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Care Management Services (CMS)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 February 2016 and was announced because we wanted to ensure there would be someone at the service's office when we called.

Care Management Services (CMS) is registered to provide the regulated activity of "Personal Care'' to young physically disabled adults. CMS carries out assessments of people's needs and produces direct payment proposals forwarded to local councils to obtain the required funding to meet their needs. The provider then enters into a contract with the individual to provide support for the funded care package, including the provision of staff. CMS currently support people in various locations across England. At the time of our inspection the service was supporting three people with personal care, one of whom was the registered provider.

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since October 2010. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also a director of the company.

People told us they trusted the care workers who supported them. Staff told us they had received training in relation to safeguarding adults and would report any concerns to a senior member of staff. The registered manager told us there had been no recent safeguarding issues. However, we identified one significant event which should have been reported as a safeguarding incident. The registered manager told us the matter was investigated internally. There was a potential ongoing safeguarding matter at time of the inspection. We will monitor the outcome of this issue.

Processes were in place to recruit staff and to carry out checks to ensure they were suitably experienced to support people with their personal care needs. Staff who joined the service had been subject to checks with the Disclosure and Baring Service (DBS). We found references for some part time staff were not detailed and only identified that they were attending a university course. We have made a recommendation that fuller reference checks be undertaken on these staff in the future. People told us that staff were almost always available to meet their needs. Some staff told us they were required to work a considerable distance from their home and family. They also said they had been required to work shifts of 48 hours or more, without relief.

Staff told us there was always a team leader available to provide information and advice. Team leaders could also call on the registered manager and other managers in the organisation for advice and support, if necessary.

People told us that staff supported them to take their own medicines. They said they had a good

understanding of the medicines they were required to take and staff responsibilities in this area was to help them take their medicines at the correct time. A record was made when staff supported people with their medicines. An agreement was in place with one individual around self-management of their medicines, although we noted this had not been recently reviewed.

People told us they felt that staff had the right skills to support their care needs. Staff told us they had received sufficient training to carry out their roles and that this training was individualised to the person they were supporting. They said that if they were required to support a different individual then they received training specific to that person's needs. Where specific training was required, on specialist equipment or specialist techniques, this was initially provided by a qualified health professional. The registered manager said the provider was an accredited training provider.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' it also ensures unlawful restrictions are not placed on people in care homes and hospitals. The registered manager confirmed that everyone supported by the service had capacity to make their own decisions and no one was subject to a deprivation of liberty order under the Court of Protection (CoP).

People told us that they found staff caring and supportive. We observed there to be good relationships between the person we visited and the care worker who supported them. Staff and people we spoke with said their relationships although professional, were as much on a friendship level as a caring one. People said their privacy and dignity was respected during the delivery of personal care and support. We were made aware that for a period of time, some care staff had been required to sleep in the same room as the person they supported, whilst accommodation was being refurbished. The registered manager told us this had been with all parties' agreement. We have made a recommendation that wider consideration of people's privacy and dignity needs is undertaken in the future. People were also supported to maintain their well-being, as staff supported people to attend general practitioner or hospital appointments, as necessary.

People's care needs were assessed before the service started delivering care. Following this assessment a care proposal was developed that detailed people's needs and their aspirations for the future. Staff told us there was sufficient information for them to carry out care effectively. They said that the people they were caring for knew about their own condition in detail and directed staff to provide the most appropriate type and level of care. People said their care plans evolved as their needs changed. However, it was not always possible to see how plans and been reviewed to ensure they fully reflected these changing needs. The provider had a complaints procedure in place. Records showed there had been no formal complaints within the last 12 months. People told us they had not raised any recent formal complaints. Some people told us they had raised concerns and that these tended to be dealt with informally.

Team leaders carried out regular checks on care delivery, through a system of observing staff practice and gathering feedback from individuals in receipt of care. The registered manager said this was to ensure that care delivered effectively met the needs of the person. People had mixed views about the registered manager and his approach. Some individuals told us he was supportive. Others we spoke with said that he did not always listen to their views and that they found the registered manager's approach intimidating.

The registered manager said there had been no recent formal management meetings because senior managers in the service had been so busy travelling round the country to support service delivery. Day to day management issues were dealt with through regular telephone contact. Daily records were limited and

did not contain a description of the types or levels of care delivered by care staff on a daily basis.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to good governance and staffing.

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 safe

Staff had undertaken training and had knowledge of safeguarding issues. We found one potentially significant safeguarding incident had not been formally reported.

Staff recruitment processes were in place, although a small number of staff had not been subject to detailed references being taken up. Staff were required to work long hours, often in different parts of the country. People told us staff on duty adequately supported their care.

People were supported to take their medicines appropriately. Risk assessments were in place for supporting people in different situations, such as trips away.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us, and records confirmed a range of training had been provided that was personal to the individual people staff supported. We did not have sight of up to date supervision and annual appraisals, although historical documents contained good detail.

All the people being supported by the service had capacity to make their own decisions although where requested, staff supported people to make day to day choices. No one was under any restrictions or orders from the Court of Protection.

People made their own decisions about the food and drink they consumed. The provision of special diets was supported by staff when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always fully supported. People, relatives and staff confirmed that staff had been required

to share bedrooms with people they cared for on a temporary basis, including female staff sharing with male service users.

People and relatives told us the care workers were caring and helpful. We observed staff supporting people with kindness and understanding. People had access to a range of health and social care professionals, for assessments and checks, to help maintain their health and wellbeing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There had not been any recent formal complaints. Concerns were often raised and dealt with informally, with no recognised record to monitor these matters.

Care plans were detailed and reflected people's individual needs. They contained an assessment of risks associated with people's care and instructions for staff to follow when delivering care. It was not always clear how care plans in people's homes had been updated or reviewed.

People were supported to engage in activities which interested them and were helped to make trips and visits within the community.

Is the service well-led?

Requires Improvement

The service was not well led.

The registered manager had not returned in a timely manner the Provider Information Return record issued by the Commission prior to this inspection. This meant important information was not available to the Commission to inform the planning of the inspection.

Daily records maintained at the home of people who used the service were limited and did not contain information on the range of care and support provided. People had mixed opinions of the registered manager's style.

Regular audits of care provision were undertaken by team leaders, including obtaining the views of people who used the service. Formal management meetings were not currently taking place at the time of our inspection.

Care Management Services (CMS)

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 8 and 9 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary service in people's own homes and we needed to be sure that someone would be present at the service's office.

The inspection team consisted of one adult social care inspector.

Before the inspection, the provider was asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered manager acknowledged that this information was not returned in sufficient time to support the planning of the inspection. We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority Safeguarding Adults team and the local Clinical Commissioning Group. We used the information they provided in the planning of our inspection.

We visited the home of one person supported by the service, who was also the provider of the service. We also spoke on the telephone with one person who was receiving support from the service, in another location elsewhere in England. Additionally, we spoke with four relatives and seven health and social care professionals to ask about their views of the service. We spoke with four members of staff, the registered manager and the business development executive.

We reviewed a range of documents and records including; two care records for people who used the service and three records of staff employed by the service. Additionally, we examined training records, complaints and compliment records, audit and review records and a range of other management documentation.

Requires Improvement

Is the service safe?

Our findings

The registered manager told us that for each person they worked with they would recruit a specific team to support that person. They informed us that the team would consist of some full time workers and a number of part time workers, usually recruited from the local university environment. Part time staff worked two or three shifts to support full time staff days off. The registered manager said that there had been recruitment difficulties in one support team. They had tried to supplement care with the use of agency staff, but this had not been successful. He said the provider had combatted this by reallocating staff from other teams to support this person.

Staff told us that they were being asked to support other care packages around the country. This often involved flying to other parts of England, sometimes at short notice. They said they also continued to provide shifts within their nominated team. Part time staff told us this put increasing pressure on them and they were asked to fill the shifts not covered because full time staff were supporting other packages. One care worker told us they had undertaken 48 hour shifts without a break or time away from caring duties, because the person required one to one support for the for each full 24 hour period and there was only one care worker on duty. Some part time staff told us they were concerned that the excess hours were interfering with their university studies. Staff told us that the registered manager and other senior staff also delivered care because of the lack of available staff. Staff also told us they had been required to undertake extra shifts to support a second person because the service had agreed to the care package before a full team had been recruited for this person.

We looked at staff duty rotas for the people being supported by the service. We noted that for one person a staff member came on duty at 8.30am on a Monday and was not detailed to finish providing care until 6.00pm on the Wednesday of the same week. Although this included two sleep-in night periods, when the staff member could be called on to get up during the night to support the person. This meant the staff member was on duty to support the individual for 57 ½ hours without relief. Another staff member was rostered to work from 6.00pm on a Wednesday until 6.00pm on the Friday, a period of 48 hours without relief. One staff member told us they had supported an individual from 6.00pm on a Wednesday until 6.00pm the following Sunday, with only minimum breaks, a total of 96 hours. Additionally, the staff member had to travel to and from the location. This meant that staff were delivering one to one support over long periods of time

Support was often provided away from the provider's main base in Northumberland meaning that no immediate relief would be available in an emergency situation, should any issues arise. Relatives told us they would offer support in urgent situations, but this could not always be guaranteed. This meant staff were required to work extensive hours without appropriate formal breaks and with limited contingency arrangements in the event of illness or emergency.

We spoke with one person and their relatives about the care they received. They told us that there had been no permanent care team in place for approximately 12 months. They confirmed that agency staff had been tried, but this had not been successful. They said staff from other parts of the country travelled to their

location and supported them and that the registered manager and other senior staff were also required to complete care shifts. They said that, with the exception of when agency staff were used, there had been no times when staff from the provider's company had not been available. We checked staff rotas and saw that the staff supporting this person were all from other identified teams, or members of the management team, but that all shifts were covered. One other relative told us there had been the occasional time when expected care workers had not attended, leaving them to care for the person.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18. Staffing.

We spoke with the registered manager about the lack of permanent staff teams for certain individuals in receipt of care. He told us that it was true that care workers were not always resident in the locality where people in receipt of care lived. He said he ensured that all care shifts were covered, paying for staff travel and accommodation to guarantee that the person received their full care package and support. He said that relatives had agreed to provide support if an urgent situation arose. He said what was most important to him was the calibre of the care staff and their ability to provide appropriate care, rather than where they lived. He said they were continuing to make efforts to recruit appropriate care staff locally, including offering incentives to potential new staff recruits.

We looked at staff recruitment records. We saw that prospective staff had been required to complete an application form and had been subject to an interview process. Disclosure and Barring Service (DBS) checks had been undertaken. DBS checks ensure staff working at the service have not been subject to any actions that would bar them from working with vulnerable people. References had been requested. However, we saw that for a number of part time staff these contained limited information. The registered manager told us that part time staff were often recruited from the local student population, who did not always have an employment history. This meant the references were frequently from tutorial staff at the university and were often limited to confirmation the applicant was attending the course. This meant that full checks were not always being undertaken as part of the recruitment process.

We recommend the provider ensures that full robust reference checks, or additional checks where limited immediate references are available, are undertaken on all future staff employed by the service to ensure people are safeguarded from risk.

The provider had a safeguarding policy in place, a copy of which was contained within the staff handbook. The registered manager told us there had been no recent safeguarding incidents within the service. We were told by people we spoke with about an incident involving a care worker and the alleged possibility that they had drunk alcohol whilst on duty and then driven a car. This was a potential safeguarding incident as it may have put individuals in receipt of care at risk. The matter had been raised with the registered manager. We spoke with the registered manager about this incident and he acknowledged that the allegation had been made. He said that he had investigated the issue thoroughly but had found no case to answer. He told us he had not alerted the local safeguarding team when the incident was reported to him because he did not view it as a safeguarding incident at the time and wished to investigate the matter himself. This meant an independent review of a potential safeguarding matter had not taken place because the registered manager had not reported the incident to the local safeguarding team.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

Staff we spoke with confirmed that as part of their training the issue of safeguarding was covered and that

they would report any concerns to the team leader. We spoke with the local authority safeguarding teams in the areas where people were being cared for. Two of these teams told us there were no current safeguarding issues involving the provider. A third made us aware of a potential safeguarding concern related to the provider which was currently being investigated. We will monitor the progress and outcome of this matter.

The registered manager showed us a range of risk assessments that were undertaken as part of people's initial assessment and care plan development. Risk assessments included reviews of specific activities that people were engaged in. For example, we saw risk assessments for people going on trips out, including the risks associated with using public transport and being in unfamiliar places, such as theatres. Part of the risk assessments included staff making themselves aware of emergency exits when in unfamiliar surroundings. People also had personal emergency evacuation plans in place within their homes to promote their safety. The provider showed us a copy of their emergency cover guidelines to ensure that help and support could be accessed 24 hours a day. The registered manager told us he or a member of the management team were always available. Staff told us they were well supported by the team manager for the person they were supporting. They said they could contact the team manager at any time and would always get a response.

People told us that equipment used in their care was provided by local NHS services or the local authority. They said that these organisations carried out regular safety checks on the equipment and serviced it at set intervals.

The registered manager told us there had been no accidents or incidents within the 12 months prior to our inspection. He said that any accidents would be recorded by the local teams and reviewed by the management, as necessary. Staff we spoke with could not recall any serious accidents or incidents within the previous 12 months.

Staff told us that they supported people with their medicines. They said that because the people they supported had full capacity they worked under the instruction of the individual to help them with their medicines. They said that the person they supported would confirm that they required certain medicines at certain times and they would support them taking these. People we spoke with told us they had a good understanding of their medicine regimes and required staff members to help take them out of packets or bottles. They said that because they were able to direct which medicines they took, at which time, the system was safe. We saw in one person's care records there was a list of medicines that the person was required to take at key times of the day. Care records did not explicitly state the method by which medicines would be supported, although there was a signed agreement indicating how person wished to be supported. We noted this was dated 2010 with no clear review date. A record was made when people were supported to take medicines.

We observed that a care worker supported one person to take some medicines be means of a percutaneous endoscopic gastrostomy (PEG) system. PEG feeding systems support people who cannot always sustain a diet through normal eating. It involves people receiving specialist feed via a tube, directly into their stomach. We saw staff followed the procedure for administering medicines by a PEG system contained within the person's care records folder.

Care staff supported people in their own homes. The home we visited was clean and tidy. Staff told us they had a cleaning rota which they followed and we saw this was in place in people's care records.

Requires Improvement

Is the service effective?

Our findings

We asked the registered manager about supervisions and appraisals. Supervision is a one to one process between staff and their manager where they have specific time to discuss matters that are important to care delivery, including any concerns the staff member may have or any other issues they wish to discuss. The registered manager showed us a copy of a detailed supervision / appraisal document. This involved the staff member detailing their views to certain questions or areas and then reviewing these with a senior manager. We noted the date on this document was 2013 and so requested further supervision documents. The registered manager sent us a range of documents related to training and direct observation of staff during the delivery of care. However, these did not include supervision or appraisal documents, where staff had opportunity to discuss matters related to their work or personal life. We could not be assured that supervisions and appraisals took place as the registered manager could not present evidence to us to show that they did. Staff did confirm that regular supervision took place.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18. Staffing.

The registered manager told us that all training was delivered internally. He said staff received detailed training that was personalised to the people that they cared for. New care staff spent their first week shadowing an experienced care worker. The registered manager told us that during this week new care staff would observe and practice key tasks related to the individual's care, such as how to use the individual's hoist or ceiling tracked hoist system, how to use the individual's ventilator and how to support people to take their medicines. He said that during the second week the new care worker would take the lead in providing care, observed and supported by an experienced member of staff. Staff and people we spoke with confirmed this process was followed. During this initial induction period there were regular reviews of the new care worker's performance and a detailed report was made of the actions they had undertaken and their skills. We saw a copy of such a report which detailed how the care was delivered and any learning points. People's individual care plans/ proposals contained example plans of how staff would be trained to meet their specific needs. People we spoke with told us they felt staff were well trained to support their specific care needs.

The registered manager told us there was no overarching training record highlighting mandatory training or detailing training that should be updated on a regular basis, although a list of health and safety training areas was included in the staff handbook. He said the company, "did not support training for training's sake", undertaking individual courses, but felt that this method of training offered the most person centred approach. We asked about specialist training for supporting people with ventilators or percutaneous endoscopic gastrostomy (PEG) feeding systems. The registered manager said that trainers in the organisation had been trained by specialist health staff and were accredited to deliver training in these areas. Professionals we spoke with told us they felt that care staff they had observed had the necessary skills to support people. This meant that whilst training was tailored to the support required by individuals, it was not clear if regular knowledge updates took place.

The registered manager also told us that the provider's company was registered with a nationally recognised training provider who delivered accredited training. He told us the company was able to offer qualifications to a certain level without further moderation. He also stated the company had supported staff in other ways, including funding a small number of staff to complete degree courses. We approached the national training provider to confirm this, but were unable to obtain a response.

Staff we spoke with confirmed they had followed and completed a two week induction programme, which involved shadowing experienced staff and being observed themselves. They told us they felt the training had been very detailed and very personal to the client's needs. Some staff felt that it would have been helpful to have additional or refresher training on general principles in areas such as moving and handling or medicines management. We asked the registered manager if staff competencies were checked following training. He told us there was regular oversight of care by the team leader who would spend time observing care practices and speaking with the individual in receipt of care about their views of the support they received. People we spoke with confirmed that new staff were supported by existing experienced staff on care packages before they delivered care on an individual basis.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. 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 decisions made on their behalf must be in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered manager told us that no one currently being supported by the service was subject to any restrictions on their freedom or were under orders from the Court of Protection. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at the time they need to be made, because they may lack capacity to do so. Staff we spoke with confirmed that people they supported had the capacity to make their own decisions.

Staff told us how they supported people to maintain their health and wellbeing. They were able to describe in detail actions they had taken to ensure people were able to access healthcare services and attend regular appointments. They also spoke about accompanying people to hospital appointments as part of their care duties. They said that if they were at all concerned about a person's health, they would discuss with them the potential need to contact their general practitioner or take other action. However, as people had capacity to make their own decisions they said they could only really offer advice and support. People we spoke with confirmed that staff helped them access and attend health services, as required.

Staff told us that rather than it being a matter of seeking consent from people, they were guided directly by the person they were supporting. Staff said that people knew exactly how they wanted to be cared for and would ask for staff to support them in certain ways; providing a drink or helping them change position in bed. They told us that if a person wanted to go out they would accompany the person at the time they wished to participate in any community based activities. Staff said that whilst they always maintained professional relationships with the people they supported, they enjoyed an element of mutual friendship, during the provision of care and support. People we spoke with told us that staff were helpful, sought consent and always worked with them to provide the support they required.

The registered manager told us that people could make their own choices about food and drink, based on their particular needs or medical conditions. Staff told us they supported people to access the meals or food they required. They said because it was the individual's choice about what they ate or drank, they could only advise or try and persuade people to drink or eat more healthily. People we spoke with confirmed they made their own choices with regard to food and were also supported by staff to go shopping.

Staff told us that a detailed record was kept of people's fluid intake and output to try and maintain appropriate levels of hydration. Where there were any concerns staff told us they would seek additional advice or support from the relevant specialist medical teams. Staff told us general practitioners had prescribed fortified drinks for people they had supported in the past, when there had been periods of concern about their nutritional wellbeing. Where people received additional nutrition support through PEG systems, this was supported. Records indicated that fluid intake levels were monitored by staff.

Requires Improvement

Is the service caring?

Our findings

One staff member told us the registered manager had moved a second person into the same accommodation as the person they were caring for, and in doing so they utilised the care workers' bedroom as this second person's accommodation. This was confirmed by people and their relatives. This meant there had been no separate accommodation for care staff when they had been required to complete sleep-in care shifts and they told us that they had to sleep on temporary beds in the bedroom of the person they were supporting. Staff felt this was inappropriate, particularly female care workers who said they had shared a room with a male person when supporting them. They also felt it was undignified for the person they were caring for. One person told us they were not upset by this arrangement, although relatives we spoke with stated they felt this arrangement was not appropriate.

We spoke with the registered manager about this. He confirmed care staff had shared accommodation with the person that they were supporting at times. He said the situation had arisen on a temporary basis and lasted no longer than two weeks, until permanent accommodation for the second person had been fully adapted. He said that the arrangement was made to facilitate the second person attending university at the start of term and was made with the full agreement of all parties involved. He told us the situation was fully assessed before it went ahead. Staff we spoke with told us that they recalled the arrangement being in place for around four to six weeks. The registered manager told us that care staff would occasionally share bedrooms with people, such as when they supported people on holiday or when they were visiting their relatives, because of the arrangement of the accommodation and to ensure appropriate night support was available outside of the person's permanent home. This meant the accommodation arrangements did not always support people's rights to dignity and privacy.

We recommend that the provider fully considers people right to privacy and dignity when planning and delivering future care arrangements.

People and their relatives told us that the carers who supported them on a day to day basis were caring and helpful. One person commented, "They are great; fantastic." A relative told us, "We've very much seen the other side in terms of quality. I am very happy with what we've got. The care has contributed to (person's name) developing." One professional we spoke with told us, "Generally the carers were very good, very supportive. I was impressed with the level of care. They obviously know (person's name) very well and there was a good rapport."

Staff told us that they built up very close relationships with the people that they cared for. Staff said that they would visit people if, for instance, they were in hospital. This was outside of their regular caring duties. We visited one person at their home and saw the relationship between the person and the care worker was generally good. The care worker told us they enjoyed pursuing activities together. This showed staff supported people in a caring and sensitive manner.

People told us that with the support they received they had been able to engage in a range of activities, both within university and work environments, but also socially. They said that all the people they had come into

contact with, from a range of organisations and institutions, had supported them to overcome barriers to attending university or work. This meant people's needs in terms of equality and diversity were supported.

People and their relatives told us they were initially involved in determining their care needs and packages. They said that they were included in early decisions about developing a comprehensive package of care and any on-going decisions about how the care package may change. They said that it had been extremely useful to have the support of the service in negotiating the complexities of the care and funding systems. One relative told us that the involvement of the service had given them, "a vision for the future that they had not previously realised was possible." Some people commented that the registered manager could be both inspirational but also very focussed and determined. They said he could sometimes be "daunting" to deal with, but they had learnt it was important to "say their piece" clearly, to be sure he heard them. They said the more they said exactly what they thought, the better the relationship with the registered manager and the service became. Other people told us that there were times they felt that "more listening and less talking" by the management should take place. This meant that whilst some people felt involved in the development of care plans, some people thought this could be further extended.

The registered manager told us that no one using the service at the current time was using an advocate. An advocate is a person who supports individual's to express their views, or preferences, or speak on their behalf if they are unable to do so. He said that part of the service that the provider delivered was to advocate for people with large organisations and support them through administrative systems. People told us that having someone to support them when dealing with these systems was extremely helpful and supportive.

People told us that the packages of care provided supported their independence. They said it allowed them to attend a range of events and maintain an independent life away from their family. They said the support they received allowed them to pursue their own interests.

Requires Improvement

Is the service responsive?

Our findings

It was not always possible from records to see how care needs were reviewed and reassessed. The registered manager told us that care needs were assessed on an on going basis and support packages would be changed as needed, depending on the person's individual circumstances. One person told us that the support they received had changed as they moved from a studying to a work environment. They told us that care workers were flexible in their approach and it was more a question of dealing with issues on a day to day basis, rather than a specific review of needs. They also told us that care workers were aware of any advice or recommendations from health professionals and incorporated these into day to day routines. They said much of what the care workers did was directed by themselves, to support them in managing their condition and their life as they wished. This meant that whilst there were ongoing changes and updates made to care packages, based on people's choices and requirements; it was not always possible to see how these changes had been formally recorded.

The registered manager told us that care plans were developed in close consultation with the person and their families. The provider's main base was a bungalow just outside Newcastle upon Tyne. The property was adapted for access by people using a wheelchair or with limited mobility. He said families considering support would be invited to stay in the bungalow for a weekend. During this period staff and managers would get to know the person and their family, what they wanted to achieve and what the individual's care needs were. It also allowed the family to ask questions and clarify issues. He said that the service also gathered together social care and medical/ healthcare reports to gain a full understanding of the person's particular health or personal issues. We saw a copy of a programme for such a visit, which included social events as well as discussions and assessments.

The registered manager said that following this meeting, along with reviewing other assessments such as health reports and the gathering of wider information, a proposal was put together to support the person making an application to receive direct payments. Direct payments is a government system where individuals receive funding to buy in their own support, independent of public care organisations. We looked at the proposals for two people. The documents were detailed. They covered a full assessment of people's needs; social and health requirements, background information about the person, information about any specific needs, such as skin care or nutritional needs, and any specialist equipment requirements. The document also contained a section on the individual's aspirations. This meant there was a full and appropriate assessment of people's needs and support requirements.

The plan went on to detail individual's physical care needs and any health care needs that would require support from local health services. A care regime detailed the care and support required during the whole day. This included support required overnight, along with morning or evening routines. A separate plan also covered any domestic duties care staff should undertake. Care workers told us that records contained sufficient information for them to deliver the required care package. They also told us that individuals often knew about their conditions in detail and directed care staff to support them in a way that best met their needs. This meant there was a detailed programme of care for care workers to follow.

People told us they were supported to participate in a range of activities and that they enjoyed a varied social life. They talked about attending football matches on a regular basis, going to concerts, participating in choirs and undertaking a range of trips. We saw evidence in records, including risk assessments and other documentation which demonstrated that people went on theatre trips and other similar outings. People and staff told us that they had been on holidays or trips abroad including places such as Spain and Croatia. One person said they had also recently been on a holiday to Cornwall. The registered manager told us that he had also arranged a "house swap", where people visited each other's locations for a week. Staff confirmed this had gone ahead and described how the two people had stopped at a halfway point to meet up and introduce themselves. People told us that staff also supported them, as necessary, with other activities, such as computer or phone use. All the people being supported had access to their own Motability vehicle and all staff were able to drive the vehicles as part of the support provided to each individual.

People confirmed that they were able to make day to day choices and that staff supported them to do this. Staff told us that they responded to people's individual's needs and choices. They said if a person wanted to go out they would facilitate them going out at the time of their choosing. They said the whole idea of the support was to allow the people they cared for to live as full a life as possible.

The provider had in place a complaints policy. The registered manager told us there had been no formal complaints within the 12 months prior to our inspection. The registered manager showed a record of some emails detailing low level concerns. Individuals told us that team leaders worked hard to address any issues that they had on a day to day basis. They said they had not raised any formal complaints and tended to speak directly with, or email, the registered manager with concerns. People told us they had frequent discussions or email conversations with the registered manager, or that he often texted them with replies. Some people told us they felt daunted in approaching the registered manager with issues and that he did not always understand their point of view. This meant that whilst some people were able to raise informal concerns some people may not have voiced their concerns due to feeling unable to freely speak with the registered manager.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since October 2010. He was present on the day we visited the office base and assisted with the inspection.

The registered manager told us he had only recently completed the Provider Information Return and returned it to the CQC. 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. He apologised for the PIR being late and said it was wholly down to the fact he had not had time to complete it. This meant information that we would have used to plan and prepared for the inspection had not been available.

We visited the home of a person who used the service. Whilst care records were detailed and highly personalised, care staff explained that they only kept limited regular records and no daily records of the care delivered. We were shown the daily records of care which were limited to a note that the person had been supported with their medicines, a record of the person's daily fluid intake and output and information related to the person's sleep pattern. The care staff showed a communication book used to highlight any significant concerns to the incoming shift. We saw there were significant gaps in the dates when handover information had been recorded, with the last entered date being October 2015. The provider confirmed that only major issues were recorded and there was no daily record of the support offered. They said that most information was passed verbally. This meant there was no effective record of the care and support that people received on a daily basis and no record of any significant care decisions.

Individuals had diverse views of the registered manager's approach. Some suggested us that he could be very caring, concerned and supportive. One person who used the service told us they felt supported by the registered manager, particularly during the establishment phase of the care package, and that he had been very helpful to them. Comments from other individuals suggested there were times when he was viewed as less understanding and sensitive to people's views. People said that on occasions it was sometimes difficult to get their views across and they did not always feel listened to. They said that the registered manager tended to try and "over intellectualise" discussions. Comments included, "Do find (registered manager) can be intimidating"; "(Registered manager) is not terribly sensitive" and "He is a very good talker. Not for listening at all." One comment was, "It's either (registered manager's) way or no way." Individuals, including professionals, said that they found meeting with the registered manager uncomfortable and intimidating. The registered manager told us the service tried to ensure that care packages had the person at the centre of them and acknowledged that he could be paternalistic at times. This meant people felt that the culture and values of the organisation were not always open and transparent.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good Governance.

We were aware the registered manager was also registered as a registered manager in Scotland, which is separately regulated by the Scottish Social Service Council (SSSC). We noted that his registration in Scotland

was currently under a temporary suspension. We asked the registered manager about this. He said this was because at the time of his application he had in advertently answered "no" to a particular question required as part of his registration, without fully reading the context of the question. We spoke with the SSSC who confirmed that the registered manager was currently under investigation by the Council.

The registered manager showed us a copy of the service audit guidelines and told us that the quality of the service was reviewed as part of the individual checks carried out by team leaders. This was done through observing the support offered by care workers directly and then discussing any issues with the person receiving care.

The registered manager explained that there were a number of systems to ensure that the quality of care delivered by the service was maintained to a high standard. He said that he and other members of the management team travelled around the country visiting the sites where they were delivering care packages. He said that he regularly spoke to people who used the service and their families, including through the medium of Skype. He described the system used to monitor both staff performance and client satisfaction with the service. He said that team leaders would spend time observing the direct care provided by individual care staff. Following the period of observation, which could last several hours, the team leader would spend time with the person seeking their views about the delivery of care and whether there were any changes or improvements needed. Following this process a report would be produced and any issues that needed to be addressed would be covered in a meeting between the care worker and the team leader. We saw copies of these reports and noted that they were detailed and that issues were addressed, as necessary. This meant there were systems in place to monitor the quality of the service.

Staff told us that they found their jobs incredibly rewarding and enjoyed the time they spent supporting the people they cared for. They said they had the greatest admiration for the people they supported, overcoming the obstacles they had encountered in life to attend university or move into employment. Comments included, "I love my job; absolutely love it. It's the only job I've really enjoyed doing" and "I do enjoy the job; I love the job. That is more about the clients; I've seen more of (person) than anybody else. The team (person) has had, I don't think I've seen such a good team." Staff said the main issue was the requirement to travel away for home to support people in other parts of the country and the excessive duty hours affecting their family lives and academic studies. Staff said they sometimes felt it was difficult to get their views across to the registered manager, particularly if they were not confident. They said they sometimes felt overawed by the registered manager's approach.

The registered manager and the provider told us they tried to ensure messages about personalised care were heard in a number of areas. The provider had attended a range of conferences and events to speak, both about his personal experiences of living with a range of health conditions and to talk about the methodology and approach of the provider organisation. The registered manager told us they also attended a number of events, to promote the organisation commercially, and to raise awareness of the approach taken in developing individual care packages.

The registered manager said they had previously held regular management meetings, usually over a two day period at the provider's main address. He said these generally took the form of a business element, coupled with a presentation by each team leader regarding the current status to individual care packages being supported around the country. He said there may also be training elements incorporated into the meeting's format. We saw copies of minutes from past management meetings. He told us that in recent months, due to the limited staffing situation, it had not always been possible to arrange formal management meetings, because he and other members of the management team were travelling around the country. He said a lot of management work was done on the move through telephone calls and so was not formally recorded in

the same way it had been previously. This meant there were no regular, formal management review or oversight systems in place at the time of the inspection and no recent formal records of management decisions.

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 17 HSCA RA Regulations 2014 Good governance System were not in place to assess, monitor and mitigate risks related to the health safety and welfare of services users. The provider had not maintained and accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitable skilled and experienced staff deployed to meet the care needs of people being supported and staff were required to work excessive hours. Appropriate supervision processes and records were not in place. Regulation 18(1)(2)(a)