Nation Care Agency Ltd

Nation Care Agency

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

About the service
Nation Care Agency is a domiciliary care service providing personal care and support to people living in their own homes. The majority of people receiving support had their care funded by the local authority. At the time of the inspection the service provided support for approximately 85 adults, which included a majority of older people and a few younger adults. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider had made some improvements to how care workers were deployed but care visits were not always carried out at the agreed time. The provider had introduced a new quality assurance system so a range of checks to monitor the quality of the service were carried out, but these were not always appropriate as they did not provide information where issues were identified so these could be addressed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider did not always ensure complaints were appropriately investigated to ensure preventative measures could be identified.

The provider had made improvements to the management of risks, but further actions were required to ensure risk management plans were always developed to provide care workers with guidance on mitigating the risks. We have made a recommendation in relation to the management of risk.

The provider had a procedure for the reporting of incidents, but investigations were not always carried out to identify lessons learned to reduce the risk of reoccurrence. We have made a recommendation in relation to the identification of lessons learned from investigations.

Care plans identified how people wanted their care provided, their communication support needs and their end of life care wishes. Medicines were managed appropriately to ensure people received their medicines safely. The provider had robust recruitment processes and care workers had completed the training identified as mandatory by the provider. Care workers had completed infection control training and had access to personal protective equipment.

People receiving support, relatives and care workers all felt the service was well run. The provider worked in partnership with other organisations. People and relatives told us they felt safe when care was being provided.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 22 January 2022) and there were breaches of regulation. We issued warning notices in relation to safe care and treatment, good governance and staffing requiring the provider to be compliant with the regulations by 28 February 2022. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had made some improvements but still remained in breach of regulations.

This service has been in Special Measures since 22 January 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nation Care Agency on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to need for consent, good governance, receiving and acting on complaints and staff at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
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 always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Nation Care Agency

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors. Following the inspection two Experts by Experience carried out telephone interviews with people who were receiving support and relatives.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 5 July 2022 and ended on 14 July 2022. We visited the location's office on 5 and 6 July 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the registered manager, business and quality assurance manager, operations manager and two care coordinators. We reviewed six people's care plans and the employment records for five care workers. We also looked at multiple medicines records and a range of records relating to the management of the service including audits. Following the inspection two Experts by Experience carried out telephone interviews with 10 people who were receiving support and seven relatives of people who had care visits.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At our last inspection the provider had not ensured care workers were always appropriately deployed to make sure care visits occurred as planned. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a Warning Notice to the provider requiring them to comply with the regulation by 28 February 2022.

The provider had made some improvements, but further action was required to ensure care workers were deployed appropriately so visits happened as planned. Therefore, the provider was still in breach of regulation 18.

• At the inspection in November 2021 we identified that care workers had been scheduled to attend more than one visit at the same time and the care workers did not always have travel time between visits. During this inspection we found the provider had made improvements because visits did not overlap and care workers had at least five minutes travel time between calls. However, we identified that a large number of visits were not happening at the agreed time and were starting over an hour earlier or later than planned.
• The local authority, as part of their contract, had an agreement with providers that visits should start within one hour either side to the agreed start time. We reviewed the records for all visits for 61 care workers which were carried out between 13 June and 19 June 2022 which showed the planned start and end time for each visit with the actual times for the visits. We found 49 care workers had at least one visit which started outside of the one-hour window which was 17% of all visits that week. 21 of these care workers had more than 20% of their visits during the week which were outside the one hour window for the start of the visit.
• We received a range of comments when we asked people receiving support and relatives if the care workers arrived at the planned time for their visit and we received a range of responses. Some people and relatives confirmed care workers arrived on or around the time of the planned visit. We also received feedback from people who received care and relatives which indicated care workers did not always arrive on time and when they contacted the provider to raise the issue there had been no improvement.

The provider had made some improvements, but care workers were still not being deployed appropriately to ensure care visits occurred when planned. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Care workers we contacted confirmed they had enough travel time between visits.
• The provider had a recruitment process in place to ensure they recruited care workers with the appropriate skills and knowledge. We reviewed the employment of records of five care workers who had started working at the service since the last inspection and we saw the records included two references from recent employers, their employment history, checks on the applicant's right to work in the United Kingdom and a criminal record check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a Warning Notice to the provider requiring them to comply with the regulation by 28 February 2022. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

• The provider had made improvements and had introduced a range of risk assessments and risk management plans, but we identified two areas were the provider needed to review their practice.
• The care plan for one person indicated the care worker supported them to undertake activities outside their home once a week which could include visiting the park or going shopping. The person's care plan also indicated they had mobility needs and required support with this. There was no risk management plan for when the person was supported to take part in activities outside of their home. This meant the possible risks had not been assessed and the care workers had not been provided with appropriate guidance on how to reduce any identified risks. We discussed this with the registered manager who confirmed they would develop a risk assessment.
• We reviewed the care plans for three people who had prescribed cream applied by care workers. Emollient creams have been identified by The Medicines and Healthcare products Regulatory Agency (MHRA) that when dried on to fabric, emollient creams can become highly flammable. We found risk assessments for the use of flammable creams had not been completed for these three people. We discussed this with the registered manager at the end of the inspection. Following the inspection, the registered manager sent a copy of a flammable creams risk assessment but during the inspection we found this risk assessment had not been completed for the people whose care plans we reviewed.

We recommend the provider follows good practice on the development of risk management plans.

• The provider had developed a number of risk assessments and risk management plans in relation to people's safety and wellbeing. People had a range of risk management plans which included skin integrity, continence care, communication, falls and moving and handling. The risk management plan identified how the identified risk affected the person and provided what actions the care workers could take to mitigate the risk.
• Each person had a risk assessment completed for their home environment and if they had any pets.
• Information sheets had been developed to provide care workers with additional information of a specific health or wellbeing issue for example cognitive disorders, choking and diabetes in addition to the risk management plan.
• Care workers completed health and safety training.
• Risk assessments were regularly reviewed to identify any changes in the person's identified risks.

• The provider had completed COVID-19 risk management plans for people who received care and for care workers which identified possible factors which could increase risks such as existing medical conditions and ethnic background.

Learning lessons when things go wrong

At our last inspection the provider did not always ensure learning took place with care plans and risk assessments being updated appropriately when things go wrong. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a Warning Notice to the provider requiring them to comply with the regulation by 28 February 2022.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

• The provider had a system for recording incidents and accidents and safeguarding concerns.
• We reviewed the two safeguarding concerns which had been raised with the local authority. The records for one concern included copies of emails from the local authority, minutes from safeguarding meetings with the safeguarding team and a list of actions which were immediately taken. The provider had not undertaken an investigation of the concern by the provider and there was no analysis of the concern.
• This meant the provider could not demonstrate that they had investigated the concern, analysed the cause and identified the actions required to prevent a similar concern. The actions were general for example, sending out a newsletter to care workers about their responsibilities but we also identified there was information about an action which had been taken but there was not information on the decision-making process in relation to the concern.

We recommend the provider follows good practice in relation to the investigation of concerns and the identification of lessons learned.

• During the inspection we reviewed the incident and accident records for four incidents which had occurred since the last inspection. We saw the records included a management review of the incident, a summary of the actions taken, the outcome and any long-term actions to reduce risks. For example we reviewed a record which related to an issue with a person receiving their medicines and the incident record indicated that the care package had been altered so that care worker were now administering the person's medicines to ensure they received them as prescribed.

Using medicines safely
At our last inspection the provider had not ensured people's medicines were always managed appropriately and safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a Warning Notice to the provider requiring them to comply with the regulation by 28 February 2022. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to the management of medicines.

• The provider had made improvements to the management of medicines. The medicine administration records (MAR) were completed included information on the medicine, the dosage, when it should be administered, and the care workers recorded clearly when the medicines had been administered. If a medicine had not been administered the care worker recorded the reason why.
• Where people had been prescribed a cream, we saw there was not always a body map completed to

indicate where the cream should be applied. The prescribed cream was included on the MAR chart and care workers indicated on the MAR when it had been applied.
• When a person had been prescribed a medicine to be administered as and when required (PRN) there was guidance in place for care workers to explain when the medicine should be administered.
• A medicines risk assessment had been completed for each person who either required support from care workers to administer their medicine or if the person was able to manage their own medicines. There was a list of the prescribed medicines and if the person had any prescribed or over the counter creams applied as part of the care plan.

Preventing and controlling infection
• Care workers confirmed they had completed infection control training and they were provided with enough personal protective equipment (PPE) such as gloves, aprons and masks.
• People told us usually the care workers wore PPE but some people stated care workers did not always wear a mask or apron when providing care. A relative told us, "She doesn't always wear an apron, but she's got the mask and gloves. As soon as she comes in, she washes her hands and then she puts the gloves on. Afterwards when she makes the bed for me, then she washes her hands again."

Systems and processes to safeguard people from the risk of abuse
• The provider had a process for reporting and investigating concerns about how care was provided and reported these issues to the local authority safeguarding team.
• People told us they felt safe when they received support in their home. One person said, "I have a lovely carer. She's lovely. I have one at the weekends and she's a very nice lady as well." Relatives also confirmed they felt their family member was safe during their care visits.
• Care workers who responded to us showed they had an understanding of the principles of safeguarding and how this might impact their role. One care worker responded, "To make sure as a carer to protect anyone who I work with from all types of abuse."

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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 when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

At our last inspection the provider had not ensured people's care had been provided in line with the principles of the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Even though some improvements had been made at this inspection further improvement was still required and the provider was still in breach of regulation 11.

• The provider had made improvements to the process to assess a person's ability to make decisions about their care, but the process did not follow the principles of the MCA.
• Where a mental capacity assessment had been carried out to identify if a person could make decisions about aspects of their care, we found these assessment were not care task specific so did not reflect the principles of the MCA.
• We reviewed the care plan for one person and there was a mental capacity assessment which indicated that the person did not have capacity to make decisions but the form stated 'The decision required - MCA required' so was not related to a specific decision based on the aspects of care being provided. We looked at their consent to care and treatment form which stated the person was unable to sign any documents. The form indicated that the person had stated they wanted a named relative to sign documents for them. As the person had been assessed as not having the ability to make decisions about their care it was unclear if they were able to make a decision about a relative signing documents for them.
• In relation to this person we found there was no evidence that the person's relatives had the legal authority through a Lasting Power of Attorney to consent to care on behalf of the person if they lacked capacity to

make decisions. A Lasting Power of Attorney is a legal document that can be issued in relation to either property and financial affairs or health and welfare and legally enables a relative or representative to make decisions in the person's best interests as well as sign documents in areas identified in the LPA. There was a Best Interest Decision recorded but this focused on which relative would be signing documents on the person's behalf and not on what care should be provided in the person's best interest.
• The mental capacity assessment for a second person stated they had a permanent mental impairment but also indicated they could make decisions. There was no information as part of the mental capacity assessment form to explain what the mental impairment was, how this might impact on the person and if there was any support the care workers could provide the person when making decisions. The mental capacity assessment did not relate to decisions about a specific aspect of the care being provided so the assessment did not reflect the principles of the MCA.
• The care plan for another person indicated that care workers should administer their medicines but ensure the person could not access the box where they were stored. Also care workers had to check to make sure the person had not turned off kitchen appliances with both directions linked to the person's memory issues. A mental capacity assessment had been completed in January 2022, which was not care activity specific, which indicated the person had capacity but there was no information relating to the guidance given to care workers to restrict access to their medicines and carry out the other checks.

The provider's processes in relation to assessing a person's capacity to make decisions about their care did not always follow the principles of the MCA. This was a continued breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had not ensured care workers always received appropriate training and support to meet people's specific care needs. This was a breach of regulation 18 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a Warning Notice to the provider requiring them to comply with the regulation by 28 February 2022. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 in relation to staff training and support.

• Care workers had now completed a number of training courses the provider had identified as mandatory for their role. The training records we reviewed showed that care workers had completed training courses which included basic life support, handling information, health and safety and awareness of mental health, dementia and learning disability. The training records showed when the care worker had completed the training course and when they had to next complete their refresher training.
• The training records indicated care workers had completed the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
• People receiving support told us they felt the care workers had the appropriate training to meet their care needs. Their comments included, "Absolutely. I've never had any problems with them at all" and, "Yes the ones who have been there a while, sometimes a new lady comes she is very nice and does her best but is still learning." Relatives also confirmed the felt care workers had appropriate training with one relative telling us, "Yes from what I see they know how to manage [family member] in the bathroom and the current carer, [my family member] is so fond of her, she comes in and starts singing, gets them up and she is very patient with them."
• We reviewed the supervision records for eight care workers, and we saw there were regular one to one and

group supervision meetings with senior staff. Regular spot checks were also carried out and the observations of the care workers practice were recorded.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to access meals and drinks they enjoyed and that their nutritional needs were met.
• People we spoke with confirmed that the care worker helped them by preparing or heating up a meal of their choice. They told us, "I have them pre-prepared in the fridge, they heat them up for them, they look to see what is available. I drink a lot of water", "They do my meals for me because I'm not very good on my legs. The carers ask me what I want and they show me what I've got in the fridge" and "Yes I get a choice of what I'm having during the week, during the weekends I just get a sandwich because it's a different carer." Relatives also confirmed care workers helped their family members with meals and supported them to choose what they wanted to eat and drink.
• People's care plans indicated if they required support with accessing food and drink and/or encouragement to eat during meals. The care plan also identified people's preferences in relation to what they wanted to eat and drink.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare and other professionals when required.
• People we spoke with explained that if they required this kind of support the care workers have helped them. One person told us, "Yes they pick up my medication and have offered to call the ambulance and do ring the doctors. I had an issue with my medication, and they were constantly on the phone to the pharmacy to get the medicines sorted out."
• Relatives confirmed that, where they were responsible to contact the GP, the care workers had informed them if their family member required input from a medical professional.
• Care plans included the contact details of the person's GP, other professionals involved in their care and which pharmacy dispensed their medicines.
• People's care plans included information on how care workers could support the person with their oral care and identified if they needed help to clean their teeth or dentures.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• An assessment of people's support needs, wellbeing and wishes in relation to their care was carried out before their care package started. People's care plans and risk assessments were regularly reviewed, and people were involved in this process.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People's care was provided with care and kindness. People we spoke with were, in general, happy with the care they received with one person commenting, "Yes I am so lucky, I was really worried, but my two regular carers are brilliant and the office are all so nice too", and "With the present care, I'm happy."
• One person explained that their care workers had a good understanding of how to support them when they were having a bad day and they knew to contact the person's relatives to provide extra support .
• Some relatives also explained that the care workers were like friends or family members with comments including "She's not just a care worker. They have a good chat and that's what my [family member] needs", "I can hear some of the banter going on. I can hear the lady just try to jolly [my family member] along. They do their best to cheer them up" and "On our birthdays the care worker brings us in a birthday cake. She brings a paper in for my [family member] because they like to read. She brings us Christmas presents. We're really good friends."
• Care plans included information on the person's religious and cultural preferences. We saw there was information on LGBTQ+ related legislation and other guidance included in the care plan folder.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to make decisions about their care and were involved in the development and review of their care plan. People's comments included "I have a care plan and had been involved in writing it" and "She asks permission all the time. She always says is there anything else you want me to do." One person explained they had a care plan, their relative were involved in discussions about it and that they had been asked questions about their care and support.

Respecting and promoting people's privacy, dignity and independence
• People had their dignity and privacy respected. People confirmed care workers treated them with dignity and respect when they were providing care. Their comments included, "Yes, in the main" and "They certainly do. If I want anything done they'll ask me." Relatives also confirmed they felt care workers provided care with dignity and respect. One relative explained that when the care worker supported their family member with personal care the care worker made sure they were covered up and their dignity was maintained throughout.
• Care workers completed training on supporting a person's privacy and dignity. Care workers who provided feedback demonstrated a good understanding of the importance of maintaining a person's privacy and dignity during care.
• People felt that care workers supported them to be more independent with one person saying, "Yes I can

do more now and they help me". Relatives confirmed they felt their family member was being encouraged to be more independent with their comments including, "They give [my family member] a hand in washing and changing. They do try to encourage [my family member] to walk to the toilet instead of using a commode. It would be easier for them to do that" and "My family member is not steady on their feet so the carers put the dirty dishes in the sink so that my family member can wash them up as they are capable of doing that."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

At our last inspection the provider had not responded to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 16.

• The provider had made some improvements to the way complaints were managed and responded to, but we found there was still further action required to ensure the outcome of investigations and the actions to prevent a reoccurrence were always identified and recorded.
• We reviewed the records for five complaints which were directly received by the provider and four complaints which had been received by the local authority and passed to the provider.
• We looked at one complaint, which had been received directly by the provider, which related to the care worker arriving late for a visit which resulted in a person not being supported to go to an appointment. The complaint records stated the reason the visit did not occur was due to the weather but the records did not take into account that the care worker was late and the reason for the visit was to support the person to attend an appointment and identify if there was any impact on the person. We saw a supervision record of the care worker which occurred after the complaint and it was not discussed with the care worker.
• A complaint, that had been received from the local authority, indicate that a person had raised concerns with how a care worker was providing care. The response to the local authority which included the action taken once the complaint was received focused on the changes made by the person to their care package and not the specific concerns the person had.
• Therefore, the provider did not always consider the issue of the complaint as part of their investigation which meant the investigation was not always effective at identifying preventative measures.

The provider did not ensure complaints were appropriately investigated to ensure preventative measures could be identified. This was a continued breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People we spoke with told us they knew how to raise a complaint and we received a range of comments related to their experiences. Most people confirmed they would ring the office, but they had not had any reason to raise a concern. Two people told us they had contacted the provider's office, but no action was taken.
• Relatives we spoke with also confirmed they had both positive and negative experiences when raising

concerns with the provider. Relatives commented, "When we do have a word with them on different occasions. It's OK for a little while and then it reoccurs again", "Yes, we ring the office, we have only made a complaint once when no one turned up, but someone came straight away.

Meeting people's communication needs; End of life care and support; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

At our last inspection the provider had not always ensured people's care plans reflected their support needs and wishes. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• People's care plans provided information on how they wanted their care provided. The provider had made improvements to the information provided in people's care plans to enable care workers to understand what care a person required and how the support should be given. There was a document which identified the specific support to be carried out during each care visit. This included descriptions of care tasks for each visit with personal preferences such as which shower gel the person preferred, where they wanted their personal care provided, when they wanted their hair washed. This meant care workers were provided with additional information to ensure the care they provided could met the person's specific wishes.
• The provider had made improvements in relation to identifying and ensuring people's communication needs were met. People's care plans identified if the person had any hearing or sight impairments and if they used any aids such as glasses or hearing aids to support them.
• People's care plans also identified their preferred language and we saw one person's care plan had been translated into Arabic. The registered manager explained that important documents could be translated into the person's preferred language if requested.
• Another person's care plan stated they used British Sign Language (BSL) and lip reading to communicate and care workers should use see through face masks to enable them to lip read and use BSL or gestures when supporting the person. The registered manager confirmed the care workers who supported this person were provided with face masks with a see through panel. The person's care plan also included a communication sheet which had pictures of the various meal options
• People's wishes relating to what care they wanted if their health was to deteriorate were now discussed with them during the initial assessment. Care plans indicated it people's end of life care wishes had been discussed with the person and/or their relatives. The care plans we reviewed indicated when the person was asked about their wishes, they did not want to discuss them at that time.
• The registered manager confirmed that at the time of the inspection they were not providing any care packages with included end of life care support.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were supported to maintain relationships with family and friends. The care plans included a section on social interests, activities, likes and dislikes which identified what the person was interested in. It was also

identified if the person had any pets. One person's care plan indicated that one visit per week was specifically the care worker should support them to go out and do activities in the community.
• Care plans identified family members and friends who were involved in the person's life and were important to them.

Requires Improvement

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.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider did not have effective and robust quality assurance processes to monitor, assess and improve the quality of services people received. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a Warning Notice to the provider requiring them to comply with the regulation by 28 February 2022. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider had made some improvements in relation to their quality assurance processes, but they were still not robust enough to provide information on where improvements were needed.
• The daily records of the care provided, which were completed by care workers on an electronic system, were audited monthly. We reviewed audits that had been completed for April and May 2022. The audits for the May 2022 included the same issues that were identified in the April 2022. The action identified in the April 2022 audits was that a telephone supervision would be organised with care workers, but records showed this did not occur until June 2022. The group supervision records showed that care workers had been informed what needed to be improve and they had apologised and agreed to ensure the records were correct but the reason for these errors was not identified so preventative measures could be taken.
• The audit forms for the daily record of care included questions related to information which was automatically added to the daily record by the system for example the person's name and the date. One question related to the care workers writing being legible but the information from care workers was typed onto the system using mobile devices. This meant the questions asked were not appropriate to enable the provider to identify were issues had occurred. There was also standard text used in all the audits we reviewed for a question relating to if all the care tasks were completed so the audit was not specific to the person's care.
• The registered manager explained the electronic call monitoring system was monitored and if they identified that a care worker had arrived at a visit either one hour earlier or later than agreed on at least one occasion, they carried out a supervision meeting with the care worker to discuss the reason. In May 2022, 19 care workers had at least one visit that started outside the accepted one-hour window. We reviewed the

records of supervision meetings held with five care workers in relation to the May 2022 visits and we saw that the supervisions did not always identify actions which could prevent visits not occurring on time. For example, three care workers had identified that they were dependant on public transport to travel between visits and this was the reason why the visits were delayed. The outcome of these supervision meetings was that the care workers should become more aware of the bus timetables but did not investigate if there were any other action that could be taken which could include checking to ensure there was enough travel time allocated between the visits. We reviewed the list of care workers with late visits in June 2022 and of the 44 care workers identified 18 had also been identified in the May 2022 list. Therefore, the visit time monitoring process implemented by the provider did not enable them to identify and resolve the issues behind visits which were carried out more than an hour earlier or later than agreed.
• The provider had made some improvements in relation to the management of risk and where lessons could be learned following incidents but the processes to monitor these improvements were not robust enough to ensure the provider could identify where further action was required and where their processes were not being followed.

The provider did not have effective and robust quality assurance processes to monitor, assess and improve the quality of services people received. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider carried out monthly audits of the MAR charts and how the medicines were administered.
• The registered manager explained there was communication with care workers through supervision meeting, a quarterly newsletter and team meetings based on postcode area.
• The senior staff in the organisation had clear roles and were aware of their responsibilities within the service.
• Care workers told us they felt supported by their manager with comments including "Yes they always listen to me and are available to talk", "Yes the office staff are organised and keep in contact with me. They are motivating and encouraging", and "Yes, I do. I have a very supportive manager and I know her for a very long time." Care workers also commented that they felt the service was well led. Their comments included, "Yes, the management is always involved. My care coordinator is also responsible and listens to me" and "Yes, I feel that there is a strong leadership."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager demonstrated a good understanding of duty of candour, they told us, "It is important to be honest and transparent when something happens, put your hands up to what has happened. Let professionals know what has happened. This is key to learning from issues."
• The provider had a number of policies and procedures which were regularly reviewed to ensure they reflected any changes in good practice or legislation.
• People we spoke with confirmed that if they had a question about their care, they would contact the office and they had been given the contact telephone number. Relative we spoke with also confirmed they felt confident to contact the office if they had a question with comments which included "I always speak to the coordinator, but if she can't answer my query she puts me on to the manager" and "Yes we would ring the office, we asked for an extra visit, and they have responded so quickly."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The registered manager explained that they would not accept a care package if they were unable to meet the persons specific cultural needs. For example, if a person required a care worker who spoke Punjabi, they

would not accept the care package if they were unable to allocate a care worker who met their specific communication need. The registered manager told us they were actively recruiting care workers from a wide range of backgrounds to meet more people's cultural and language requirements.
• People and their representatives were supported to be involved in the development and review of the care plans.
• The registered manager explained they had regular communication with people they were supporting through care plan reviews, spot checks, an annual survey and they were planning to send out a newsletter twice a year.
• People told us they felt the care service was well led and they were happy with how their care was provided. One person said, "Yes, they are a very good company." Relatives also confirmed they felt the service was well led and that the care provided was good. Commented included, "There's a carer my [family member] been having for quite a while now. She's absolutely the best ever. She's an amazing lady. I can just hear the laughter she brings to my [family member], the connection's just brilliant. She can't do enough for my [family member]" and "[My family member] has had the same two ladies for the past couple of years. They are always happy to see the two ladies. I think it's at the point now where [family member] sees them as personal friends as opposed to carers."
• Most people we spoke with said care workers complete all the tasks they are supposed to do during each visit. However, one person suggested that their care workers did not always understand what they are asking and consequently some tasks are not carried out. Comments included, "Sometimes you have to tell them. Sometimes they understand sometimes they don't understand. What do I do if they don't understand? Sometimes things don't get done" and "Yes they do, they help me wash and do my breakfast and they clear up too."
• Most relatives confirmed that care workers did all the identified tasks during a visit but one relative commented it does vary with care workers. The comments included "Yes this carer does, we have carers who didn't. Some don't clean [family member's] bathroom once they have used it. The current carer genuinely cares" and "Yes wash and apply cream for [family member] and put clean clothes on."
• Care workers confirmed they regularly reviewed the care plans for people they supported but as they visited the same people they had a good understanding of their support needs. Their comments included, "As often as possible. I have regular clients, the office notify me when there is changes and then I read the new care plan" and "When I have new clients I read the support plan and risk assessment in detail. My regular clients I understand the tasks very well."

Working in partnership with others
• The provider worked in partnership with a range of organisations. The registered manager explained they worked with the local authority, healthcare professional, social workers based at the local authority and hospital and other local voluntary organisations.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 as they did not ensure care was always provided in line with the principles of the Act. Regulation 11 (3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective complaints process to ensure complaints by service users and others were appropriately managed. Regulation 16 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity The registered person did not have appropriate checks in place to assess, monitor and mitigate the risks relating health, safety and welfare of services. Regulation 17 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient suitably qualified, competent, skilled and experienced staff were deployed to meet people's support needs. Regulation 18 (1)(2)