

# Companion for Care Services Limited Staffordshire

## Inspection report

55 St. Edward Street  
Leek  
ST13 5DN

Tel: 01538387782  
Website: [www.companion4care.co.uk](http://www.companion4care.co.uk)

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27 October 2022

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## Ratings

Overall rating for this service	Requires Improvement ●
Is the service safe?	Requires Improvement ●
Is the service well-led?	Requires Improvement ●

# Summary of findings

## Overall summary

### About the service

Staffordshire is a home care service providing personal care to adults with a range of support needs in their own homes. At the time of the inspection there were 24 people using the service, some of whom had a learning disability.

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.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

The provider had made significant improvements since our last inspection, and they were no longer in breach of regulations. However, further improvements were still required to ensure the systems in place were always effective.

**Right Support:** We found improvements were required to ensure the provider supported people in line with the restraint reduction standard. People were supported to have maximum choice and control of their lives however, further guidance was required to ensure staff clearly recorded how they supported them in the least restrictive way possible and in their best interests; the policies and systems in the service required further review to support this practice.

**Right Culture:** Since our last inspection, systems in place to improve the service had been implemented, however further improvements were still required. The systems to identify missed calls were not always effective. The provider had not ensured all required referrals were made. People's care records had however, been reviewed to ensure people received calls in line with their care plan. Staff shared a positive culture which was person centred and they were encouraged to be open and honest when things went wrong. People, their relatives and staff were involved and engaged in the service.

**Right Care:** The provider had made improvements since our last inspection to ensure staff were recruited safely and people's medicines were managed safely. People's care plans detailed how their care was person centred and promoted their dignity. People were protected from the risk of infection through effective control systems in place. Lessons were learnt when things went wrong.

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

### Rating at last inspection and update

The last rating for this service was requires improvement (published June 2022) and there were breaches of regulation. The provider had received a warning notice following the last inspection and they had to be compliant with this. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

### Why we inspected

We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Staffordshire on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

### Follow up

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?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Staffordshire

## 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

This inspection was carried out by 1 inspector for the 1st office visit and 2 inspectors for the 2nd office visit.

#### Service and service type

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

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

Inspection activity started on 12 October 2022 and ended on 10 November 2022. We visited the location's office on 12 October 2022 and 27 October 2022.

#### What we did before the inspection

The provider was not asked to complete the required Provider Information Return (PIR) for this inspection.

This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We reviewed other information we had received about the service.

We asked Healthwatch if they had any information to share about the service. They did not have any feedback to share. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We sought feedback from the local authority and reviewed a copy of their most recent visit report with completed actions. We used all of this information to plan our inspection.

#### During the inspection

We spoke with 6 people who used the service about their experience of the care provided. We spoke with 5 members of care staff plus the provider/registered manager. We reviewed a range of records. This included 4 people's care records and medication records. We looked at 4 staff files in relation to recruitment and staff supervision. We also looked at a variety of records relating to the management of the service, including audits and action plans. We also spoke with a social worker from the local authority.



# Is the service safe?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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.

### Staffing and recruitment

At our last inspection the provider had failed to robustly recruit staff to ensure they were suitable to support people who used the service. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

- The provider had made improvements since our last inspection to ensure staff were recruited safely.
- Staff employment history and any gaps had now been explored and documented.
- The provider completed Disclosure and Barring Service (DBS) checks on staff prior to their employment. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- People we spoke with confirmed the right number of staff attended their calls as required.

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

- The provider had systems and process in place to help safeguard people from the risk of abuse, however, these were not always followed.
- We were made aware of an alleged safeguarding incident and raised this with the registered manager. They confirmed they had been informed and had started an investigation. This included putting measures in place to protect people from potential further harm. Whilst we found no evidence of harm, the provider had not made a safeguarding referral or contacted the police.
- Following our prompt, the provider made the required referrals and submitted a notification informing us of the incident. The registered manager had mitigated the immediate risk and took action to review their systems to ensure future referrals are made within a specific timeframe. We also reviewed other records and the provider had made the required referrals and took action following concerns being raised.
- We found on 2 consecutive occasions, staff had not alerted the provider when a person had not answered the door. Although the person had not been at home at the time of the calls, the provider acted to ensure staff raised this going forward to ensure the safety of people receiving care.
- People we spoke with confirmed they felt safe. One person told us, "I feel safe with the carers." Staff were trained to recognise and report on abuse, and they told us the process they followed if they had any concerns. One staff member told us, "We [staff] always make sure people are safe, happy and comfortable, if I have any concerns they always get dealt with and acted on."

### Assessing risk, safety monitoring and management

- People's risks were assessed and monitored, however some records required further reviewing.
- People's care records contained up to date risk assessments which were personalised and reflective of their current health and wellbeing needs. We found however; some assessments had not been reviewed in line with their documented review date. The registered manager took prompt action to review these.
- People we spoke with confirmed staff knew them, their needs and any risks they had. One person told us, "All the carers who come are very good, they all know what I need." One staff member confirmed, "We definitely know people's risks and any new concerns are shared in the communication book in people's houses."

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
- We reviewed 1 person's records where further improvements were required to ensure the provider was supporting this person in line with the restraint reduction standards. For example, ensuring their records clearly detailed where lower level restraint was tried first. We reviewed a recent incident form which detailed the use of restraint. However, it did not break down who was supporting which part of the person's body or clear specific details following the use of restraint.
- The provider had supported this person for 1 month prior to our inspection and the registered manager told us they were working with the local authority to safely support this person and reduce restrictive intervention. They also informed us the number of incidents involving this person had reduced since the provider started supporting them. Staff received training to safely meet this person's needs and a debrief with the person and staff was recorded following any incidents.

#### Using medicines safely

- The provider had made improvements since our last inspection and people's medicines were managed safely.
- People's 'when required' medicine (also known as PRN medicine) protocols had been reviewed to provide staff with clear guidance and instruction.
- People's medicine administration charts we reviewed were completed and people and staff we spoke with confirmed people received their medicines as prescribed. One person told us, "They [staff] support me with my medicines, I have no concerns at all."

#### Preventing and controlling infection

- People were protected from the risk of infection through effective control systems in place.
- People and staff confirmed staff wore the required Personal Protective Equipment (PPE) during visits. Staff also confirmed they had access to PPE.
- Staff completed training in infection control and COVID-19 with their competencies checked to help protect people from the risk of infection.



### Learning lessons when things go wrong

- Lessons were learnt when things went wrong.
- Staff confirmed the process they followed when things went wrong, including reporting any concerns to the office and either the registered manager or clinical lead investigated.
- The registered manager reviewed accidents and incidents and ensured actions were taken to mitigate the risk of reoccurrence. They completed monthly analysis of the records to identify themes and trends.

# 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.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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

At our last inspection the provider had failed to ensure quality assurance system were fully effective at monitoring the service and identifying areas for improvement. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- The provider had made improvements since our last inspection; however further improvements were required to ensure the systems in place were always effective.
- The provider had not identified through their system when staff were not following procedure for missed calls. Staff had used their system to sign into the call for 1 person, however they did not complete the call and the care had not been received. When we raised this, the provider updated their systems and ensured staff followed an effective reporting process.
- Further oversight was required to ensure staff effectively recorded specific details following the use of restraint. The registered manager planned to review this and ensure people were supported in line with the restraint reduction standard.
- We found 1 occasion where the provider had not followed their safeguarding policy and made referrals to appropriate bodies following an incident being raised.
- Since our last inspection, however, the registered manager had employed a clinical lead to help support with the actions required to improve the service and the care people received. Improvements had been made and the provider now sent correct information within their monthly action plans, which they were required to send following a condition we placed on the provider's registration. They also updated their website to include their current rating.
- The registered manager completed regular audits and checks on the service, this helped identify areas for improvement. People's care records were reviewed, and people received the calls they required as documented in their care plan. The registered manager completed a quarterly report, and this identified where staff were using incorrect codes on people's medicine administration charts. They took action to provide staff with guidance for the correct way of recording through team meetings and supervisions.

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

- Staff shared a positive culture where they were supported to provide people with person-centred care.
- Staff we spoke with confirmed they received regular support from seniors and the registered manager. One staff member told us, "The registered manager is easy to get in contact with, if we need anything they help."
- The provider's values were displayed on their website so people who used the service could see their principles for care.

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; Working in partnership with others

- The provider understood the duty of candour and they worked in partnership with others.
- Staff were encouraged to be open and honest when things went wrong. The registered manager told us when things go wrong, they apologised to the person involved and took any required action.
- The provider worked in partnership with others. Following our last inspection, the provider had worked with the local authority to make improvements to the service and to the care people received. The provider had completed their quality monitoring actions identified from the local authority.
- The registered manager told us they had regular communication with occupational therapists (OT's), district nurses and people's general practitioners (GP's) to effectively meet people's needs. We also spoke with a local authority social worker, who informed us they were working with the provider to meet a person's needs.

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

- People, their relatives and staff were involved and engaged in the service.
- The provider gave people the opportunity to share any feedback and suggestions to their care. For example, the provider completed telephone calls to people who used the service. They had recently increased the regularity of the calls to ensure any concerns people had been consistently met. We also reviewed the monthly audits of people's daily records. They included where senior staff had completed spot checks on people using the service to gain their input into their care.
- The registered manager held meetings to discuss aspects of people's care, they informed staff of any changes and ensured they were involved in any ideas to make improvements to people's care.