Utmostcare Limited

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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

About the service
Utmostcare Limited is a service providing care and support to people in their own home. The service offered both regular daily visits to people receiving personal care and live-in staff members providing a 24-hour support service. At the time of the inspection the service was supporting 33 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People were protected from the risk of abuse and people told us they felt safe. We found other risks to people using the service were not clearly identified and managed. We also identified concerns in relation to the safe management of medicines. Staff had access to sufficient supplies of personal protective equipment (PPE) and received training in infection control, however risk assessments lacked sufficient detail in relation to managing risks of infection and the use of cleaning products.

Systems were in place for staff recruitment, induction and training, with ongoing support and monitoring via supervisions, spot checks and staff meetings. We have made a recommendation in relation to obtaining staff employment histories. We have also made a recommendation in relation to continuity of staff deployment, to ensure people receive care from staff who understand their needs and have sufficient travel time to consistently meet preferred visit times.

People's needs were assessed prior to the delivery of care. We have made a recommendation in relation to person-centred care planning. People told us they received care from staff who were kind, caring and treated them with dignity. Staff spoke about people with respect and understood the importance of protecting people's privacy and seeking consent.

Staff told us they were supported by the management of the service. The service and provider had processes in place to monitor the quality and safety of the service. We found however these systems had not been fully effective in identifying the concerns we found. Systems were in place to respond to concerns or complaints, and people told us the management of the service was easily accessible.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice but we have made a recommendation in relation to how people's mental capacity is described within care records.

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

Rating at last inspection

This service was registered with us on 15 February 2021 and this is the first inspection.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The service was responsive to our feedback and told us about actions they were taking to mitigate risks, including additional staff training and increased auditing of the service.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Utmostcare Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since it was registered with the Care Quality Commission on 15 February 2021. We sought feedback from the local authority.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with 10 people using the service and 8 family members. One additional family member shared feedback via CQC's online feedback form.

We also spoke with 9 members of staff, including three senior care workers, three care workers, one agency care worker, the operations manager and the registered manager, who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received email feedback from one additional care worker.

We reviewed a range of records. This included 6 people's care and support plans, as well as people's medicines records where they received support with this task. We looked at three staff files in relation to recruitment, training and supervision. We reviewed a variety of records relating to management of the service including policies and procedures, accident and incident records, compliments and complaints and audits of the service.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We sought feedback from professionals and received a response from three professionals during the inspection process.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Some risk assessments were either not present, had not been updated in a timely manner, or lacked sufficient detail to help staff understand and respond to risks. For example, assessments did not provide sufficient guidance on the safe use of bed rails. Records showed, and an agency staff member confirmed, one person had previously put their legs on top of the bed rails and sometimes wanted to get out of bed which could place them at risk of falls. The risk assessment did not describe how this risk could be lessened.
- Some care plans contained insufficient information about people's medical conditions. One person's care plan did not include information about their significant illness. This meant staff did not have enough information to understand and respond to health risks. Another person's risk assessment did not provide enough guidance for staff about how to lessen an identified risk of stroke.
- Another person was assessed by speech and language therapy. Due to swallowing difficulties, the person was prescribed drink thickener for long term use. Their care plan instead instructed staff, "Carers can occasionally add thickener to her water if [person] has difficulty swallowing". The registered manager told us a family member usually added the thickener, however staff were required to assist when the relative wasn't available. This meant we could not be assured thickener was consistently used in line with SALT guidance.
- Staff supported some people to use equipment such as electric beds and hoists. We found records did not indicate who was responsible for maintaining equipment, or the required frequency of servicing. Records did not show when servicing had been undertaken to ensure equipment remained safe for use.
- Fire risk assessments stated each person had a smoke alarm, noting this was tested every six months. Risk assessments did not specify who was responsible for testing the smoke alarm, or consider factors such as nearest escape routes, or people's ability to escape from a fire, such as for people cared for in bed. Risk assessments also failed to consider risks associated with the use of emollient creams. Emollient creams can be easily transferred from skin on to clothing and bedding, and testing has shown increased fire risks when fabrics are contaminated. Therefore, a risk assessment should be in place.
- Where people used pressure relieving equipment, such as pressure cushions, care plans did not provide instructions where staff were responsible for checking and assisting to maintain the equipment. Where people required repositioning, care plans lacked sufficient detail about how staff should safely achieve this. One person's care plan stated "requires to be repositioned at every care call to prevent…pressure sores" but did not state how the person should be repositioned or refer to the use of a slide sheet, which staff used to move the person on the bed.
- Systems were in place to document accidents and incidents, however we identified completed accident and incident forms were not an accurate record of all incidents which had taken place. For example, care notes for one person dated 30 June 2022 and 8 July 2022 noted 'blood patches' had been observed on the person's body. The registered manager told us the office had not been informed due to a "gap in

communication" and stated auditing processes of care records had not identified the concerns.

Risks to people were not clearly identified and managed. Risk assessments were either not present or lacked sufficient detail to help staff understand and respond to risks. This was a breach of Regulation 12(1)(2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. The registered manager and operations manager advised that shortly prior to our inspection, the service had transferred records to a new care records system, after identifying the previous system was not sufficiently robust. The operations manager advised the service was due to receive further support from the software provider to produce more personalised risk assessments.

● People told us they felt safe. People's commented included, "I'm definitely safe with the carers at my home at the moment", "Yes, I do [feel safe]. [Staff] seems to know about everything that needs doing" and "I have no safety issues with the care I'm getting at the moment". Some relatives described instances where people could have been placed at risk. Relatives commented, "I have witnessed them using the hoist and putting the sling on. Last week they put the sling on inside out" and "In the past they have gone without leaving the bed control near her."
● Staff we spoke with provided examples of how they monitored and responded to risks. One staff member told us they paid close attention and ensured a person encountered no obstacles when walking with a frame. Another staff member described how they supported a person with catheter care and checked for any leakage or blockage, understanding any problems should be reported to district nurses.
● Staff attended weekly meetings which were used for reflective discussions about people's care needs. Staff told us this helped them to understand how to respond to changing needs. A staff member explained how this process helped staff learn from management feedback and ensured their knowledge of people's needs remained current whilst they were caring for other individuals.
● Accident and incident record forms did not evidence manager oversight of individual incidents. However, we requested supporting documentation which showed appropriate actions had been taken by the registered manager, including liaison with external professionals and updated risk assessments.
● Recent monthly audits of accidents and incidents did not contain a detailed analysis, however, they noted staff had been updated via team meetings and noted there had been no trends.
● The registered manager shared examples of how learning had been used to improve practice. For example, following an incident where staff had responded to a person's distressed behaviours, the service accessed additional training for staff about positive behaviour support.

Using medicines safely
● Electronic medicines administration records (MARs) did not consistently provide a full, accurate and contemporaneous record of administration. For example, a MAR dated 5 to 21 September 2022 omitted a person's prescribed medicine. Some electronic MARs contained gaps, or used various codes such as 'O', meaning 'Other reason', without accompanying explanation. The registered manager advised following the recent introduction of a new system, staff would be provided with further training.
● Some MARs did not include prescribed creams, meaning MARs did not contain an accurate record of their administration. This was not in line with the provider's medicines policy.
● Care plans did not provide staff with sufficient information regarding the safe application of topical medicines. For example, one person's 'My Skin' care plan stated skin should be 'patted dried, and prescribed lotion applied" but did not specify the types of cream in use, where each cream should be applied, and the recommended thickness and frequency of application.
● One person's electronic MAR for September 2022 showed a medicine was given twice daily on 13 occasions between 5 September 2022 and 22 September 2022. The MAR instructions stated, "One at night".

In response to our feedback the registered manager sought guidance from a GP, who confirmed the medicine should be given once daily in the morning. The registered manager told us they had relied on the person's next of kin to update the service about the person's prescriptions.

● One person was prescribed a course of antibiotics. A MAR was not in place to contemporaneously record administration. The registered manager supplied a MAR they had signed themselves retrospectively, stating, "a paper MAR chart was completed in the office following discussion with carers who confirmed the antibiotic was administered." This was not in line with best practice, which states staff must record the medicines support given to a person for each individual medicine on every occasion.

● Some people needed support with medicines 'as and when required' (PRN). PRN protocols were in place for some PRN medicines, however we identified staff were supporting people with other medicines on a PRN basis without protocols in place, such as one person's suppository and another person's pain relief gel.

● One person was prescribed a medicine which if not administered on an empty stomach, may not give the benefit of the full dose. The registered manager advised the medicine was administered at the correct time, but the MAR did not include this instruction and records did not evidence when the medicine was given.

The service had not ensured the proper and safe management of medicines, including record keeping of the administration of medicines. This was a breach of Regulation 12(1)(2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback and where required made contact with GPs to clarify people's prescriptions, and updated medicines administration records. The registered manager told us upcoming face-to-face medicines re-training had already been booked prior to our inspection as the service had identified this as an area for development. The registered manager advised spot checks and auditing would be increased in frequency as part of an action plan to ensure safe medicines practices were embedded.

● Staff received training about medicines support and a competency assessment was carried out. A staff member described carrying out accurate checks prior to administration, advising, "[Prescribed medicines are] inputted into our software application…check on each box, prescription, the direction of use…labelled on box…what time and what dosage, and of course frequency of use."

● The service assessed whether people could manage their medicines independently, and promoted people's independence. For example, one person was able to self-administer their tablet medicines, and staff told us they would only intervene if the person requested their assistance.

● Some people told us they received safe medicines support. One person advised, "They take it out of my dossett box and pass it to me…it's on time. They have never given me the wrong medication because I normally know what it is when it comes to me." A second person added, "I take medication and it's managed by the carers who stand over me while I take it."

Preventing and controlling infection

● People's care records contained a risk assessment for 'cross infection' in relation to COVID-19. Each person's risk assessment advised staff to wear personal protective equipment (PPE), call the GP to report suspected infections and follow government guidelines, without providing further detail about what these were. The risk assessments did not consider personal factors which could place people at greater risk from infections, such as medical conditions or vaccination status, or explore other steps necessary to prevent infection, such as assistance to maintain their home environment.

● Where staff were responsible for assisting with domestic duties, care plans and risk assessments did not provide information for staff about the safe use and storage of cleaning products. The risk assessments we reviewed contained a phrase "All hazardous substances are kept away" without specifying the location. One person's care plan described that staff were responsible for "all the housekeeping tasks" without further

explanation. This meant there was a risk domestic tasks may not be carried out appropriately, as records lacked sufficient guidance, which could place people at increased risk from infection.
● Some relatives felt staff approach to supporting people with personal and domestic hygiene could be improved. A relative commented, "The carers have the right protective clothing but, I've highlighted problems of hygiene, for example, they arrive and leave the house and do all the duties with the same gloves on". Another relative advised, "As a family member, I had my way of doing things and it left a pleasant smell and [person] was clean, but the carers do things differently…They are just washing my [relative] with water and not using all the cleaning [products]". A third relative advised, "The carers wear the right protective clothing…I think however, the domestic skills are poor."

Systems were not operated effectively to ensure appropriate infection control measures. This was a breach of Regulation 12 Regulation 12(1)(2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and families told us staff wore PPE. Comments included, "They have always their masks on, apron and gloves" and "The carers wear full protective clothing and gloves to reduce infection…they have good standards of hygiene and keep the house clean".
● Staff received training about infection prevention and control. Compliance was monitored via spot checks, including observations of staff use of personal protective equipment (PPE) and food hygiene. Staff also received ongoing reminders regarding safe practice during supervision and staff team meetings.
● Staff had access to sufficient supplies of PPE. A staff member commented, "We have [an] abundant supply." Staff told us they understood when PPE should be changed and how to safely dispose of PPE.
● An infection control policy and related procedures were in place. The service obtained information about staff COVID-19 vaccination status during recruitment and had accessed COVID-19 testing kits in line with previous government guidance. At the time of our inspection government guidelines had changed to state staff should no longer conduct regular asymptomatic testing.

Staffing and recruitment
● The service had not consistently obtained staff full employment history, since leaving education. For example, one person's application listed their employments using years, without the date or month they commenced and finished jobs. This meant it was not possible to accurately check for employment gaps.

We recommend the service obtains a full employment history, together with a satisfactory written explanation of any gaps in employment, as part of a robust recruitment process, to make sure suitable staff are recruited to support people to stay safe.

● Other safe recruitment checks were carried out. Staff completed an application form, attended an interview and preemployment checks included references from previous employers, a medical questionnaire and disclosure and barring (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Safe systems were in place for the use of agency staff to support with live-in care. Records showed the service obtained written profiles showing recruitment checks and training history. We reviewed the records for one agency staff member which showed the registered manager had spoken with the worker about their experience and suitability prior to deployment.

● We reviewed the scheduled visits and login times for three staff. Rotas showed staff were not consistently given sufficient travel time, and staff did not consistently stay for the scheduled visit length. One staff

member had completed some visits in a different order to the schedule, meaning people's requested visit times were not consistently met.
● Some staff told us travel time between care visits was sometimes insufficient, particularly at peak traffic times.
● People and families told us staff arrival times varied, and they would prefer more consistent staff deployment. One relative advised, "The arrival times are very sporadic which means we both have to adjust our lives because I don't have a clue what times they will come". Other relatives commented, "We have 10-12 carers, and they change a lot", "I think the timekeeping could be improved…they came two hours late the other day" and "It would be better to have the same carer for the day instead of four different carers four times a day to get to know my [relative's] challenges." Comments from people included, "I never know quite what time they are coming…it doesn't cause any problems in the morning but it can be difficult at lunchtime."

We recommend the service reviews their approach to ensure the deployment of staff promotes a consistent and reliable service, considering travelling time to make sure people receive the amount of care that has been agreed in their care plan.

The registered manager explained new software had been recently introduced after it was identified that systems were required to accurately log and analyse visit data. The operations manager explained the service was responding to staff feedback, advising the new system helped calculate travel time and the service accepted new customers within an agreed geographical area to help minimise travel distances. The registered manager advised they regularly reviewed staffing capacity and there was continuous recruitment to ensure sustainable staffing levels.

● Electronic systems enabled oversight of the delivery of care. Staff used a mobile application to login to each visit and data could be reviewed in real-time. The operations manager explained a manager was responsible for daily monitoring to ensure all visits had been successfully attended.
● Some people provided more positive feedback about punctuality and continuity. People commented, "The timekeeping is fine and they stay for the full duration of time", "No set time, but I know approximately when they will be coming…they have never missed a visit" and "I get a rotation of four carers…punctuality is totally fine". A relative added, "I found it quite bewildering in the beginning…they chopped and changed over a lot in the first week, and then it settled down and [staff name] became very regular."
● People told us there was flexibility in staff deployment to meet ad-hoc needs. People's comments included, "Yes, they have always been flexible if we have needed to change" and "I have been to the hospital two or three times and let them know I might be back a bit late. The carers can be flexible."

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. Staff had completed safeguarding training and staff we spoke with could describe how they would recognise signs of abuse and concerns for people's welfare. Staff understood their responsibility to report safeguarding concerns.
● The registered manager encouraged staff to share any concerns for people's safety, advising, "[I] always operate open door policy, I always told [staff I] want feedback." Safeguarding and whistleblowing policies were in place.
● The registered manager held weekly virtual staff meetings to discuss people's care, providing an opportunity for staff to raise any concerns or highlight changes in needs. Minutes of these meetings were not documented, however staff told us the meetings provided a useful forum for staff. A staff member commented, "Staff bring to [manager's] attention every [person] dealing with changes, any concern, bring it there." A recent staff meeting had also been used to provide staff with more detail about the six key

principles of safeguarding within the Care Act 2014.

● The registered manager and operations manager understood their responsibility to identify and respond to safeguarding and whistleblowing concerns. The service had worked in partnership with the local authority when a recent potential safeguarding concern had been raised. Records showed the local authority had been satisfied with the service's response and no further action was required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
- Some people's care plans contained statements regarding their mental capacity, without evidence of a decision specific mental capacity assessment having taken place. For example, one person's care plan stated, "[Person's name] lacks the mental capacity to make informed decisions due to physical and mental health decline. [Person] gets confused at times and is unable to express herself verbally". We requested evidence of a mental capacity assessment and the registered manager advised, "[Name] does have capacity to communicate her care needs…care plan have been updated to reflect this clear information."
- People were asked to sign a consent form, acknowledging their agreement for the service to assess and meet their care and support needs. The consent form did not refer to information sharing arrangements, such as consent for family members to access electronic care records, or for information to be shared with other parties, such as health and social care professionals.

We recommend the service review their approach to ensure records accurately reflect people's mental capacity in relation to decisions about their care, to ensure their human and legal rights are upheld.

The service was responsive to our feedback. The operations manager explained the records had arisen as a result of a non-decision specific prompt within a new electronic care plan format. The operations manager advised feedback had been given and they demonstrated their understanding of the MCA. We were advised records would be updated where required.

● The operations manager demonstrated their understanding of the principles of the mental capacity act. For example, they described the importance of listening to a person's wishes during care planning, and respecting their own choices, where this may sometimes differ from what a family member believes is in someone's best interests.
● Some people had a lasting power of attorney (LPOA) in place. This is a legal document which allows the person to appoint one or more people to help them make certain decisions, or to make decisions on their behalf. The operations manager advised they would check information about LPOA with the LA where they held this information, and said if needed would seek their own evidence to ensure a LPOA was valid.
● Staff we spoke with understood the importance of seeking people's consent, prior to the delivery of care. Staff received training about the mental capacity act.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We observed care plans and risk assessments had been documented with varying levels of detail, meaning some assessments did not present a fully holistic view of people's physical, mental health and social needs. We observed where risks were identified, in some cases relevant risk assessments were not documented as part of the care assessment process, for example, in relation to the use of bed rails. Some risk assessments noted the type of risk, signs and mitigation measures but lacked detail about the assessed level of risk and whether the assessor was satisfied risk reduction measures had reduced the risk to an acceptable level.
● The operations manager and registered manager took a hands-on approach, delivering some of people's initial care, to help inform their assessment and identify which staff had the right skills to meet people's needs. Where the service had been asked to provide support at short notice, such as to enable a hospital discharge, this approach helped ensure managers could provide incoming staff with initial feedback whilst a care plan was under development. Weekly meetings were also held to update staff about people's needs.
● People's needs were assessed prior to the delivery of care, with information inputted directly into a care plan. This included family and professionals contact information, such as GP, and information about the person such as preferred social activities, their physical and mental health needs, communication needs, assessing skin integrity and planning the care required.

Staff support: induction, training, skills and experience
● Staff completed a training and induction programme. The service accessed e-learning endorsed by the local authority. Before starting employment, staff accessed e-learning to help prepare themselves for the role, and spoke positively about the quality of the learning materials.
● Staff new to care had completed, or were working to complete, the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff accessed additional learning via a local authority specialist trainer, who supported with subjects including managing risks of falls, skin care and catheter care. A staff member told us this training had been helpful in their role, advising, "Very helpful, because will deal with practical…things [we] see…particular solutions offered to make job easier or [meet] customer priority [needs]".
● New staff were mentored by experienced staff. A competency assessment was carried out before new staff worked without supervision and this process included gathering feedback from people using the service.
● Staff received ongoing support and feedback via three monthly supervision meetings and spot checks, weekly catch up meetings, monthly staff meetings and an open door policy with their manager.
● Staff received moving and handling training via online learning and practical experience via shadowing. The operations manager explained when a new item of equipment was delivered to someone's home, such

as a hoist, the service requested an occupational therapist visit to demonstrate to staff how to safely use the equipment. We found competency assessment and spot check records lacked detail about moving and handling tasks. The operations manager told us a training need had already been identified, and explained they had been enrolled for an upcoming 'train the trainer' course in moving and handling.

● Most people and families were satisfied staff were trained to meet their needs, or where staff lacked experience, could do so with appropriate guidance. People's comments included, "I have full confidence in their capabilities", "I don't see the carers as experts in regards to training, but they do their best for me" and "She seems to know about everything that needs doing and if she doesn't understand anything she calls on her employers for more information." A relative added, "Sometimes with an inexperienced carer, you have to re-explain the care that's needed and it can become tedious at times."

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

● Some people using the service required a softer texture diet to aid swallowing. One person's care plan noted staff should use a hand blender to puree solid foods. No further instructions were provided to describe how to check whether the blended consistency was safe for the person to consume

● Care plans noted where people required support with nutrition and hydration but some contained limited information about people's preferences, likes and dislikes. For example, one person had limited communication. A care plan asked staff to provide a cup of tea with breakfast and at other visits the person should be "encouraged to take enough fluid". Their drinks preferences were listed as 'hot drink and yoghurt'. The care plan did not advise how the person liked their tea and daily notes indicated the person sometimes preferred hot chocolate and cold drinks.

● Staff undertook training about food safety and hygiene, and eating and drinking support. Staff we spoke with understood the importance of providing people with a choice of food and drink, and told us they prepared meals and drinks in line with people's wishes.

● Most people and families provided positive feedback regarding staff support. People's comments included, "They make me meals and normally give me a jug of water…I can always reach my drink", "I have a lot of ready meals…[staff] will remind me what is left in the freezer…[staff] will make me cups of tea...water is always there" and "They are very persistent about making sure I drink a lot of water. I have a glass and a jug, and they are meticulous to make sure these are filled up."

● A smaller number of people provided less positive feedback. A family member commented, "They don't seem to be able to cook eggs for breakfast, toast can be half done. It seems to vary. They make drinks, but again it does vary…some say they can't use the stove, and others just do it. They try to take the food away before she has finished."

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

● The registered manager and operations manager were committed to effective multi-agency working and had a good understanding of local systems and the roles of other professionals.

● The service worked with local health and social care professionals to provide temporary care for people. This helped enable people to leave hospital in a timely manner. The service was responsive to referrals, and a professional compliment received by the service stated, "We appreciate the speed in response to referrals, the communication you provide and the flexible capacity you have."

● The service engaged with care commissioners regarding concerns for people's welfare and changes in people's care needs. For example, records showed the registered manager had worked to share information to enable a social worker to review ongoing concerns for someone's safety following unwitnessed falls.

● Staff were encouraged during team meetings to monitor and report any changes, such as deterioration of a person's health. Weekly and monthly meetings were also used to discuss changes in people's needs, such as updating staff about district nursing intervention.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us staff were kind and caring. People's positive comments included, "They always come in smiling, sometimes [I] get a hug. They are just pleasant" and "The personality of the carers is very friendly, very approachable and very caring." Relatives added, "They have all been lovely", "They are very caring and compassionate" and "They are so pleasant, always come in cheerful. It's nice to open the door to someone smiling and cheerful."
- Some people told us staff supported their emotional needs through compassionate social interactions. People's comments included, "They are always very polite when they come in, always acknowledge me and ask how I am" and "They are very jolly and talkative and listen to my problems and act on them where necessary."
- A smaller number of relatives provided less positive feedback regarding staff support. For example, one relative stated, "We had a cluster of carers who were nice and friendly and talkative, but the ones we have now are a bit stern, hard and regimented. There is lack of compassion and empathy." Another relative said, "She finds them a bit rough sometimes when they apply the [name of] cream." The registered manager told us as part of an action plan that staff spot checks would be increased from quarterly to monthly.
- The registered manager and operations manager promoted a staff culture that was person-centred and inclusive. The registered manager explained they ensured staff understood the person-centred approach expected of them from the point of recruitment, explaining they advised staff, "[To] respect people's views in terms of person-centred [wishes for] how [they] want care…not enforcing own values on [person], [and it is] ok for them to say no to something."
- Staff and managers spoke about people with respect. Some staff had previous or personal experience of providing care and support, and spoke about their passion for supporting people. One staff member told us, "I'm in love with this job…according to [my] religion if [I] care for elderly people is a good thing…[I'm] happy to be in UK, happy to be a carer."

Respecting and promoting people's privacy, dignity and independence

- People were supported by staff who treated them with dignity and respected their privacy. People's comments included, "They make sure the curtains are pulled. They tap on the door" and "[Staff] always make sure we have the space to ourselves and make sure we are not going to be interrupted. [Staff] usually lock the back door if I am having personal care."
- Staff described supporting people in a dignified manner when helping with personal care. A staff member told us, "[I seek] permission before [I] go ahead…and even when alone in house, [I] close doors and windows…cover…part [of person's body], take personal care gradually."
- Some care plans noted where people could carry out tasks for themselves, such as being able to wash

certain areas of their body or self-administer medicines. Staff told us they encouraged independence and gave examples such as encouraging people to wash areas of their body they could reach. A staff member advised, "[I] need to understand what capacity individual has, what he or she [is] able to do, some people… can wash [their] face, front, chest and may require assistance with only washing their back."

● Some people and families expressed their views about whether staff promoted independence. One person commented, "I would recommend Utmostcare Limited to other people because it's helped me to be more independent than I would be without it". Comments from relatives included, "I think the carers know my mother needs about 70%, not 100%. The carers do promote my mother's independence" and "They don't encourage people to do things for themselves. It would be nice if they could let the [person] do what they were able to do. Sometimes they have picked up a spoon and tried to feed her."

● People's personal information was kept secure and staff understood the importance of maintaining secure care records to ensure people's confidentiality was maintained. Staff explained they did not allow anyone else to access data on the electronic care system by ensuring their mobile phones were securely stored when not in use. We observed safe storage of records at the office location.

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

● Staff described how they involved people in day to day decisions, such as meal choices. A staff member advised, "[I] prepare food for [person] based on choice, [relative's name] has prepared a menu, for morning [and] most care calls, if [person] doesn't know what they want to eat, usually give her the menu, [then] easier for her to make a choice."

● Most people and families told us staff listened to their views and involved them in day to day decisions about their care. People's comments included, "They listen to what I ask them to do, and they do it", "I'm allowed to make my own decision about my care. If I need anything specific, they will act upon my requests" and "They ask if there is anything else I would like them to do."

● A smaller number of people told us staff did not always involve people in day to day decisions about their care. For example, one person commented, "They know more or less what to do. They don't ask me, they just get on with it. I know what to expect."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans included varying levels of personalisation about people's care needs and what was important to them, such as their life history and hobbies. Some care plans contained detail such as how a person preferred to be washed or items that needed to be left within reach at the end of each visit. A relative advised, "We have a basic care plan which covers general things, but not really covering his personal needs. They know my husband ok, but I think they could know him better in his needs".
- Care plans documented people's "desired outcomes", however these lacked meaningful personalised detail about what people aimed to achieve. For example, one person's desired outcome was stated as, "Maintain my physical and mental health and emotional wellbeing". Their live-in carer explained that rather than maintain their baseline, the person was very motivated to recover their mobility via physiotherapy. The live-in carer supported the person with regular physio exercises, however this was not referenced within the person's care plan.
- There was variable feedback regarding whether people were familiar with their care plan and arrangements for reviews. Comments included, "Yes…it's reviewed every time I need anything", "I have a copy…I don't see many people come to review the care plan. He has not had a telephone review", "I haven't seen that…but I think [manager] does phone up to know if all is well" and "I have a care plan, but I don't have much knowledge about it".
- There was variable feedback regarding whether people's preferences of staff gender had been adequately explored during assessments. Comments included, "No [was not asked], and both come. No objection", "[Relative] was never asked that, so she has one of each. She seems to be alright about it", "Yes, I asked for a female for personal care", "No [was not asked]. I am not particularly worried about that because my idea is that if you were in hospital you wouldn't have an option" and "She doesn't like male carers giving her a shower, so they are looking into getting her a female".
- The service had not formally documented care plan review discussions where people received ongoing, rather than short-term care. We were advised some review discussions had taken place by phone or in-person. The operations manager explained challenges had included people being readmitted to hospital before reviews could be held and computer system issues. The registered manager shared some email and text messages showing contact with relatives. Care plans contained review dates but did not state who had been involved in each review.
- Some people told us their experience of the service was impacted by a lack of staff continuity. A relative advised, "They clean her teeth before breakfast, she would prefer it after breakfast, and they always seem to be in a hurry to get away. They don't always stay the full amount of time." A second relative added, "Sometimes the arrival times have affected her eating times. I have reported this and the office in the

process of rectifying it." A person added, "I would have to say that given time it might work well, and if there were not so many carers, but when you have ten people it can be a little bit tricky, the communication."

We recommend the service review their approach, to ensure care planning, including arrangements for care reviews and staff deployment, is focused on the person's whole life, to ensure care plans fully reflect physical, mental, emotional and social needs, including people's preferences, interests and aspirations.

● Care plans contained information about people's protected characteristics, such as marital status, ethnicity and religion. One person using the service practiced a religion. The service worked with a staffing agency to identify a staff member of the same faith. We spoke with the agency staff member, who explained how sharing a faith with the person helped them to meet the person's needs, describing how they supported the person emotionally, including in prayer.
● Staff we spoke with could describe people's preferred routines where they supported people on a regular basis. Supervisions and staff meetings were used to encourage staff to reflect together on their experiences of providing care and to enhance their understanding of best practice. We noted a recent staff meeting had been used to deliver a session for staff about strengths based practice and the importance of recognising people's potential, strengths and capabilities. At another meeting staff had reflected on their experiences of supporting someone with mental health needs to successfully take more initiative for their personal care.
● Some people and families described how their experiences improved once staff got to know them, and better understood their needs. People commented, "Once I got regular [staff], they knew what I needed exactly", "I am familiar with them and they are familiar with me" and "I think the cares know me enough to know what my likes are and dislikes". A relative added, "I have seen a great improvement in my [relative] since [carer] has been there. She seems to have come out of herself and seems to be getting on quite well."
● Some people received temporary care following hospital discharge. The registered manager told us the service was committed to remaining responsive to these referrals and to encourage people's independence during the period of support. A staff member described how they worked flexibly with people recovering at home, explaining, "[It] takes [people] time to get…used to environment again, before short while, see they are able to move, we encourage that, [see] what they can do for themselves…whatever becomes bit stressful for them, come in [to help], allow them do some of those things to get back their confidence."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication needs were clearly identified. Care plans identified where individuals needed support to communicate effectively, for example, due to hearing or sight loss.
● Staff showed insight around supporting people with differing communication needs. Staff described supporting someone whose ability to verbally communicate varied, and at times they used facial expressions or gestures. A staff member explained how they promoted effective communication at meal times, advising, "When we speak [person] understands what we are saying, in most cases replies with head movement, then know yes with a nod, when comes to meals…usually bring food in original pack…show to her, when bring particular one [person] wants…will give a nod."
● People and families provided variable feedback regarding the effectiveness of staff communication, with some describing what they perceived to be a language or understanding barrier. Relatives commented, "They don't always understand what she is saying. They do seem to get crossed wires", "The English is poor at times, but he points to what he wants", "There is a language barrier which has some effect on my

mother's care. It's not because they are not doing a good job, it's because of the misunderstanding" and "She has difficulty understanding what they say as she is hard of hearing and they do have accents…I think they understand and speak English alright." The operations manager explained staff were required to complete an English language test and were encouraged to build rapport to achieve positive effective communication.

● We also received positive feedback. One person told us, "My carer is in her early 20s and I'm in my early 90s, but even with the big age gap, she is still easy to talk to. She never seems rushed." A relative added, "I find the carers very friendly…They talk to both of us and [are] always willing to support."

Improving care quality in response to complaints or concerns

● A complaints, suggestions and compliments policy was in place, which informed people how concerns could be escalated if they were not satisfied with the response received, including to the Local Government and Social Care Ombudsman (LGSCO). The LGSCO are a public service which investigates complaints about councils and adult care providers in England.

● Processes for raising compliments, concerns or complaints were accessible. Comments from people and families included, "I would just phone up", "The manager is always saying 'just contact me if there are any problems'" and "I have only got to phone the office and make my complaint there."

● The service's compliments and complaints records showed one complaint had been logged since the start of the service. This noted that action had been taken to resolve the person's concern within 24 hours.

● People and families described examples where they had informally raised concerns which were satisfactorily resolved. One person told us the service had respected their wish not to send a particular carer, advising, "I had one cut my lip when shaving. I asked for him not to come back. Everyone is okay at the moment." A family member told us the registered manager had been responsive when they raised concerns a carer had not arrived, explaining, "The carer left a message that was missed, so the manager came to the house and took full control of the rest of her care which I thought was a credit to the company".

● One person's representative raised concerns during our inspection regarding the quality of care received, and provided consent for us to share their concerns with the service. The registered manager reviewed the concerns and provided prompt and detailed feedback, including any required actions they had identified.

End of life care and support

● The service had an end of life care policy in place which reflected national best practice guidance.

● At the time of our inspection the service was not supporting anyone receiving end of life care.

● The service was responsive when a person required emergency support following a bereavement; records showed the service had worked with the local authority to provide urgent interim care.

● Compliment records showed the service had received positive feedback after supporting someone receiving palliative care. The person's relative commented, "I found them to be compassionate, kind and so very caring not only to my [relative], but to all of us, as a family. My [relative] looked forward to their visits and they always managed to put a smile on her face, no matter how much pain she was in."

● People's care records documented whether they had a DNACPR in place. DNACPR stands for do not attempt cardiopulmonary resuscitation and a DNACPR form is used where a decision has been reached that if the person's heart or breathing stop, cardiopulmonary resuscitation (CPR) should not be attempted.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Records did not reflect full and accurate information in respect of each person using the service. Electronic medicines administration records had failed to accurately record the administration of some medicines. Some care records contained contradictory information or did not identify all of the tasks staff supported people with. For example, one person's care plan did not state that staff were involved with checking and reinflating their pressure relieving cushion. The person's care plan and staff care notes also referred to them by their surname, rather than preferred first name, in several places. Another person's care plan described them as lacking mental capacity however we were later advised by the registered manager this statement was inaccurate and would be amended.
- Risk assessments lacked sufficient detail to help staff understand and respond to risks. This meant systems and processes were not fully effective in identifying and assessing risks to the health, safety and welfare of people who used the service. For example, risk assessments lacked sufficient detail in areas such as the use of bed rails, fire safety and health conditions.
- Audits had been conducted in relation to accidents and incidents, infection control, medicines and care plans. Audits had not been fully effective, because they failed to identify some of the concerns we found. For example, audits did not identify that some people were using topical medicines which were not included on medicines administration records. We reviewed a care plan audit which failed to identify the person's care plan lacked detail about the use of pressure relieving equipment, their medical conditions, the application of topical creams, the risks associated with the use of emollients and use of COSHH products. The service had not completed financial transactions audits in line with the provider's policy, where the service was involved in supporting people with their shopping.
- Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. Quality monitoring processes had failed to identity that the service had not reported certain events, including a safeguarding concern, to CQC in accordance with requirements. The registered manager submitted the required notifications promptly in response to our feedback.

Governance systems did not effectively assess, monitor or improve the service to ensure compliance with all required regulations. This was a breach of Regulation 17(1)(2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. Whilst audits had failed to identify some of the issues we found,

the management team had identified that further training was required for the staff team about medicines and told us training was due to take place. The service had also identified that the previous electronic care records system in use did not meet the needs of the service. Work had taken place to transfer care and medicines records onto a new system, shortly prior to our inspection. The operations manager told us the service provider was due to provide the management team with further training to enable them to use the system effectively.

● The operations manager outlined how the service's new electronic care system would support with monitoring staff compliance. The system provided data about staff visit login times and also issued alerts, for example, if a staff member hadn't noted a task as completed.
● Systems were in place monitor the quality of care delivered by staff, including three monthly spot checks and competency assessments for staff during their induction period. This included a competency assessment for the administration of medicines.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager and operations manager were social work professionals. They described how their background skills enabled them to understand the importance of delivering holistic person-centred care, empowering positive risk taking, effective partnership working and the need to understand legislation and best practice guidance.
● The registered manager and operations manager identified opportunities to learn from the skills and experience of others, and had a reflective learning approach. For example, when starting recruitment, the managers invited two external social care professionals to assist with the interview process to enhance their approach. At the time of our inspection, the service was also seeking to establish a joint working relationship with a local care home; it was hoped this would enable newer staff to gain more experience of supporting people with complex needs, and would benefit the care home by assisting with staffing shortages.
● People and families told us the management of the service was accessible. Comments included, "We have the number, we have the email address as well. Yes, it's answered promptly", "When I phone the office I normally get somebody and they pass it on to whoever it concerns", "The manager is pretty good day and night" and "I can call the office [about] anything without any fuss."
● Staff told us they were well supported and received ongoing relevant training, supervision and and mentoring. Staff presented as keen to learn and succeed in their roles. Staff were able to contact management for support and advice when needed. Staff comments included, "Whenever [I] want to gain access to them [management], they are always there", "Very approachable managers" and "They [managers] are very flexible people…I think they are approachable."
● Some staff were recruited from abroad or elsewhere in the UK. The management team spoke positively about enabling staff to access employment and settle in the local area, and hoped to inspire staff to pursue further professional studies. One staff member told us the service had provided access to a vehicle and helped them adapt to driving in the UK, advising, "[I] have international driving licence, [operations manager] took me around with car, [to gain] confidence on driving on UK roads." They spoke positively about the supportive management approach.
● The service had a duty of candour policy in place. The registered manager understood the importance of open and transparent communication. At the time of our inspection, no serious incidents had occurred requiring a formal written duty of candour response. Records showed the service had demonstrated an open approach when dealing with matters such as incidents or concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others

● The service worked closely with health and social care partner agencies. This included the delivery of short term support for people leaving hospital. Feedback from professionals included, "Overall the service we have received from them is good", "They…work well with us. Good feedback received from some service users families" and "I have worked with Utmostcare on a number of cases. Their support and care for the service users has been excellent to date. They have provided above and beyond…They have been willing to support with all cases and have maintained a positive stance throughout."

● Some people and families told us the service had asked for their feedback. Comments included, "No, I have had no questionnaire", "I would like the opportunity to arrange more meetings with the company to discuss my mother's care needs in more detail", "Yes, [registered manager] comes in to see me and checks on things…brought me some nice flowers the last time she came" and "Not really. They have had a visit before now to see if things are okay."

● The operations manager explained the new electronic care system would enable management to keep formal records of people's feedback, including care reviews. They told us it had been difficult to carry out meaningful reviews and quality assurance due to the numbers of people who required only short term care, meaning people often left the service before a review could take place.

● Systems were in place to engage with staff. This included weekly and monthly staff meetings. Minutes showed staff had been encouraged to give open feedback, such as discussing issues with the previous electronic care records system. Management had responded to staff feedback and at the time of our inspection a new system was in use.

● The service was committed to staff development which provided staff with opportunities to help develop the service. The registered manager explained experienced staff had progressed into senior care worker roles and at the time of our inspection a care worker had been given the opportunity to work in the office to support with the transition to the new care records system. The worker told us, "[I] wanted something different, wanted to see another aspect of how service users are supported within managerial position."

● The service had conducted a staff survey in 2022. The service sought support from an external professional to carry out statistical analysis and the summary concluded, "the staff who took part in this survey are happy with the way we ran our services…we will however not rest on our laurels…and strive to achieve excellence by having management meetings on this survey". No other actions had been formally documented as part of the analysis. The operations manager explained how staff feedback informed plans to develop the service. Staff had noted driving time as a logistical concern. The operations manager explained actions they were taking, including an agreed geographical area for new customers to minimise driving distances.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not clearly identified and managed. Risk assessments were either not present or lacked sufficient detail to help staff understand and respond to risks. The service had not ensured the proper and safe management of medicines, including record keeping of the administration of medicines. Systems were not operated effectively to ensure appropriate infection control measures.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems did not effectively assess, monitor or improve the service to ensure compliance with all required regulations.