Priory Care Services Ltd

HQ Priory Care Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was the first inspection of the service since the provider registered with the Care Quality Commission (CQC) in November 2017. This inspection took place on 14 November 2018 and was announced. We gave the provider 48 hours' notice of the inspection visit because the registered manager could be out of the office supporting staff or providing care. We needed to be sure that they would be available.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. The agency provides a service to adults with physical disabilities and older people, including people living with dementia. Not everyone using HQ Priory Care Services receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection 61 people were provided with personal care by the agency. The service had a contract with the local authority to provide people with domiciliary services.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe with the care provided and with the staff who supported them. However, the provider's risk assessments and risk management plans did not have adequate guidance for staff to follow to minimise possible risks to people.

Care plans did not include all the information staff needed to care and support people in line with their needs and preferences. This was despite the service being provided with relevant assessment information from the local authority.

Medicines were not managed in line with current guidance. Incomplete information and lack of instructions on how medicines should be administered meant that people may not always receive their medicines safely and as prescribed.

The principles of the Mental Capacity Act (2005) were not always followed to make sure people's rights were protected.

The provider had some systems in place to monitor and improve service delivery. This included a complaints system, telephone feedback and observations of staff practice. Other quality assurance systems needed development to ensure that all aspects of the service were effective and meeting people's needs.

Despite the above shortfalls, people and relatives were happy with the care provided and told us they experienced a flexible service. People were treated with kindness and respect and supported by the same

staff which provided consistency of care.

People felt that staff respected their privacy and dignity and helped them to remain as independent as they could.

People had information on how to make a complaint and knew how to do so.The provider responded appropriately to any complaints they received.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to managing risk for people using the service, care planning, consent, staff recruitment and governance. We have also made a recommendation about staff training on the management of medicines. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's health and welfare had not been fully assessed. Staff did not have sufficient information to minimise risks and help keep people safe.

Recruitment processes required further improvement to help ensure that staff employed were of good character and suitable for their roles.

The provider did not have appropriate arrangements in place to manage all aspects of medicines safely.

People felt safe and confident with the staff who supported them. The provider understood their responsibilities to protect people from abuse and knew how to report any concerns.

There were appropriate numbers of staff employed to meet people's needs and provide a safe service.

Is the service effective?

Requires Improvement

The service was not always effective.

People were encouraged to make their own decisions and remain in control of the support they received. However, the provider was not working in accordance with the Mental Capacity Act 2005 (MCA).

People received appropriate support with their nutritional and healthcare needs. Support needs in these areas were not always documented however.

People were supported by staff who received regular training and support to meet needs and carry out their role.

Is the service caring?

Good

The service was caring.

People and their relatives were consulted about their

assessments and involved in developing their care plans.

People and relatives confirmed that staff were always respectful and maintained people's privacy and dignity when providing care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always reflective of people's care and support needs and could put people at risk of inappropriate care. They lacked personalisation to enable staff to deliver care and support that was responsive to their needs.

Although care records needed improvement, people and relatives were involved in reviewing their care and found the service to be consistent and flexible.

People were confident in reporting concerns to the registered manager and felt they would be listened to. Arrangements were in place for dealing with complaints and responding to people's comments and feedback.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not established effective governance systems to routinely assess, monitor, and where required, improve the quality and safety of the service people received.

People's care and monitoring records were not consistently maintained to accurately reflect the care and support provided to people.

There was a registered manager in post. People, relatives and staff were positive about the management of the service.

HQ Priory Care Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This comprehensive inspection took place on 14 November 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was carried out by two inspectors 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 service.

We visited the office location on 14 November 2018 to see the manager and office staff; and to review care records and policies and procedures. We reviewed 11 people's care records to see how their care and support was planned and delivered. We checked employment records for five staff members and training and supervision records for the staff team. We also checked other records relating to the management of the service. These included staff allocation records, quality assurance audits, minutes of meetings, findings from questionnaires that the provider had sent to people and relatives, complaints and accident/incident reports.

We spoke by telephone with three people who used the service and six people's relatives to obtain their views about the care provided.

After our inspection, the registered manager sent us additional information we requested in relation to training for staff and policies.

Requires Improvement

Is the service safe?

Our findings

Risks to people's safety had not been fully assessed by the provider and did not inform staff how to manage people's risks effectively to help keep them safe. The provider's risk assessment included a tick box with a rating based on level of importance and high, medium or low risk. There was limited information about how people should be helped to move and transfer according to their individual needs or preferences and how to reduce the risks. Aside from reference to a person needing two staff to assist them, assessments did not take into account any risks associated with the equipment, the person's health conditions or any other individual factors. People's moving and handling assessments contained numerical ratings indicating how much support they required in each area, from fully dependent to independent. There were also risk ratings out of 10 indicating how high the risks were. However, these did not identify exactly what the risks were and how to minimise them. Five people's risk assessments were marked 10 out of 10, meaning the highest possible level of risk to them. For example, one person's risk assessment had a risk rating of 10 in relation to transferring to the toilet or commode but there was no further information about how to support them safely with this activity. Another person's assessment stated that staff should assist them to use the stairs, but there was no information about how this could be done safely and no mention of any equipment used for this task.

Where people's care was arranged by the local authority, they had provided the agency with comprehensive assessment information about people's needs and potential risks to their safety. However, we found the service's own risk assessments did not always reflect these details and copies of this information was not kept in people's homes. For example, one person's local authority assessment included, "I do feel anxious when the carers move me about, I have a hospital bed with airflow mattress. The carers use a slide sheet to move me about. This makes me anxious about having personal and continence care." There was no reference to this in the provider's care and support plan which stated, "All care in bed". The person's mobility rating had not been recorded and there was no reference to the equipment the person used or the number of staff required to support them.

Where people were at risk of developing pressure ulcers, there were no specific risk assessments or care plans covering what their risk factors were, how high the risk was and how staff should support people or what equipment people were using to reduce the risks. There was no information about whether or how often people should be supported to change position and care records did not show that staff were doing this. Where it was recorded that there was a low risk of people developing pressure ulcers we did not see any evidence of how the provider had arrived at this conclusion because there was no detailed assessment.

Risks associated with people's home environment had not been assessed. This meant the provider had not determined if the environment was safe for both the person and staff, by checking for potential hazards, the risks these posed and the measures needed to reduce these.

Although people told us they experienced safe support from staff and there had been no incidents of people coming to harm, there was a risk of people receiving inappropriate care. This was because staff did not have complete, accurate information about the risks associated with people's needs.

Medicines were not managed safely and in line with current guidance. We were therefore not assured that people received their medicines as prescribed. Although the service had policies in place which directed staff on how to ensure people received their medicines on time and as prescribed, these were not always followed. Care plans did not always detail the medicines that the person had been prescribed or the level of support the person required with the administration of their medicines. People's care plans contained information about the medicines they took although this was inconsistently recorded. Information about the dosage of each medicine the person was to take and its form, such as tablets was recorded. However, there were no details about what the medicines were for, how often and at what times of day they should be taken, what to do in the event of an overdose or what side effects were likely. Where people used topical medicines such as creams to help prevent pressure ulcers, there was no information other than "apply cream" in the care plans and this was not included on medicines administration records. This meant there was a risk that staff might apply the wrong cream or would not know what parts of the person's body they should apply it to.

Where people were prescribed medicines when required (PRN), there was no information about when the person should take them and why. One person's care plan stated that staff should support them with medicines "if needed." It was unclear what this meant. The same assessment also stated that the person's spouse dealt with their medicines. Another person's care plan had conflicting information about what type of support they needed with their medicines. This meant staff did not have accurate information about people's prescribed medicines, which in turn could lead to medicines errors.

Medicines administration records (MARs) did not include sufficient details about people or their medicines. MARs did not include the names of the medicines, dosages, how often or at what times they were prescribed for. Staff had recorded the date and time they supported people to take their medicines, but entries were incomplete or were illegible where times or dates had been corrected. One person's MAR showed staff usually supported them to take medicines four times a day, but within one week there was one day with only one entry, one day with two entries and two days with three entries. The inconsistency with record keeping meant we could not be sure people were receiving their medicines as prescribed.

Staff had completed medicines training although the registered manager had not observed their practice to check it was safe. The National Institute for Health and Care Excellence (NICE) guidance recommends workers should have their competency assessed annually. NICE guidance provides recommendations for good practice around management of medicines for adults who are receiving social care in the community.

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The required recruitment checks had not always been undertaken before staff began work. There was a risk of people using the service being supported by unsuitable staff. Application forms and information about the applicants' previous employment history was incomplete for three members of staff. The provider requested two staff references as part of their checks, but two staff members' files showed only one reference had been received. Whilst the registered manager told us they had followed this request up, there was no record to confirm this. In two files, employment references requested by the provider did not correspond with their most recent employment on the staff member's application form. In another staff member's file, a reference had not been obtained from their previous employment in health and social care. References were not always stamped to confirm the authenticity of the referee or confirm whether the applicant had worked previously in a registered care setting.

This meant the provider's recruitment processes were not robust enough and the provider had not obtained

all the necessary checks to verify staff were of good character and suitable for their roles. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager agreed to check all staff members' files and strengthen the recruitment process. We will check for improvements at our next inspection.

We did find other recruitment checks had been completed appropriately. There was confirmation of a criminal record check and staff only started in post once this had been received. Records showed that people's identity had been verified and the provider checked a person's eligibility to work in the United Kingdom where relevant. Interview notes, a health declaration and copies of qualifications and training certificates were also available on staff files.

Despite the above shortfalls, people and their relative told us they felt safe with the staff and the care provided. One person said, "Yes I feel very safe with them, they're all different but all very nice. I have built a relationship with them, a friendship. A relative told us, "My [family member] is safe and very well treated by the staff."

People were supported by staff who understood their responsibility to protect people from possible abuse. Staff attended safeguarding training as part of their induction and updated this every year. The provider had appropriate policies and procedures for responding to concerns of suspected abuse. The registered manager understood her responsibility to report any concerns and knew what action to take should an allegation of abuse arise. Two safeguarding concerns had been raised about the agency since it started operating. At the time of this inspection, investigations were still in progress.

People who used the service told us that there were enough staff to meet their needs. They told us that staff were punctual and always stayed their allotted time to make sure that all aspects of care were covered. People told us that they received their care and support from consistent staff members which enabled them to build up positive relationships. They told us they received their visits on or close to their chosen time and that significant delays from the care staff were rare. One person said, "They are rarely late but if they are going to be late for whatever reason, the office phones and apologises. I appreciate the traffic is awful, but their time keeping is very good and they are always sorry if they are late." Another person told us, "I have had some problems with carers not turning up on time but it's getting better as I've got regular carers now. I do feel safe with them. I never feel like I am just a quick visit that they have to do and leave as quick as possible. If they are late, they are most apologetic and I still get all my time, they are never in a rush to go, and stay the full half hour." Another person said, "[Staff are] very good with their timekeeping. They do everything they should and more and are never skimping or looking at the clock."

The service used an electronic scheduling system to plan people's visits, allocate staff and to monitor and ensure all calls were being attended in a timely way. This system provided clear information where staff cover was needed and if calls were cancelled by people or not required. Where people needed two staff to support them, the system highlighted this.

People were supported by staff who understood their responsibility to protect people from infection. Staff received training on infection control and food hygiene safety as part of their induction. Staff were provided with personal protective equipment and clothing and people confirmed these were always used.

Requires Improvement

Is the service effective?

Our findings

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 Act. The application procedures for this for people living in their own homes are through the Court of Protection. We checked whether the service was working within the principles of the MCA.

The provider's records covered mental capacity and did not assume people lacked capacity to make decisions for themselves. People had signed their care plans, assessments and a 'consent to care' form to indicate that they agreed to the proposed plan of care. However, we found the provider did not have a good understanding of the requirements of the MCA where people may not have had full capacity to make these decisions. They had not followed processes to assess people's capacity and ensure decisions about their care were made appropriately. For example, one person's care plan stated they had "undiagnosed dementia" and could "sometimes get confused". Another person's care plan stated that the person possibly had dementia and had difficulty making decisions for themselves. However, in both cases, a mental capacity assessment form had been marked as 'not applicable' despite the potential for either person's mental capacity to fluctuate or be reduced. Two people's consent forms had been signed by relatives on their behalf, despite the MCA stating that one person may not consent on behalf of another adult without the necessary legal powers. Neither of these people had a mental capacity assessment, which was marked as not applicable, and there was no evidence that they or anybody else had been consulted in making decisions about their care. A third person's consent form had not been signed at all.

We found information about people's mental capacity was contradictory regarding their capacity to make decisions about their care. One person's assessment included statements such as, "Expresses needs verbally and has full capacity," "does not have capacity" and a note that a relative had Lasting Power of Attorney (LPA) for this person. Two people's care plans noted that a family member had a LPA and therefore had legal power to make decisions on that person's behalf. However, a copy of the LPA was not available and there was no information about whether it related to healthcare or financial matters. This meant there was a risk of inappropriate decisions being made about people's care as the provider had not confirmed that relatives providing consent were lawfully authorised to do so.

The above issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had not followed the MCA principles in relation to documenting people's level of capacity, people confirmed that staff always consulted with them before they provided care and support. A relative told us, "They [staff] always ask my mother what she wants doing and do what she wants. She is in control." Another relative said, "She's [staff member] very nice and they chat away together while she's

helping him. I'd say he's fully consulted and involved with his care. It's all very relaxed and easy."

People's needs had been assessed by the registered manager and local authority commissioners. This enabled the service to check they had the necessary resources to deliver the right support. Before starting a homecare service, the manager met with people to determine what support and care people wanted and required and agreed the chosen frequency and times of calls. People told us their care needs had been thoroughly discussed with them and/or their family and they felt the care was specific to their needs. One person said, "I was fully involved in the care plan assessment - every step of the way. Everything was my choice. They chat to me all the time and say 'what would you like today?' and give me a choice." A relative told us, "The family were involved in the initial assessment and made sure it was enough for [my relative's] needs."

Despite the positive feedback, we found the provider's assessment records did not always reflect the details provided by the local authority. The registered manager confirmed that copies of needs assessments and information from the local authority were not kept in people's homes. She acknowledged that the agency's own assessment should reflect such information and agreed to change it to include more details about people's needs.

Feedback from people who used the service complimented staff's abilities and skills. They told us they felt were well-cared for and that staff knew them and their needs well. Comments included, "Goodness yes, they are well trained. They know how to use the hoist and I've never had any worries about how they look after her", "The girl that comes to help [my relative] seems very well trained and definitely knows her job and what she's doing" and "I think the girls [carers] we have are very well trained and suited to care of the elderly."

Arrangements were in place for staff learning and development. Staff completed induction training that reflected the Care Certificate, a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. A new administration staff told us they had worked alongside the registered manager to learn about how the agency ran and had also gone on visits to meet people and understand the carers role. Following induction, staff completed mandatory training relevant to their role and were expected to refresh this every twelve months. This training included medicines administration, moving and handling, health and safety, safeguarding and emergency first aid. Although staff had completed medicines administration training, we found the management of people's medicines was not safe. We recommend that the service finds out more about training for staff, based on current best practice, in relation to medicines management.

Staff files contained certificates to show what training had been completed and when. Other courses included fire safety, infection control, food hygiene, principles of person centred care, equality, diversity & inclusion, role of the home carer, MCA in practice, effective communication, dignity & respect, nutrition & wellbeing and dementia.

The registered manager told us staff had undertaken practical training through another agency on how to transfer people safely and use mobility equipment. Two members of staff had also undertaken training in PEG feeding to enable them to support a person's needs. We noted that all other training offered to staff was DVD based. The registered manager acknowledged that additional learning methods would broaden staff's knowledge and practice and agreed to look into other available resources, including local authority training.

Staff received formal support from the registered manager to discuss and review their development needs

and performance. This included supervision meetings every two months and an appraisal every six months. The registered manager also undertook unannounced observations of care staff in people's homes to check how care was being provided.

People were supported with nutrition and hydration where this was an identified need. People and their relatives told us they were always offered meal choices and support where this was needed. However, care plans did not always explain the support people required with their meals, their likes and dislikes, any cultural preferences or dietary requirements including specialist diets, such as those associated with a diabetes condition.

People felt their health needs were understood by staff who took prompt action when they were unwell or needed further healthcare support. One person told us, "One time they came and found me on the floor and the carer called the ambulance for me and stayed with me until they came - I don't know where else she should have been but she put everything else on hold to be there with me. Brilliant." Relatives told us the agency always contacted them if staff noticed their family member was unwell or needed to see the doctor.

Despite the positive feedback, we found care plans did not always reflect people's healthcare needs and how staff should meet them. Where people had specific medical conditions, there was a lack of detail around what these were and how they affected people. This meant staff may not know how to identify signs a person's health might be deteriorating or what action they should take in response. For example, one person had a history of severe mental illness that required a hospital admission, but there were no further details about this and no information for staff about any risk of relapse. Another person's assessment stated that they were no longer able to care for themselves because of their health problems but there was no information about what these health problems were. Two people's assessments described them as having borderline diabetes, a condition that may lead to them developing type 2 diabetes, but there was no information about how to support these people with their needs.

Records did show how staff monitored people's health and liaised with relevant healthcare professionals to ensure people received the care and treatment they required. For example, some people had involvement from community nurses. Staff had also contacted people's GPs on their behalf when they identified health concerns.

Good

Is the service caring?

Our findings

People told us the staff always treated them with consideration and kindness. They confirmed they were supported by regular staff which meant there was opportunity to build relationships and friendships. People spoke warmly about the carers that supported them and felt they were treated with respect. One person said, "The staff are lovely, I haven't had a bad one yet. I have got no complaints whatsoever. I couldn't ask for better staff; they never say no, nothing is too much trouble. They are patient and polite - respectful, they definitely go the extra mile." Another person said, "The staff are smashing, polite and professional - it's the highlight of my day when they come." Relatives were also positive about the staff. Their comments included, "They have a warm gentle manner, they don't rush. Sometimes they stay longer than their allowed time and they always ask if there's anything else they can do before they go and check that he is comfortable" and "I hear the carer talking to [my relative] when they are helping her. Everything is always very calm and unhurried - at her pace and in line with what she wants." Another relative said the carers always talked with their family member when supporting them.

Some people using the service had support from relatives living in their homes, so the care from the agency was additional to their main carers' assistance. People told us the carers provided invaluable social contact as well as physical help. A family member told us, "It's not easy having people coming into your home to help but the girls [carers] make it much easier with their attitude. They come in with smiles and are so considerate, not just of my [relative] but of me and my home too. They attend to his needs but they make time to speak to me and check I'm okay as well." Another relative commented, "I think what I like is the two that come to us now, they don't assume anything. They are very kind to my [family member] but they also recognise this is my home and they are careful in the way they do things. I can't fault them, I really can't."

People and their relatives felt confident that staff upheld people's rights to privacy, dignity and independence. One relative told us, "They allow her to do what she can for herself. They encourage her to try, it helps her to feel less dependent. It's very good care." People confirmed that staff always asked for their permission before supporting them and staff knew their preferences and needs. Everyone said that staff ensured their dignity and privacy was upheld whilst having care.

People's right to confidentiality was protected. In the office, people's personal information was kept secure and on the service's computer system, records were only accessible to authorised staff. In people's homes, care records were kept in a place agreed with the person using the service.

People were given information about the service they could expect to receive. When people first started using the agency they were provided with a copy of the agency's service user handbook and Statement of Purpose. We reviewed these documents which contained useful information about the type of services provided, what standards people should expect, how to make a complaint as well as details of the agreed calls, their duration and number of carers. This enabled people to make informed choices about whether the service could meet their needs.

Requires Improvement

Is the service responsive?

Our findings

People told us the service was reliable and staff stayed as long as they should. People said they had regular staff and received their visits at the times they preferred and needed. Relatives spoke about the benefits of the flexibility of the service. One relative told us, "The office staff are always very helpful if I have to ring to ask for a visit to be altered for any reason. They always change things round for me." Written feedback from another relative included "[Staff] has been a great help to us as a family in helping [my relative's rehabilitation] following 11 weeks in hospital. [Staff] even came in early whenever we asked him, if [my relative] had a hospital appointment and always had him ready when he had [his treatment]."

People and relatives said they had been involved in developing the care plan to take account of what their needs and preferences were. Not everyone we spoke with had been receiving support long enough to be at the stage of having a review. However, those people who had told us their care arrangements were regularly reviewed. One person said, "They review things every six months but if there is any change before that they would review it sooner. They often phone to check how things are going - they seem very concerned." A relative told us, "I wasn't involved in the original care plan but I am involved when they do the reviews."

The registered manager told us reviews took place when people's needs changed, such as after a period of time in hospital, following an accident or a reduction in the number of calls. However, there was no planned timescale for when people's care needs should be discussed with family and reviewed. The date of review stated "as and when required" in the care plans. This meant there was a risk ongoing reviews of people's needs could be overlooked.

Although people spoke positively about the care they received, this was not always reflected in their care records and the care plans did not provide sufficient information and guidance about people's particular health and social care needs. For example, care plans did not describe where people required particular support in relation to mobility, catheter care and for managing pressure ulcers. Plans did not always set out the best ways for staff to communicate with people with consideration of how conditions such as dementia and sensory impairments affected people's communication.

We found care records developed by the provider were not as person centred as they could be. People's likes, dislikes and preferences in respect of their daily routine were not recorded and care documentation did not always provide staff with information about the person's interests or details about the person's life history. This meant that if people found it difficult to communicate their needs there was no information to guide staff on people's preferred routines and to ensure that meaningful and relevant activities were provided. We did see one person's care plan explained how to support the person to be comfortable in bed, including which personal items staff should ensure were within reach for the person's comfort and safety, but other care plans did not reflect this type of information. The registered manager agreed to review and update people's records with more personalised details.

Similar to our findings in relation to risks to people earlier in the report, people had specific health and medical conditions and care plans lacked detail as to what these were and how these conditions affected

individuals and impacted on their daily living. This meant care staff did not have full information to enable them to support people in ways which were responsive to their needs. Although care plans were in need of improvement, people and relatives told us staff had a good understanding of people's needs and were happy with the support provided.

The service had been provided with comprehensive information from the local authority to enable staff to provide appropriate care yet this had not been included in the provider's own care plans. The registered manager acknowledged this and agreed to improve the documentation. This included plans to add a one page summary about the person to assist the emergency services with information about people's health and medical history.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

We discussed the Accessible Information Standard (AIS) with the registered manager. The AIS requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. The registered manager told us they would arrange for documents to be formatted into large print or another language if needed.

People knew who to speak to if they had a complaint or were unhappy with any aspect of the service. People and relatives told us they were confident any issues would be dealt with and had been given a copy of the complaints procedure. A relative told us, "We had a few issues with times with the early visits but that has been sorted out now. We spoke to the office about it and it was quickly dealt with." Another relative shared an example where they requested a change of carers and this was immediately addressed.

The local authority (LA) told us they had received eight complaints about the agency in the last twelve months and these had all been resolved. A representative from the LA told us complaints were "dealt with very quickly and professionally" and said, "[The registered manager] consistently liaises with [the LA] to feedback and seek support where necessary." Records supported what they told us. There was clear detail about the nature of the complaint, how it was investigated, action taken with the outcome and any measures put in place to reduce a reoccurrence. These included further training for staff, a change of carer in some cases and a reminder for staff on infection control procedures.

At the time of the inspection no one was receiving end of life care. We noted people's care plans did not include people's wishes, views and thoughts about end of life care as this had not been considered as part of the care planning process. We discussed this with the registered manager who told us they would consult with people and their families. Following our inspection, the registered manager confirmed she had contacted a hospice representative to obtain information about best practice and to organise end of life care training for staff. This would help ensure that people could be appropriately supported and staff had information about people's wishes, should this be needed in the future.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have adequate systems in place to monitor the quality and safety of the service. The provider had not identified the issues we found relating to people's risk assessments, care planning, medicines management, staff recruitment and providing care in line with the MCA. This meant people who used the service were at risk of receiving inappropriate care due to a lack of oversight by the provider. Without appropriate audits and checks, the registered manager was unable to assure themselves that the service was running effectively and issues were followed up and addressed. As outlined earlier in the report, we found care records were not up to date and reflective of the care people received.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of the service were well-led and the provider frequently checked if people were happy with the services they received. People and their relatives were asked for feedback via questionnaires and telephone calls each month. This involved asking people for comments about staff timeliness, kindness, training, communication and if there were any complaints or concerns. Records we sampled were all positive. People had responded "very good/excellent" on the two written questionnaires that had been returned. The registered manager also monitored complaints and identified poor timekeeping had been a theme when the agency first started. She told us this had now improved and comments from people and relatives supported this.

The registered manager or director carried out unannounced visits to observe staff practice and obtain feedback from people and their relatives. This enabled them to check staff were providing care to people in the best ways. Records showed positive findings on carers' performance. People consistently reported they were happy with their carers, also rating staff as good or very good. Where any improvements were needed, the registered manager addressed this. One example related to daily records and a discussion with the carer to record medical sheets accurately.

People and their relatives said the registered manager and staff were easily contactable and were very kind and supportive. Comments included, "I know the manager. I think the service is very good. I can always get hold of someone either at the office or on the emergency number - it's always manned. I think it's a consistently good service."

Without exception, people receiving support and their relatives said they would recommend the agency to their friends and family. Comments included, "Yes, absolutely I would recommend them, they were very good at sorting out the issues we had and everything is working very well with the current carers" and "Yes I think it's a good company, the carers are very nice and I think they are very conscientious. I wouldn't hesitate to recommend them."

There was a welcoming and open atmosphere in the service. During our inspection, the registered manager and staff were courteous and polite when responding to telephone queries from people, relatives and staff.

The provider had plans to recruit more care co-coordinators to support the management of the service.

People received a service from staff who worked together as a team and who felt supported by the registered manager. Staff meetings were held every two to three months and enabled staff to discuss people's care and support and any issues affecting the service. At the latest meeting, staff discussed improving practice related to medicines administration and the management of pressure sores. The registered manager maintained an electronic record to monitor staff training and ensure they refreshed skills and knowledge as needed.

People could be confident that important events which affect their health, safety and welfare would be reported appropriately. Records confirmed the provider had lawfully notified us about reportable events involving people using the service, such as alleged abuse or deaths and changes that happen at the service. Details of accidents and incidents were recorded in people's notes, monitored and reviewed each month by the registered manager. This was to check appropriate action had been taken to reduce the risk of them happening again. We noted there was no separate accident/incident form for staff to report on events such as falls or injuries. The registered manager agreed to address this and sent us an example copy shortly after our inspection. This would enable the service to have a better overview of any emerging patterns or themes where people came to harm.

The provider was prepared to work in partnership with other agencies to ensure people received the care and support they required. The registered manager had been engaging with external stakeholders, such as the local authority to look at ways of improving service quality, for example, end of life care arrangements and staff training.

This was a new agency and the registered manager understood what was required to develop the service. During our inspection, the manager welcomed any guidance we gave and recognised that further work was needed to meet the fundamental standards of quality and safety. Following our inspection, we were provided with evidence that she had started to make improvements, for example, with people's care records.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and reflective of people's assessed needs. They did not always include people's likes, dislikes, personal background or cultural and religious preferences. Regulation 9 (1) (3) (b) (I)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity, the provider did not act in accordance with the MCA (2005). Regulation 11 (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not ensured risks to service users' health and safety were adequately identified and managed and they did not follow safe and proper management of medicines. Regulation 12 (1)(2) (a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance

The provider did not have effective systems to assess, monitor and improve the quality and safety of the service.

The provider did not maintain accurate, complete and contemporaneous records in respect of people using the service.

Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that persons employed for carrying on of a regulated activity must be of good character. Regulation 19(1)(a). The registered person had not ensured that the specified information in schedule 3 of the regulations was available in respect of staff employed for the purposes of carrying out the regulated activity. Regulation 19 (3)(a).