Connections Care Limited

Connections Care Ltd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Connections Care Ltd is a domiciliary care agency providing personal care to adults living in their own home. During our inspection visit, the service was caring for 56 people. 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
People and relatives were overwhelmingly positive about staff and told us the service provided safe care. However, during this inspection, we found some aspects of the service were not always safe or well managed.

Medicines were not always managed safely. We found some risks to people's care had not been assessed and the provider had not kept an appropriate oversight that equipment used by staff to move people had passed the required safety checks. These areas were discussed during the inspection, and immediate action taken. There was a safeguarding procedure in place, staff had received training and were aware of signs of abuse and what action to take. Infection and prevention measures were in place to ensure people and staff were safe. Recruitment was mostly managed safely but gaps in employment were not consistently explored.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, we found the provider was not recording relevant discussions and decisions about the care of people who lacked capacity to make decisions.

Quality assurance measures in place had not always been effective in identifying or addressing the issues found during this inspection. We found records were not always detailed or complete and management oversight had not always been robust in ensuring the service was always safe.

We received positive feedback about the management team being approachable and responsive. People using the service and their relatives told us about the positive impact that the service had on their lives and told us they would recommend the service. During this inspection, the provider was receptive to the inspection's findings and acted on the issues identified or told us the actions they would take.

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

Rating at last inspection
The last rating for this service was good (published on 23 August 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement and Recommendations
We have identified breaches in relation to how consent was recorded, safe care of people and management of the service 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Connections Care Ltd

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
This inspection was conducted by one inspector and an 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 and sheltered accommodation.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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 19 December 2023 and ended on 9 January 2024. We visited the location's office on 19 December 2023.

What we did before the inspection

Before the inspection, we reviewed all the information we held about the service including information about important events which the service is required to tell us about by law. We requested feedback from other stakeholders. These included the local authorities safeguarding teams, commissioning teams and Healthwatch Leeds. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 8 relatives of people using the service. We spoke with 7 staff members; this included care workers, senior care worker, the care coordinator, and the registered manager.

We looked at care records for 4 people using the service including medicine administration records. We looked at training, recruitment, and supervision records for staff. We also reviewed various policies and procedures and the quality assurance and monitoring systems of the service.

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 good. 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.

Using medicines safely
- Medicines were not always managed safely.
- We found concerns about staff administering medicines that had been previously dispensed by a relative into a dosette box; this is not in line with best practice guidelines.
- In our review of the medication records, we found an example of one person being supported to take paracetamol several times a day and the required 4 hours gap had not being respected.
- One person was given their medication covertly however, there was no evidence that the required healthcare professionals had been consulted and that this was the safest and least restrictive option for this person.
- Medication audits provided had not identified the issues found during this inspection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate good management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection, the registered manager sent us evidence and told us the actions they were taking to address these concerns.

Assessing risk, safety monitoring and management;
- Risks to people's care were not always assessed and recorded safely.
- Risk assessments lacked detail about essential areas of people's care. For example, one person was at risk of choking due to their health conditions; there was no specific choking risk assessment and care plan in place to ensure staff were managing the risks appropriately and that they would know what to do in case of a choking incident. One person was at risk of developing issues with their skin integrity, but their skin integrity risk assessment and care plan lacked detail about the repositioning regime and equipment in place to manage these risks.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate risks to people's care were always well managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection, the registered manager sent us evidence and told us the actions they were taking to

address these concerns.

● The registered manager was monitoring if equipment used by staff to move people was safe to use and had passed the required Lifting Operations and Lifting Equipment regulations.
● People and relatives shared positive feedback about the safety of the service. Their comments included, "Yes, I feel safe. No question of it" and "Yes, absolutely safe. [Person] is new to the service. The team and manager are good and [person] gets on well with them."

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Mental capacity assessments and best interest decisions were not being completed.
● Records did not always show who was involved in the decision making and if relatives had Power of Attorney to make decisions.
● The provider was not following their own policies and best practice guidance in relation to the MCA.

This was a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not always ensuring that consent to care was always being assessed or recorded for people who lacked capacity to make decisions about their care. This placed people at risk of harm.

● We did not find evidence that people who lacked capacity to make decisions about their care were receiving care that was not in their best interests.
● People and relatives told us staff asked consent before supporting people with care. One person told us, "The lady or man carer get me my dinner and ask me what I want for dinner. I can eat what I want and have a choice. I enjoy what I am having. They [staff] get on with it. I love my tea and they give me plenty of soft drinks."

Staffing and recruitment
● Most aspects of staff recruitment were managed safely. However, we found examples where employment gaps had not been fully explored.
● People were supported by a consistent team of regular care workers and told us staff arrived on time and stayed for the agreed duration of the call. People told us, "Oh yes, they [staff] are always on time and get the jobs done. They are not in a rush. I have had no missed visits" and "The carers are on time and will call me if they are delayed. They stay and do the jobs they should do." One relative commented, "They do come on time. [Person] has timed medicines at 8.00am and they guarantee to come on time."
● There was an electronic monitoring system in place that allowed the registered manager to monitor staff. This helped manage the risk of missed or late visits.

Systems and processes to safeguard people from the risk of abuse
● Staff had a good knowledge of the signs of abuse, the safeguarding procedures and who to inform if they

had any concerns or concerns had been raised to them.

Learning lessons when things go wrong

● Staff knew how to safely deal with accidents and incidents such as a medical emergency or a fall.

● We reviewed the provider's management of accidents and incidents and found these were safely managed. The registered manager explained to us their oversight of these instances and the actions taken when required and lessons learnt.

Preventing and controlling infection

● Infection and prevention measures were in place to ensure people and staff were safe.

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 good. 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.

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

- We found management oversight had not always been effective in ensuring the service was safe and following its own internal policies and regulatory requirements. As a result, risks to people's care were not being appropriately assessed, such as risk of choking or risks with skin integrity. Medicines were not always well managed, and consent to care was not always sought in line with requirements. The registered manager explained us that there had been several management changes at the service recently; this had an impact on the service and issues had been already identified and a plan put in place some weeks before our inspection.
- Quality assurance checks were in place. However; these had not always been effective in identifying and ensuring the necessary improvements had been acted upon. For example, medicines audits were completed but these had not identified the issues found during this inspection. Audits on staff's files were being completed, however these did not identify issues with employment gaps. Care plan audits were done but these did not identify that MCA documentation was not being completed.
- Records about people's care were not always complete.

Systems were either not in place or robust enough to demonstrate effective oversight and management of the service. This could place people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider carried out regular spot checks to oversee staff performance and to check the quality of care and people's experiences.
- People and relatives told us they knew the registered manager and felt the service was well managed. Their comments included, "I have met the manager a few times and she is 100% approachable. Whatever I have asked for she has been supportive" and "The senior staff come with the carer sometimes and the manager calls me from the office. It's absolutely well managed. We never had a problem. It ticks over nicely."
- Feedback received from people and relatives was unanimous in recommending the service to others. Comments included, "They are friendly and very helpful. I can't think of anything to improve the service. The carers are brilliant. Without doubt, I would recommend them" and "I like their people-oriented approach as they put our needs at the forefront. I would 100% recommend them to others."

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 Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong. This includes informing people and their relatives about an incident, providing reasonable support, providing truthful information and accountability when things go wrong. The registered manager understood their responsibilities in relation to this requirement.
● The registered manager was responsive and open with the inspection process; they quickly acted on the issues discussed during the inspection and demonstrated a willingness to continuously learn and improve.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they enjoyed being supported by the service and some people highlighted how important it was for them to have their communication and cultural needs respected and met. One person told us. "They [staff] definitely have the skills and can communicate with [person]. [Person] speaks Gujarati and the carers can speak Gujarati." A relative commented, "We get regular carers from a group of 3 and are very lucky to get carers who speak our language Urdu and understand our culture."
● There were communication systems in place to ensure good communication with staff, such as team meetings, where relevant aspects about the service were discussed. Staff told us they enjoyed working for Connections Care Ltd.
● The provider was gathering regular feedback via contacts with people and questionnaires to staff.

Working in partnership with others
● The registered manager maintained good working relationships with partner agencies. This included working with commissioners and health and social care professionals, and other organisations who could support them in the delivery of care.

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 Mental capacity assessments and best interest decisions were not being completed.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's care were not always assessed and well detailed in risk assessments and care plans. Medicines were not always well managed.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management oversight had not always been robust and quality assurance processes in place had not been effective in addressing the issues found at this inspection.