Concept Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Concept Home Care Limited is a provider of community home care services. It provides personal care to people living in their own homes in the community. It provides a service to younger and older people. At the time of the inspection it was providing personal care to one person.

People's experience of using the service:
People did not receive a service that was safe and were not protected from abuse or avoidable harm.

Staff were not given opportunities to review their work and development needs. Safe recruitment procedures were not followed.

People's needs were assessed before they began to receive care and support from the service, however they were not regularly reviewed.

People were not always treated with dignity and respect and were not supported to express their views.

The service was not well-led and there was a lack of robust and effective quality assurance processes.

Policies and procedures had not been reviewed or revised so could not be relied upon to provide up to date guidance for staff.

People were supported to eat and drink in line with personal choice.

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

Rating at last inspection:
This was the first inspection at Concept Home Care Limited.

Why we inspected:
This was a planned comprehensive inspection.

Enforcement:
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
The overall rating for this registered provider is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate

action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Following the inspection we received an application from the registered provider to cancel their registration with the CQC. This application is currently in process.

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 safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

details are in our well-led findings below.

Inadequate

Concept Home Care Limited

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:
The inspection was carried out by one adult social care inspector on the first day, and two adult social care inspectors on the second.

Service and service type:
Concept Home Care Limited is a domiciliary care agency. It provides personal care to people living in their own homes.

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.

Notice of inspection:
We gave the service 72 hours' notice of the inspection visit because it is small and we needed to be sure that the registered manager would be in.'

What we did:
CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. Prior to the inspection we contacted Cheshire East Council to seek their views of the service. They informed us that the provider had asked to be removed from their list of providers and therefore they did not

commission with the service. We also reviewed information we held about the service and checked whether we had received any notifications about events which the provider is required to tell us about by law.

Providers are required to send us key information about their service, what they do well and improvements they intend to make. This information helps support our inspections. We looked at the information the provider had sent us about the service in the Provider Information Return (PIR).

During the inspection we visited the office location to meet with the registered manager. We also spoke with one service user, one relative and a care worker in person and one care worker and two Stockport Metropolitan Borough Council [SMBC] staff by telephone. We looked at one person's care records and other records relating to the operation of the service. After the inspection visits we asked the registered manager to provide some additional information and liaised with two SMBC again.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm and abuse. Some regulations were not met.

Systems and processes to safeguarding people from the risk of abuse:

- Allegations of abuse had not been reported in line with local safeguarding protocols.
- The way a specific allegation had been handled had caused significant and ongoing distress to the person involved.
- Staff lacked an understanding of their responsibilities regarding safeguarding and had not reported incidents to the relevant external agencies [whistle-blowing].

The failure to protect people from abuse demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- People were not protected from the risk of avoidable harm. Accident/incident records were not completed.
- There was insufficient information provided to staff about the signs, symptoms and response to a person's food allergies.
- People's specific risks were not reflected in risk assessments or care plans so the person remained at risk of harm or receiving inappropriate care.
- The management of medicines was not safe. The service did not have a medication administration record [MAR] template for staff to complete should they need to administer medicines.
- Staff had frequently applied a cream and/or ointment however there was no evidence provided of corresponding MAR records.

Care and treatment was not provided in a safe way. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment

- The service was operating on limited staff resources and had been unable to recruit a staff group to meet care and support needs.
- The absence of one member of staff left gaps in service's ability to provide care one week in four.
- The registered provider did not have a business continuity/emergency plan in place.
- The registered manager stated that staff involved in incidents referred to in this report had left the service for unrelated reasons however was unable to provide any supporting evidence.

Care and treatment was not provided in a safe way. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●Recruitment procedures were not safe. A staff member had begun working prior to the outcome of safe recruitment checks and adequate references had not been received.

The above information demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Preventing and controlling infection

●There was a policy and procedure in place providing guidance to staff of measures to take to prevent and control the spread of infection.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Some regulations were not met.

Staff support: induction, training, skills and experience

●Staff were not given opportunities to review their work and development needs.
●Although the registered manager had indicated four staff had received an annual appraisal in the last 12 months, we found this was not correct and that no staff had received an annual appraisal.
● Support and supervision for staff was not provided and a staff member told us that they only saw the registered manager when the person using the service was present.
● Staff lacked understanding of their responsibilities regarding protecting people from abuse. This demonstrated that staff had not received adequate or effective training.

The failure to provide appropriate supervision and appraisal and ongoing effective training demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff spoken with told us that they had received an induction training when they commenced employment which prepared them for their role.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Care and support was not delivered in line with standards, guidance and the law as detailed within this report.
●An assessment of people's needs was carried out before they received care and support. However, this was not reviewed regularly to ensure care was provided in line with people's needs and choices.

Supporting people to eat and drink enough to maintain a balanced diet;
●People were supported to eat and drink in line with their personal choices and preferences.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

●Staff supported people to access a range of services to maintain their health needs including other agencies involved in people's care and support.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

- The registered manager provided a copy of a Mental Capacity Act policy implemented on 6 March 2019, however this was not fit for purpose. It did not mention the Mental Capacity Act 2005. There was no information about process to follow if someone lacked the mental capacity to make a particular decision or of how to support a person to make a decision in their best interest.
- The service worked alongside representatives, such as social workers, advocates, medical professionals, for complex decisions about care and support needs.

Requires Improvement

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

People did not always feel well supported and were not always treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

●During the inspection we received feedback and saw evidence that a person had not been supported when they had disclosed allegations of abuse causing them ongoing distress.
●Language used in recording evidenced a lack of dignity and respect. We saw descriptions such as 'moody'; 'silly' and 'attention seeking'. Records also evidenced a lack of respect, entries in daily notes included comments such as, 'Told [Name] firmly he was going, end of'; 'not kicked off yet' and 'Told [Name] off'.

Failure to treat people with dignity and respect at all times demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to express their views and be involved in making decisions about their care

●There was no clear system in place to seek feedback from people using the service, their family or representatives.
●A person told us of their ongoing distress and dissatisfaction with the service they received from Concept Home Care Limited. They were dissatisfied with the actions of the registered manager and told us that they had not been listened to.
●People who were unable to make certain decisions about their care were supported by an advocate. An advocate is a person who supports people to ensure that their rights are protected.
●The provider had a policy in place to ensure that people using the service were treated without discrimination.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●There was no process for regular evaluation of people's care and support plans to ensure that they were reflective of changing needs and preferences.
●Although the registered manager had indicated that an annual review of people's care needs took place, we found that this information was not accurate.
●The registered manager had updated office held care plan records, they had not ensured that an updated version was available for staff use within the person's home. Therefore, staff would not have been aware of any changes.
●A person and their representatives had not been involved in recent care review and were unaware that a review had taken place.
●Care plans were basic and lacked information about specific needs which were evident in daily note entries.
●Care planning did not include sufficient detail about people's communication needs and preferences.
●The service could not meet the commissioned care needs of a person one week in four.

The failure to assess, plan and provide care and support that met people's needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The service also provided 'companionship' support. We saw that a person was well supported to access the community and take part in activities of their choice when receiving this type of support.

Improving care quality in response to complaints or concerns

● Ongoing dissatisfaction with the service received had not been dealt with in line with the provider's complaints policy.
●Staff told us that when a person using the service had raised concerns "nothing happened".

End of life care and support

●At the time of the inspection the service was not providing a service to anyone at end of life.
●The registered manager informed us that staff received guidance on the care and support needs required at this stage of life working together with the district nurse team.

Inadequate

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

There were widespread and significant shortfalls in service leadership and some regulations were not being met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes were not in place to assess and monitor the quality of the service.
- The registered manager had no oversight of service provision or staff practice.
- The lack of robust quality assurance procedures and managerial oversight meant that the registered manager failed to identify continuous learning to improve the quality of care.
- The registered manager failed to identify that the standard and safety of care provided had been compromised leading to the breaches of relevant regulations noted within this report.
- The registered manager did not report allegations of abuse under safeguarding procedures.
- The registered manager demonstrated a lack of awareness of the responsibilities and legislation linked to their registration.
- The registered manager did not ensure that the provider's own policies were kept up to date and were followed.
- The registered manager did not understand the meaning or requirements of the Accessible Information Standard. This is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.
- Records were disorganised. Throughout the inspection the registered manager was unable to provide documentation requested by the inspection team.

The failure to ensure an effective system to assess, monitor and mitigate risks to the service and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Registered persons are required to notify the CQC of significant events that occur in the service. These are incidents that enable CQC to monitor the service and analyse any risks that might be arising. We found that the registered manager failed to inform the CQC of allegations of abuse.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

●Care plans lacked detail to ensure that care and support was provided in line with people's needs and preferences.
●People's care and support needs were not regularly reviewed.
●Complaints, including ongoing dissatisfaction with the service provided, were not handled in line with the provider's own policy.
●The service did not have a business continuity/emergency plan in place to detail how the service would continue in the event of an emergency.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Staff told us that there was a lack of communication from the registered manager and that they rarely saw them.
●Relationships between staff, people using the service and the registered manager had broken down.
●There was no system in place to regularly seek the views of people using the service, relatives or staff.

Working in partnership with others
●The service worked alongside health and social care professionals such as GP, social worker and district nurses.