

Maverick Care Ltd

# Christies Care - Windsor & Maidenhead

## Inspection report

Office 226, Porter Building  
Brunel Way  
Slough  
SL1 1FQ

Tel: 0175398333

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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?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Christies Care Windsor and Maidenhead is a domiciliary care service for people living in their own homes in the community. 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. At the time of our inspection, five people used the service and four people received personal care.

### People's experience of using this service and what we found

The service did not identify or mitigate all risks to people, which meant staff may not know how to keep people safe. Systems to manage people's medicines were not always fully implemented to make sure people received their medicines as prescribed. The service was not familiar with local authority safeguarding procedures. Staff were able to identify signs of abuse and told us they would report concerns to management.

Staff recruitment procedures were not robustly followed and placed people at risk of being supported by unsuitable staff. People's relative told us their family members received agreed levels of staff support on time. Infection prevention procedures were in place. Relatives told us staff wore appropriate personal protective equipment to reduce the risk of COVID-19 transmission.

Initial assessments were not holistic and did not capture relevant information about people's needs or preferences. Staff did not always complete training to meet people's needs prior to providing unsupervised care and support. Staff told us management supported them through their induction and felt prepared for their role.

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; the policies and systems in the service did not always support this practice. Documentation did not consistently follow the principles of the mental capacity act code of practice.

Relatives felt their family members received caring and kind support from staff, with comments such as, "[Care workers] seem caring, they treat [my family member] with dignity" and "I can't sing their praises highly enough, it's good team work. They care for [family member] with kindness and respect, they understand [family member] has dementia".

Care plans did not contain all relevant information about people needs, likes and dislikes. One relative said, "I don't think they know [family member's] likes and dislikes, if there was a bit more conversation, they might have understood their needs a bit more". Some care plans contained detailed information about people's background and hobbies.

The service understood the requirements of the accessible information standard to identify and take relevant action to meet people's communication needs. Care plans included information about how staff should adapt their communication. However, the full range of communication tools was not considered for one person with complex needs. We have made a recommendation in relation to the accessible information standard.

The service had not identified whether people had do not attempt resuscitate notices in place, which was important to ensure staff had the right information and to enable them to check such notices were appropriate and lawful.

The service had not always established robust systems to monitor the quality and safety of the service. Policies and procedure were not consistently up-to-date with relevant national guidance or professional standards. The deployment of the registered manager meant there had not been effective oversight of procedures and staff practice. The service had identified this previously and recruited a new manager who commenced 4 May 2021. The manager demonstrated a person-centred value base and knowledge of the regulations. They were responsive throughout our inspection and had already taken some action to mitigate risk prior to our inspection.

Staff and people's relatives were consistently complimentary about the support and responsiveness of the nominated individual, who delivered a significant amount of care directly.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

This service was registered with us on 9 December 2020 and this is the first inspection.

#### Why we inspected

The inspection was prompted in part due to concerns received about staff training and lack of oversight by the registered manager. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, response 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. The service has implemented a service improvement plan to address the concerns we found during our inspection.

#### 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 person centred-care, safe care and treatment, good governance, staff training and fit and proper persons employed.

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 always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Christies Care - Windsor & Maidenhead

## 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

The inspection was carried out by one inspector. An Expert by Experience contacted relatives of people using the service for their feedback. 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. The service had appointed a new manager who intended to submit an application to register and was being supported by the registered manager for a three-month period.

#### Notice of inspection

We gave a short period notice of the inspection to arrange consent for phone calls to people's relatives at

home ahead of the onsite inspection.

Inspection activity started on 13 May and ended on 1 June 2021. We visited the office location on 18 May 2021 and conducted a remote inspection meeting on 24 May 2021.

#### What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We contacted two healthcare professionals who were involved in people's care and treatment. However, they advised us they did not come into contact with care workers as part of their role and could not provide us with any feedback. 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.

#### During the inspection

The service told us three people were not able to communicate with us over the phone and another person did not wish us to contact them, which was confirmed by their relative. We spoke with four relatives about their experience of the care provided. We spoke with eight members of staff including care workers, the registered manager, the manager, and the nominated individual. 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 three people's care records and two people's medication records. We looked at three staff files in relation to recruitment and staff training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

# 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; Using medicines safely

- Assessments to identify and reduce risks were not always accurate, complete or up-to-date. One person's risk assessment did not identify all hazards in relation to their epileptic seizures. Staff were not always trained in epilepsy awareness or how to administer emergency rescue medicine; there was no guidance about what staff should do if the person's family member was not present to respond to emergencies. One staff member we spoke with said they would contact the person's family member. Another staff member said they would call an ambulance first. Although the likelihood of the risk was low due to known information about frequency and triggers of epileptic seizures, the person was placed at potential risk of harm as staff did not consistently know how to respond in an emergency appropriately.
- Two people were identified as being at risk of choking due to swallowing difficulties. One person's risk assessment provided no additional information about the hazards or how to reduce them. The manager confirmed the record was inaccurate and the person was not at risk. Another person's risk assessment included information about hazards, however it failed to identify staff training in choking first aid as a safe measure to reduce risk of harm.
- One person's risk assessment document ticked 'yes' that a financial risk assessment was required. However, we found the risk assessment was blank. The manager confirmed the list was inaccurate and took action to amend it.
- Risk assessments were not always fully completed or regularly reviewed. For example, one section in a person's moving and handling risk assessment about who was at risk of hazards was left blank and had not been reviewed within the agreed three months.
- Staff roles and responsibilities were not always clearly defined in relation to medicines administration. Staff were involved in the preparation and administration of a person's prescribed thickener powder, however, the service had not established a medicines administration record (MAR) for staff to document this.
- Medicines records were not always accurate and did not include whether people had a known allergy or not. The registered manager had handwritten the time of a medicine on a person's MAR incorrectly. The printed time on the medicines dosset box was accurate and indicated the person had received their medicines at the correct time. However, systems to identify errors were not effective, which placed people at risk of harm.
- Information about people's needs in relation to medicines was limited and risk assessments were not always complete, which meant new staff may not have access to information to support people with medicines safely.

We found no evidence that people had been harmed however, systems in relation to medicines and

assessing risk were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at potential 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.

The manager took immediate action to review risk assessments and provided a timely action plan to address the concerns raised. This included a full review of all people's risk assessments with support from another registered manager arranged by the provider. In addition, the manager planned to refresh their own risk assessment training to ensure they were up-to-date with current national guidance standards and approaches.

#### Staffing and recruitment

- Recruitment processes were not always robustly implemented to make sure staff were of good character and suitable for their role. We found gaps in the content and the number of employment references for three staff. Managers had not acted to verify information, or risk assessed the suitability of staff where standards were not met, prior to staff commencing work.
- Information contained in job applications, such as reason for leaving a previous job and incomplete information about previous employers, was not followed-up by the service.
- Staff interview records were incomplete. Several interview questions were not answered in two cases and very brief answers for a third candidate, with no further exploration. Explanations about why the candidates were successful and suitable for the role were not documented.

The provider's recruitment systems were not always implemented to protect people using the service from unsuitable 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.

- A provider audit of staff recruitment checks and training was undertaken in April 2021 following concerns raised via the Commission. The audit identified and addressed some gaps in recruitment procedures such as, an additional employment reference for one member of staff was sought. However, other discrepancies were not identified or addressed. In response to our inspection the manager took action to review the processes in relation to verifying documentation to ensure this was robust.
- Disclosure and Barring Service (DBS) were carried out prior to employment. The DBS check ensures criminal records are disclosed and people barred from working with certain groups such as vulnerable adults would be identified.
- Other staff checks such as the right to work and health questionnaires were completed by the service.
- Relatives told us staff generally arrived to provide care on time. Staff rotas showed in general appropriate levels of staff were allocated to meet people's needs. We found three gaps where two staff would usually provide care. The manager explained the family member had not required two staff on these occasions and the service was able to be flexible with an agreed notice period. The same staff supported people wherever possible to promote continuity of care.

Systems and processes to safeguard people from the risk of abuse;

- The service safeguarding policy and procedure provided guidance about when and how staff should report concerns. Staff we spoke with demonstrated knowledge about how to identify safeguarding concerns and told us they would report to the manager.
- The management team were not familiar with local authority safeguarding policies and procedures. Contact details for local safeguarding teams were not included in documentation for people or staff to enable easy access. The manager took immediate action to address this during our inspection.
- The service followed their policy never to use people's bank cards to purchase goods, to reduce the risk of financial abuse. However, other systems to protect people from financial abuse were not always robustly

implemented. For example, receipts were not always obtained for purchases made by staff on people's behalf and no explanations were recorded. The service had previously checked with the person and gained recorded confirmation for the amount spent and purchases received, however no other action had been taken to learn from this and improve implementation of financial procedures. The manager took immediate action and introduced a system that required all staff to upload photos of receipts to the electronic system, which would be checked by management.

- People's relatives told us they felt their family member received safe care. One relative commented, "The initial assessment was very good and included a risk assessment, it took into account things like steps and any equipment that was needed".

#### Preventing and controlling infection

- The service did not always complete risk assessments to identify whether people were at higher risk of COVID-19. Staff who were employed by other health and social care providers had risk assessments in place, however, these did not identify specific risks or safe measures to reduce the risk of transmission. The manager took immediate action to review these risk assessments and provided us with amended improved versions.

- Staff told us they had access to plenty of personal protective equipment (PPE) such as masks, visors, gloves, aprons, overshoes and hand sanitiser, used to reduce the risk of transmission.

- Relatives who saw staff in their family member's homes told us staff always wore PPE.

- One person with hearing loss found it difficult to understand them when they wore masks. Staff wore visors instead of masks when supporting this person in order to maintain communication and promote general emotional wellbeing.

- The service kept a log of staff COVID-19 regular lateral flow testing to ensure this was completed consistently. We made the service aware of a recent update to government guidance to homecare staff access to COVID-19 PCR tests. The manager took action to access these additional tests.

#### Learning lessons when things go wrong

- Systems were not established to log or track concerns and incidents. For example, action taken by the nominated individual to address a whistleblowing concern in relation to staff training, was not logged to demonstrate the status of the investigation, outcomes or agreed actions.

- During our inspection the manager introduced a concerns log and demonstrated they had learned where things had gone wrong with staff training. Prior to our inspection the manager had taken action to prevent staff supporting people where they had not completed the required mandatory training.

# 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.

Staff support: induction, training, skills and experience

- The Commission received a whistleblowing concern in April 2021 that staff were not supported to receive appropriate training prior to supporting people. We found the service did not always make sure staff had completed mandatory training such as medicines, safeguarding, first aid, infection prevention control or food safety prior to supporting people. The nominated individual told us this was due to difficulties with accessing face to face training during the COVID-19 pandemic and they had initially relied upon staffs' training with previous employers. However, this did not explain why online training had not been completed. Training certificates were not always obtained from previous employers in order to check the standard of training and not all staff had previous experience or training in health or social care.
- The nominated individual explained that one member of staff had refused to complete online training and two others had not had time due to other employment commitments, which were not acceptable explanations for not having achieved this.
- Staff training and development plans were not always designed to meet people's specific needs. For example, epilepsy awareness and emergency rescue medicine training were not available to staff, despite this being a recommendation in the person's care plan and risk assessment. Some staff had not received dementia or communication training prior to supporting people with these needs.
- One member of staff told us they supported a person to take their medicines alone and had been shown what to do by the nominated individual as part of their induction. However, they had not received medicines training or a competency assessment prior to administering medicines. Staff allocation records showed the staff member had supported the person unsupervised on three occasions. We were informed by the manager the nominated individual had advised them they had been present and administered the medicines directly, which was confirmed on the MAR. However, this information contradicted what the staff member told us about working alone. The absence of a robust audit trail meant we were not assured that people always received medicines support by trained, skilled staff.

The service did not always ensure staff had the training, skills and experience required to meet people's needs effectively. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they received support and guidance from the nominated individual as part of their induction which they felt prepared them for their role. Records confirmed staff shadowed more experienced staff before working unsupervised.
- Relatives had confidence in the nominated individual's knowledge, who delivered a significant amount of

care to people directly. One relative told us a care worker demonstrated experience in supporting people who lived with dementia.

- At the time of our inspection some progress had been made towards staff completing mandatory training. The manager had taken action to stop an untrained member of staff from working until they had completed training and been assessed as competent.
- The manager took action to review staff training plans to meet people's needs.

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

- The service did not complete holistic assessments of people needs. There was no reference to people's emotional needs or protected characteristics such as religion, sexual orientation or disability.
- One person's care plan failed to identify their diagnosis or experience of living with dementia. Staff told us the person sometimes became distressed when showering or changing their clothes. Their care plan did not contain any guidance about how staff should support the person or consider whether this was linked to sensory issues associated with dementia. This meant there was a risk of staff using ineffective, inconsistent approaches. We received feedback from a person's relative that staff understood their family member's dementia diagnosis.
- Assessments were sometimes incoherent. For example, one person's moving and handling assessment identified they were at medium risk of falls. However, the falls assessment was left blank. This meant there was no guidance for staff to follow to effectively meet the person's needs or manage risk.
- The service had not completed a medicines assessment of needs for one person who received staff support with this. The person's care plan stated an outcome was to prompt the person to take their medicines twice a day. However, staff we spoke with told us they assisted the person by taking medicines out of the dosset box. This showed a lack of understanding about the difference between these roles and meant staff did not have the information they needed to meet the person's needs consistently.

The service did not complete robust assessments of people needs in line with expected standards and national guidance. This was a breach of Regulation 9 (Person centred support) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager took action to improve systems to make sure assessments of needs were comprehensive. An action plan was developed to review all care plans and risk assessments and templates were being reviewed to address people's holistic needs.

Supporting people to eat and drink enough to maintain a balanced diet

- The service had not fully explored a person's nutritional needs as part of the initial assessment. A hospital discharge summary stated the person required twice daily nutritional supplements to drink. However, this was not referred to in the person's care plan which stated the person ate a "normal diet". We raised this with the manager who advised the person managed this themselves and did not require staff support. However, the absence of this information in the person's assessment and care plan meant staff were not fully informed. In addition, this contradicted the care plan goal which stated, "intake and outtake [of food and drink] to be observed".
- We spoke with a member of staff who said the person had needed less support to prepare meals over time as their independence had increased. The person's relative confirmed this and had no concerns about their nutritional intake. We were satisfied the lack of robust assessment had not adversely affected the person. The manager advised they would take action to review the person's care plan and ensure future assessments and care plans were comprehensive.
- Staff we spoke, demonstrated detailed knowledge about another person's nutrition and hydration requirements and their role in meeting the person's needs.

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.

- The service implemented systems to assess people's mental capacity. However, assessments were not fully documented in accordance with the principles of the mental capacity code of practice. For instance, the justification for assessing the person's mental capacity or why a person could not retain information was not included. Neither was the outcome of the assessment written in a coherent way to establish whether the person lacked capacity for certain decisions. The manager agreed that improvements to documentation was needed and took action to review this.
- People's care plans included whether they could make decisions about aspects of their care. Staff told us they sought people's permission before providing care and would respect people's wishes if they declined, which would be reported to the manager.
- Consent to care forms were in place and signed by people or their relatives, as part of the best interest decision process.

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

- The service liaised with a person's pharmacy in relation to a medicines review following a hospital discharge.
- Other agencies such as community healthcare professionals involved with people's care were referred to within care plans, in case the service needed to contact them about people's health.

# 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 staff did not always have the skills to confidently interact and engage with people to support them well.

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

- Staff did not always receive communication training prior to supporting people and did not always have the skills to aid their communication and engagement with people. This meant they sometimes relied upon people's relatives for guidance. A relative told us staff interaction with their family member had improved over time. The manager told us they would review staff training needs to identify learning and development areas.
- One member of staff told us they had initially read a person's care plan but did not have ongoing access to this and was unaware if there had been any changes. They relied upon the person's family member for guidance about how to support them.
- People's relatives were positive about how staff treated their family members with comments such as, "The carers know [family member], they are kind. They are exactly what I hoped for, very engaging. I don't have to ring them, they ring me. They treat [family member] with 100% dignity, if they didn't [family member] would soon tell me" and "I can't sing their praises highly enough, it's good teamwork. They care for [family member] with kindness and respect, they understand [family member] has dementia. [Family member's spouse] was under immense pressure before they started visits. They have alleviated stress, [family member's spouse] is confident in the care they provide, they used to want to be involved, now they are able to step back because they trust [care workers]."
- A staff member told us they had time to converse, build trust and a rapport with a person who was generally not agreeable to accepting new people in their lives.
- One relative told us their family member's independence had improved. Staff spoke about supporting people to do things for themselves as much as possible.

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

- Care plans were sometimes written in the first person without clarifying whether this was the person's true voice, or guidance taken from discussions with the person's relative, where it had been established the person was sometimes unable to understand information or communicate their needs.
- Care records documented how to involve people and relatives in choices and decisions about their care. For instance, care plans provided guidance to staff to inform and involve relatives in the event of an incident or accident.
- Relatives told us there were involved in their family member's initial assessment and had access to their care plans.
- Staff we spoke with told us they would always explain and show people what they were doing to involve

them.

# 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.

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

- Pre-admission assessments did not always gather enough information about people's background, preferences or likes, such as food and drink. One staff member told us they weren't "too familiar" with one person's needs as they did not support them very often and would be allocated as the second care worker to "help". Not enough information was in the care plan for the member of staff to check or challenge if the other care worker was not carrying out the person's wishes.
- One person's care plan included their enjoyment of specific music genres and detailed information about their backgrounds and hobbies. However, this level of detail was not consistently applied. For example, one person's care plan stated they wished to attain their previous social and leisure pursuits but did not state what they were.
- Another person's daily records consisted of a tick list of detailed tasks. Whilst this was an important prompt for staff to confirm they had met all the person's complex needs, there was no opportunity for staff to document the person's demeanour, or response to interactions. We noted that staff had included a handwritten note about a person experiencing an epileptic seizure and action taken. The manager took action to review the template to make improvements. Other people's daily notes included more personalised information about people's wellbeing.

### 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.

- There was an appropriate Accessible Information Standard policy and procedure in place. People's care plans included information about sensory loss, communication difficulties and preferred methods of communicating.
- Staff told us they used key words to support one person and paid close attention to their body language and facial expressions to understand their mood and what needs they were expressing. The service had not considered or explored whether the person may benefit from technology or communication aids.
- Staff had previously reported to management that a person was finding communication with staff difficult due to COVID-19 face masks. The service took action and assessed the person's needs and agreed staff could wear visors instead of masks, to enhance communication and maintain the person's wellbeing.

We recommend the service explores whether people would benefit from specialist referrals to consider the

full range of communication tools available to meet people's needs.

Improving care quality in response to complaints or concerns

- The service had not received any formal complaints. The manager showed us a template to log complaints which they would use to track outcomes and monitor for any trends.
- Relatives consistently told us they were able to raise any concerns with the nominated individual [NI] and had always been satisfied with the outcomes received. For example, one relative said, "I raised a concern about a carer being very late and [NI] sorted it."
- People and relatives received written information about how to raise a complaint when care commenced.

End of life care and support

- At the time of our inspection people being supported were not approaching or at the end of their life. The service had an end of life policy in place and had recently made end of life training available to staff.
- The service did not explore whether people had do not attempt resuscitation notices from their GP or hospital consultant. This meant staff would not know if this was in place or where to find information in the event of life saving treatment being required. In addition, the service had no way of checking that any notices were appropriate and lawful. The manager took action to review this with people immediately after our inspection.

# 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 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;

- The service had not established or implemented robust audits to monitor the safety and quality of care. The nominated individual (NI) advised the management structure and deployment of the registered manager meant they were not fully involved with the running of the service. They told us this meant the governance of the service was not effective and compliance systems to meet regulations and manage risk, such as staff recruitment, medicines management and staff training were not fully understood or implemented. The registered manager told us they were not fully aware of staff training gaps and said this was due to them working from home, which they identified was a barrier to effective oversight and communication with operational staff, including the NI. Action was taken by the service to rectify this in January 2021 to recruit a new manager, who commenced employment 4 May 2021 after their notice period.
- The new manager had identified areas of improvement and took some action to manage risk. For example, they had put a hold on one employee until they had completed mandatory training. We found the manager to be responsive throughout the inspection and they submitted an initial action plan to address gaps and drive improvement. The nominated individual told us they were committed to supporting the manager to develop in their role and was following their guidance in relation to quality and safety standards. However, at the time of our inspection not enough time had passed for the new manager to fully identify or address the areas we had found or provide assurances this would be sustained.
- We found numerous examples of management and care records that were not up-to-date, accurate or complete. For example, risks to people were not accurately identified, information in care plans was incomplete and medicines records were inaccurate.
- Policies and procedure were not consistently dated to support regular reviews. The service medicines policy and procedure referred to out of date national guidance and legislation. This meant managers did not have appropriate guidance to refer to, to maintain expected standards of care and safety.

The service had not established effective governance systems to manage risk or monitor the safety and quality of 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 took action to address the concerns raised. This included a planned schedule of audits, a review of policies and procedures and a debrief to all its services to implement learning.

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

outcomes for people; 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

- Some systems such as initial assessments and care plans did not always promote a robust framework for person-centred care. However, relatives' experience about staff practice and care delivered to people, was generally positive. We received comments such as, "There is nothing to change, I just hope they continue" and "Nothing needs changing, their strength is communication, [the nominated individual] is an excellent communicator, I know what is going on all of the time".
- After our inspection the manager provided us with a review feedback form which they intend to implement. This was more personalised and focused on asking people about progress towards their own goals and achievements.
- Staff told us they felt well supported and listened to by the nominated individual. The new manager had introduced themselves to people using the service and staff members and was keen to establish positive working relationships as part of an open culture.

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

- No incidents had occurred that met the criteria for responding and reporting under the duty of candour requirements.
- The manager demonstrated they understood duty of candour requirements and an appropriate policy and procedure was in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service completed quality assurance questionnaires' with people, covering all aspects of care. We reviewed two of these which stated people were happy with the care provided and no areas of improvement were identified.
- The service held regular staff meetings. We reviewed the minutes for two of these, which included updates about COVID-19 rules, staff vaccinations, discussion about people's needs, reminders about safeguarding processes, training requirements and thanks to staff for their hard work, for which they all received a festive gift in April.
- The manager planned to implement a scheme to recognise and reward staff who 'went the extra mile'. This was to be judged through feedback from people using the service and staff nominations every quarter.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The service did not complete robust assessments of people needs in line with expected standards and national guidance.</p>
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Systems in relation to medicines and assessing risk were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at potential risk of harm.</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The service had not established effective governance systems to manage risk or monitor the safety and quality of the service.</p>
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The provider's recruitment systems were not always implemented to protect people using the service from unsuitable staff.</p>
Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The service did not always ensure staff had the training, skills and experience required to meet people's needs effectively.