Diverse Care Services Limited

Diverse Care Services

Inspection report

Sheldon Chambers, 2235-2243 Coventry Road
Sheldon
Birmingham
West Midlands
B26 3NW

Tel: 01214488590
Website: www.diversecareltd.co.uk

Date of inspection visit:
21 March 2018

Date of publication:
16 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 March 2018 and was an announced inspection. This was our third inspection at this location. At our last inspection in April 2016, the provider was rated as 'Good' and was found to be meeting all of the legal requirements of their registration including but not limited to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Diverse Care Services is a domiciliary care service which is registered to provide personal care services to people living in their own homes, including adults and older adults living with physical, learning and/or mental health conditions such as dementia. At the time of our inspection they were providing personal care and support to 80 people.

The provider is required to have a register 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was in post at the time of our inspection.

The provider had some systems and processes in place to monitor the quality and safety of the service. However, some of these were not always implemented effectively to ensure records were robust or that information gathered was used to drive improvements within the service. The providers quality assurance practices had failed to identify the shortfalls that we found during our inspection and had the potential to compromise the safety and quality of the service. Therefore, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we have taken at the end of the report.

The provider had not always ensured that staff had access to information regarding people's health conditions or associated risks such as specialist diets or epilepsy. However, people were supported by regular members of staff who got to know their care and support needs well through speaking with them and/or their family. Staff knew the risks associated with people's health and knew what action to take in order to keep people safe.

People were supported by enough members of staff who had the knowledge and skills they required to care for people safely and effectively. This included the safe management of medicines so that people received support to take their medicines as prescribed, if required. However, the provider had not always ensured that robust recruitment practices had been followed consistently to ensure only suitable people were employed to care for people.

People were protected from the risk of abuse and avoidable harm because staff received training and understood the different types of abuse and knew what actions were needed to keep people safe. The provider had also ensured effective systems were in place to report and investigate any concerns raised,

which included working collaboratively with external agencies.

People were supported by staff that were kind, caring and respectful and who took the time to get to know people and their families. People were encouraged to be as independent as possible, where possible and were supported to have food that they enjoyed.

People knew how to complain if they were unhappy and they were confident that their concerns would be responded to efficiently and effectively.

Staff reported to feel supported and valued within their work and felt that the provider maintained open, honest and transparent communication systems within the service. The provider had some management systems in place to assess and monitor the quality of the service provided to people. However, some of these were not always implemented effectively to ensure records were robust and information gathered was not always used effectively to drive improvements within the service.

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.

The provider had not always ensured staff had the information they required regarding people's health conditions and associated risks in order to care for people safely and effectively. However, staff knew people well and were aware of these risks and what action they needed to take to promote the safety of people they cared for.

The provider had not always ensured that robust recruitment practices had been followed consistently to ensure only suitable people were employed to care for people.

People were supported by enough members of staff who had the knowledge and skills they required to care for people safely.

People were protected against the risks of abuse and avoidable harm because staff understood how to keep people safe when providing care, could recognise the signs of potential abuse and knew what the reporting procedures were.

Staff had the knowledge and skills they needed in order to support people to take their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People's rights were protected by staff that understood their responsibilities to care for people lawfully.

People's needs were met by staff that were trained and supported to carry out their role.

People received enough food and drink and were supported to have food that they enjoyed.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect.

People were supported by staff that took the time to get to know them well and who understood the things that were important to them and their families.

Is the service responsive?

Good

The service was responsive.

People were included in the planning and reviewing of their care so that care was delivered in a way that met people's individual needs and preferences.

People's views were sought and the provider used this feedback to drive improvements.

People knew how to make a complaint if they were unhappy and were confident that these would be dealt with efficiently and effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had some systems and processes in place to monitor the quality and safety of the service. However, some of these were not always implemented effectively to ensure records were robust or that information gathered was used to drive improvements within the service.

Staff felt supported and valued within their work and reported good communication systems between them and the registered manager.

Diverse 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.

This inspection took place on 21 March 2018 and was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available at the office location. The inspection team comprised of one inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. The provider submitted their PIR as required. We also looked at the information we held about the service. This included statutory notifications from the provider that they are required to send to us by law about events that occur within the service, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection we spoke with nine people who used the service, six relatives of people who used the service, the managing director and the registered manager. We attempted to contact twelve care staff and managed to speak in detail with four.

We looked at the care records of four people in detail to check how their care had been planned, reviewed and recorded, which included the medicine administration processes. We also looked at five staff files to check the provider was adhering to safe recruitment practices as well as at records maintained by the provider about the quality of the service. These included records kept in relation to accidents and incidents,

staff training, competency checks as well as compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, the provider was rated as 'good' in this area. However, we found that some of the provider's assessment and record keeping practices did not always promote the safety of people and improvements were required.

We found that some risks to individuals had been identified and some management plans were in place. These included standard, generic risk assessments such as those relating to the environment as well as more individualised risk management plans, specific to the care needs of people. However, we found that these were not always sufficiently detailed or did not always include key information about people's health conditions and any associated risks. For example, staff we spoke with told us that one person they cared for was at risk of choking and required a thickening agent to be added to their drinks. This person's care plan and risk assessment did not detail the need for thickened fluids in order to reduce the risk of choking. We also found that one person was at risk of seizures. This was not identified as part of the provider's initial assessment process and had not been reflected in their care plan or risk assessment. Staff we spoke with told us that this person was supported by their relatives in the event of a seizure and if they suspected the person was having or had had a seizure, they would alert the relative immediately and record the incident in the persons daily care records. Staff advised that the person's seizure pattern determined what care they were required to provide. For example, if the person had experienced a seizure during the night, the family would inform the carers and they would not be required to provide personal care as the person would be left to rest. We asked the provider why this information had not been included within the persons care file. They told us that this was not detailed in the information they had received from the local authority when they were first asked to provide the care package and it was not identified at the time of the initial assessment. However, since receiving our feedback, the provider had consulted with the persons' relatives and their regular carer and had updated the persons care plan and risk assessment accordingly.

Further to this we saw that another person presented with behaviours that may be considered challenging, including verbal aggression, as part of their physical and mental health needs. This risk was not consistently reflected throughout the persons care plan and/or risk assessments and did not include detailed management plans to support staff to know how best to support this person at these times. Nevertheless, staff we spoke with told us how they ensured people were kept safe. One member of staff told us, "There is a lot of information in the care files but we get most of the information we need from hand overs when we first take over a person's care package and from speaking with their relatives; we are lucky that we get to see people on a regular basis so we get to know them well". Staff knew who required a specialist diet including thickened fluids, and those that had specific health related risk factors including, diabetes, epilepsy and behaviours that may be considered challenging. They were aware of the signs and symptoms to look out for if the person they cared for became unwell. Therefore, the lack of detail was not found to have an impact on the safety of care being provided to people at this time. However, sufficiently detailed records can promote the safety of people receiving care by ensuring staff have all of the information they require. We fed this back to the registered manager at the time of our inspection. We saw that they updated the care files of the people we had identified as part of our inspection immediately and assured us that they would review all other records and update them accordingly.

All of the staff we spoke with confirmed that the provider's recruitment processes promoted the protection of people who used the service. This included a formal interview, references and a Disclosure and Barring Service check (DBS). However, records we looked at showed that the provider had not consistently verified the validity and authenticity of staffs employment references in accordance with safe recruitment practices. The provider recognised this shortfall and stated that checks had been made, but not recorded. They agreed that a more consistent approach and additional quality monitoring checks were required in this area. We saw that staff performance was monitored and managed through regular supervision meetings and spot checks.

People we spoke with told us that they felt safe using the service. One person told us, "Oh yes, I feel safe with them [staff], they [staff] are nice people". Another person said, "Yes I feel safe, no-one comes here who worries me; they let themselves in and always leave me secure". A third person stated, "They [staff] make me feel safe and comfortable; my wife feels reassured too as she knows I am safe with them". A relative we spoke with explained that they felt their loved one was safe in the care of the staff because they seemed caring and they always ensured the 'job' was done properly.

Staff members we spoke with were able to explain to us how they kept people safe from the risk of abuse and avoidable harm. They shared with us their understanding of abuse and were all aware of their roles and responsibilities, including what the reporting procedures were. One member of staff gave us an example of a time when they had reported a safeguarding concern to the registered manger. They told us, "I was concerned about a service user [person] as I felt their needs weren't being met properly and they needed a review, so it could have been neglect; but [registered manager] spoke with their [persons] social worker straight away and spoke with the person, so it all got sorted very quickly". Another member of staff said, "There are different types of abuse such as physical, financial and neglect. I've never had any concerns, but if I did I would report them to my manager straight away and record it; I know I can call social services or CQC myself if I needed to but to be honest [management team] are very good at dealing with anything like that". Records showed that staff had received training on how to keep people safe from avoidable harm and abuse. The registered manager was also aware of their roles and responsibilities in association with making safeguarding referrals when required. Information we hold and records we looked at showed that a number of safeguarding concerns had been raised since our last inspection. We found that the provider had taken appropriate action and had liaised with the appropriate investigating bodies in order to assess and address the issues being raised.

All of the people we spoke with told us they received their care reliably and rarely experienced any late or missed calls. One person told us, "They [staff] are very reliable; I have had a late call but that was because of the snow, generally they are pretty much on time". Another person we spoke with said, "They [provider] are excellent, they even turned up here in the snow! You can't get more dedicated or reliable than that!". The registered manager showed us an electronic call monitoring system that they used to assist them in ensuring people received their care calls as planned. They explained that they monitored the system throughout the day and that it would alert them if a carer had not turned up to a care call or were running late. The registered manager said, "We contact the carer to make sure they are okay and get an estimated time of arrival; we would then let the person know that their carer was on their way to reassure them". We observed someone who had called in to the office to check on the status of their care call; the registered manager reassured them that the carer was running on schedule and would be with them on time. One member of staff we spoke with said, "We [staff] get a regular rota so we know who we are seeing and when, so we are able to get in to a good routine; they [provider] are also good at making sure we have enough time for travel between the calls". We saw that the electronic call monitoring system had access to a live mapping system via the internet which estimated the time of travel between one address and another. This allowed the provider to ensure care calls were scheduled and planned within a realistic time frame.

We found that some people required support to take their medicines. People and staff we spoke with, as well as records we looked at confirmed this. One person said, "The carer [staff] gives me my medicines in the morning, there's no problems, I always receive it on time". Staff we spoke with told us that they received training in safe medicine management and were able to tell us how they implemented this in their day to day work. One member of staff explained, "We [staff] always make sure our hands are clean. We check the details on the medicine pack to make sure they are for the person we are caring for and in date; then we pop them out and give them to the person to take with a glass of water, and then record on their medicine administration chart (MAR) that they have taken it". Another member of staff told us that some people need a little more reassuring and prompting, for example if they have dementia. In this instance, they told us they had to be extra vigillant to ensure the person had taken their medicines before recording it on the person's MAR. Staff we spoke with told us that if they noticed any changes to a person's medicines or saw that a person had not taken any medicines as prescribed; they would report this to the office staff straight away. This showed us that arrangements were in place to support people with their medication if identified as a support need.

We found some examples to show that the provider had learned lessons from incidents that had occurred within the service. For example, we saw that a number of people had raised concerns about the inconsistency of care staff at the weekends. The provider recognised the importance and value people held to the continuity of care they received from regular care staff and explored ways to prevent such issues from re-occurring in the future. This included sourcing additional staff specifically to work at weekends in order to promote greater consistency within the service. However, not all incidents within the service had always been recognised as opportunities to learn lessons and drive improvements; this was due to some ineffective quality monitoring practices within the service. Nevertheless, we found that this had not impacted upon people's safety but improvements in this area would promote the quality of the service. We fed this back to the provider at the time of our inspection. They recognised that more could be done in this area and advised they would re-visit their quality monitoring practices as part of their on-going internal service development plan.

Good

Is the service effective?

Our findings

Everyone we spoke with told us they thought the staff were well trained and had the knowledge and the skills they required to do their jobs safely and effectively. One person told us, "They [staff] seem to be [well trained] as they always know what to do". Another person said, "The older carers do [know what they are doing] definitely; some of the younger ones need a bit more time to break themselves in, but they are all fine". A relative we spoke with stated, "Mum has no complaints so they must be well trained to do their jobs". Staff we spoke with and records we looked at confirmed that they had received sufficient training and they were confident that they had the knowledge and skills they required to do their jobs safely and effectively. This included an induction programme which covered the care certificate as well as opportunities for shadowing other experienced staff before they started care calls independently. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. One member of staff told us, "The induction was great and I had the opportunity to shadow for a week. I had training and gained a lot of experience from my previous job but they [provider] needed to be confident I had the skills I said I did I suppose; it's very thorough and supportive". Another member of staff said, "When I first started I had a lot of training in the office and also spent time shadowing; I had to have my competencies signed off before I could start working properly and now we have regular refresher training". This meant that staff received a comprehensive induction programme to help them feel ready and prepared for the job. The registered manager had a system in place to monitor the training to ensure that any outstanding training was arranged. This included the electronic care planning system. The registered manager explained that staff details were also included within this system and that the system allowed them to allocate 'reminders' so that it would alert them when any training or outstanding actions were due, such as staff appraisals or reviews of staffs' Disclosure and Barring Service (DBS) checks. This ensured that people received care from staff that had the necessary skills to provide it.

Staff we spoke with told us that they felt supported with any day to day issues and that there was always someone available to offer help and advice during both the day and out of [office] hours. One member of staff said, "It is so much better than any other service I have worked for; [management team] are so friendly and approachable, you can call them about anything at any time as they are always available either in the office or 'on-call'. Anything you ask or mention gets dealt with straight away, there is no hassle or stress". Another member of staff told us, "It's very supportive here, I often come to the office to speak with [managers] and we have informal catch ups and formal supervision; we are listened to and you see changes based on feedback". A third member of staff gave an example whereby they were asked to visit a new service user and received a handover on the persons needs over the phone. They explained that by the next day all of the necessary paperwork was already at the persons home address. They said, "They [managing director] is so quick and efficient at making sure we have everything we need to care for people properly, it's very good". We found that the provider held regular spot checks and supervision sessions with staff to continuously monitor their performance and competencies as well as to discuss any other learning and development needs or to offer support and guidance as required. Records we looked at also showed that the provider held regular team meetings and information was also shared with staff via a social media forum. The registered manager explained that they could send group communications to all staff via this

forum but the security setting ensured that any replies from staff were only visible to the management team to promote staff confidentiality. Staff confirmed that collectively these systems ensured there were effective and supportive forms of communication within the service.

We found that care was provided to people with their consent. People we spoke with told us that staff involved them in making choices and decisions about their care. One person told us, "They [staff] always ask before they do anything". Another person confirmed, "Yes, they usually check with me what needs doing, especially if it's anything for the first time, but I have had them for a while now, they know my routine and they just do it".

The Mental Capacity Act (MCA) 2005 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 so that they can receive care and treatment when this is in their best interests, for example, to keep them safe and when it had been legally authorised under the MCA 2005. In order to deprive a person of their liberty within the community, providers are required to notify the local authority who is responsible for applying to the court of protection for the authorisation to do so. The provider advised that no-one they cared for was receiving care under the court of protection at this time. They stated that a person's capacity to accept a care package was assessed as part of provider's initial assessment and then regularly reviewed. The provider was able to explain their understanding of their roles and responsibilities in this area and stated that if a person's capacity was compromised they would make a referral to social services for a best interests meeting to be held in order to ensure the relevant processes were followed. If necessary, an application would then be made to the court of protection via the local authority. Staff members we spoke with were also aware of the Mental Capacity Act 2005 and the implications this had in practice. One member of staff told us, "It [consent] is about talking to them [people] and asking them [people] what they want and need; I would always ask for their permission before doing anything and it's important that we always give people choices about things like food and what they want to wear". All of the staff we spoke with told us that they would always assume a person had capacity to consent and make choices and if a person refused care they would respect their decision and would alert the office, unless their care plan reflected care was to be provided within a person's best interest. In these situations, staff explained that they would offer reassurance and encouragement to a person, which may mean leaving the room and returning later to try again. One member of staff gave an example of a person they cared for living with dementia, they said, "Sometimes [person] will refuse to have a wash or get dressed and they can get a bit aggressive, so I just leave the room and give them time to calm down and then try again. They know me and I know them so well because I see them first thing in the morning and last thing at night, seven days a week, so you get to know how to support a person. I know when they are likely to come around or when they are adamant [in their refusal], so as long as they are safe, I will just try again the next time I visit; it's never a problem". Training records we looked at showed us that staff had received training on supporting decision making and mental capacity act awareness.

We found that people were supported to have sufficient to eat and drink and that staff prepared food that they enjoyed. One person we spoke with told us, "The carers ask me if I want anything to eat or drink". Another person said, "I can make myself a drink but the carers do always leave one out to make sure I have enough". A third person stated, "I am offered a choice [of what to eat or drink]". We found that where people were supported to eat and drink, this was in keeping with their care needs and preferences. For example, we saw that people's care records included information about the types of foods and drinks they enjoyed. One person's care file read, "[person] I like to have a sandwich or sometimes beans or egg on toast for a change; to drink, I like tea with one sugar". Staff we spoke with were aware of people's preferences and dislikes but

also recognised the importance of giving choice. One member of staff said, "Many people I visit are like me, creatures of habit and you find they will have the same thing for breakfast most days but would prefer a variety at lunchtime; we always ask though". Staff we spoke with were also aware of people's special dietary requirements including those with diabetes or for example, people who have been prescribed a specialist diet from a speech and language therapist due to swallowing difficulties and the associated risks of choking.

Everyone we spoke with and records we looked at showed that people were supported to maintain good health. One person told us, "They [staff] definitely look out for me, they advised me to see the District Nurse once". Another person said, "They [staff] are very good; they have checked me over and advised me to go to the doctor once or twice". Staff we spoke with were familiar with people's health needs and were able to tell us what action they would take if someone became unwell or if their needs had changed. One member of staff we spoke with said, "We get to know people really well, so we can tell when something's not quite right and would always notify the office and support them to see the GP if necessary". Another member of staff gave an example of how a person's mobility needs had changed and they informed the office who immediately made a referral to the Occupational Therapist for a review. Records we looked at confirmed this.

Good

Is the service caring?

Our findings

Everyone we spoke with apart from one person told us that the staff were kind, caring and patient. One person said that some care staff could be abrupt, but they were unable to elaborate or provide any examples of this. Nevertheless, we fed this back to the provider for further exploration. Other people we spoke with were very positive about the staff that supported them and told us that they generally saw regular care staff and were able to build a good rapport with them. One person said, "They [staff] are all kind and patient". Another person told us, "All of the care workers who have visited have been lovely". A relative stated, "They [person and carer] have a good laugh together".

People and staff we spoke with and records we looked at showed us that staff took the time to get to know people and they were able to develop positive relationships with the people they cared for. One person could not praise their care staff enough and told us that switching care agencies to Diverse Care had restored their faith in the care system. They said, "They [staff] are the best ever, if it wasn't for Diverse Care I couldn't see a way forward; they are all brilliant and deserve a reward for doing such a difficult job". It was evident from speaking with staff that they had gotten to know the people they cared for well. One member of staff told us, "You see the same people day in day out and you get to really know them and become fond of them. Some of them only see us in a day so it's important that we spend time with them and have a chat; it's lovely. It's just so sad when they die. I was at a funeral last week for one of my ladies; I'll miss her".

We found that people were supported to maintain their independent living skills as much as possible. One person we spoke with told us, "They [staff] always encourage me to do things for myself, to do as much as I can for myself, not pushing me, but they know it is better if I can keep doing things". Another person said, "They [staff] help me to keep my independence and only help me with things I can't manage but let me do the things I can". A family member said, "They [staff] do encourage him to do things and will encourage him to move his arms and his legs as best he can". We saw that care plans were developed to encourage people to maintain their independence and identified tasks that they were able to do for themselves and the level of support they may require. For example, we saw a care plan that recognised that a person was able to wash themselves, but required reminding and prompting from care staff due to memory difficulties. Staff we spoke with told us they offered people gentle encouragement and prompting during personal care tasks and only assisted when required. One member of staff said, "Its important people remain as independent as possible, we don't want to take their skills away, but some just lack confidence or need reminding and encouragement".

All of the people we spoke with said that the staff were respectful and were mindful of protecting their privacy and dignity. One person gave us an example of this and told us, "When I am in the bath they will come out of the bathroom because I can wash myself, and they will come back in when I call them. They will help me out of the bath and put a towel around me; they turn around whilst I dry my private areas". Another person said, "They [staff] always close the doors and curtains". A third person stated, "They [staff] are always very polite and respectful". A relative we spoke with informed us, "They are caring when washing him and they cover him over with the towel". We confirmed this by speaking with staff. One member of staff told us, "We always make sure doors and curtains are closed during personal care". Another staff member said, "We

will always make sure people's privacy and dignity are respected as much as possible by closing curtains and doors, and for example by asking family members to leave the room if needed; I will always speak to them as well throughout to distract away from it a bit".
People told us and records showed that people were actively involved in their own care and they felt listened to. We saw care plans were reviewed regularly as a matter of routine or as required if their needs changed. One person told us, "There is a care plan in my book and my last review was September last year; nothing's changed". During our inspection we heard people contacting the office to make changes to their care plan and call schedule which was further confirmed by records we looked at. These changes were accommodated and showed that the service listened to people, acted upon their requests and put people in control of their care.

Good

Is the service responsive?

Our findings

We found that people were receiving personalised care that was responsive to their individual needs. People told us that they had a choice about aspects of their care including the preferred time of their care calls, the level of support they required and whether they received their care from a male or female member of staff. One person told us, "We chose what time they [staff] come within reason and we usually know who's coming because its regular, but if not they usually will let us know". Another person said, "Yes, we are involved in making decisions about when and who visits and what we need [support with]". A third person explained, "Yes, they ask me [want I want]; I asked to have a lady for personal care and they do always send a lady". This showed that the provider was respectful of people's wishes, choices and preferences when planning and delivering care services.

We saw personalised care plans where people were referred to by their preferred name and their personal beliefs, values and preferences were respected. People we spoke with confirmed this and told us that staff were aware of their cultural beliefs and preferences. One person told us, "They are aware of my cultural beliefs". A relative we spoke with said, "They [staff] converse with him about things like that so they know about his cultural beliefs but he doesn't have any preferences with regards to gender but other preferences like food, times are respected". Staff we spoke with were mindful of respecting people's wishes, preferences and personal beliefs and values. One member of staff told us, "We get to know people well and respect the way they likes things done; everyone is different at the end of the day". Another staff member told us, "I am aware of peoples religious and cultural beliefs because this is included in their care plans but I don't care for anyone at the moment who is actively practicing a religion that affects the way I care for them, but I have in the past, like halal meat or vegetarian diets or some Caribbean people have a specific way of cooking or specialist products for their hair". Care records we looked at had detailed care plans which informed staff of how people liked things done.

We spoke to the provider about how they ensured other aspects of people's equality and diverse needs were met, for example, concerning their sexuality. The registered manager advised that at present, they were not providing care to anyone who identified themselves as Lesbian, Gay, Bisexual, or Transgender (LGBT). However, they informed us that they recognised the importance of respecting people's choices and preferences in accordance with all diverse care needs irrespective of the protective characteristics (as defined by the Equality Act 2010 including but not limited to age, disability, race, religion or belief, and sexual orientation) they related to. They said, "We always speak about people choices and preferences with regards to the care they receive and we tailor the service we provide accordingly to be sensitive to and respect any specific requirements. We also do this for staff; for example we have some staff who are Muslim […] and have [expressed] their preference for providing care to females; we respect this and plan the rota accordingly".

People we spoke with and records we looked at confirmed that people were consulted for their feedback on the service. One person we spoke with said, "The girls in the office [management team] came out to make sure everything was okay". Another person told us, "We have had a couple of questionnaires". The registered manager told us and records we looked at showed that the provider sent satisfaction surveys out

to people asking for their feedback and would visit people to undertake a review of their care when required. Most of the feedback the provider had received to date had been positive and any queries or concerns that had been raised outside of this process had been dealt with using the complaints procedure.

We saw that the provider had a complaints policy and procedure. Information pertaining to this was included in the information starter pack which was given to people when they first joined the service. All of the people we spoke with were aware of who the management team were and what they would do if they wished to raise a complaint. People were confident that their concerns would be dealt with effectively and efficiently, and those who had raised a concern reported to be satisfied with the providers response. Records we looked at showed that complaints had been recorded along with the action that had been taken to address the issues raised. To develop this further, the provider spoke of their intent to evaluate the outcome of the action taken at a later date by following this up with the person to ensure that the action taken had continued to be effective at preventing the situation from re-occurring in the future. The provider also recognised the benefit of keeping a log of smaller issues that were raised, which were not considered formal complaints, but required some action to be taken to improve service user satisfaction. This would further enhance the quality monitoring practices and support the provider to drive improvements.

Requires Improvement

Is the service well-led?

Our findings

At our last insepction, the provider was rated 'good' in this key question. However, at this inspection, we found that the provider had not sustained a good standard of practice in all areas of their quality monitoring systems and processes and some improvements were required.

The service was required to have a registered manager in place as part of the conditions of their registration of the service. A registered manager was in post at the time of our inspection.

It is a legal requirement for providers to display their rating, to show whether a service was rated as outstanding, good, requires improvement or inadequate following an inspection. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of the care provided. The provider has a regulatory duty to ensure that ratings are displayed legibly and conspicuously at both the office location and on their website within 21 calendar days of the date at which the inspection report was published. We found that the provider had not displayed their rating on their website effectively. We checked the provider's website when planning for the inspection and found that they had an interactive CQC logo which directed people to the report on our website; however, the rating was not displayed and there was no guidance to the public to click on the logo in order to be re-directed to the provider's CQC report on our website. We discussed this with the provider at the time of our inspection. They informed us that they believed the interactive logo was sufficient and were unaware of the specifics of the regulations requirement. The provider contacted their webpage designer immediately and this was rectified within 10 minutes of the call. The provider had displayed their rating at the office location.

We saw that the provider had some systems and processes in place to support them to monitor the quality and safety of the service. However, we found that some of the provider's quality monitoring practices had lapsed since our last inspection. The registered manager explained, "When we were last inspected we had a consultancy agency supporting us with our quality monitoring practices which included more in-depth analysis of results and information that we had gathered from things like surveys and complaints. Regrettably, since disengaging with the consultant, we have not kept this up as well as we had hoped". This reflected our findings. For example, we found that monitoring checks of staff recruitment files had failed to identify the inconsistent approach to verifying the authenticity of staff's employment references. We also found that internal processes for auditing the care files were flawed and had failed to recognise the omission or inconsistent recording of important information, including information relating to peoples support needs and risk management plans. Furthermore, feedback received from people and/or those closest to them by way of complaints, satisfaction surveys or care reviews had not been collated and analysed to enable the provider to identify any trends or themes that could support them to drive improvements within the service. Nor had any actions taken or outcomes been evaluated for their effectiveness. Whilst no harm had come to people as a result of these shortfalls, the provider recognised that these were areas that required improvement in order to promote the safety and quality of the service moving forward.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. The provider informed us that they had recently recruited to a senior care post and planned to draw on the skills of the appointee to undertake some of the internal quality monitoring practices. The registered manager explained that this would allow for 'fresh eyes' and a more 'independent' viewpoint on the practices embedded within the service in order to promote increased validity and reliability of the quality monitoring systems and processes. We will monitor the effectiveness of this new role and check improvements made to the quality monitoring at our next inspection.

Providers are required by law to notify us of specific events that occur within a service by submitting statutory notifications. These are forms that we ask the provider to send to us, to inform us of any situations or incidents that are happening within the service that we need to be aware of such as accidents/incidents, safeguarding concerns and/or deaths. Information we hold showed that the provider had submitted some notifications to us detailing events within the service. However, upon further exploration, the registered manager had not always recognised some incidents as reportable and had therefore not submitted a notification to us. We discussed this with the registered manager and they explained that some information had been shared or discussed with them by social workers but they had not been made aware that the incidents were being investigated as potential safeguarding concerns, but more as a complaint or care review. Following our discussion, the registered manager was able to demonstrate their enhanced clarity of their understanding of what constitutes as a reportable incident or event and they were aware of their roles and responsibilities with regards to submitting statutory notifications to us.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. The provider submitted their PIR as required and the information provided was detailed and on the whole, reflected our findings, with the exception of some of the shortfalls outlined above which had not been effectively captured by the providers quality monitoring systems.

There appeared to be a clear leadership structure within the service and people and staff we spoke with knew who the registered manager was and how to contact them if they needed to. All of the staff we spoke with told us that the communication between the management and staff was effective, open and transparent. They felt involved and well informed of any changes or developments within the service. Staff also told us they felt supported within their work and reported the registered manager and the managing director to be 'supportive' and 'approachable'. One member of staff said, "It's a really nice place to work, I am always popping in to the office and they [management team] always make time to speak with you; they make sure we haven everything we need". Another member of staff told us, "It's great, there's no stress or no headache about anything here, it's well run and well organised and nothing is ever a problem, you can call or go to the office any time". Staff we spoke with also told us they felt valued and listened to within the service. The provider recognised the hard work and commitment of staff and told us that they showed their appreciation through enhanced payment schemes. For example, they advised that they had recently introduced payment for travel and training costs as well as increased staffs salaries to above the minimum wage. The registered manager also said, "We always recognise good practice and this is acknowledged". They gave us an example of how a member of staff had gone 'above and beyond' their duties in caring for a person who was at the end of their life. The family had taken over the care of their loved one at this time, but the person's regular carer continued to visit in their own time to provide ad-hoc respite breaks and support to the family members. The registered manager told us, "This was really appreciated by the family and demonstrated not only the caring nature of the staff member but also their devotion to the people they care for and their families. We sent them a bouquet of flowers and a card to say 'Thank you'".

We asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that

requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was able to tell us of their understanding of this regulation and showed us examples of how this was implemented in practice. For example, complaints records showed how the provider had acknowledged the complaint and contacted them to apologise and inform the complainant of the actions taken. We also found the provider to be open, honest and co-operative throughout the inspection process. We found that the provider was well organised and any information we asked for was provided without delay.

Whistle-blowing is a term used when a member of staff raises a concern about wrong-doing or illegality that may be occurring within the organisation in which they work. Whistle-blowers are protected by law to ensure that they are protected as far as reasonably possible, against the risk of reprisal. Staff we spoke with confirmed that they were aware of the whistle-blowing policy and processes within the organisation and felt confident raising concerns both internally and externally (with CQC for example), if they felt that this was required.

We found that the provider had developed good working relationships with external agencies to the benefit of the people they supported, including social workers, district nurses, local GP's and other health care professionals, such as Occupational Therapists.

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 17 HSCA RA Regulations 2014 Good governance The provider had some systems and processes in place to monitor the quality and safety of the service. However, some of these were not always implemented effectively to ensure records were robust or that information gathered was used to drive improvements within the service. The providers quality assurance practices had failed to identify the shortfalls that we found during our inspection and had the potential to compromise the safety and quality of the service.