Crescent Community Care Services Limited

Crescent Office

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place between 10 and 13 July 2018 and was announced. We gave notice of our intention to visit Crescent Office so as to ensure that the people we needed to speak with were available.

This was the first inspection since the service registered with the Care Quality Commission on 30 June 2017. The service location had previously been registered under another name and at that last inspection they were rated Good.

The inspection involved visits to the agency's office and conversations with people, their relatives and staff. The agency provided approximately 180 people with a domiciliary service. People received a range of different support in their own homes. Many of the people were older persons, including people living with dementia and a physical disability.

The service is required to have a registered manager and there was one in post who was also the co-director of the service. 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.

Risks associated with the management of medicines had not been identified. Information about people's medicines was not always recorded. Medication administration charts were not used and it was not always clear that people had received their medicines as prescribed. Staff had not been effectively trained in medicines and did not have their competency checked. People using the service and their relatives who spoke with us, told us their medicines had been administered safely.

Training records could not evidence staff had received the training they needed to meet people's needs effectively. Whilst most staff told us they felt supported, the registered manager had not provided staff with regular supervision or appraisal. The registered manager did not regularly monitor staff's performance when they worked with people in their own homes.

People told us they were always asked for their permission before personal care was provided, however their ability to make decisions was not always assessed in line with the Mental Capacity Act, 2005 (MCA). Staff's understanding of the MCA was limited.

There was not a robust quality assurance process in place. Audits to assess the quality of service provision were not in place and action plans were not developed to ensure improvements were made.

The registered persons had not always notified CQC of significant events that occurred in the service.

Accidents and incidents had been documented at the service, although records lacked detail about actions

taken to prevent further occurrences. Risk assessments identified risks for each person, although some needed more detail.

People's needs had been assessed prior to receiving care so their needs and wishes could be identified and recorded. Some people had detailed and personalised care plans in place but others were more basic and were largely a list of tasks.

There were enough staff to ensure people did not experience missed visits, however some people and their relatives told us visits were sometimes late. People were appreciative of the support they received from their regular care staff, but some people received care from staff they did not know.

Staff had been recruited in a safe way to ensure new members of staff were safe to support people. Staff were supported with a planned induction.

People and relatives said they felt people were being cared for safely. Staff knew what to do if they thought people were at risk or harm or abuse.

Most people told us kind and caring staff supported them and relatives said staff were usually professional in their approach. Staff were mindful of protecting people's rights to choice, dignity and respect.

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication needs were assessed and staff demonstrated an understanding of how to meet these.

People were protected from the risk of infection as staff understood infection control procedures and used protective equipment when needed. Staff assisted people with meal preparation and people were supported to access other healthcare services when needed.

Feedback from people was sought and there was a complaints procedure in place. Staff were not formally asked for their feedback about the running of the service but they told us they could make suggestions and these were acted on.

Staff worked well together and mostly felt supported by the registered manager, the co-director and the office staff.

We identified 4 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not protected from risks associated with the unsafe management of medicines.

Risks to people had been assessed and staff could describe how they kept people safe, however some risk assessments needed more detail.

There were enough staff to meet people's needs although some people and staff felt the service was short staffed at times due to staff absence.

The provider had effective recruitment procedures in place.

People were safe from harm because staff were aware of their responsibilities and able to report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not effectively supported because they had not always received the training they needed to fulfil the requirements of their role and they had not received regular supervision or appraisal.

The provider did not protect the rights of people using the service in line with the Mental Capacity Act 2005.

People were supported with their nutrition and hydration needs.

People were supported to access healthcare services where necessary.

Is the service caring?

Good

The service was caring.

People were treated with kindness, sensitivity and compassion

from staff.

People's privacy, dignity and independence were promoted.

People had confidence and trust in the staff that supported them regularly. Most people had a continuity of staff, however some people told us they did not know the care staff who supported them.

Information about people was stored confidentially.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Most people felt they received a service that was responsive to their needs, however some people did not get their visits on time.

Some people's care plans were detailed and person-centred while others largely contained a list of tasks.

People and relatives were involved in their assessment and care planning process.

People and their relatives told us they would complain to the managers if they needed to. Concerns were dealt with informally and resolved for people.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have effective systems for ensuring the quality and safety of the service and for making improvement.

The provider had not always notified CQC of significant events.

People and most staff felt they were well supported by the management team and they were approachable

People had been asked their opinion on the service they received and systems were in place to ensure feedback had been acted on.

Crescent Office

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.

Inspection site visit activity started on 10 July 2018 and ended on 13 July 2018. It included visiting the office location on 10 July to see the registered manager and office staff; and to review care records and policies and procedures. We carried out telephone interviews with people who used the service, their relatives and staff and sent questions by email to staff.

We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure that the staff and people we needed to talk to would be available.

The inspection team consisted of one adult social care inspector. Before an inspection we review information that we have about a service to inform and plan the inspection. This includes information we have received and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We had not received any notifications about this service. The provider was not 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. We discussed this information during the inspection.

We spoke with nine people by telephone and the relatives of 16 people. We spoke with five care staff, and seven care staff responded to our questions by email. We also spoke with the registered manager. We reviewed records which included 10 people's care plans and daily records and 10 staff files. We reviewed the provider's policies, procedures and records relating to the management of the service such as staff training and recruitment records, complaints file and accident and incident records.

Requires Improvement

Is the service safe?

Our findings

All people that we spoke with told us they received a safe service. Comments included: "Yes, very safe because we trust the carers", "Yes, we have good carers we can trust and a key safe", and "I feel very safe with the carers".

We found that people were not adequately protected against the risks associated with medicines. People did not have detailed information about their medicines in their care plans. For example, it was stated 'nomad in situ' or 'prompt with meds'. There was no information available to staff about why a medicine had been prescribed or what the possible side effects could be. Additionally, there was no information about people's preferred method of taking their medicines or how much support they needed with this. This meant that staff did not know why people were taking their medicines or how to monitor the effectiveness of them and people may not receive their medicines in the way they needed or preferred.

People had their medicines in a pre packed container. There was a list of medicines that people needed to take in the container. This included a description of the tablet and how often they should be taken. A medication administration record (MAR) was not used. This meant that there was not a record of each individual tablet that had been taken by a person. Without clear documentation people could be at risk of not receiving their medicines as prescribed. When we discussed this with the registered manager they told us that staff recorded the number of tablets that people had taken on the person's log book. When we looked at these records we saw that this was confusing, the section was titled 'Number of meds given/refused' and staff had not always identified whether the medicines had been given or refused. The registered manager told us they would have been given because if there were any concerns staff would have phoned the office for advice.

Some medicines are prescribed to be taken when required. These are used to treat short term medical conditions or long-term conditions when people may experience 'flare ups' such as medicines to manage agitation, anxiety and pain. There was no guidance available to staff to say what the medicine was for, when they might need to take it or how much to use.

Medicines prescribed in a liquid form or for a short period of time such as anti-biotics were not in the pre packed container. The registered manager told us that people would only be supported with these if the person could take the tablets out of the packets or pour the liquid themselves, they went on to tell us that if they couldn't they would inform their social worker who would put measures in place to ensure the person had their medicines as needed. A member of staff told us that the recording of these medicines could be improved as it was sometimes difficult to keep track of when people had taken them or needed them next. This could put people at risk of not receiving their medicines as prescribed.

Staff had been shown how to use the medicine pre- packed container during their induction but had received no other medicine management training. Staff were not assessed to ensure they were competent to support people with their medicines.

Despite this, people told us that staff supported them appropriately with their medicines and they were administered safely.

The failure to fully protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

People were involved in the development of their care plans and risk assessments. Staff were made aware of risks to people's safety through care plans. Staff were provided with some guidance about how to support people when they were at risk, for example when a person was at risk of falls, guidance was in place of how to reduce this along with a falls checklist and the mobility equipment needed. We saw that risk assessments varied in their detail. Some were comprehensive and contained clear guidance for staff, while others were brief and contained basic information only. Staff we spoke with told us they had sufficient information to support people safely and were able to manage any risks to people's health and safety. One member of staff told us "I always look in the care plans, the information in there means I can support people safely".

Environmental and equipment risk assessments had been completed to ensure both the person using the service and the staff supporting them were safe. For example, we saw risk assessments had been developed for fire risks and the use of a wheelchair. Risk assessments were reviewed on a regular basis and information was updated as needed. One member of staff told us "We have this information before we go on a visit so we know what to look out for".

There were systems in place to record incidents and accidents. Care workers described how they would report any incidents to the office staff. One staff member said, "If we have any issues we report it straight away and someone from the office will come and reassess the situation and resolve any problems." We viewed the incident records and there had been four incidents recorded in the last year. There was no written evidence about what action had been taken in response to the incidents but the registered manager told us they had been investigated and did not warrant further action. All incidents varied in nature and it was therefore difficult to determine how the service would analyse trends or patterns. The registered manager told us and staff confirmed that if there were areas of learning, staff would be informed via, phone calls or memo's.

Although not all staff had received training in safeguarding and could not confidently describe what safeguarding meant, all staff confirmed they knew how to support people if they thought they might be at risk of abuse. One staff member told us "I would call the office straight away and they would sort it out", another member of staff said, "I would tell them in the office, I could also go to CQC, I would make sure that the person was safe" and third member described a previous incident where they had been concerned for a person's safety and the registered manager went out and supported them and put measures in place to ensure the person's safety.

Staff had been recruited through a recruitment process that ensured they were safe to work with people at risk. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks would identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Suitable references were obtained and any gaps in recruitment history were thoroughly explored. Staff confirmed that they were not allowed to start work at the agency until satisfactory references and criminal record checks had been received.

There was mixed feedback from people and relatives about the sufficiency of staff. Most people told us that there were enough staff to meet their needs, whereas others felt that the service was sometimes short-staffed. One person told us, "They stay long enough to do the things they're meant to do". Another person

told us, "There's not enough staff when several go off sick". Most staff told us they thought there was enough staff to meet people's needs, however three members of staff commented on other staff member's sickness. One member of staff told us "There's a few staff that aren't reliable, I don't think this is managed properly". The provider was continuing to recruit staff, however, in the interim period had ensured that people's care calls were covered. This was managed by a new system put in place where named staff members were on call and would be readily available to work if another staff member was absent from work. The registered manager told us "We used to have the occasional missed call so we came up with this new system, it has really helped". As a result, people's care was not affected and there were sufficient staff to meet people's needs.

There were suitable procedures to ensure that people were protected from infection and cross-contamination. Staff were provided with personal protective equipment and clothing and people and relatives confirmed that these were used. One person told us, "They always wear aprons and gloves".

Requires Improvement

Is the service effective?

Our findings

There was a mixed response from people who used the service and their relatives about the support they received. One relative told us "The senior staff are on the ball and the less senior ones are willing to learn. We've all got to learn", another said "Most of the carers are good but we have had some poorly trained and skilled carers," and a person told us "The regular carers are great but if they're not my usual ones, it varies a great deal".

We looked at the training records of eight care staff during the inspection. Of these staff seven had completed moving and handling training, five staff had completed safeguarding awareness training, none had completed the Mental Capacity Act training, none had completed health and safety training and none had completed dementia care training.

The home's training policy did not list which training courses care workers should undertake or how often they should be refreshed. The registered manager told us the core subjects, such as safeguarding, should be updated "every couple of years". We saw that some staff had not had training as regularly as this, if at all.

When we spoke with staff most confirmed they had not received training in areas such as the Mental Capacity Act, dementia, medication or end of life training. When we asked staff, what could be improved at Crescent Care three members of staff told us they would like more training. One staff member told us "The new staff need more training and support, they get a bit of training at induction but it needs to be more in depth, it must be so daunting for them going to people's houses on their own".

When we discussed our concerns with the registered manager, they told us they thought the staff were competent to carry out their roles because they either had previous training from another provider or had undertaken an NVQ in Health and Social Care. They acknowledged that staff needed frequent training to refresh their knowledge and to keep up to date with changes in legislation. They told us that they would look into providing more training.

Supervision and appraisal are processes which enable staff to reflect on and learn from practice, providing professional development; motivation and support in their role to support them to care for people effectively. The provider had a supervision policy which stated, 'Supervisions should be carried out at least two to three times a year'. Records showed, and staff confirmed, they had not received regular supervision or an annual appraisal. For example, two staff members had not had a supervision or appraisal since March 2016 and another had not had any since February 2017. Some staff told us they would like more supervisions while others said they didn't feel it was necessary as if they had any issues they would speak to the registered manager and were confident the registered manager would tell them if there were any issues or changes.

The failure to provide staff with appropriate support, training, supervision and appraisal as necessary to enable staff to carry out the duties they are employed to perform is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff were provided with an induction which was in line with the Care Certificate. The Care Certificate induction standards are nationally recognised standards of care, which staff new to care are expected to adhere to in their daily working life to support them to deliver safe and effective care. Staff were positive about the induction they received, one member of staff told us "The induction covered loads of things, there was a lot of information but the support was brilliant". Records showed and staff confirmed that they shadowed more experienced staff members as part of their induction.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who 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 capacity to make particular decisions, any made on their behalf must be done so in their best interests and in the least restrictive way possible.

People with mental health conditions known to affect their capacity had not been assessed for their ability to consent to their care and treatment. For example, two people living with dementia had no mental capacity assessments concerning their care and treatment. We did not see any evidence that anyone using Crescent Care had consented to the care and support that had been put in place.

We saw records where it described a person as being confused and non-compliant with their personal care at times. This person had been assessed as having capacity to make decisions about their care by the local authority when they first starting using Crescent Care. The registered manager told us that the person's mental health had deteriorated, however they were unable to provide evidence of an appropriate assessment of the persons capacity. There was a risk that for some people whose mental capacity had changed or fluctuated, their ability to make their own decisions may not be identified as the service was not checking whether people's ability to make decisions had changed or not. The registered manager went on to tell us that they were not convinced that this person should still be living in their own home due to safety reasons. They told us that if they had concerns about a person they would tell their social worker, we could not see any evidence that this had taken place, nor that any best interest decisions meetings about where the person should live had occurred. This means that the service was not working within the principles of the Mental Capacity Act (MCA) 2005.

Staff were unable to tell us what the MCA was. One staff member told us "I've heard of it but can't say what it is", another said "It's been a while since I've done it, I'd ask the office" and a third said "Sorry, I don't know". The registered manager told us they didn't provide specific training in the MCA but they gave staff a booklet about it. Not all staff could recall being given the booklet.

The provider was not compliant with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with people and relatives, they told us that the staff checked their consent and that people were happy to be supported by them. One person we spoke with told us "They always ask my permission before they help me" and a relative said "The staff always check he's ready to get the support, they talk him through what they're going to do and why".

People, when required, had support to prepare food and drink. They told us that they could choose and were supported according to their choices and preferences. One person told us, "They make me a drink and get my porridge, then they microwave me a meal in the evening". A relative told us "They make her a drink and warm up her food. They try and encourage her to drink". Staff were knowledgeable about people's preferences and dietary requirements and spoke about the need to remind and encourage some people to

eat and drink enough each day. Care plans provided guidance for staff. For example, some people's care plans advised staff to ensure people had sufficient fluids available to them in-between their care visits.

Some people were assisted with household chores, this was recorded on the care logs and ensured people lived in an environment that was suitable to their needs.

People's healthcare needs were met and people, when necessary, were supported to make and attend routine health care appointments to maintain their health. Staff monitored people's health and wellbeing and supported them to access or request referrals to services as and when required. For example, one person had developed a pressure sore and we saw records that the care worker had informed the office, who in turn had made a referral to the district nurse. There was a coordinated approach to people's healthcare. Records showed and people told us that staff supported them according to the recommendations of external healthcare professionals. The registered manager told us that they had a good relationship with social workers and some of the district nurses.

Care staff told us that the communication between themselves and the office staff was sufficient to understand any changes in the service or to the people who used them. One staff member told us "If there are any changes with anyone we get a phone call and it's updated on our app". Another member of staff said, "We are always told about changes, sometimes we get numerous phone calls a day, it can get a bit much sometimes, I think there could be a better system".

Good

Is the service caring?

Our findings

All the people that we spoke with told us they were supported by staff that were kind and caring with the exception of one person. This person said, "I think they don't really care, they are too young". The positive comments included: "They're very caring and light and happy. They're like my family, you do get to know them", "Yes, they are kind and caring, I can't fault them" and "Yes, they are always nice, they are very good at communicating". We saw numerous 'Thank you' cards, one relative had written 'Our hope was mum could stay at home, you helped us achieve this, we wouldn't hesitate to recommend Crescent Care'.

There was mixed feedback from people in relation to the consistency of staff. Most people and their relatives told us that they received support from the same member of staff at each visit and were appreciative of this. One person told us "There's continuity of staff and it's lovely". However, some people told us that they did not always know the staff that supported them. One person told us "I don't have regular carers, I often don't know who is coming or what time". The registered manager was aware of this and told us they were working hard to ensure that this improved by ensuring, as much as possible, that people were allocated staff who were familiar with their needs. One relative told us "The manager listened to us, he's choosy and sends in experienced carers now. The main one who comes is very experienced, she oversees everyone else and makes sure everything gets done as it should be".

Processes were in place to ensure that staff knew people's needs and preferences. Staff told us they knew what support people needed because it was either written on their care plans or on the app that they had on their phones. One staff member told us "It's good to have the app because we can see what people need even before we go into their homes". There was information in people's care plans to ensure that even when staff had not visited a person before, they were made aware of their care requirements.

People received care and support which reflected their diverse needs in relation to the seven protected characteristics of the Equality Act 2010. The characteristics of the Act include age, disability, gender, marital status, race, religion and sexual orientation. For example, staff members told us they observed one person's religious needs by removing their shoes when they visited their home and supported another person to attend church and listen to music associated with their faith. Peoples' preferences and choices regarding these characteristics were appropriately documented in their care plans

Some people were more independent than others, the service accommodated this and planned people's support accordingly. Most people told us that they were supported to be independent. One relative told us "The staff try and get him to do as much for himself as possible". However, another relative said, "No, they don't go into that much, probably because they are there for a limited time". All staff were able to describe how they promoted people's independence. For example, one staff member told us "I try and encourage people to do things for themselves, like washing their own face".

All people and relatives told us that staff protected their privacy and dignity. One person told us "They are respectful of me, they close the door and cover me with a towel when helping me to get washed and dressed". A relative said "Yes, all carers do respect my husband, they protect his dignity when conducting

very personal things". All staff could describe how they were able to protect people's privacy and dignity. For example, one staff member told us "I always close the door and curtains when I'm helping with personal care" and another member of staff said, "I make sure I cover the person with a towel when I'm delivering personal care".

The provider ensured that people had access to the information they needed in a way they could understand and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. For example, the registered manager told us they used braille, large print and read information to people who were visually impaired. We saw that one person had an hour of care per week allocated to them where staff helped with letters and bills because they were registered blind.

Information about people was stored securely in the office. Staff had passwords to access the apps on their phones and information about people was removed after each visit. This meant that information about people was kept confidential.

Requires Improvement

Is the service responsive?

Our findings

Most people told us the service provided was responsive to their needs. One person "It's a very good service, the girls are pleasant. They're on time and reliable", another person said, "I'm very contented, they are good and support me in the way I like" and a third told us "Over the years, they have been on time". Two people and two relatives told us their calls were not always delivered at their preferred time. One person told us "They're supposed to come at 8:15 but sometimes they don't come until 9:30. I've had enough by then, I want to go to bed and I'm waiting and waiting. It gets my wild up". Another said, "The morning is consistent but the evening calls can be as late as an hour". Staff told us they could usually get to people on time but could sometimes be delayed by traffic or needing to fit an unplanned call in. Staff also told us that having no travel time caused difficulties on occasion. One staff member told us "I'm always able to be on time but unfortunately we have no travel time between jobs, so more often than not that will encroach on a client's allocated time. Thankfully many of the people I see are quite happy for me to leave once everything is done anyway" and another staff member said, "I feel that I can get to the people on time and stay the allocated time, although I feel that I can call the office and inform them that I am delayed and if I feel that a certain person may require longer visits then the office will allocate that and ring social services".

Following an assessment of people's needs, care plans had been devised that contained information about people's needs in relation to their physical, mental, emotional and social well-being. This included people who were living with dementia, mental health conditions and physical disabilities. People were also asked to complete a form titled 'About Me'. This included information about the person's current and past interests, previous jobs, preferred routines, things could cause anxiety and how people preferred their personal care to be delivered. Staff told us this form was useful. One staff member told us "It really helps us to get to know the person and how they like things done".

Some care plans were very detailed and provided comprehensive information about people's needs. We saw that one person who had complex health needs had a care plan in place which contained photographs of the way they liked help with moving and positioning and of how to put on their foot splint. Another person needed support carried out in a specific way due to their mental health needs. The care plan contained step by step guidance so staff were able to provide support in the way the person felt most comfortable with. However, other care plans were more basic and largely contained a list of tasks to be completed at each visit. This meant there was limited personalised information to guide staff about how to support these people.

People told us they had confidence that the care staff who visited them regularly knew them and their needs well but care staff who did not visit them regularly did not always know how to meet their needs in their preferred way. For example, a relative told us "Our regular carers are brilliant but some of the others don't know what they should be doing" and another said, "The regular ones know what they're doing, they know him well". Most staff we spoke with told us the care plans usually contained enough information in order for them to care for people in the way they preferred. One member of staff told us "If I need to know anything, I'll look at the care plan, yes, there's enough information on them". However, three members of staff told us it would be useful if care plans contained more information. One staff member told us "sometimes they

(care plans) are quite vague so I'll ask other carers or phone the office for more information". When we discussed this with the registered manager they were unable to explain why care plans differed in quality.

All care plans needed to be detailed and personalised in order for staff to be able to provide support to people in the way they preferred and we recommend the registered persons seeks guidance from a reputable source to ensure this is done appropriately.

Care plan reviews with people and their relatives took place between three and six monthly or sooner if people's needs had changed. People told us they felt involved in planning their care and could also discuss any issues or concerns at this time. Records confirmed that areas discussed at care plan reviews included overall satisfaction, reliability and timekeeping, attitude of staff and changes required. Most comments were positive. For example, one comment stated 'All carers are approachable and like family'. Other people and relatives had made suggestions to improve their care. For example, one relative had requested that care staff always ask whether the person had been to the toilet. If any changes were needed to be made the person's care plan was updated, this ensured care plans were current and up to date guidance was available for staff.

The provider had a complaints procedure. This was provided to people when they started to use the service. People and representatives said they knew how to complain. We looked at the complaint log and saw that no complaints had been recorded. The registered manager told us this was because issues and concerns were addressed at people's reviews or people phoned the office and their concern was resolved at that time. They went on say they asked people if they would like to make it a formal complaint and people said they did not if their concern was resolved. People and relatives confirmed this. For example, one relative told us "Yes, I know how to complain, I've phoned the office with a few niggardly things and also in reviews, they have been sorted out" and another relative said, "I've phoned, I'm not happy with a certain carer, they weren't right for my relative, they try not to send them but have to once in a blue moon". Although individual issues were acted on we did not see that this information had been used to analyse concerns at a service level or identify patterns and trends.

The service supported people at the end of their lives. We looked at the records of a person who was receiving end of life care. The person also had the support from district nurses who were visiting regularly. This person did not have a specific end of life care plan in place, when we discussed this with the registered manager they told us it was because the district nurses led on the care that was needed, records confirmed that the care staff were carrying out instructions from the district nurses which meant the person was receiving care in line with their end of life needs. We saw that there was no information in any care plans about people's end of life wishes. This meant that staff would have been unable to identify how people wished to be cared for at the end of their life. They would also not be aware of their wishes following death. The registered manager explained that when people were approaching the end of their lives, the service contacted people's relatives or other health professionals who would support at this time. Where appropriate, there were Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place. Staff told us that they felt able to care for people at the end of their lives despite receiving no training in this from Crescent Care.

Requires Improvement

Is the service well-led?

Our findings

Systems and processes were not always effective in monitoring and improving the quality of the service. We found that there were no documented audits undertaken at the service. This meant there was no regular audit of medicines, training, accidents and incidents, or care plans. The registered manager said care plans were reviewed when people had their reviews, but this did not include oversight of the overall quality of care plans or daily records in order to identify areas for improvement. When we discussed the lack of quality monitoring systems in the service, the registered manager told us that they used the feedback from reviews to improve care for people. These did not identify the concerns we found in the service. We have reported in other domains the shortfalls we found in care planning, support to staff, adhering to the mental capacity act and medicines management.

A failure to have effective systems and processes in place to monitor the safety and quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the Care Quality Commission (CQC) must notify the CQC about certain changes, events and incidents affecting their service or the people who use it. We use this information to monitor the service and to check how events have been handled. When we reviewed the accidents and incidents documented at the service we found we had not received statutory notifications in relation to safeguarding incidents including allegations of abuse. Each incident had been notified to the local authority safeguarding team as appropriate. We discussed the requirements for reporting with the registered manager and they told us they would review CQC's guidance for registered providers and ensure notifications were made correctly in future.

Failure to make appropriate statutory notifications to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider engaged people and their representatives in the running of the service and invited feedback through the use of questionnaire surveys. This was carried out on an annual basis and we saw the results from October 2017. Feedback was predominantly positive and we saw that people had been complimentary about the service they received.

The service did not extend seeking feedback on the running of the service to staff in a formal way. Staff were not provided with surveys, nor did they attend staff meetings. One member of staff told us "We used to have staff meetings, it was nice for everyone to get together and I found them quite useful, it's a shame we don't have them anymore". Another staff member said, "I suggested to the manager that we should have staff meetings, they happened for a while but then they fizzled out, I think it's because a lot of staff didn't bother to turn up". However, most staff told us that they felt able to make suggestions to the registered manager on a one to one basis and said they had acted on the suggestions made. For example, the app on staff member's phoned was developed following feedback from staff.

The registered manager who was in post was co-director of the agency and worked alongside the other co-

director who also took a very active part in the running of the business. All people and relatives that we spoke to consistently gave positive feedback about the registered manager and the other director. They were described as open, pleasant, approachable and caring. All members of staff with the exception of one also thought the registered manager and director were supportive. One member of staff told us "I feel valued by the management team, they are supportive" and another staff member told us "The manager has helped me both professionally and personally, it really helped".

The registered manager told us that they knew what was happening with the people and staff in the service because they "filtered through reviews and carried out spot checks". This was difficult to evidence as there were no records of this. Some staff told us that the registered manager had not carried out a spot check recently although they used to. Despite the lack of formal systems or records, the registered manager was knowledgeable about people's needs who used the service.

All the staff expressed commitment to the people who used the service. They used comments such as "I love meeting and getting to know the clients", "It's lovely knowing you're helping people to stay in their own homes" and "I've got such lovely clients". Staff were also complimentary of each other. They said, "We're a good team" "We're like a big family" and "The staff team is great, most of the carers are brilliant at their job".

Staff had clear information about their role and responsibilities. However, staff were unable to describe the difference between a senior care assistant and a care assistant. One member of staff told us "Being a senior means nothing" and another said, "There's not a lot of difference". Staff were issued with a Code of Conduct which detailed amongst other things the standards of work expected by the agency.

The provider worked in partnership with other organisations to make sure they were providing appropriate care for people. These included social services and healthcare professionals such as GPs, dentists and occupational therapists. We saw there was a section on reviews where people were asked if the service could support them access any other services. Additionally, the registered manager had organised for the service to work in partnership with the University College of London Research Team which aims to improve the quality of life for people with a dementia living in their own homes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure of the registered persons to make appropriate statutory notifications. Regulation 18 (1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to adhere to the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to fully protect people from the risks associated with the unsafe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to audit the safety and quality of the service provided at the home. Regulation 17 (1) and (2) (a) (f)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

The failure to provide staff with adequate training, supervision or appraisal.
Regulation 18 (2) (a)