the office, "They came and spoke to me, asked me if I was happy with the service. I said I had no reason to make a complaint." They added, "I would complain if I needed to, I know I can look in their book, it tells me how."

Requires Improvement

Is the service well-led?

Our findings

Wythenshawe had undergone a significant change in management since July 2015, about which we had been fully informed. The registered manager at the time, who was also a partner in the company, withdrew from the business along with another partner. Stockport Council were concerned about the ability of the service to fulfil all its care packages, and removed about half of them and assigned them to different providers. They imposed a cap on the number of hours of care provision per week which they would commission Wythenshawe to provide. This cap was still in place at the date of this inspection, but Stockport Council told us that the number of hours currently commissioned was well below the cap, so it was not having an effect on the service.

A new registered manager was appointed in July 2015, who remained in post until August 2016. Wythenshawe had then recruited an acting manager whom we met on the first day of our inspection, but tendered their resignation on 5 September 2016. We considered the rapid changes in managers when assessing how well the service was led. The provider expressed their determination to find a new registered manager as soon as possible, and then to grow the service in a gradual manner.

We asked the provider about how they monitored the quality of the service. There was a programme of spot checks although the last one had been done in June 2016, and they had not been done by the previous registered manager in the last couple of months before they left in August 2016. The checklist of items on each spot check included punctuality, wearing ID badge, wearing uniform, carrying and using personal protective equipment (PPE), familiarity with the care plan and involving the person using the service. There was also space to record the care worker's communication skills, and where applicable how they handled medication tasks. However, we were concerned that a failure to complete quality monitoring audits meant shortfalls in care planning and communication had not been addressed at the time of our inspection.

The provider said because they were present every day in the office they had a good knowledge and understanding of all the people supported by the service and of the staff. This was possible due to the size of the service. However, there were no audits of care plans (and as was mentioned earlier scheduled reviews had not been done). This meant there was a lack of oversight of the quality of the care provided. This was a breach of Regulation 17(1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In conversation with the acting manager and the provider, we became aware of two recent incidents which ought to have been reported as safeguarding matters to the CQC. One involved an allegation that one or two care workers had not recorded one visit on the daily reporting sheet in the property of the person they were supporting, and also had failed to report that cash was not present which was supposed to be there for another agency to do shopping. (There was no suggestion that the care workers had removed the cash.) This allegation had been reported to a social worker from Stockport Council, who we were told was in the process of organising a safeguarding strategy meeting. The acting manager told us it was their belief that the social worker would inform the CQC. However it is the provider's responsibility to ensure that all abuse or allegations of abuse are notified to the CQC.

The second example involved a person using the service who had been in hospital. Wythenshawe were informed the person was being discharged and arranged for the regular care worker to make the call. They let themselves into the house but could not find the person, who they expected to be in their bedroom as usual. They telephoned the office to report this, which was in accordance with the 'No access' protocol. In fact the ambulance service had left the person in the lounge, and they had fallen from the sofa to the floor, where a friend later found them. No injury was caused. The care worker later said they had looked in the lounge from the doorway, but had not seen the person. This was a safeguarding concern which was due to be discussed at a strategy meeting, but the service had not notified the CQC. We later learnt that the allegation of neglect was not substantiated.

These failures to notify the CQC about safeguarding matters were a breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

There was a set of policies and procedures in the office, partly in paper form and partly on the computer. Most of these had been purchased from a commercial supplier and adapted for the use of Wythenshawe. The ones in paper form were accessible to staff, but we understood that staff did not access the computer system. Even the policies on the shelves were quite dense and included sections that were not relevant to this service. We saw, however, that important policies were discussed at staff meetings. For example at a meeting in August 2016, where nine staff out of 12 attended, the acting manager had gone through the policies on electronic call monitoring, professional boundaries, accidents, daily records, infection control, safeguarding and dignity in care. Therefore staff had been reminded about these essential policies.

That meeting had been a means of transmitting information to staff. It was less clear whether staff had had the opportunity to raise issues themselves. There had been three other staff meetings during 2016 but minutes of these were not available. A staff questionnaire had very recently been sent out to all 12 staff, and two replies had been received so far. One expressed the desire for the rotas to include travelling time between calls, the other for waiting time between calls to be reduced. The provider told us that they would take staff views into account but not everything could be changed.

We asked staff about how they felt working for Wythenshawe. One care worker said, "I like the job. Everyone is good here." They added that if there was one thing they could change they would like more training. Another member of staff said they felt supported in their work, both by the former registered manager and by the provider. They said that staff helped each other when they could. This was a sign of good staff morale. They added that they would like to see a more stable staff, with reduced staff turnover. We raised this issue with the provider who agreed it was a problem. They had observed that staff would stay for a while, gain experience, then move on to other jobs in the care industry. The service was constantly attempting to recruit new staff. This meant there was a risk of lack of continuity of care workers for people using the service.

We saw from two examples that the provider used disciplinary processes appropriately and fairly when necessary. Incidents were investigated before a decision was reached. The decisions we saw were proportionate but laid emphasis on ensuring that people using the service were protected from abuse. Additional spot checks were done when there were any doubts about a care worker's suitability or competence.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not reported all allegations of abuse to the Care Quality Commission Regulation 18(2)(e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not carrying out adequate assessments of the needs and preferences of service users Regulation 9(1) and 9(3)(a)

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient systems in place to assess, monitor and improve the quality of the service Regulation 17(1) and (2)(a)

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had allowed two care workers to work before they had received a valid DBS certificate. Regulation 19(1)(a) and (3)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate training to enable them to carry out their duties. Regulation 18(2)(a)