Conquest Care and Support Agency LTD

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Conquest Care and Support Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of our inspection 54 people were using the service. 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
During the inspection we found risk assessments were not always robust enough and medicines were not always managed safely. Safe recruitment practices were not always followed to help ensure staff were suitable to support the people who used the service. Care workers did not always arrive at the agreed call times.

Recording systems were not robust enough to monitor and mitigate the risks relating to the health, safety and welfare of people using the service. Additionally, systems were either not in place or robust enough to demonstrate service improvement was effectively managed.

The provider had not always ensured people received care in line with the principles of the Mental Capacity Act 2005 (MCA). People were not always supported to have maximum choice and control of their lives and the provider could not demonstrate people were always supported in their best interests. While the provider had policies and systems in place, these were not always robustly implemented.

We recommended the provider consider current best practice guidance to ensure they are working within the principles of the MCA.

Staff were supported in their roles through induction, training and supervision. They knew how to respond to safeguarding concerns and how to help to keep people safe.

The provider undertook initial assessments and used these with local authority assessments to develop a care plan to meet people's needs. People and their relatives told us they knew who to contact if they had a concern.

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

Rating at last inspection and update
The last rating for this service at the previous premises was good (published 21 June 2019).

Why we inspected
This focused inspection was prompted by a review of information we held about the service. We have found

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

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 changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Conquest Care on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, recruitment and good governance a 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Conquest Care and Support Agency LTD

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 conducted by two inspectors. After the inspection, two Experts by Experience supported the inspection by making phone calls to people who used the service and their relatives to ask for their feedback. 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.

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.

Inspection activity started on 01 March 2023 and ended on 23 March 2023. We visited the location's office on 14 March 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including notifications of significant events. We sought feedback from the local authority and professionals who work with the service. We also 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 took this into account in making our judgements in this report.

During the inspection
We spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 5 people's care records, multiple medicines records and 5 staff records. A variety of records relating to the management of the service, including audits, were also reviewed. We spoke with 10 people who used the service and 13 relatives. We reviewed 21 care workers written feedback of their experience of the service.

Requires Improvement

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 good. At this inspection the rating has changed to 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
• Risk assessments were not always robust enough to help reduce the risk of avoidable harm to people. One person had a task list for care workers that included to check the person's catheter bag. However, there was a lack of detailed information about risks regarding personal care and what the care workers should look for when providing catheter care. For example, indicators of dehydration, infection or other concerns that would need to be reported to medical or health care professionals.
• The local authority risk assessment for this person indicated they were at risk of choking when they ate in bed. We saw the provider's assessment and care plan did not explore this concern about the person eating in bed or provide written guidance to staff to mitigate the risk of choking.
• The care plan for a second person, which had been developed by the local authority social worker, indicated the person was living with gastro-oesophageal reflux disease (GORD) which is when acid from the stomach leaks up into the oesophagus. The provider informed us despite the local authority's assessment indicating the person should get up from their bed, the person was reluctant to so. However, there was no written risk assessment or guidance for care workers in the care plan about how to support the person if they decided to eat their meals in bed to prevent or reduce the occurrence of potential uncomfortable symptoms such as heartburn, bloating and belching, feeling or being sick and pain when swallowing or difficulty in swallowing. The provider told us this was because the person had a medical background and were aware themselves of what to do. This meant the care workers had not been provided appropriate guidance and were dependent upon the person to advise them on how to provide suitable care in relation to their medical condition.
• We found the local authority assessment for a third person indicated they required a soft diet due to digestive problems, but this was not recorded in the provider's care plan. This meant the care workers had not been provided with guidance to ensure the person received food in a way that met their medical needs.
• The initial assessment for a fourth person identified they needed a falls risk assessment, medicine risk assessment and feeding assessment. However, the provider was unable to demonstrate these were in place. The only available risk assessments were in relation to moving and handling, conducted by external occupational therapists. This meant that specific risks were not always assessed to ensure care workers had information on how to mitigate the identified risks.
• We also saw the records for the maintenance of this person's hoist were not completed. Therefore, it was not clear how the provider ensured the equipment being used to transfer the person was safe as the records were not up to date.
• The environmental risk assessments for a fifth person indicated there were concerns about smoke and

carbon monoxide detectors in the person's home not being in good working order. However, there was no action recorded of what was done to mitigate the risk and keep the person safe.

Systems had not been used effectively to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There were risk assessments and guidance for the use of a hoist and slings written by an occupational therapist.

Using medicines safely
• Medicines were not always managed safely. We found one person was prescribed medicines including anti-depressants and ulcer medicines, but there was no information about what these medicines were for. Care workers were advised to observe for generic reactions including shortness of breath, sweating, pain and/or rash that could be due to medicines. This meant care workers did not have guidance specific to the medicines they were administering.
• Two people used creams, but we found no information about where to apply the cream, for example shown on a body map. The type of cream was not recorded and records did not indicate if it was prescribed. Additionally, there was no information if the emollient cream was flammable and required a risk assessment.
• Another person's assessment confirmed they required support with medicines and a medicines risk assessment was required. However, the provider was not able to demonstrate these were in place. This meant people may not have received their medicines as prescribed.
• We also saw for this person when medicines were not administered, the reason for this was not always recorded in the notes section of the medicines record.
• Medicines were not audited effectively to help ensure they were administered as prescribed. The provider used an electronic MAR system and used a print out of this as an audit. However, there was no evidence the provider had audited the spreadsheet as we saw discrepancies. Under the outcome heading where it should have said if the medicines were administered, we saw for example, 'no outcome recorded' but without a reason and 'Client refused' but not what action was taken. Therefore, we could not be sure people were receiving their medicines as prescribed.

The provider did not always ensure the proper and safe management of medicines. This placed people at risk of harm. This was a further breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider told us after the pandemic it was difficult to recruit and retain staff. They said most of their care workers had been with them for less than a year but they believed they had enough suitable staff to meet people's needs. However, the feedback received by people using the service and relatives indicated there were not always enough care workers, care workers did not always arrive on time and they did not always have travel time factored into their hours.
• The provider had an electronic call monitoring system which identified when carers arrived and left a visit, but this was not being used effectively. CQC analysis of the care workers' in and out call times identified the care hours delivered were double the planned amount of care hours. Care workers being recorded in two places at once contributed to this effect.
• We also found that the actual times of calls did not always reflect the time agreed with the service user as recorded in the care plan. For one person the daily notes on 06 March 2023 were generated at 11.05 for a for visit scheduled 8.30 to 9.00 and at17:32 for a visit scheduled between15.30-16.00. The care worker recorded,

'wife upset that I arrived late'. On 07 March 2023 the notes were generated at 15:27 for a visit scheduled to take place 13.35 – 14.05 and later in the day at 19:08 for a visit that was scheduled for 17-17.30. The daily notes on 10 March 2023 had a scheduled visit time 20-21:00, but the care worker's daily visit note was generated at 22:07. •The daily notes for another person for the first week of March 2023 indicated evening visits were scheduled from18.30 to 19.30. Generated notes were timed from 8 minutes late to 2 hours late. This meant that people might not have received the care they needed in a timely manner as there may have been extended periods of time between visits which could have resulted in delays in receiving medicines and support with food or personal care.
• Some people and their relatives told us care workers could arrive late and were not always the same care workers. Comments included, "It can be between half an hour and an hour difference [of when the care worker arrives]", "Sometimes they don't turn up when they are supposed to. It's either too late or too early, especially at night. We have our dinner at about 5 o'clock, they are supposed to come about 5.00. Sometimes it's 4 o'clock and we have not had our dinner. It's not worth them coming then. It happens quite often" and "They come 45 minutes to an hour late sometimes. The majority of the time they are late. Some turn up on time, usually the lunch time call. However, if the breakfast call is late, [person] has just had breakfast and is not ready for lunch."
• Some people told us there was a lack of consistency of the care works, Comments included, "It's not consistent, I don't know what time they are turning up. When they do turn up, I have to ask who they are", "Every visit there is a new person who you don't know and they don't know if they are coming again" and "I don't know who is coming. I don't have a problem with it."

Care workers not arriving at the agreed call times was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notwithstanding the above, other people and relatives told us care workers arrived on time and stayed the correct length of time. Comments included, "They stay until they have done what I've asked them to do", "They stay the right amount of time. They don't cut corners" and "They arrive on time. Reliable, attend every time. If there are changes they agree with me. They do the time. [Care workers] get everything done that [person] needs."

• The provider did not always follow safe recruitment procedures to help ensure new care workers were suitable for the work they were undertaking. We reviewed the recruitment files of 5 staff. Although the provider had requested them, 2 of the staff did not have work references or DBS checks back. Disclosure and Barring service (DBS) checks are criminal record check that employers undertake to make safer recruitment decisions.
• At the time of the inspection, the provider was not able to demonstrate they had completed risk assessments to help mitigate risks and keep people safe, where references and DBS checks were not in place.
• After the inspection, the provider sent us 'Employees starting work before an enhanced DBS certificate is completed' forms for staff without DBSs. However the form indicated criminal record check documents had been received and the applicants were not barred from working with children and adults. As the DBSs had not yet been received this was incorrect information and therefore not an effective risk assessment.
• One staff member did not have proof of their eligibility to work in the UK.

Not following safe recruitment procedures was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• After the inspection, the provider sent us evidence they had received a DBS check for one of the staff members we identified as not having one.

• Notwithstanding the above, other staff had checks regarding their identity, eligibility to work in the UK, employment history, references from previous employers and criminal record checks.
• New care workers completed an induction where they shadowed a more experienced member of staff.

Learning lessons when things go wrong
• It was not always clear from the records, how complaints and incidents were responded to, as lessons learnt were not written down to help improve service delivery.
• The provider told us they recorded individual incidents in service user files but could not tell us how many incidents there had been in the last 12 months, as there was no audit or overview of the incidents to help improve service delivery. This meant there had been no analysis of what preventative measures were implemented to help mitigate the risk in the future.

We found no evidence that people had been harmed however, recording systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider explained there was an absence of centrally stored accidents and incidents information along with analysis and auditing to identify emerging and concerning trends was due to a number of factors. This included the service going through a transition period, the appointment of a sizeable number of new care workers, changes to the IT system and the additional work being conducted by the provider to attain an externally awarded quality management system certification.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems and processes to help safeguard people from abuse. This included safeguarding adult and whistleblowing procedures.
• Care workers had completed safeguarding training to help ensure they had the skills and ability to recognise when people were at risk of abuse and the action to take to help make sure people were safe.
• People and their relatives told us they felt safe. Comments included, "Yes, [person] is safe. Some have the same language" and "I think [person] is safe. I have gone through several services. No concerns for safety."

Preventing and controlling infection
• The provider had systems in place to help prevent and control infection, and to help keep people safe.
• Care workers had relevant training and were provided with personal protective equipment (PPE) such as gloves and masks to help protect people from the risk of infection.
• People and their relatives confirmed care workers wore PPE and followed good hygiene practices. People said, "They wear gloves, masks and they wash their hands before they do anything" and "I feel safe. My carers put on masks, gloves and an apron and deal with me in a professional manner."

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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 and found it was not always.

• The provider told us they had not completed any best interest decisions, as people had the capacity to consent to their care or someone with the legal authority to do so had been appointed. However, it was not always clear from people's records how consent was sought.
• There was a lack of recorded information by the provider about decision making processes. The records for one person we reviewed did not have a mental capacity assessment completed by the provider or written information to indicate the provider had formally sought consent from the person to provide their care.
• Two people's care plans had a sentence at the end of them which stated the care plan was agreed by both parties. However, only the Conquest Care representative had signed it. There was no evidence the provider had asked the person for their consent regarding who provided care or evidence of MCA assessments by the provider.

We recommend the provider consider current best practice guidance to ensure they are working within the principles of the MCA.

• Care workers received training on the principles of the MCA.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to starting the service to confirm their needs could be met by the provider. The provider sought copies of local authority assessments and there was evidence they referred to these assessments to develop their own care planning documents.
• Care records were regularly reviewed to help ensure people's needs were being met by the service.
• People were involved in care planning and made choices about how they wished to receive their care. Comments included, "They came and asked what I needed", "They asked my [relative] what support [they] need" and "We had an initial meeting before the care plan started. I was pleasantly surprised with the initial conversation."

Staff support: induction, training, skills and experience
• Staff were supported to provide appropriate care through an induction, training and supervision.
• Care workers received training and support relevant to people's needs and most people thought the care workers were well trained. People and their relatives told us, "Some come in and they know what to do", "Very well trained and skilled. The first week they learnt how my relative likes things. They do things her way" and "Yes, they seem like they know what they are doing. They use prompts and guidance." A care worker told us, "I always find training is good to keep me up to date on any changes and helps me to carry out the job to the best of my ability."
• The provider undertook spot checks of care workers working in people's homes, to help ensure good practice when supporting the people they cared for.

Supporting people to eat and drink enough to maintain a balanced diet
• Care workers supported people to meet their nutritional and hydration needs. People's nutrition and hydration needs were recorded in care plans, so care workers had the information to provide appropriate support.
• People and their relatives told us care workers provided low level support in relation to meals and mainly heated food up. They were happy with the support provided and one relative said, "Yes, they support [person] with meals. There are options and they give choices. They encourage [person] to eat."

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• People received support to maintain good health.
• Most people told us relatives supported them with healthcare access. However, where it was identified as a need, the provider worked in partnership with family members and other social care professionals to help them access appropriate healthcare services.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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.

Continuous learning and improving care
• Quality assurance systems such as audits were not being operated effectively as demonstrated by a number of shortfalls identified during the inspection.
• The provider told us the local authority put money on a card for a person they supported, so care workers could do the person's shopping. The provider did not ensure information related to supporting the person with shopping was included in the care plan and there was no evidence of how the management team check receipts to help ensure there was no financial mismanagement of the person's money.
• Care plans records did not always have robust risk assessments to help keep people safe.
• We found information, such as employment references missing from some staff records which meant checks during the recruitment process were not robust enough.
• The provider's medicines audits were not effective. Therefore, it was not clear if medicines had been administered appropriately.
• Care workers logging in and out times to a care call were not formally monitored. A recorded audit was not completed to identify trends and make improvements to service delivery.
• Incidents were not audited and therefore there was no evidence of lessons learned to reflect what preventative measures were put in place.
• The provider did not have audits to identify MCA principles were not always being adhered to appropriately. We found that the provider did not always evidence how they had sought consent from people they provided care to.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate service improvement was effectively managed. This was a repeated breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The service was family run and the registered manager told us they tried to develop a culture where there was open communication on every level and at times managers were hand on in providing care, so they understood what was happening in the service.
• People and their relatives were involved in planning their care and care workers were aware of how to meet people's needs. Most people and their relative felt supported.

• Feedback from staff was mixed as some felt they were in a vulnerable position of a manager being able to threaten dismissal unjustly and therefore could not raise issues with the management team. Most staff, however, did feel supported. Comments included, "Yes, I do feel supported by my manager as I go out to carry out my task from day to day", "Any time I meet challenges in the field, I call them for advice, and it is always helpful" and "I feel that our managers are very supportive."

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 provider understood their responsibility around the duty of candour and of the requirement to notify appropriate agencies including CQC if things went wrong.
• The nominated individual told us, if something goes wrong, they have to be open and honest about it.
• The provider had policies and procedures in place to respond to safeguarding alerts and complaints and knew who to notify.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•Managers and staff understood their roles and responsibilities. The nominated individual was also the owner of this family run company.
•The provider told us as they were a process of transition, they were aware of some gaps in service delivery and having identified them, were moving forward with new systems.
•People and their relatives generally thought the management would respond to any concerns and confirmed they were asked for feedback. People said, "They have contacted me to check up on their workers" and "They call me. [Is] everything ok, do I need anything else? That's the head office."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and relative's views were sought through care planning and telephone monitoring.
• People's diverse needs such as culture, religion and language spoken were considered as part of the assessment process.

Working in partnership with others
• The provider worked in partnership with various other health and social care professionals.
• Where appropriate they liaised with other relevant agencies, such as the local authority and community health care professionals to ensure people's needs were met. For example, care workers attended a moving and handling assessment carried out by the occupational therapist before a person using the service was discharged home from a hospital stay.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not make sure that recruitment procedures were operated effectively to ensure the suitability of each person employed to care for service users. Regulation 19 (1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always assessed or done all that was reasonably practicable to mitigate the risks to the safety of service users. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)

The enforcement action we took:

We have issues the provider with a warning notice requiring them to comply with the regulation by 28 July 2023.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always effectively operate systems and processes to monitor and improve the quality of the service. Regulation 17 (1)

The enforcement action we took:

We have issues the provider with a warning notice requiring them to comply with the regulation by 28 July 2023.