Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Active Support Service Limited

7 Alexandra Street, Kettering, NN16 0SX

Tel: 01536510545

Date of Inspection: 25 November 2013

Date of Publication: December 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Requirements relating to workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Active Support Service Limited
Registered Managers	Mrs. Andrea Adams Mrs. Mandy Coyne
Overview of the service	Active Support Service is a domiciliary care service based in Kettering. It provides personal care and social support to just over 100 people living in their own homes in Northamptonshire. At the time of our visit 11 people were receiving personal care from Active Support.
Type of services	Domiciliary care service Supported living service
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 November 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We found that where people may not have the capacity to consent there were no records to show their capacity to make specific decisions had been assessed or how decisions made on their behalf were in their best interests.

We spoke with two people who used the service and three relatives. One person told us " The staff are nice and kind" another person told us, "Staff are very good and always arrive on time." A relative told us the service was "excellent" saying they had "no concerns at all".

We found that although people were happy with the service care records did not always contain all the information staff needed to care for people safely and appropriately.

We found that not all the necessary pre recruitment checks had been carried out to ensure that staff were able to work safely with children and adults who may be vulnerable.

We found that the manager and team leaders carried about telephone checks to ask people using the service for their feedback. Records showed that they also carried out visits to people's homes when staff were there to check whether staff were punctual and to observe staff working with people. We saw that people were also able to give feedback on the service via an annual satisfaction survey.

The manager explained that team leaders carried out audits on care records. The audits undertaken had not identified the issues that we found with assessments and care plans and had not led to these areas being addressed.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 03 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

We found that where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with two people who used the service both spoke highly of the support they received. They told us that staff respected their wishes. The relative of one person who used the service told us that staff listen to their family member.

We found that where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. We looked at care records for five people. Within files for two people we saw a statement that their relative made all decisions for them due to their complex needs. There was no detail of the relative's authority to make decisions on behalf of their family member, such as a power of attorney. There were also no records to show that the person's capacity to make specific decisions had been assessed or how decisions made on their behalf were assessed as being in their best interests.

Care records stated that staff gave one person their medication disguised in food and used an aid for one person which could be restrictive to the person's movements. There was no record of the person's capacity to consent to this or, if they were unable to consent, details of how it was assessed as being in their best interest. We discussed this with the manager of the service who told us that she would ensure that these areas were assessed and advice sought from the relevant professionals.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with two people who used the service and three relatives who all spoke highly of the service. One person told us " The staff are nice and kind" another person told us, "Staff are very good and always arrive on time. On one occasion they were ten minutes late but the rang ahead to let me know." A relative told us the service was "excellent" saying they had "no concerns at all".

We found that although people were happy with the service, care records did not always contain all the information staff needed to care for people safely and appropriately. We found that two people had been assessed as being at high risk of developing pressure ulcers but their care plans did not detail how staff should care for them to reduce this risk. We saw that the pressure assessments had not been updated for over twelve months.

The care plan for one person noted that they self injured when they became bored or distressed but did not detail how staff should support the person to alleviate this. We saw that another person disliked having their head touched. We looked at their personal care plan to see how staff assisted the person to wash their hair and to carry out other personal care without causing distress. We found that the care plan did not make any reference to this.

We saw that although care plans were being reviewed and updated regularly, some risk assessments had not been reviewed in the last twelve months. This meant that the information may no longer be relevant.

We spoke with four members of staff. All were spoke positively about the care they provided and about Active Support. Staff explained that they were always introduced to people before providing care to them to ensure that people did not receive care from someone they were not familiar with.

We found that there were arrangements in place to deal with foreseeable emergencies. Staff told us that there was flexibility built into their schedule of visits which meant that they

could do extra visits if needed to cover if a colleague was not able to work due, for example, to sickness. Staff told us that there was an 'on-call' system to ensure that they were able to speak to a manager if they needed to when the office was closed.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were not consistently protected from the risk of abuse because the provider had not always taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

One person who used Active Support told us that they did not have any concerns about the service but would talk to the manager if they had.

We saw that the service had a policy on safeguarding adults and children and that staff received training in both.

We spoke with four staff about safeguarding, they were able to tell us about their role in safeguarding people from the risks of abuse and harm. This included how to raise concerns both within the organisation and externally. One person told us that they had not received any training in safeguarding but they were aware of the need to report any concerns to their manager.

We saw that the manager kept a record of all safeguarding allegations and the action taken to ensure the safety of those involved.

We looked at the care records for one person and saw they stated staff should use an aid for one person which could be restrictive to the person's movements. There was no detail of how this had been assessed as appropriate or in the best interests for this person.

We found that not all the necessary pre recruitment checks had been carried out to ensure that staff were able to work safely with children and adults who may be vulnerable.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

Appropriate checks were not always undertaken before staff began work to ensure that staff were safe to work with children and adults who could be vulnerable.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that appropriate checks were not always undertaken before staff began work. We looked at employment records for five staff. We found that gaps in people's employment history were not always followed up as part of the recruitment process. For example one person had not accounted for four years in their recent employment history. There was no record of this be discussed with the person. We saw in the record of the person's interview they stated they had worked within the care sector but this was not included in their employment history.

We found that although checks were made with the disclosure and barring service (DBS) prior to staff starting to work for Active Support appropriate references from previous employers were not always obtained. We saw that one person had one reference from a job they had only had for a few months and another reference that did not state the job title or company of the person giving the reference. We saw that two staff files did not contain any references.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider had a system in place to regularly assess and monitor the quality of service that people receive but this was not always effective in identifying and addressing areas for improvement.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that the manager and team leaders carried about telephone checks to ask people using the service for their feedback. Records showed that they also carried out visits to people's homes when staff were there to check whether staff were punctual and to observe staff working with people. We saw that people were also able to give feedback on the service via an annual satisfaction survey.

The manager told us that where issue were identified these were fedback to staff through supervision sessions or team meetings to ensure that appropriate actions were taken.

We saw that the manager has a system in place to monitor complaints, accidents and incidents to make sure that lessons were learnt and any themes were identified.

We discussed with the manager how care records were audited to ensure that they were accurate, up to date and contained the relevant information needed by staff to care for people safely and appropriately. The manager explained that team leaders carried out audits on care records. The audits undertaken had not identified the issues that we found with assessments and care plans and had not led to these areas being addressed.

The manager explained that staff training was monitored individually by team leaders during staff supervision. One person told us that they had not received training in safeguarding. We saw that this has not been identified and rectified through the person's supervision sessions.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: We found that where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. (Regulation 18(1)(b))
Regulated activity	Regulation
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare.(Regulation 9(1)(a)(b)(i)(ii))
Regulated activity	Regulation
Personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met:

This section is primarily information for the provider

	People who use the service were not consistently protected from the risk of abuse because the provider had not always taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.(Regulation 11(1)(a)(2)(a)(b))
Regulated activity	Regulation
Personal care	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: Appropriate checks were not always undertaken before staff began work to ensure that staff were safe to work with children and adults who could be vulnerable. (Regulation 21(a)(i)(ii)(b))
Regulated activity	Regulation
Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider had a system in place to regularly assess and monitor the quality of service that people receive but this was not always effective in identifying and addressing areas for improvement.(Regulation 10(1)(a)(b))

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 03 January 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk