Red Brick Care Ltd

Citibase Slough

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

Summary of findings

Overall summary

About the service
Citibase Slough is a service providing care and support to people in their own homes. At the time of the inspection the service supported 12 people, and we were told everyone received support with personal care. The service provided both regular daily visits to people receiving personal care and at times provided live-in staff members providing a 24-hour support service. The service supported people in Surrey and Berkshire.

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
People were supported by a service that was not well managed or monitored. The registered manager lacked sufficient knowledge of regulatory requirements, and audits were either not in place, or not effective to assess, monitor and drive improvement in the quality and safety of people's support. The service had failed to inform the Commission of incidents and information they are required to, and we also recommend the provider develop their knowledge and approach in relation to the duty of candour, to ensure applicable incidents are identified and an appropriate response made.

Relatives described raising concerns and complaints to the registered manager regarding people's experiences of care. Some people and relatives felt the registered manager was approachable and comments included, "We believe we have a good relationship with [registered manager's name]" and "If I did have any concerns I would contact the office." Some relatives felt issues remained unresolved or had worsened, with one relative advising, "I have phoned to speak about our concerns and the carers have been even worse… They don't have enough staff as even the office staff cover duties. We are never told when the carers are running late which is awful."

We found risks to people using the service were not clearly identified and managed. We also identified concerns in relation to the safe management of medicines, concerns regarding staff testing for COVID-19 and a lack of oversight in relation to accidents and incidents. We recommend the service improve their organisation and record keeping in relation to staff COVID-19 testing. Some people told us they felt safe, but there was mixed feedback in relation to safe administration of medicines. Comments from relatives included, "They generally provide great care…There has not been an issue with medication" and "We have had to take back control for medication as wrong doses were being given."

The service identified required learning for staff, however at the time of our inspection staff had not received training in subjects such as dementia, end of life care, and equality, diversity and human rights. We recommend the service seek advice from a reputable source in relation to staff training and ensure staff have access to regular supervision. The service assessed people's needs, and carried out reviews of people's care and support plans, although we found reviews were not always documented to evidence whether people and their families had been involved in reviews to make decisions about their care.

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.

Support was not always caring and person-centred. Some people and families provided positive feedback regarding their care, with comments including, "I am getting excellent care" and "The carers are all very, very good with my relative, there is one male carer who is very good and my relative enjoys his company." A number of people expressed concerns regarding the impact of staff rushing to finish visits and not staying the agreed visit length. One relative commented, "Not all carers want to be here and rush in and out." A person using the service added, "People have different attitudes, some will always be in a rush. They all treat me with respect and are caring and that is what I want and need." We recommend the service develop their approach, to ensure people are consistently treated with dignity, respect and kindness.

Some people required support from healthcare professionals and the service liaised with families or made referrals to access support. The service also worked with local authorities and feedback from professionals generally indicated the service worked well in partnership with other organisations.

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

Rating at last inspection
This service was registered with us on 28 August 2019 and this is the first inspection.

Why we inspected
This was a planned inspection following the service's registration with CQC.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Following our inspection visit the provider took some actions to mitigate risk, including reviewing medicines practices and submitting retrospective notifications of incidents to CQC.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, recruitment practices, good governance, complaints, assessing people's mental capacity to consent to care, and in informing the Commission of incidents and information they are required to.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Citibase Slough

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 Care Act 2014.

Inspection team
The inspection was carried out by one inspector, one assistant inspector and one Expert by Experience.

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.

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

Notice of inspection
We gave the service 48 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 21 July 2021 and ended on 2 August 2021. We visited the office location on 21 July 2021 and 22 July 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We reviewed information we had received about the service since it was registered with the Care Quality Commission on 28 August 2019. We also sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with one people using the service and nine family members. We also spoke with five members of staff, including the registered manager who also acted as the nominated individual, one team leader and three care assistants. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included nine people's care and support plans, as well as people's medicines records where they received support with this task. We looked at five staff files in relation to recruitment, training and supervision. We reviewed a variety of records relating to management of the service including policies and procedures, quality assurance surveys, staff meeting records and evidence of auditing.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We sought feedback from professionals and received a response from three professionals during the inspection process.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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.

Assessing risk, safety monitoring and management

- The provider did not do all that was reasonably practical to mitigate risks. This was because some risk assessments were either not present or lacked sufficient detail to help staff understand and respond to risks. One person using the service had a diagnosis of asthma. The registered manager advised the person was supported to use three inhalers daily to manage their breathing, any medical concerns were reported to the person's relative who liaised with the GP, and the person was left at a 45 degree angle in their bed or chair. This information was not included within the person's care plan or a risk assessment. This meant staff did not have access to information within the care plan to understand how risks associated with asthma were mitigated.
- People were not protected from risks associated with anticoagulant medicines. Two people using the service were prescribed anticoagulant blood thinning medicines Apixaban and Rivaroxaban. The registered manager confirmed they were not aware these were anticoagulant medicines. This meant the medicines were not identified in people's records as an anticoagulant, and no risk assessment was in place to inform staff of the risks associated with this medicine. Staff we spoke with had varying levels of awareness in relation to the risks associated with blood thinning medicines.
- Some people using the service had bed rails in place. One person's risk assessment identified a risk of falls and stated bed rails must be raised at all times. The risk assessment did not consider other potential risks associated with use of bed rails, such as risk of limb damage from entanglement with bed rails.
- One person using the service sometimes experienced distressed behaviours when supported by staff, and had responded to staff physically, such as by kicking and punching. The risk assessment relating to the person's behaviours lacked detail, and advised staff to remove themselves from the environment, to contact the office and leave the person for a few minutes to calm down before trying again. Conversations with staff identified known specific triggers for the person's distress, however the risk assessment did not include sufficient detail about these triggers or preventative strategies.

We found no evidence people had been harmed, however systems were not robust enough to demonstrate risks were effectively identified and managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risks to staff safety were considered. Risk assessments considered the environment staff would be visiting, including food preparation areas, presence of pets, infection control, exposure to smoke and any concerns about uneven flooring or carpeting.

● Risks to people's oral hygiene were routinely assessed. Each person's care plan contained a personalised oral hygiene plan, identifying any concerns in relation to oral care, and outlining the type and frequency of assistance required to promote good oral health.
● People at risk of falls and people unable to mobilise were protected from risks of harm. Care plans contained detailed information about people's level of mobility and assistance required, including the use of equipment aids. We viewed the records for one person who was unable to walk and experienced pain and spasms in their leg. The care plan described in detail how staff should support the person with personal care and transfers using a hoist, to minimise pain or discomfort to them.

Using medicines safely
● People were not routinely supported with their prescribed medicines in a safe manner. Recording systems did not evidence safe medicines administration had taken place. We reviewed paper copies of medication administration records (MARs) held at the office location and found several gaps. One person was prescribed a short six tablet course of an antibiotic in February 2021 but only three signatures were found on MAR records. Another person required a cream to be applied to their legs and feet every morning. During the month of June 2021 the MAR chart showed only two dates had been signed. The registered manager advised gaps had been identified and ascertained to be missed signatures, not missed doses, however the registered manager had not documented actions taken and therefore we could not evidence whether they had taken action to investigate the MAR discrepancies.
● People who received pain relief medicines were not consistently supported safely. One person was prescribed paracetamol which required a minimum gap of four hours between doses. Daily records showed multiple occasions where the timing of visits indicated staff had administered doses within four hours. Staff rotas also showed scheduled visit times would not accommodate a four hour gap. The rota we reviewed for the dates 26 June 2021 to 24 July 2021 showed morning visits scheduled at 9.15am and lunch visits scheduled for 12.00pm. Due to potential risks of harm, we advised the registered manager to raise a safeguarding alert to the local authority.
● One person using the service was prescribed a transdermal patch. Patches are thin pads with an adhesive back that are applied to the skin, and medicine from the patch is absorbed into the body over a period of time. MAR records and daily staff notes did not identify where each patch had been administered. This was not in line with documentation best practice guidance. Staff should record the application of each patch and include the specific location, and also document when the old patch has been removed in a similar way to documenting when the patch is applied.
● People's medicines were not consistently administered following safe medicines best practice. During the inspection we identified three people where staff administered or left people with medicines which had been prepared by family members. Staff had not witnessed family members preparing medicines from original packaging, medicine compliance aids or liquid medicines, including a liquid controlled drug Oramorph. For one person staff administered medicines from a pot which was prepared by a family member whilst staff supported the person with personal care. When staff were asked whether they checked if the family member had selected the correct medicine, one staff advised, "not really" and another staff member explained they were very familiar with the person's medication, and could identify the tablets from their appearance.
● Another person was left with a pot of medicine and syringe a family member had prepared. The relative raised concern their family member had been left restless and in pain when staff had given the morning medicines pot in the evening. It was agreed only one pot of medicines would be left for staff to provide, and the registered manager was unable to confirm if medicines errors had occurred, advising, "I didn't witness or carers didn't witness what was put in the pot." This was unsafe medicines practice as staff could not verify what tablets they were leaving with the individual.

Systems were not established to promote safe medicines practice. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager agreed to follow up the concerns identified and advised staff rotas had been changed to ensure paracetamol was given at four hourly intervals. The registered manager also agreed to review recording for the administration of transdermal patches, and to review arrangements where family members were preparing medicines for staff to administer.

● People's care plans identified the level of support required with medicines and identified who was responsible for the ordering and collection of repeat prescriptions. A medicines risk assessment also considered whether a safe storage location was required for medicines, away from any children or pets at the property.

Staffing and recruitment

● People were not consistently supported by staff who had been safely recruited. The service's policy in relation to Disclosure and Barring Service (DBS) checks stated an existing, enhanced DBS certificate, completed within the previous three years, may be an acceptable short term option, however a risk assessment was required to confirm the certificate provided a suitable level of assurance. We viewed the records for three staff who started work prior to receipt of a new DBS. Written risk assessments were not in place, and staff files did not evidence a previous DBS certificate had been viewed. The registered manager advised previous DBS certificates were seen, and obtained copies of these certificates which were supplied after the inspection visit.

● Records relating to staff recruitment did not evidence that people's health had been explored, to consider if reasonable adjustments were needed to enable them to work safely. The registered manager advised this topic was discussed at interview, however the registered manager did not keep a record of people's responses to interview questions, and instead a tick sheet was used to assess the person's suitability for the role. The interview template supplied did not include a question about people's health and fitness for the role.

● Gaps in employment were not explored, reasons for leaving previous jobs were often omitted from applications, and the service did not ensure they had received a full work history since the job candidate had left education.

● The service's reference policy stated staff must provide two references, one of which must be their most recent employer. Staff files did not provide evidence of risk assessment where the service had been unable to obtain two references in line with the policy. One staff member had one reference on file. This was not the person's most recent employer, and the dates given on the reference did not match the dates provided on the job application form. This discrepancy had not been identified by the registered manager and no risk assessment was in place.

Systems were not in place for the safe recruitment of staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff confirmed interviews had taken place prior to receiving an offer of employment. A structured induction programme was in place, including mandatory training, and the competency of staff was assessed in relation to supporting people with personal care, safe medicines practice and moving and handling, including the use of equipment to assist people.

Preventing and controlling infection

● We were not assured the service had monitored staff testing for COVID-19. Feedback from staff indicated

the service was not following the Government recommendation for home care workers to undertake a weekly PCR test, which are sent via post to check for signs of COVID-19 infection. At the time of our inspection the registered manager confirmed the service had run out of PCR test kits and stated an order would be placed. Staff indicated they had access, and were regularly completing LFD home COVID-19 test kits, but most staff feedback suggested PCR tests were not conducted weekly. Comments from staff about PCR tests included, "[I] try to do after two weeks roughly", "I do those occasionally even though we haven't had any coming through as late" and "[I] sometimes do that. Once a month."

We recommend the service improve their organisation and record keeping in relation to staff testing for COVID-19 infection, to support the prevention and control of infection.

The registered manager agreed to order a new supply of PCR COVID-19 test kits.

● The registered manager had undertaken additional training in relation to infection control. This enabled the registered manager to train staff in the correct donning and doffing procedures for personal protective equipment (PPE). We were advised the registered manager had conducted this training and observed staff donning and doffing PPE in the community. The registered manager had not recorded the dates training was undertaken with individual staff, and therefore we could not evidence when this had taken place. Infection control was also included as a mandatory training course for all new staff as part of induction.
● People were supported by staff who wore appropriate PPE. Staff told us they access to sufficient supplies of PPE and feedback from people using the service confirmed staff used PPE correctly. A person commented, "All carers have always worn full PPE-mask, gloves and apron, I have never had to challenge them on this." A relative added, "They kept to a small regular team through COVID-19 which was reassuring for us. They all still wear full PPE which pleases me."
● The service's infection control policy had been updated in response to COVID-19 and included detailed information in relation to handwashing, use of PPE, disposal of waste procedures and safe handling of soiled linen.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives generally told us they felt safe. One person commented, "I would give them a certificate of merit I feel that safe and well looked after."
● Staff received yearly safeguarding training and understood their responsibility to raise safeguarding concerns internally and externally with the appropriate agencies. A member of staff commented, "I would know to call Police if a crime was committed, if safeguarding needs investigation and no crime I would forward to [registered manager's name], and they would action going forward."
● We reviewed safeguarding records held by the service in relation to two concerns recorded during 2021. We found only one of the two records contained information about actions the service would take to reduce the risk of reoccurrence. The registered manager provided verbal feedback to explain how concerns relating to missed visits and inaccurate visit recording would be addressed through the introduction of an electronic monitoring system. A safeguarding report advised the electronic system would be in place by 15 May 2021, however at the time of our inspection this was not in place. The registered manager told us staff rotas were currently double-checked to avoid errors.

Learning lessons when things go wrong
● Staff understood their responsibility to report incidents of concern. A staff member described how they would respond to an accident such as a fall, commenting, "First of all I would call ambulance, would then immediately call the office to say someone had fallen."
● The service kept written records in relation to safeguarding concerns, compliments and complaints. Whilst

some individual incidents, such as complaints, showed evidence of learning, no formal auditing or quality assurance process was in place to formally consider wider themes or trends.

● The registered manager recalled one incident/accident form had been completed since the start of the service, although this was not easily accessible at the time of our visit. For one individual three incidents of distressed behaviours were logged onto behaviour recording charts, known as Antecedents, Behaviour and Consequences (ABC) charts. Daily records showed events which had not been logged as incidents/accidents, including behaviours of distress and a person who was suspected of choking on saliva and coughed continuously for 15-20 minutes. The service had not followed the provider's policy which required incidents to be recorded on the relevant incident/accident form. Formal audits did not take place in relation to incidents/accidents and in the absence of completed forms, we could not evidence how the service was identifying learning, themes or trends.

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.

This is the first inspection for this newly registered service. This key question has been rated 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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.

- Best interests documentation was not in line with the MCA. People's care plans contained a document entitled "Personalised Best Interest / Adult with Incapacity Plan". The document identified three "areas" of mental capacity including whether the person had dementia, whether the person had short or long term memory issues and if they ever required others to make best interests decisions on their behalf. The document stated answering yes to any question would require a plan for best interests, to consider what types of decisions need to be made and when and how staff should go about this. The assessment tool was not in line with the principles or best interests assessment framework of the MCA.
- Some people's care assessments enclosed an MCA form. The first question of the form asked "Is the service user designated and lacking mental capacity under the MCA 2005?". A further question asked, "If yes, summary of reasons for designation." For one person living with dementia, this question had been answered "[Person's name] has been diagnosed with onset dementia". This decision was not in line with the principles of MCA, which states any assessment should start with a presumption of capacity. MCA assessments were not decision specific and there was no evidence or rationale as to how decisions about mental capacity had been reached.
- One person using the service was living with dementia and was resistant to support from staff, at times showing distressed behaviours. This person's care plan contained a plan for best interests, however care

assessment paperwork did not include an MCA assessment. The registered manager confirmed an MCA assessment wasn't recorded, but stated the person presented as having episodes of confusion and found it "a bit of a challenge" to answer questions at the assessment. The decision to commence care should not have been made without the completion of a formal MCA assessment, to consider if the person could consent to care.

● People's care plans did not consistently evidence whether a DNACPR was in place. DNACPR stands for do not attempt cardiopulmonary resuscitation and a DNACPR form is used where a decision has been reached that if the person's heart or breathing stop, cardiopulmonary resuscitation (CPR) should not be tried. For three individuals information about whether they had a DNACPR was left blank in their care plans. The registered manager confirmed following the inspection these people did not have DNACPR in place, however the absence of this information could lead to uncertainty for staff or paramedics should an emergency occur.

● The registered manager did not understand their responsibility to seek verification where a relative had identified themselves as holding a Lasting Power of Attorney (LPOA). When asked during the inspection whether the registered manager would ask to see a copy of a LPOA document, they advised, "Previously no, now you mentioned think important to see a copy, to be on the safe side." This meant relatives were identified in people's care records as having responsibility for key decisions without evidence they had legal authority to act on the person's behalf.

Effective systems were not in place to ensure the service operated in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback and agreed to develop their approach. The registered manager planned to review and update mental capacity assessment templates in use.

Staff support: induction, training, skills and experience

● The service identified core training to equip staff with the knowledge and skills needed to deliver effective care. Records showed all staff had completed some areas of training including safeguarding, infection control, food hygiene, fire safety and moving and handling. An induction course was sourced from an external training provider and the service also employed a team leader who attended a train the trainer course, enabling them to provide practical training, such as the demonstration of hoist equipment. This person's certificate was not included within their staff file and we asked the registered manager to obtain a copy. This identified the staff member's certification had recently expired.

● People living with dementia were not routinely supported by staff who had received formal dementia training. At the time of our inspection, the staff team had not undertaken dementia training during their employment at the service. The registered manager explained staff were supported informally when they asked questions about dementia, and diagnoses were included within people's care plans. Conversations with staff demonstrated varying levels of awareness in relation to dementia, with one staff member only referring to "challenging behaviour" when asked about their previous experience of dementia awareness training. Another staff member demonstrated better knowledge, describing the importance of encouragement and giving someone living with dementia enough time to express themselves.

● Training records showed staff had not received some training the service had identified as required learning. Topics included supporting people's behaviours, end of life care and dysphagia, which means difficulty swallowing. Records also showed three staff had not undertaken tissue viability training, which relates to the vulnerability of people's skin and how to prevent skin breakdown. The inspection also identified training in relation to equality, diversity and human rights was not identified as a training requirement for staff.

● The service required staff to receive supervision and a spot check of their competency four times per year. At the time of our inspection spot checks and supervision meetings were overdue for some staff. For example, one staff member employed in July 2020 had received only two spot checks, with the last check completed in January 2021. We also observed only one supervision record on file, dated January 2021. Other staff members, such as the service's team leader, showed a greater number of supervisions had been completed, however this was variable, with one staff member's last supervision held in December 2021, and we found another staff member who started employment in March 2021 had no spot checks or supervision records on file.

We recommend the service seek advice from a reputable source to review arrangements for staff training. We recommend the service ensure staff have access to regular supervision in line with the provider's policy.

The registered manager responded to our feedback and booked staff training in relation to dementia and equality and diversity. The service's team leader and registered manager also booked to attend train the trainer courses in relation to first aid, safe handling and administration of medicines and moving and handling.

● The registered manager and team leader engaged with external organisations during the pandemic, to access opportunities for learning. Learning opportunities had included a course in leadership, safeguarding children and multi-agency risk assessment processes. Managers had attended a course to help care workers monitor people's health and recognise signs of deterioration in a person's wellbeing. This training was undertaken in July 2020 however the registered manager confirmed learning had not yet been shared with the staff team, advising they planned to develop and deliver a learning event.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to the delivery of care. An initial assessment explored people's physical, medical and mental wellbeing needs, also identifying any areas of risk. The assessment explored the person's background, things which were important to them, and what support was already provided by existing support networks such as close family.
● People's care records indicated regular reviews took place to either fully or partially review care plans. Records did not always identify whether the person, or any representative or advocate had been involved in reviews. One person's care plan showed five reviews between February 2020 and December 2020. Records showed one entry from September 2020 with discussion which took place at a review. The registered manager confirmed people and representatives were involved in reviews, however documentation was not always made of these meetings or telephone calls.
● The service explored the use of technology to enable care to be delivered safely. This included liaison with occupational therapy to ensure the equipment in place was suitable to enable people to transfer safely. This also helped promote people's independence when people were keen to transfer from their beds but required suitable equipment.

Supporting people to eat and drink enough to maintain a balanced diet
● People's care plans contained information about the level of support required with nutrition and hydration. We observed some people received family support and did not require assistance from staff. Some care plans contained a menu planner to help staff understand people's preferred food and drink choices. Care plans prompted staff to ask people what they would like to eat and drink, and daily records showed staff encouraged fluids where this had been identified as a need.
● The service supported a person at risk of weight loss. A family member provided positive feedback regarding support offered to maintain an appropriate diet, advising, "Our relative had lost a lot of weight

when they were in hospital and we realised they were more capable in the morning than the afternoon/evening and so their main meal was swopped to lunchtime and this has resulted in my relative putting some weight back on which is wonderful, that shows how good the carers were in being flexible to change their duties to help our relative."

● A second relative shared concerns regarding the quality of support at mealtimes. The relative explained a second carer prepared breakfast whilst the person was supported with personal care. They said this meant a hot breakfast gets cold, or a cold breakfast such as cereal gets soggy before the person was ready to eat. The relative added their concerns about hot drinks, explaining, "[Person's name] has one sugar, but was getting four sugars." Concerns were also raised that staff had left tea bags in the person's flask, meaning the pouring spout became blocked, causing the person to become distressed and burn themselves when trying to open the flask. The relative advised this concern was raised and no longer happened as often.

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

● Staff understood their responsibility to report any changes or concerns to the registered manager to determine if liaison was required with another agency. An on-call system was in place to enable updates and outstanding tasks to be shared between the registered manager and team leader who covered on-call duties. Staff confirmed they were able to phone about concerns, although one staff member explained when office staff were busy there could be a delay in response, advising "[I] would say communication, sometimes it tends to lack a little bit… they do respond to calls, sometimes can be a delay."

● The service shared evidence of referrals they had made to other agencies to help support the health and welfare needs of people. This included contact with agencies such as occupational therapy, speech and language therapy, social work teams and hospital discharge teams.

● People's care records also evidenced contact with services to respond to healthcare related concerns. One person's care records included liaison with a district nursing team to offer assistance with obtaining a urine sample. Another person's care records showed staff had collected medication after a pharmacy had failed to deliver medicines, and rearranged delivery dates with the pharmacy to prevent medicines running out in future.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● People did not consistently receive respectful and dignified care. Feedback was variable and many relatives raised concerns staff were rushed. Relatives' comments included, "Sometimes they only stay five minutes, sometimes a bit longer but they are just rushing in and not interacting with my relative at all", "Some carers are respectful, some who just rush in and obviously just want to get out. We can have a laugh with some of them but some don't speak" and "The carers do not want to interact with my relative, most of the carers are rude and uncaring. They turn up in bad moods which is not professional or nice, when they are in these moods they won't even make my relative a cup of tea or even get them a glass of water." Comments suggested care was sometimes more focused on completing tasks than considering people's overall wellbeing or engaging in meaningful and respectful interactions.

We recommend the service develop their approach, to ensure people are treated with dignity, respect and kindness during all interactions with staff.

● We received some positive feedback from people and families regarding their interactions with staff, indicating some people felt they were treated with respect. One person commented, "I am getting excellent care." Comments from relatives included, "Really lovely carers, really gentle with my relative", "They are all respectful to my relative, never raise their voices and so patient" and "Our relative gets on with them all and has some right banter with them."

● Staff described practical methods for protecting people's privacy and dignity whilst providing care and support. A staff member commented, "[We] have standards of care to be met to promote privacy and dignity, everything in our power, one simple things we do, during personal care is shut the curtains." Another staff member added, "[We] have to be polite, talk to them like family…cover them with a towel, before have to talk to them first…have to tell them…I can help you."

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

● People received information about the service with their care plan. This did not contain details of advocacy services, however at the time of our inspection, most people had families who supported people with decisions about their care and support. Care assessments showed involvement of people and families when initial decisions were made. Some care plan review discussions had not been documented, and therefore we could not consistently evidence how people had been involved in decisions about changes to

their care.

● Relatives described approaching the registered manager when concerns arose and changes were required. Feedback indicated the registered manager had worked with families when decisions were required about people's care. One relative explained, "We have had to point some things out to the carers, such as our relative will do certain things but they need time to do them-rushing them will not work… we have contacted the manager and we are all working together to work around our relative and their needs."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
● People received insufficient information about the service's complaints process. The service had a detailed complaints, suggestions and compliments policy in place, however information provided to people alongside their care plans contained very limited information about how complaints would be handled. This did not include information about how complaints would be acknowledged, whether verbal as well as written complaints would be accepted, and what support the service could offer for people who needed help to log a complaint.
● Information about how to make a complaint directed people to an attached complaints form. This could have deterred some people from raising a complaint, if they struggled with written communication, as the information provided gave no alternative options.
●The information enclosed with people's care plans did not include how to escalate concerns or take action if a person was not satisfied with how the provider managed their complaint. For example, contact information was not included for CQC or the Local Government and Social Care Ombudsman. The registered manager advised they would provide additional information if they became aware someone was dissatisfied with a complaint outcome, however it did not appear this information was made freely available to people when they started using the service.

Systems were not in place to inform people joining the service about support available to make complaints, or where to raise concerns or complaints externally. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager confirmed the complaints procedure document would be updated to provide additional information to people and families about the complaints process.

● We viewed the records for four complaints which had been logged by the service. We were advised the complaints were received verbally and logged by the registered manager. Records indicated follow up which had taken place, how the complaint was resolved, and lessons learnt for the service.
● Some feedback from relatives indicated complaints were acted upon, with one relative commenting, "I am 100% confident that if I have a concern or complain I can phone [registered manager's name] straight away and she will sort it. Never actually gives feedback but issue usually resolved."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 and relatives provided mixed feedback as to whether people's needs and preferences were met. One person described staff support had enabled them to achieve more independence, advising, "I am so well cared for that I have reduced carers from three visits a day to one…This routine ensures I am clean which I want." Other feedback was less positive and indicated at times people's needs were not met. Comments from relatives included, "They are always rushing my relative who is getting anxious. The carers don't have time to bath my relative which they should", "I have to keep nagging the carers to wash my relative's hair every week" and "Most of the carers leave the lights on and the back door unlocked and I am always telling them not to…Why would you put someone in winter clothing over the last couple of weeks? I went into our relatives room and they were sitting in a long sleeved top and cardigan sweltering."

● Care plans contained detailed person-centred information, including people's backgrounds, preferred hobbies and support from others who were important to them, such as close family members. Care plans gave a detailed description of people's daily routines, providing staff with a person-centred outline of how someone wished to be supported at each daily visit.

● The registered manager provided feedback regarding how staff used knowledge of people's hobbies and backgrounds to stimulate conversation and socially engage people. Specific examples were given, such as engagement with someone in relation to their love of gospel music, bible reading and karaoke. We found staff daily notes were task focused and therefore it was difficult to consistently evidence these interactions were taking place.

● At the time of our inspection, the service was not required to support anyone with hobbies, social activities, or to access work or learning opportunities. The registered manager advised this was because most people had family support.

● People's care plans did not always include full information to identify protected characteristics. One person's care assessment identified their religion as Sikh however this information was not included within their care plan. People's sexual orientation was often omitted from care plans and the registered manager confirmed this aspect of people's identities was not routinely explored as part of care needs assessments.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were clearly identified. Care plans identified where individuals needed support to communicate effectively, for example, due to cognitive impairments or sensory loss. We viewed the records for one person living with memory issues, hearing loss and requiring glasses. A detailed care plan for communication support was in place, instructing carers on how to support the person with their hearing aids, and how to communicate effectively, to give the person time to process information.

● Staff showed insight around supporting people with differing communication needs. One staff member commented, "[i] give [people] time to understand what we are trying to say and express themselves, it's very important for client to express themselves back to us." Another staff member described showing someone food choices to pick from, when they were unable to express themselves verbally. A third staff member advised when supporting a particular person with dementia visual prompts were important, advising, "I since discovered when changing t-shirts, hold up a new one, [person's name] knows it's time for a clean t-shirt."

End of life care and support

● The service had an end of life care planning policy in place. At the time of our inspection the service was not supporting anyone receiving end of life care, although had done so previously. We viewed a thank you

card which had been received by the service after caring for a person who sadly passed away. The family expressed their thanks to the staff who supported their relative.

● At the time of our inspection, staff had not received end of life care training, which was identified by the service as required learning. Some staff told us they had previously received training in relation to providing end of life support, such as with previous employers. One staff member commented, "[I] try to do things make them feel good in last remaining few weeks/months, [registered manager's name] will push us to make person's life as comfortable as possible."

● People's care plans contained blank sections in relation to advanced care planning wishes. The registered manager explained this support was offered but had been declined, either because people's medical conditions were not life-threatening or people had preferred their wishes to remain private.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered manager also acted as the Nominated Individual, meaning they were responsible for assessing and monitoring their service against legal requirements. We were not satisfied the registered manager had sufficient knowledge of regulations to do this effectively. They did not have a good knowledge of regulations in relation to safe recruitment, duty of candour, or other regulations under the Health and Social Care Act 2008. They demonstrated some awareness in relation to CQC's key lines of enquiry (KLOEs).
- Audits took place in relation to medicines management, medicines administration records (MARs) and care plans. Audits had not been effective, as they had not identified the concerns we found in relation to medicines administration or the quality of MCA assessments.
- The registered manager advised MAR charts were checked monthly and a random selection of daily notes for around seven or eight people were read monthly. A log was not kept evidencing work undertaken and the paper records weren't signed or otherwise marked to indicate if they had been checked. This meant we could not evidence quality checks had taken place.
- We found records did not always contain an accurate, complete and contemporaneous record in respect of each service user. For example, the registered manager failed to record discussions which had taken place with a person in relation to their visit times and medicines administration. When queried with the registered manager, they advised "This was not recorded as it was a verbal discussion with [person's name]." This meant the registered manager had failed to document their discussions and decisions in relation to this person's care.
- Formal systems were not in place to review wider themes, trends or learning from incidents and accidents, compliments and complaints and safeguarding concerns. The registered manager could recall one incident form had been completed since the start of the service, although this was not easily accessible at the time of our visit. For one individual three incidents of distressed behaviours were logged onto ABC charts and we found other concerns had been logged in daily records or communication logs. This meant the service had not followed the provider's policy in relation to recording incidents, and we found no evidence the registered manager had sought to collate information to analyse learning for the wider service.
- Formal systems were not in place to quality review or audit the recruitment, supervision and training of staff. This meant the service had not identified the concerns we found in relation to safe recruitment. We also identified training was either incomplete or overdue for some staff, including the team leader's training certificate which was obtained at our request following the inspection. The training matrix used colour coding to indicate completed training or gaps, however the document did not include training dates,

meaning this was not an effective oversight tool.

The service was not effectively managed and good governance was not established. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. CQC had not received any safeguarding notifications from the service throughout its history. We observed a safeguarding folder which contained two safeguarding concerns which had required submission of evidence to the local authority.

Systems were not in place to identify or report incidents to CQC in accordance with requirements. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

The provider agreed to make retrospective notifications to CQC at our request following the inspection.

● The provider confirmed the organisation's statement of purpose had been updated in January 2021. This had not been shared with CQC and there was a legal requirement for the organisation to do so.

Systems were not in place to make the required notification to CQC in accordance with requirements. This was a breach of Regulation 12 (Care Quality Commission Registration Regulations 2009).

The provider agreed to make a retrospective notification to CQC at our request following the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There was poor management oversight of people's daily visits. Records often included a date but no times for the person's first daily visit. Subsequent daily records included a start time but no finish time. The registered manager's response indicated effective action had not been taken. They advised this had been raised verbally with staff however it was stated the issue had "been going for months now, sometimes do remember, sometimes doesn't get done." We also found a lack of scheduled travel time between some visits on staff rotas. Feedback showed these ongoing issues were impacting on people's ability to receive person-centred, quality care. Comments from relatives included, "Two carers should come…for 30 minutes but it is more like five minutes. They are always rushing my relative", "They are supposed to be there 30 minutes… sometimes they only stay five minutes" and "We do not have any phone calls to let us know the carers are running late…their visits do not last 30 minutes more like 15-20 minutes."

● Care plans contained disrespectful language as part of a mental health assessment tool to categorise people's behaviours under a heading "Challenging Behaviour – Severe" with options including "violent", "destructive" and "severe deviance". This document was shared with people in their own homes, using disempowering language to describe people's distress, such as referring to one person having "outbursts". The assessment gave a basic description of the person's behaviour without reflecting the distress experienced by person, or reflecting behaviour was a form of communication for someone unable to express themselves effectively due to cognitive impairment.

● Staff had not received formal training in relation to respecting people's equality, diversity and human rights (EDHR). Some people's care plans did not contain information about their sexual orientation, religion or marital status. This meant staff unfamiliar with the person may not have awareness about the person's protected characteristics to enable them to provide person-centred care.

Systems did not drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to take action in response to our feedback. Staff were booked to attend EDHR training and the registered manager agreed to review arrangements for staff rotas. The registered manager advised the service planned to introduce an electronic recording system which would enable better oversight of people's daily care including visit timings.

● Some people and relatives provided positive feedback regarding the management of the service. The registered manager covered some care visits and was in contact with some families regarding people's support. One relative commented, "We have a good relationship with [registered manager's name] and have found her approachable." Another relative added, "We believe we have a good relationship with [registered manager's name], [it] feels that she does listen to us."
● Staff indicated they felt supported by the registered manager, and staff described being encouraged by the registered manager to provide people with quality care and support. A staff member commented, "Culture is provide care that works for client, rather than makes your life easier, even if working under pressure and can feel it…we push." Another staff member added, "[Registered manager's name] says if client has frustrations…when they shout at you, don't see client as problem but circumstance, taught to communicate in kind, polite way." A third staff member advised, "[Registered manager] very free to talk to, she's just lovely...she's one in a million."

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
● A duty of candour policy was in place. We spoke with the registered manager and team leader who demonstrated a general awareness of their duty to be open and transparent with people using the service. The registered manager did not have a good working knowledge of the statutory duty of candour, meaning they did not fully understand their responsibilities should an incident take place requiring a formal duty of candour process.
● We reviewed safeguarding records in relation to a person who passed away following an admission to hospital. In the days leading up to the person's hospital admission, the service had missed four care visits. The concerns met the criteria to be investigated further as part of a statutory duty of candour process. The registered manager advised a telephone conversation took place with the person's relative, however this telephone conversation was not documented. This meant the service had failed to keep a secure written record of all meetings and communications. There was also no evidence a written account, including an apology to the relative had been issued.

We recommend the provider develop their knowledge and approach in relation to the duty of candour, to ensure applicable incidents are identified and an appropriate response made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service distributed a quality assurance questionnaire for people and families using the service. Questionnaires were printed in English using standard size print, and the registered manager stated they would have capacity to print the document in different languages or large print if this was required. We reviewed the returned questionnaires. Where people had made suggestions of improvements, the registered manager advised these had been followed up with individuals, however this had not been documented, and the section entitled "What actions will the branch take" was left blank on all documents. We observed a

team meeting had been used to share people's feedback with staff, highlighting the importance of timekeeping and communicating lateness, as well as sharing positive feedback.

● The registered manager advised a questionnaire had also been circulated to staff, however most staff chose not to engage with this process. Staff were able to give feedback through informal contact with the registered manager, supervision meetings and team meetings. Staff we spoke with felt able to raise any concerns or suggestions with the registered manager. One staff member commented, "[Registered manager] does take feedback on board, follows on and actions issues. People are free to voice any concerns or issues…very approachable."

Working in partnership with others

● Professional feedback indicated the service worked effectively in partnership with other organisations. The service had developed links with local authorities in different counties. Comments from a commissioning professional included, "Very prompt when dealing with them, show empathy from correspondence, very timely, don't have any concerns working with them as a provider."

● The service also worked with healthcare professionals when people's needs required support from district nurses, occupational therapists or speech and language therapy. A professional commented, "I had no poor interactions and the staff member I spoke to was polite, listened to my recommendations, gave me the information they could and then appeared to take on board my advice and requests."

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose Systems were not in place to make the required notification to CQC in accordance with requirements.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Systems were not in place to identify or report incidents to CQC in accordance with requirements.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Effective systems were not in place to ensure the service operated in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems were not in place to inform people joining the service about support available to make complaints, or where to raise concerns or complaints externally.

Regulated activity	Regulation

Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Systems were not in place for the safe recruitment of staff.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not clearly identified and managed, and systems were not established to promote safe medicines practice.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not effectively managed and good governance was not established. Systems did not drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service.

The enforcement action we took:

We served a warning notice.