Continuity Healthcare Services Ltd

Continuity HealthCare Services

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service: Continuity Healthcare Services Ltd is a domiciliary care agency. It is registered to provide personal care to people in their own homes, including, older people, people with mental health care needs, and people living with dementia. At the time of the inspection visit the service supported 120 people.

People's experience of using this service:
• People had not always received their care visits at the times expected.
• Staff understood how to keep people safe and protect them from avoidable harm.
• People's needs were assessed to ensure they could be met by the service.
• Staff knew about the risks associated with people's care and management plans had been completed for all identified risks.
• Staff were recruited safely, and there were enough staff to provide the care and support people required.
• Staff completed training to support people with medicines, but staff competency was not checked to ensure they did this safely.
• There were safe procedures to prevent the spread of infection.
• Staff received training and support to be effective in their role.
• People made their own decisions about their care and were supported by staff who understood the principles of the Mental Capacity Act 2005.
• Where required people were supported to meet their nutritional needs and to maintain their health and well-being.
• Staff were caring and respected people's rights to privacy and dignity.
• People were involved in planning their care and were consulted about the care provided,
• Care plans contained the information staff needed to provide personalised care.
• Systems were in place to manage and respond to any complaints or concerns raised.
• The provider understood their regulatory responsibilities and had effective processes for assessing and monitoring the quality of the service.

Rating at last inspection: Requires Improvement. We rated the service requires improvement in all areas and found two breaches of the regulations. The last inspection report was published on 4 May 2018.

Why we inspected: This was a planned inspection based on the date and the rating of the previous inspection. We had also received concerns about the service that we had referred to the local authority and to the provider to investigate which we needed to review. The overall rating for the service has changed to good, with improvements required in the key area of safe.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Continuity HealthCare Services

Detailed findings

Background to this inspection

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

Inspection team: One inspector, an assistant inspector and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The assistant inspector and expert by experience supported the inspection by making phone calls to people who used the service.

Service and service type: Continuity Healthcare Services Ltd is a domiciliary care agency. It provides personal care to people living in their own homes, including, older people and people living with dementia. CQC regulates the personal care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also the provider (owner) of the company.

Notice of inspection: This comprehensive inspection took place on 8 May 2019. The inspection was announced. We gave the service 24 hours' notice of the inspection because we needed to be sure the registered manager and other staff would be available to speak with us.

Inspection activity started on 14 March 2019 and ended on the 8 May 2019 when we visited the office location to meet with the registered manager, speak with staff; and to review care records and policies and procedures.

What we did: Prior to the inspection, we looked at the information we held about the service and used this to help us plan our inspection. This included concerns and complaints we had received and information the provider must notify us about, such as allegations of abuse. We had not requested a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We gave the provider opportunity during the inspection to discuss this with us. We contacted the local authority commissioners for the service. The commissioners told us they had visited the service in January 2019 and had identified several concerns about the service. The provider submitted an action plan and worked with the commissioners to address the concerns. The local authority commissioner told us they had revisited the service in April 2019 and the service had made several improvements.

We spoke with the registered manager, who is also the provider for the service, the general manager, care manager, quality manager, two care co-ordinators, the administration manager and two members of care staff. We also spoke with 19 people, and 16 relatives of people who used the service by telephone.

We reviewed a range of records. This included, four people's care records, including risk assessments and medicine records. Three staff personnel files, including recruitment, induction and training records. Records of complaints and management audits and checks.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse.
• At the last inspection the provider had not ensured people were always protected from the risk of abuse. We found a breach of the regulations because systems and processes were not established or operated effectively to immediately investigate any allegation of abuse.
• At this inspection we found improvements had been made and the provider was no longer in breach of the regulations.
• All staff had completed safeguarding training since the last inspection. They had been provided with an updated staff handbook with safeguarding and whistle blowing information. The telephone number of the local authority safeguarding team had been added to staff identity badges, so they had the number if they needed it.
• People we spoke with felt safe with the care staff and would be comfortable raising any safety concerns with a manager. One person told us, "The carers are wonderful. I trust them..."
• Staff spoken with knew how to identify abuse and would report concerns to a manager or the local authority safeguarding team.
• The managers knew the procedure for reporting concerns to the local authority and to us (CQC) to ensure any allegations or suspected abuse were investigated.
• A manager told us, "We refer all allegations or suspicions of abuse to the local authority. We now have an electric tracker (document) were all safeguarding concerns are recorded so we can review the actions we need to take and identify any patterns.

Assessing risk, safety monitoring and management.
• At the last inspection the provider had not ensured all risks to people's care had been assessed and managed safely. At this inspection we found improvements had been made.
• People's individual risks were assessed prior to starting the service and care plans described the actions staff should take to minimise the identified risks.
• Copies of risk assessments were available in people's homes, for staff to follow.
• The care manager told us, "Staff are very good at referring any changes with people's care, so we can re-assess people's needs and update assessments, and refer for equipment or medication reviews if needed."
• Staff knew how to manage risks associated with people's care and had completed training to manage people's risks and keep them safe. This included, helping people to move and administration of medicines.

• Some people required equipment to help them move. They told us staff knew how to use this safely. A relative told us, "They hoist him carefully and properly."

Staffing and recruitment.
• In January 2019 we received concerns about late calls to people. We were told about one person whose

visit could be up to two hours late, which meant they missed their medication time and put them at risk. We referred these concerns to the local authority safeguarding team and reviewed them during this inspection.
• We asked people if care staff arrived at the times expected. People had different experiences. Some said care staff arrived around the same time each day, others said care staff were often later than expected. One person told us, "They come as soon as they can in the morning. It can be anytime between 8.30 a.m. and 10.30 a.m." Some people said care visits in the week were consistent but times at weekends could vary. For example, one person said, "The earliest they come is 9.30 a.m... At the weekend it could be up to 11.00 a.m."
• The provider had identified call times to people were inconsistent. To improve this, they had implemented an electronic call planning system which monitored the time staff arrived and left people's homes. The system alerted the office if staff had not 'logged in' so the office staff could find out why and let people know staff were running late. On the day of our office visit the system was working effectively.
• The managers told us they were still in the process of reviewing call times to ensure staff worked consistently with the electronic planning system and followed their call rotas.
• There were sufficient staff to ensure people received all their care calls.
• Most people felt that care staff stayed for long enough to do everything they needed.
• Two of the 30 people we spoke with said care staff rushed occasionally and didn't always wash them thoroughly. The managers said they would address this with staff.
• The provider's recruitment process included checks to ensure staff who worked for the service were of a suitable character. Disclosure and Barring Service (DBS) checks and references had been obtained before staff started work.
• Not all recruitment documents had been fully completed. Dates were missing from some documents and in one file proof of identity checks were not consistent.
• The care manager, who was appointed in March 2019, had identified improvements were needed to the recruitment checking process and had plans to improve this.

Using medicines safely.
• People who were supported to take their medicines, had a risk assessment and a care plan completed so staff knew what medicines people were prescribed. Where required, this included a topical creams care plan and body map to show where each cream was to be applied.
• People spoken with were satisfied with how staff supported them to take medicines and said staff made sure they took them at the right time. For example, one person said, "Sometimes my morning medication is given late if the morning call is delayed, but the rest of the calls throughout the day are timed to reflect this."
• Staff had been trained in safe medicines management. However, competency assessments were not completed following staff training to make sure they put their training into practice and worked in line with the provider's medication policy. The managers told us a medicine competency assessment would be implemented.
• Staff signed a medicine administration record (MAR) to confirm medicines had been given.
• The managers told us they had reviewed and strengthened the medication procedure since our last inspection. One told us, "There is no back log as MAR's are checked when they are returned to the office. We now have an electronic tracker where all medication audits, including any errors or gaps are recorded as well as the action taken, such as discussion with the staff member or re-training."

Preventing and controlling infection.
• People told us care staff washed their hands and always wore gloves and aprons when assisting with personal care or applying creams.
• Staff completed training and understood their responsibilities in relation to infection control and hygiene.
• Staff confirmed they had a supply of single use gloves and aprons which they collected from the office.

Learning lessons when things go wrong.

• The provider had a procedure in place to record and review any incidents or accidents.
• This process had improved since the last inspection when the provider did not have an overview of incidents or evidence they had made the necessary improvements. Accidents and incidents were now recorded on an electronic tracker, so they could be monitored and identify any patterns.
• Staff understood the importance of reporting and recording accidents and incidents, so care could be adjusted, and people remained safe.
• Staff told us there are incident forms they could complete at the back of the folders in people's homes.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• People's needs were assessed before they started using the service.
• People told us, "[Care co-ordinator] sat with her and went through it quite thoroughly." Another said "The manager came out and asked what we wanted. They have been able to deliver it."
• Care records documented the support people required.
• People's needs were kept under review to make sure they continued to be met.

Staff support: induction, training, skills and experience.
• Staff told us they received an induction when they started working at the service which included training and 'shadow' shifts. They also had opportunity to read care plans to get to know what care and support people required.
• People said care staff were competent and well trained. For example, a relative told us, "Some [care staff] are very professional. I can't fault them." Although two relatives questioned some care staff understanding of dementia. The managers told us they had identified a need for staff to complete dementia training and this had recently been delivered to staff.
• The managers told us that some staff already had care experience when they started to work for the company. Previously, the provider accepted training certificates from other employers as proof of competency. However, the managers found staff had not always been trained to the level they would expect. To address this all staff were completing the Care Certificate to make sure they had the basic skills and knowledge to carry out their role, safely and effectively. The Care Certificate is the nationally recognised induction standard.
• The provider had a regular training programme for staff to complete their mandatory training and any specialist training. For example, dementia training. One told us about the training, "It helped me understand dementia. the training was good. Each person is different, and it gave a good insight into dementia and how this effects people."
• Since the last inspection the provider had supported all the management team to complete a level 5 qualification in leadership and management. They also supported staff to progress to further qualifications in care if they wished.
• Staff told us they had individual meetings and spot checks of their practice to make sure they were working to the provider's policies and procedures. One told us about their meetings, "It is nice to have these as you can look at your strengths and weaknesses."

Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA.
• At the last inspection improvement was needed in how the provider implemented the MCA. At this inspection we found improvements had been made.
• The managers understood their responsibilities under the Act and knew to contact the local authority if they had concerns about a person's capacity.
• People using the service made daily decisions for themselves, or with the support from relatives and staff. A manager told us, "Everyone we visit has capacity to make decisions for themselves or with the support of families."
• Staff had completed training in MCA and understood how this affected their practice. One told us, "MCA is for when people can't make decisions for themselves and you have to make decisions in best interest. I always assume people have capacity, any concerns I would refer to the manager, so they could re-assess person and arrange best interest meeting."
• Records demonstrated people's consent to care was sought and people's rights with regards to consent and making decisions were respected by staff.
• Where relatives, or others involved in people's care, had the authority to make decisions on people's behalf. This was recorded in their care plan.

Supporting people to eat and drink enough to maintain a balanced diet.
• Staff understood people's individual dietary needs and made sure people who required support with their nutritional needs had sufficient amounts to eat and drink. For example, one person required assistance to eat their food. Staff said they had time to sit and assist the person to eat and ensure their meal was eaten.
• Risks associated with people's eating and drinking were assessed, and how to manage identified risks were recorded in care plans for staff to follow.
• Some people were at risk of choking and required their food and fluids prepared in a specific way. For example, pureed, thickened or administered through a PEG. A PEG is a way of introducing nutrition, fluids and medicines directly into the stomach, where the person is unable to swallow or is at risk of choking. Staff knew how to prepare special diets and advice was recorded for staff in care plans about how to prevent choking, and what to do if the person choked. Instructions were available for staff to ensure people received enough nutrition and fluids through a PEG to maintain good health.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care.
• People we spoke with made their own health care appointments or had family who supported them to arrange these.
• Staff monitored people's wellbeing, such as their general health, and informed families or referred people to health care professionals if they identified any concerns. Relatives told us, "A carer phoned me and told me my mother was not well." Another said "If there is anything wrong they will tell me. For example, one called me in to look at a bruise she found on his back."
• Care staff completed training to support people's health conditions, such as epilepsy. Guidelines were available for staff about how to manage the condition and administer emergency medication if needed.
• The management team and staff worked with health and social care professionals to improve outcomes for people. Such as SALT (Speech and language therapists), GP's and district nurses.
• Service user information included a 'customer transfer document' with snap shot of person's needs, preferences and likes etc. This would help to provide consistent care if the person went into hospital, respite care or another care setting.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported.

• People spoke positively about their care and described staff as kind and friendly. Comments from people included, "They are lovely people… [my regular carer] is very good with me, he knows all my ways, we get on very well."

• Two out of the 35 people we spoke with thought staff attitudes could be improved. They told us, "Most of them are brilliant but the odd one is not right for the job," and, "One is very good at her job ... another is friendly but a bit lazy and is not very patient."

• The managers had identified through feedback from people that some staff attitudes could be improved. The staff concerned had been spoken with and where required performance management plans were in place. Some staff had recently left the service.

• People told us staff treated them well. For example, one told us, "My muscles get all knotted up and they rub me with cream and massage it in. They are very helpful." A relative said "They have a joke and a laugh with her."

• People said staff were kind and thoughtful. For example, "They are friendly. One [care staff] ran an errand for me today and got me some milk. They are very obliging."

• Comments from other people included, "They [care staff] always ask me if there is anything else I want doing," and, "They will do anything else we want them to."

• The care manager told us that the new care plan format had information about people's social activities and hobbies so care staff could have meaningful conversations with people.

Supporting people to express their views and be involved in making decisions about their care: equality and diversity.

• People were involved in their assessment process, and care plan reviews. The provider had also introduced satisfaction phone calls to people.

• People made everyday decisions about their care.

• Staff understood people's communication skills. The managers told us, some people's first language was not English and where they preferred to communicate in their first language they were able to provide staff who spoke the same language. They said, "This means we can gain a better understanding of their preferences and identify if they are unwell."

• The managers told us about a person who used the service who was profoundly deaf. They were arranging a review meeting to discuss the person's care needs and had requested an interpreter who used British Sign Language to support the person to express their views during the meeting.

• Some people said they had difficulty understanding some care staff whose first language was not English. For example, "Communication is a bit difficult. When they talk quickly I can't understand them. I have to ask

them to say it again."
• Most people said staff had time to sit and talk with them during visits.
Staff knew about people's cultural needs. A staff member told us, "I can speak some people's language, so they can share how they like things doing. I also know how they like their tea made and some people like to listen to specific Asian programmes on the radio."
Staff also told us about how fasting for Ramadan sometimes effected how people took their medicines during the day.

Respecting and promoting people's privacy, dignity and independence.
• Staff treated people with dignity and respected their privacy. One person said, "I told them that I preferred not having a male carer and they have always respected that." A relative told us, "They don't make him feel embarrassed."
• People were supported to maintain their independence and to continue to do things for themselves. Some people told us, how care staff encouraged them to wash by themselves and only helped with the areas they could not reach.
• Some people told us how the support they received meant they could remain living at home. Comments included, "If I didn't have them [care staff] I couldn't manage," and "Their support is invaluable."
• Staff knew how to promote people's privacy and independence. For example, "Make sure you knock and let people know you are there before you enter. Always ask for consent before you do anything and close doors and curtains when providing personal care."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• People's care and support was planned with them when they started using the service. Each person had a care plan for staff to follow.
• We reviewed four people's care records that included care plans and risk management plans.
• Plans provided staff with information about how to support people in a way that met their needs and preferences.
• Care records supported staff to keep people safe and well. For example, plans explained how to move people safely and reminded staff to check pressure areas where people were of risk of skin breakdown.
• The care manager had identified care plans needed developing to be more person centred and was in the process of updating people's plans. They told us, "Each person is having a full comprehensive assessment and care plan review to ensure people needs are up to date and care plans are accurate." The process included referring people to GP's for medication reviews and to occupational therapists for mobility assessments if needed.
• Staff knew people well and referred any changes or concerns about people's care to the care co-ordinators or managers, so they could take action.
• Staff were informed of any changes in people's care through a messaging service on their mobile phones. Staff said this worked well.
• Most people said they usually received care from regular staff. Comments from people included, "They are reliable, and we get regular carers."
• Some people said the service at weekends was not as consistent as during the week. The managers had identified this and had changed their recruitment process to ensure staff knew the expectations would be to work weekends.
• People said care staff knew their preferences and provided care in the way they preferred. One person told us, "He asks them not to use soap and cream under his arms and to use talcum powder and they do."
• Where possible the provider was flexible and accommodated people's requests for change to time of calls. Comments included, "If I want an early call because of a hospital appointment I call them, and they will come at 7.30 a.m. If I tell them in advance they are flexible."
• Information was available in large print and could be made available in other languages if required. This was in line with the 'Accessible Information Standard' which is a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand the information they are given.

Improving care quality in response to complaints or concerns.
• At the last inspection improvement was needed in how the provider recorded and managed complaints. At this inspection improvements had been made.
• Systems were in place to manage and respond to any complaints or concerns raised. All concerns and complaints were recorded on an electronic tracker, so they could be monitored, and any patterns identified.

• People knew how to raise complaints and had been provided with complaints information when they started to use the service.
• People felt confident to speak with the managers about any concerns they might have.
● The management team regularly checked people were happy with the service they received so any concerns could be dealt with quickly.

End of life care and support.
• At the time of this inspection no one supported by the service was at the end stage of life.
• Care records contained information about people's end of life wishes, if they chose to share it.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

At the last inspection we rated well led as requires improvement. This was because we found a breach of regulation 17, Good governance, as the provider had not ensured the service was safe and effectively managed. At this inspection the provider had made the required improvements and was no longer in breach of the regulations.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
• The provider told us at the time of the last inspection they had 'lost sight of the overview of the service'. The provider said due to staffing issues they were providing care calls to people, as well as trying to manage the service. Which meant quality assurance processes and records management was not taking place.
• Following the visit by local authority commissioners in January 2019 the provider agreed not to accept new clients until improvements had been made. They worked closely with commissioners to make the required improvements and started to accept people again from March 2019.
• Since the last inspection the provider had made significant investment and improvements to the service. This included strengthening the management of the service by employing a general manager, care manager, and a quality manager. They had implemented an electronic call planning and monitoring system to ensure people received a consistent service including care calls at the time expected.
• The provider also planned to introduce a team leader role, to support staff by carrying out supervisions and spot checks on competencies. The team leaders' responsibilities would also include returning records from people's home to the office every two weeks for checking.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care.
•The provider understood their responsibilities and the requirements of their registration. For example, they understood the need to be open and honest when things went wrong so lessons could be learnt. They had submitted notifications when incidents had occurred that they needed to tell us about, and their latest CQC rating was displayed on their website as required.
• The management team understood their roles and responsibilities. They were motivated and enthusiastic about the service provided and the improvements that had been made and were planned. One told us, "We have a wonderful team, lots of positivity and we are all working together to take the service forward."
• The general manager told us they had planned management workshops with an external trainer to support managers in their roles.
• At the last inspection quality assurance processes and records management required improvement. At this

inspection improvement had been made.
• There were effective processes for monitoring the quality of service provided. This included satisfaction phone calls and surveys to people, reviews of people's care, robust recording and monitoring of complaints, medication, safeguarding and incidents. Improved staff training, supervision and performance process. The electronic care planning system to monitor people received their calls around the time expected, and staff stayed long enough to provide all the care people required.
• Managers told us about the improvements that had been made. Comments included "People's call times are more regular without a doubt. Calls are monitored closely any changes to call times are followed up with the staff member. We now have a robust staff performance management process for this, which is new."
• The provider told us, "In the past when carers used to refer changes to the office, such as people's mobility, due to lack of management things were not always followed up. This doesn't happen now, as management are on the ball."
• Staff felt supported in their role and told us they had no concerns about the service people received. One told us, "I have no concerns at all, it's come on absolutely marvellous. [Provider and general manager] and everyone are so focused on giving the clients exactly what they want. It's lovely." Another told us, "[General manager] cares about staff too. He phones to make sure I am ok, he is very supportive."
The provider had action plans in place to review and monitor progress and improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
• Most people thought the service was well managed and said managers had been in contact with them to see if they were happy with the service.
• Feedback from people, relatives and staff was encouraged through phone calls, review meetings and quality questionnaires.
• Feedback from people and staff was used to support continuous improvement. Action taken from feedback was recorded and monitored weekly by the general manager.
• People were provided with telephone numbers, so they could contact the office if needed.
• Staff had regular staff meetings. Individual meetings and observations of their practice had started to take place regularly.
• Staff felt able to raise concerns directly with the managers and said communication within the service was good. For example, "If you have any concerns you can approach the management team, they always try to resolve things."
• Staff were positive about the service provided and said they were happy in their work. One said, "I love it. I really enjoy coming to work."
• We asked staff if they would recommend the service to a family member. All said they would. One told us, "Absolutely. Staff have been well trained. Managers are approachable and [Provider] is always willing to speak to you. We provide good care and we have a good crew."

Working in partnership with others
• The management team had developed positive working relationships with people's families and health and social care professionals, such as GP's, district nurses and the local authority and clinical commissioners (CCG) which assisted in promoting people's physical and mental health.