Continuity Healthcare Services Ltd

Continuity HealthCare 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

The inspection site visit took place on 27 and 28 February and 3 April 2018 and was announced. The inspection was prompted in part by information of concern received from a member of the public, about the standard of care being provided.

Continuity Healthcare Services is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to adults with different needs, including dementia, physical disabilities and learning disabilities. The service provides twenty four hour support to two people. There were 38 people using the service at the time of our inspection visit.

At the last inspection in January 2017, the service was rated Good overall. However at this inspection we found improvements were required in the provider's understanding of their responsibilities as the registered person. They had not ensured that systems were established and carried out to effectively assess, monitor and improve the safety of the service, or assess, monitor and mitigate the risks relating to the health and safety of people who used the service. They had not maintained accurate and complete records for people and their governance system did not ensure their practice was always evaluated or improved. Therefore the rating has changed since our previous inspection, from Good to Requires Improvement overall. This is the first time the service has been rated Requires Improvement.

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. The registered manager was also the provider, therefore we will refer to them as the provider throughout the report.

The provider lacked some understanding of their responsibilities as a registered person to have oversight and to ensure that systems were maintained to effectively manage events to keep people safe and to evaluate events to make improvements to the service. An allegation of abuse had not been referred to the appropriate authorities. Some staff had gaps in their knowledge of essential issues, such as safeguarding adults. There was a lack of consistent and central recording of events, including incidents, safeguarding concerns, complaints and medicine errors.

We found processes to monitor the quality of service were not always effective and improvements were required in the way the service assessed, monitored and improved the quality and safety of the service for people. Audits were not always followed up to ensure action had been taken where improvements were required.

People's records were not always complete and accessible. Care plans contained gaps and were not always accurate. We found some identified risks relating to people's needs had not been assessed in full on their care plans. Staff records contained gaps. It was not clear what care qualifications staff had or when the

provider had checked staff's suitability to work with people who used the service.

There were gaps in the provider's understanding of their responsibilities in relation to the Mental Capacity Act 2005 [MCA] and improvements were required to ensure people's capacity was assessed where required and consents were obtained in accordance with the MCA.

People told us individual staff members were caring. Staff knew people well and understood their likes, dislikes and preferences for how they wanted to be cared for and supported. Staff respected people's right to privacy. People were supported to eat and drink a diet that met their needs and preferences. They were supported to maintain their health.

People were confident to raise any concerns or complaints about the service, however improvements were required in the way people's feedback about the service was managed and how information was made accessible to people.

The provider had been working closely with commissioning authorities to make recommended improvements to the service.

We found breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

Events that might mean a person was at risk of harm were not consistently identified and managed effectively. An allegation of abuse had not been referred to the appropriate authorities. Some risks to people's health and safety had not been properly managed to protect them. It was not clear when the provider had checked staff's suitability to work with people who used the service. People received their prescribed medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some staff had gaps in their knowledge of essential issues and had not been encouraged to develop within their roles. There were gaps in the provider's understanding of their responsibilities in relation to the Mental Capacity Act 2005 [MCA] and improvements were required to ensure people's capacity was assessed where required and consents were obtained in accordance with the MCA. People were supported to maintain their health.

Is the service caring?

Good

The service was caring.

Staff knew people well and understood their likes, dislikes and preferences for how they wanted to be cared for and supported. People told us staff were caring and respected their privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were confident to raise any concerns or complaints about the service, however improvements were required in the way comments about the service were managed and how information was made accessible to people.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of understanding and oversight by the provider, which meant people may be at risk of harm and management systems were not always effective because they did not identify concerns or drive improvement at the service. The provider had worked closely with commissioning authorities to make improvements to the service and people were satisfied with the service. Staff felt supported by the provider.

Continuity HealthCare 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 was 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.

The inspection visit took place, on 27 and 28 February, and 3 April 2018. It was a comprehensive inspection and was announced. This was to ensure the provider and staff were available to talk with us when we visited. The inspection was undertaken by one inspector.

The inspection was prompted in part by information of concern received from a member of the public, about the standard of care being provided to one person. The information shared with CQC was of concerns about the management of risk of dehydration. We looked at this as part of our inspection.

Due to the short timescale between scheduling and conducting our inspection visit, the provider was not asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The provider was able to tell us the information we would have asked about in the PIR.

Prior to our visit we reviewed the information we held about the service. We looked at information received from the public and from local authority and NHS commissioners. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority or by the NHS. Both commissioning authorities told us they had made visits to the service within the last 12 months, following complaint information they received about the standard of the service. The NHS commissioners made a placement stop on the service between October and December 2017, whilst the service made required improvements. A placement stop is where commissioners do not refer new people to be supported by the

service.

During our visit we spoke with the provider, the care coordinator and five care workers. Following our inspection visit we spoke with one person who used the service and seven relatives to ask for their views of the service.

We reviewed seven people's care plans to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated this key question as Good. At this inspection we found improvements were required in how risks to people's health and safety were managed, how events which might mean a person was at risk of harm were managed and referred to the appropriate authorities. Therefore the rating has changed since our previous inspection, from Good to Requires Improvement.

We looked at how people were protected from the risk of abuse and spoke with staff to gauge their understanding of their responsibilities to safeguard people who used the service. Staff had limited knowledge of adult safeguarding procedures and told us further training in safeguarding would be beneficial. For example, no member of care staff we spoke with, including senior staff in the care office, were aware allegations of abuse should be reported to the local safeguarding authority for statutory investigation of concerns. The provider told us until January 2018, they had trained new staff themselves in adult safeguarding procedures, however our discussions with the provider demonstrated they lacked of knowledge about their responsibilities to report safeguarding allegations to the appropriate authorities. We discussed this with the provider, who acknowledged there was a gap in their understanding of the procedures.

Therefore they assured us they would arrange further safeguarding training for all staff to ensure their skills were updated with an external trainer. When we returned on the third day we found improvements had been made. We found they had made a referral to the local safeguarding authority for one person and actions had been taken to protect the person's safety. They had not notified the CQC of the event, but forwarded a statutory notification to the CQC following the third day of our visit.

The provider had not given people who used the service or staff, contact details for the local safeguarding authority. This meant people and staff did not know who to contact if they had a concern. Two relatives told us, "No I wouldn't know what to do. I would call the Police" and "I've never heard of a safeguarding team. I don't know if I have the telephone number." The provider's safeguarding policy was not up to date and did not include the local authority's adult safeguarding procedures and contact details. When we returned on the third day we found the provider had displayed contact details for some local safeguarding authorities in their care office and they assured us they would provide contact details to people in their own homes.

We found this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, the provider updated the policy to include the local safeguarding authorities contact details and made these available to people in their care office. However, they did not confirm how they would make this information available to people in their own homes. On the third day of our inspection we saw evidence care staff were in the process of carrying out an online refresher course in safeguarding.

Prior to this inspection visit, the CQC received information of concern, that a person using the service was not receiving sufficient hydration to keep them well. During our visit we looked at the records available for

this person. The provider was only able to share limited information with us because they had not obtained the person's care records from them when their care package ended. We found the care plan identified risks associated with the person's needs and these included a known risk of dehydration. However, there were no detailed assessments of the identified risks, such as dehydration, although the care plan provided care staff with basic guidance on how to reduce risks to the person's well-being. Due to the gaps in the person's care records, we could not see how staff supported the person on a daily basis. Due to the lack of records available, we obtained further information from the authority who commissioned the person's care about how they were supported. We found the concern had not been substantiated and the person had been supported in a way that met their needs.

We looked at whether the risks to people's health and well-being had been properly assessed and their safety monitored to ensure they stayed safe. The provider told us they wrote people's care plans and risk assessments. From the care plans we looked at, we found some identified risks had been recorded but not all. For example, one person required support with percutaneous endoscopic gastrostomy [PEG]. PEG is a medical procedure where a tube is passed into the stomach, in order to maintain people's well-being when they are unable to take in food and drink orally. The person's care plan contained some guidance about the person's PEG needs and care staff had updated the person's daily records confirming how they supported the person with this need. The person's relative also confirmed care staff supported their family member with this need. However, the provider told us staff did not support the person with their PEG requirements because their relative did this and so there was no specific care plan or assessment of risk for this activity on the person's records. We discussed with the provider there was evidence care staff were supporting the person with this need and therefore guidance should be available to care staff to enable them to support the person safely and any risks should be clearly assessed to protect people. They told us they would review the person's care needs and update their care plan to clearly identify what support they required.

A further example where we found risks to people's safety had not been managed properly concerned the same person. The person's relative told us they were unable to move without support and they had no specialist equipment to support them to move around inside their home. There was no specific care plan or assessment of risk for how the person was supported to move around within their home and it was not clear from talking with care staff, how the person was being supported. We discussed these issues with the provider who gave us their assurances they would contact the person's funding authority for advice and review the person's care plan and risk assessments straight away. On the third day of our inspection visit, the provider had not reviewed or updated the person's care records.

Another person's care plan recorded they used specialist equipment to support them with their mobility, and used pressure relieving equipment to reduce the risk of skin damage. Records showed the person had limited ability to communicate verbally. We spoke with the provider about the person's needs and they told us the person used a hoist in their home to support them to move about. The person's care plan did not provide information about the hoist and how staff should support the person to mobilise within their home. In addition, there was no risk assessments associated with the person's limited mobility, risk of skin damage or communication. This meant the risks to this person's health, safety and well-being, had not been properly managed and they could be at risk of receiving care that was inappropriate or not safe.

The provider told us no one had been assessed for their risk of falls, despite telling us some people had limited mobility and were supported to move using specialist equipment. This meant people could be at risk of falls. Therefore this demonstrated the provider's lack of understanding about their responsibility as the registered person, to ensure risks to people's safety were minimised.

We looked at how accidents and incidents were reported and how the provider used the information to

identify patterns or trends to help minimise risk. The provider told us they were aware of six 'incidents' which had occurred over the last 12 months, however, the information related to these incidents had been held at each person's house. This meant the provider was unable to get an overview of incidents and take the necessary improvements. The provider acknowledged this and said in future they would make sure incident reports were held centrally at the care office. On the third day of our inspection, we found the provider had still not obtained copies of the missing incident reports. They told us the reason incident reports were not recorded in a consistent way was because, "I was overwhelmed at that time, but now I have more staff to share the work and I can monitor events."

The provider showed us how late and missed calls were recorded in a hand written list. Since their record began in July 2017, the provider had recorded one missed care call in October 2017 and 4 late care calls. The provider's record contained no evidence of how the missed care call had been managed and what actions had been taken to reduce the risks to the person involved. We discussed this issue with the provider who told us, "I would speak to the carers involved and I would advise the funding authority about the missed call."

It was not clear when recruitment checks had been carried out to make sure staff were suitable and of good character to support people safely before they began working for the service, as there gaps in the records. Records showed the provider's recruitment procedures included obtaining references from previous employers and checking staff's identities with the Disclosure and Barring Service (DBS) prior to their employment. The DBS is a national agency that holds information about criminal records. However, records did not clearly show when DBS checks had been obtained and how they were checked by the provider, before staff started working with people who used the service. We discussed this with the provider and since our inspection visit they have provided their assurance all staff have undergone appropriate checks and these have been recorded on their files.

The provider told us not all staff received medicine training and staff who were not trained, did not support people with their medicines. The provider told us they completed observations of staff and signed them off as competent before they could support people alone with their medicines.

Staff completed hand written medicine administration records (MAR), in people's homes, to record when medicines had been administered. The provider told us they completed the initial information on people's MARs and these were distributed to their homes by care staff. We saw the MARs contained pictures of medicines on them which did not reflect the medicines the person was taking. We discussed this with the provider and explained this may be confusing for care staff if they thought the pictures were supposed to represent the actual medicines to be administered. In addition, there was no place on the MARs for staff to make additional comments about reasons why medicines may not have been administered and they did not identify if the person had any allergies. We discussed these issues with the provider and we found on the third day of our inspection visit, they had reviewed the format of the MARs to make them clearer in accordance with current best practice.

The provider told us they completed a MARs audit for each person, every two weeks, when care staff returned people's daily records to the care office. They told us at present they were two months behind with this audit. We looked at an audit completed for one person in December 2017. We saw errors and actions for improvement had been identified, however completion of actions had not been checked. We discussed this with the provider who told us they had completed some of the identified actions to make improvements to the service, but had not recorded them on the audit.

We found there was no central or consistent method of recording medicine errors. The provider told us there

had been one medicine error in the last 12 months, however this record was not available as it was in the person's care plan in their home. Due to the lack of records, it was difficult to see how the medicine error was managed to improve the service and reduce risks for people to make them safer.

The provider and care coordinator explained care calls were scheduled for people using an electronic rota system. At present care call times were being monitored by the provider, as they manually checked the times staff had signed in and out on people's daily records, as part of their care plan audits. The provider told us they were made aware of late or missed calls by people or staff telephoning them to advise of any problems.

People told us there were enough staff to provide them with support when they needed and told us care staff stayed for the duration of the care call. People were of divided opinion about whether they had regular carers. One person told us, "We have a team of regular carers" and another person told us, "We don't have regular carers". The care coordinator explained staffing levels were worked out in advance to be flexible to people's needs.

People told us care staff wore personal protective equipment (PPE) such as gloves and aprons, when they supported them with personal care. One person told us, "The first thing they do is put gloves on. They wash their hands regularly." They told us care staff disposed of the PPE hygienically within the home. Staff were able to explain what action they took to reduce the risk of spreading infectious diseases.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated this key question as Good. During this inspection we found improvements were required in how people's capacity was assessed, how people were supported to make decisions in their best interests and how their consent was obtained. We found there were significant gaps in staff training and in staff recruitment procedures. Therefore the rating has changed since our previous inspection, from Good to Requires Improvement.

People's needs were assessed when they began using the service and care staff explained how they continued to monitor people's health and referred them to other healthcare professionals if any changes were identified. One relative told us, "Sometimes carers ring through to the district nurse and the GP when [Name] is ill." Where risks to people's health had been identified, care plans showed guidance for care staff about how to recognise changes in people's health and what action to take to maintain their well-being. One care worker explained how they worked with other health professionals to maintain people's well-being. They said, "I call the district nurse if there are any issues and they are good, they always come. I will make notes on people's daily records of any district nurse referrals. I go through the district nurse notes after they have visited and update their advice on people's care plans." Another care worker explained what they would do if they noticed someone's health declining. They told us, "I raise any concerns with management and I am happy with the action they take."

Care staff had received some training on how to support people with their specific needs, such as diabetes awareness and dementia awareness. However, some staff had not received training on other specific needs, such as catheter care and support with PEG feeding. Some staff told us they learnt how to support people with catheter care, from other care staff. On the third day of our inspection visit, the provider confirmed 12 care staff had received training on PEG feeding from a qualified, external trainer, since the second day of our visit.

The provider told us up until the beginning of 2018, they had trained staff themselves in all areas. However, we found some staff had gaps in their knowledge of essential issues, for example in how to refer safeguarding issues to appropriate authorities for statutory investigation. Staff we spoke with had limited understanding of the Mental Capacity Act, which meant they may not have supported people in accordance with the MCA and people's rights may have been affected in a negative way.

There was limited information available to confirm what training care staff had received because there were gaps in staff files and the provider's electronic training matrix was not accessible. The provider shared their training matrix with us following our inspection visit and we found there were gaps in staff training. For example, we found no staff member had received training in the Mental Capacity Act 2005 [MCA], since joining the service.

The provider explained at the beginning of 2018 they had taken steps to improve staff training and new staff now received an induction lasting two days from external trainers. This included one day of practical moving and handling training and another day covering key topics such as, health and safety, infection control, food

hygiene and adult safeguarding. Care staff then shadowed more experienced members of staff for another day or until they felt confident to work alone. Care staff were positive about the induction and training they had received. One staff member told us, "I shadowed my clients until I felt confident." However, we found the provider's induction training did not reflect the Care Certificate. The Care Certificate provides staff with a set of skills and knowledge that prepares them for their role as a care worker. The provider told us they did not support people to obtain the nationally recognised Care Certificate, so we asked them to demonstrate how their induction reflected the standards included within the Care Certificate. We found that certain areas were not covered, for example MCA. This demonstrated the provider's induction was not equivalent to agreed national standards and they were not acting in accordance with nationally recognised guidance for effective induction procedures. On the third day of our inspection the provider told us they would support any new staff to undertake the Care Certificate in association with a local college.

The provider had not considered how they encouraged staff to develop within their roles and study for nationally recognised care qualifications. They told us, "We are not supporting anyone at present to do qualifications, we will do this in the future." The provider had no record of staff care qualifications, however some staff told us they held care qualifications obtained at a previous job.

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 an assessment shows a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We asked the provider if anyone's care and treatment could amount to a restriction of their liberty and if anyone was subject to a Court Order to authorise restrictions agreed by the Court of Protection. The provider had limited knowledge around this area and was not aware it was their responsibility as the registered person, to ensure people's rights were protected and that applications were in place if required. The provider was not aware if anyone already had a Court Order in place, because they had not asked people or their relatives. We discussed this with the provider who assured us they would contact the local authority for immediate advice and review people's needs to establish if Court Orders were already in place, or were required.

The provider told us because most people who used the service lacked the capacity to make decisions, staff worked within the MCA and made decisions on their behalf in their best interests. For example, staff supported people with everyday choices about what to wear. We found staff made decisions for people in their best interests, for example, referring people to health professionals when they were ill. Staff told us most people had relatives who they involved when making best interest decisions. One member of care staff told us, "I call the GP for people and will record this in their daily records and advise the manager and family." Relatives confirmed staff had contacted them for advice when making certain decisions, for example referring people to the GP. However, we found best interest decisions were not consistently recorded, so it was not clear on people's care plans why the decisions had been made and who had been involved in making the decisions. On the third day of our inspection we found improvements had been made and the provider had documented best interest decisions for some people who they felt required support in this area.

During the first and second day of our inspection, we found no one who used the service had undergone assessments for their understanding and memory, to check whether they could weigh information sufficiently to make their own decisions or whether decisions would need to be made in their best interests.

The provider was not aware it was their responsibility as the registered person, to ensure assessments of people's understanding were recorded on their care plan and staff were provided with guidance about how people should be supported to make decisions if required. On the third day of our inspection we found improvements had been made. The provider told us following their further MCA training, they had "Realised it was their duty," to carry out assessments of people's understanding where required. We saw evidence the provider had prioritised people who they felt required support in this area and carried out assessments of their understanding. They were in the process of carrying out assessments for other people who needed support in this area.

We found the provider had not established if people had legally appointed representatives who could make decisions about their welfare on their behalf. Records showed people's relatives had signed people's consent forms for decisions such as agreeing to care and treatment. However, there was no information recorded to show if relatives had the legal authority to make decisions on behalf of people, so there was a risk peoples legal rights may not be upheld. We discussed this issue with the provider who advised us they would clarify if people had legal representatives as soon as possible, in order to ensure people's rights were protected. On the third day of our inspection, the provider had clarified the status of one person's legal representative.

The provider acknowledged there were gaps in their understanding of their responsibilities under the MCA and they made a commitment to improve their understanding by attending further training. The provider assured us they would update their process for obtaining people's consent in accordance with the MCA. We discussed with the provider that some staff we spoke with had limited understanding of the principles of MCA. The provider acknowledged no staff had received in depth training in MCA and during the third day of our inspection we found the provider and care coordinator had undergone further training and care staff were in the process of carrying out an online refresher course.

Some people received food and drinks prepared by care staff. People told us staff gave them a choice of food at meal times. Care staff told us they prepared microwaveable meals only. One person told us, "They leave a drink in reach." Care staff told us people's care plans included a list of their needs and any cultural or religious preferences for food. Staff told us they knew people's individual requirements and made sure people were supported with food and drink, in a way that met their needs. One staff member said, "We ensure at every call we give people a drink and leave some on the table where they can easily access it. We encourage people to drink." he provider told us they were not currently supporting anyone who was at risk of malnutrition or dehydration. They said, "We would use food and fluid charts for people with appetite issues and also if they were losing weight…We would refer any concerns we had to the local authority and make referrals to health professionals."

Good

Is the service caring?

Our findings

At our last inspection we rated this key question as Good. At this inspection, we found people were as happy using the service as they had been during our previous inspection. The rating continues to be Good.

People who used the service told us they felt staff cared about people and valued them as individuals. One person told us, "I have had nothing but kindness from staff. The care is fantastic." Two relatives told us, "Staff are very caring, polite and respectful" and "Staff are very pleasant, they explain what they're doing before they do it." All the staff we spoke with enjoyed their work. Two staff members told us, "I get to know people. It's like looking after my own relative" and "I love the job and the fact that I am able to help others…I feel it's rewarding and I have a sense of achievement at the end of the day."

The provider told us person centred care meant, "It's all about the individual and people's needs are different. We try to be as personal as possible, we don't generalise and we are specific about people's preferences." Staff shared the provider's caring ethos. One member of staff told us, "Every person is an individual, no client's needs are the same as the next person. I find out from them, 'What can I do for you today?' It makes them happy."

People told us staff were compassionate and supported them according to their individual needs. Two relatives explained how care staff communicated with people who had limited verbal communication skills. They said, "I hear carers being cheerful with [Name]. [Name] is sometimes resistant and one member of staff sings to calm them down. This brings an element of calm" and "The carers talk to [Name] a lot and that makes them happier."

Some people's preferred communication methods were recorded in their care plans, however this was not consistent for everyone. For example, a member of staff explained how they communicated with one person who had limited verbal communication. They told us, [Name] can understand certain words the family use, so we use them as well. It is not recorded on their care plans, we know them. They move their hands or use facial gestures when they understand."

Care staff told us some people they supported did not speak English as their first language. They explained how they managed this issue. One carer told us how they learnt a few words of another language and spoke them to the person they supported, they said the person, "Responded positively" and this helped to improve the person's wellbeing. Other care staff told us how it was sometimes difficult to communicate with people who spoke a different language and explained they relied on people's relatives to translate information. One carer told us, "We don't understand what [Name] says, but it's OK because the family can translate." Another carer told us, "I speak different languages, so I support people who speak those languages. They feel more comfortable and can share things easier." We discussed this with the provider who was aware of the issue and told us, "We are struggling to fulfil people's language requests. We try to attract staff who speak different languages when we recruit. We are currently getting by with family to translate."

Staff told us they had training on equality and diversity issues and were confident they could support people to maintain their individual beliefs and preferences. One carer told us, "I talk to people, I make it my business to know everything about them. I talk to them about their life history." Staff told us about one person who observed a religious faith and how they respected the person's beliefs and removed their shoes before supporting them.

Records showed people had not been asked about all their protected characteristics when they were reviewed by the provider, such as their sexuality. We discussed this issue with the provider and they told us they would make changes in the way they gathered important information about people, to improve the way they supported people.

Staff understood the importance of treating people with dignity and respect. A member of staff gave an example of how they helped to maintain people's privacy, they told us, "I close the door and cover people when I assist them with personal care. We are trained and we respect individual's dignity."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated this key question as Good. At this inspection, we found improvements were required in the way comments were managed and how information was made accessible to people. Therefore the rating has changed since our previous inspection, from Good to Requires Improvement.

People told us they were happy with the care and support staff provided. One relative told us, "This company are very responsive, they listen." They went on to explain how they had "Teething" problems when they began using the service, but told us the provider, "Put it right". One person told us, "I'm happy with the service. I am happy to tell them if I need anything. Staff ask if there's anything else we need."

Relatives said they would raise any concerns with staff. One relative told us, "I ring [Name of provider] straight away. They will turn round complaints in hours." Other people told us they had raised concerns with the provider and they were satisfied with the action the provider had taken. However, we could not see how the concerns had been managed or what improvements had been made to the service, as a result as there was no evidence any such concerns had been recorded by the provider. The provider told us there had been two complaints received by the service within the previous 12 months. Records showed the complaints had been received from commissioning authorities about the standard of service two people had received. The complaint investigations had been completed by the commissioning authorities and the provider had made a record of them on their own complaint forms. The provider told us they had never received any written complaints about the service and therefore had not completed any complaint investigations. However, we found the provider had received comments about the standard of the service and had not recorded these as part of their complaints process. For example, people had provided feedback as part of a quality survey and during telephone calls. Because the information was not recorded, we could not see how the provider managed any issues or how they identified if any action was required to improve the service.

The provider's complaints policy informed people how to make a complaint, however, the policy was not clear. The policy did not identify a timescale for investigating a complaint once it had been received, it did not state if complainants would receive a written response to their complaint and it did not specify what people's rights were to appeal following receipt of that response. We discussed this with the provider and we found on the third day of our inspection visit, they had reviewed the policy and made the process clearer for people.

We saw two compliments had been received in the last 12 months. For example, there was evidence of a compliment from a relative about the standard of care received. They wrote, 'Thank you so much for the care you have provided for [Name] after discharge from hospital they have improved so much and a lot of it is due to the care they receive from your carers.' The provider explained compliments were shared with staff.

We found the provider had not always looked at ways to ensure important information was made accessible to people with different needs. For example, information in different languages for people whose first language was not English, or easy read picture format for those with limited communication skills. The provider told us they were not aware of the NHS's Accessible Information Standard. This is a standard set to

ensure people with a disability receive accessible health and social care information and care providers are required by law to follow the standard. The provider told us in future they would review how information was made accessible to people with different needs.

The provider explained how people were initially assessed by themselves or the newly appointed care coordinator, before they first used the service. They told us a meeting was held with people and their relatives in their homes and they were asked for their views on how they felt they or their family member should be supported. People confirmed they had been taken part in meetings and felt involved in planning their or their family members care and support. People told us they were happy to contact the provider directly if they wished to change how their care was provided and they were also invited to meetings to review their or their family members care. The provider explained how they always tried to involve people in decisions about their care. They gave an example of someone who was cared for in bed and told us they would ask consent to hold the care review meeting in the persons bedroom. The provider explained they used the care review to ask people what was working well and what was not working so well and then they updated the person's care plans accordingly.

When needed, the service supported people at the end of their lives. The provider explained staff had received end of life training from a registered nurse. They explained how staff worked alongside other organisations to provide end of life care to people, to enable them to remain in their own home. The provider explained they supported care staff in the event of someone's death, they said, "I ask staff if they want to take time out."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we rated this key question as Good. At this inspection we found improvements were required in the provider's understanding of their responsibilities as the registered person. Therefore the rating has changed since our previous inspection, from Good to Requires Improvement.

The provider had operated since August 2015, when they set up the service and was also the registered manager for the whole period. We found an event which called into question one person's safety, had been not been referred to the appropriate authorities, these included the local safeguarding authority and the CQC. The provider agreed there were gaps in their knowledge about safeguarding and had made improvements to the way they managed safeguarding events following our feedback on the second day of our inspection visit.

There was a lack of consistent and central recording of events, including incidents, complaints and medicine errors. This made it difficult for the provider to demonstrate how they maintained an oversight of their responsibilities and ensure events were managed, to protect people and evaluated to make improvements to the service.

We found processes to monitor the quality of service were not always effective. The provider, who is also the registered manager, told us they completed all the audits of the service and this meant there was no other independent scrutiny of the quality of the service. The checks included a care record audit, where the provider told us they checked people's daily records and care plans every six months. The provider told us they had completed six of these reviews so far. We looked at one person's audit dated December 2016 and saw the provider had identified areas for improvement. We found the actions had not been taken. The provider told us they had not asked a staff member to follow the action plan and had not ensured required actions had been completed.

The provider also conducted an audit of each person's medication administration records every two weeks, when care staff returned people's daily records to the care office. The provider told us they were two months behind with these checks. We found this audit was also not effective because the provider had not ensured required actions had been completed and recorded. The provider told us the reason checks were not up to date was because they previously did not have enough staff in place in the care office. A care coordinator left during 2017 and was not replaced immediately. During this period, the provider had been undertaking all managerial tasks themselves. They said, "We went backwards a bit." They assured us they now had sufficient senior staff to undertake required tasks such as audits and reviews of people's needs, in order to make improvements to the service. The provider told us at present there were no checks made on staff files, however this would be completed soon by the newly appointed training manager.

The provider did not always work within the MCA. The provider agreed there were gaps in their knowledge about this area and took steps following our feedback to research their responsibilities and make some changes to the way they assessed people's understanding. However further improvements were still required to ensure people's consent was obtained in accordance with the MCA.

Some staff training had not been effective because it was facilitated by the provider who had gaps in their knowledge of key area. The provider's induction was not equivalent to agreed national standards which meant they were not acting in accordance with nationally recognised guidance for an effective induction procedure. Following the second day of our inspection, the provider had taken steps to improve staff training.

The provider's policies did not always reflect best practice. Following our inspection visit we saw the provider took steps to improve their policies, however further improvements were still required. For example, the provider's safeguarding adult's policy did not include information about the local safeguarding authority. This meant people did not always have access to up to date and accurate information. The provider had not always looked at ways to ensure important information was made accessible to people with different needs.

The provider had ensured people visiting their care office had access to the CQC rating given to the service at our previous inspection. However it was not displayed on their web-site until after the second day of our inspection visit, following our discussion with the provider high-lighting this was their statutory responsibility.

The provider lacked some understanding of their responsibilities as a registered person to ensure risks to people's safety were properly managed, that systems were established to effectively assess, monitor and improve the safety of the service, to ensure accurate, complete and accessible records were maintained for people and that their governance system ensured their practice was evaluated and improved.

We found this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had been working alongside local authority and NHS commissioners to make improvements to the service. The local authority commissioners had visited the service once within the last 12 months and made recommendations for improvements. The NHS commissioners had made several visits within the last 12 months, following complaint information they received about the standard of the service. The NHS commissioners made a placement stop on the service between October and December 2017, whilst the service made improvements as specified by the commissioners. A placement stop is where commissioners do not refer new people to be supported by the service.

Relatives we spoke with were satisfied with the quality of the service. One relative told us, "I'm happy with the service." A member of staff told us, "I like the way the service operates. The management communicates very well with the clients and with staff and they have an open door policy so we can talk anytime." A relative told us, "There's a newly appointed receptionist and an emergency out of hours number, so it easy to talk to someone and they always call me back."

All the staff we spoke with told us they felt supported and motivated. Staff told us communication within the service was good and they could always speak with the provider if they needed to. Staff explained they shared important information using a confidential, electronic, messaging service. A member of staff told us, "If I have questions, I can ask the online forum and I always have someone to talk to." Staff told us they had regular staff meetings where they could, "Discuss any issues we have and what to do to improve." Staff told us they felt happy to make suggestions to the provider. On the second day of our inspection visit, we found there were no records of recent staff meetings. However there was evidence a meeting was held following our visit.

The provider told us they kept up to date with best practice by reviewing information provided by organisations such as the United Kingdom Accreditation Service [UKAS], where they received updates on legislation. They told us, "I read widely and I know changes in legislation."

The provider engaged with people and encouraged them to share their experiences of the service. People had been asked to complete a survey in December 2017. We saw 14 responses had been received, however the results had not yet been collated by the provider or shared with people. We found the results were mainly positive. Several people had raised a concern that phone calls to the service were not always answered. We discussed this with the provider who told us they had made improvements to the service following these comments and employed a receptionist, to ensure people could always contact the service when wished. The provider explained they made telephone calls to people, to obtain feedback about the service. We saw people had shared both positive and negative views. The provider explained how they reviewed people's responses and took steps to make improvements to the service. For example, one relative had raised issues about the times of care calls. The provider showed us they had conducted a full review to ensure the person's care needs were being met as a result of their relative's comments. However, some actions were not recorded, so it was difficult to see what improvements were made.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were protected from the risk of abuse and improper treatment because systems and processes were not established and operated effectively to immediately investigate any allegation of abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems or processes were established and operated effectively to assess, monitor and improve the safety of the service provided or to assess, monitor and mitigate the risks relating to the health and safety of people who used the service. They had not maintained accurate and complete records for people or staff. Their governance system did not ensure their practice was evaluated or improved.