Classic Home Care Services Limited

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Inspection report

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13 May 2019

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:

Classic Home Care Service Limited provides a domiciliary care service to 90 people living in Epsom and the surrounding area. Care and support is provided to people living in their own homes and flats. Support is provided to people living with dementia, learning disabilities, younger adults and people living with mental health needs. Live-in care was also provided to five people at the time of the inspection.

Not everyone using a domiciliary care agency receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided, such as supporting people to access the community.

People's experience of using this service:

People and their relatives told us they were happy receiving care and support from Classic Home Care Services Limited. People received their medicines on time and care worker's competency to safely support people to take their medicine had been assessed. However, best practice guidelines around the safe management of medicines had not consistently been followed. Risk assessments were not in place when medicines were left out, protocols were not in place for the use of 'as required' medicines and Medication Administration Records (MAR charts) had not consistently been amended following changes in prescribing instructions.

Further improvements were needed to ensure that risk assessments and care plans were sufficiently detailed, so care workers had clearer guidance.

The principles of the Mental Capacity Act 2005 (MCA) were not consistently adhered to or followed. For example, some people's care plans were signed by their relatives. Consideration had not been given to establishing whether the person was unable to sign and consent to their care plan and whether their relative had the legal authority to sign the care plan.

Auditing processes were in place but failed to consistently identify shortfalls and drive improvement. We have made a recommendation about the quality assurance and audit process.

Care workers treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible. One person told us, "They encourage us to be independent." Another person told us, "The girls are lovely."

People were supported to maintain a balanced diet where care workers were responsible for this. People received the support they needed to stay healthy and to access health care services as and when required.

Relatives spoke positively about care workers supporting their family members and told us they were kind, caring and patient and treated them with dignity and respect.

A complaints policy was in place and people told us they felt confident in approaching the registered manager with any concerns or queries. Feedback was regularly sought from care workers, people and their relative and used to drive improvement.

Rating at last inspection:

At our last inspection, the service was rated "Good". Our last report was published on 29 November 2016.

Why we inspected:

This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Enforcement:

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. Action we told the provider to take is outlined at the back of the report.

Follow up:

We will speak with the provider following the publication of this report to discuss how they will make changes to ensure the rating of the service is increased to at least Good. We will continue to monitor intelligence we receive about this service until we return to visit as per our re-inspection programme. An action plan from the provider will also be requested. If any concerning information is received, we may inspect sooner.

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

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?

Good

The service was 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

Classic Home Care Services 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

This inspection was carried out by one inspector and an expert by experience who interviewed people who used the service and their relatives on 10 May 2019. An expert by experience is a person who has personal experience of using or caring for someone who uses domiciliary care services.

Service and service type:

Classic Home Care Service Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection:

We gave the service 5 days' notice of the inspection site visit because some of the people using the service needed to provide consent to a home visit.

Inspection activity started on 10 May 2019 and ended on 13 May 2019. We visited the office location on 13 May 2019 to see the registered manager and office staff; and to review care records and policies and procedures.

What we did:

Prior to the inspection we reviewed information we held about the service, for example the provider information return (PIR) and information shared with us by members of the public. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make

During the inspection we gathered information from:

•15 people who use the service and seven relatives
•The registered manager, provider and two members of the office team.
•Six care workers
•Records of accidents, incidents and complaints
•Audits and quality assurance reports
•10 care plans and subsequent risk assessments.
•Policies and procedures
•Medicine Administration Records (MAR charts)
•Staff rota's, training records, staff files and business continuity plan
•Statutory notifications

After the inspection we shadowed two care calls and requested further information from the registered manager around the safe administration of medicines.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: 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.

Using medicines safely:

●We found shortfalls in systems and processes to help ensure the safe management of medicines.
●Best practice guidelines around the safe management of medicines in the community were not consistently being adhered too or followed. The provider's internal medicine training pack and medicine policies and procedures failed to reflect best practice and failed to refer current legislation. This posed a risk that care workers were not aware of up to date practice regarding safe administration of medicines. Subsequent to the inspection, the registered manager told us that care workers were in the process of receiving updated medicine training.
●Guidance produced by National Institute for Health and Care Excellence (NICE) refers to the need for a risk assessment to be in place in the event of medicines being left out for the person to take later. One person's daily notes and MAR charts identified that on a number of occasions in March 2019, care workers had left out a person's medicines for them to take later. These medicines included antibiotics alongside a statin medicine (medicine used to lower cholesterol). Risk assessments were not in place and the person's care plan failed to demonstrate that it was safe for care workers to leave the medicine out. The provider had not considered the risks associated with this practice. We brought these concerns to the attention of the registered manager who following the inspection, confirmed that risk assessments had been completed.
●A number of people were prescribed medicines on an 'as required basis' (PRN). Care workers did not consistently record the reason why this medicine was administered. PRN care plans or protocols were not in place to inform staff when to administer these medicines, or what their intended affect was. This would increase the risk of people not being administered these medicines correctly. Following the inspection, the registered manager told us that care workers would be receiving training on the recording of PRN medicines.

●One person was prescribed a PRN medicine for pain relief. The prescribing instruction on the MAR chart was 5ml. However, care workers had been recording '10' on the MAR chart when the medicine had been administered. We discussed this with the registered manager and provider who told us that the person could inform care workers if they were in pain and that the person's GP had changed the prescription to 10ml. This change in prescribing was confirmed in documentation which demonstrated that this change in dosage had occurred in March 2019. This change in prescribing instruction had not been reflected within the person's care plan or MAR chart.
●Despite the concerns above, people told us they received their medicines on time. Care workers were observed to administer medicines with diligence, patience and care. They explained to the person what their medicine was for and how they would like to take it.
●Care workers competency to safely support people to take their medicines was assessed and regularly reviewed.

Assessing risk, safety monitoring and management:

●Care workers were knowledgeable about the risks posed to people. Care plans also included information on risks posed to people. Whilst some information was available in care plans, personalised and specific risk assessments were not in place. For example, care and support was provided to people living with catheters and PEG tubes (Percutaneous endoscopic gastrostomy). Specific risk assessments were not in place around how to safely manage the person's care and how to mitigate any risks of infection control when providing catheter or PEG care. People living with a catheter can be at risk of bacteria entering the body and infection control measures can mitigate this risk.
●A risk assessment form was in place which considered the internal environment, external environment, health of the service user and kitchen appliances. The risk assessment assessed whether the risk posed was low, medium or high. However, when the risk was assessed as high, guidance was not consistently in place on how to mitigate the risk.
●We brought these concerns to the attention of the registered manager who following the inspection sent us a copy of their revised risk assessment which they were in the process of implementing and advised would be implemented within four weeks.
●Despite the concerns above, care workers demonstrated a sound understanding on how to safely support people and were able to describe the risks posed to people and how they supported them. For example, one care worker told us about the importance of wearing protective personal equipment when supporting people with catheter care and always ensuring that the tap to the catheter bag was closed.

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

●People who used the service, relatives of people and care workers said the service was safe and they felt safe with the support provided. One person told us, "I'm very safe with the girls coming in and looking after me."
●People were supported and protected from the risk of abuse or harm. Care workers understood their roles and responsibilities to protect people from abuse. Care workers spoke confidently about the indicators of abuse and how to report concerns both inside the service and to external agencies. Training records confirmed that all care workers had received up to date training on safeguarding adults from abuse.
●Care worker's competency around safeguarding was assessed. This competency assessment considered their knowledge and understanding of safeguarding and the potential signs of abuse.
● Care workers understood the importance of leaving people's property safe and secure. One care worker told us, "I always make sure backdoors are closed. I try to leave everything clear and ensure I put the key back into the keysafe." Another care worker told us, "I always make sure people are warm and the heating is on, especially in winter."

Staffing and recruitment:

●Care workers were recruited safely. Full employment checks were completed before staff started working with people, including gaining accurate references and a full employment history. Disclosure and barring service (DBS) checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
●People, relatives and care workers told us that there was enough staff to cover the care calls. One care worker told us, "There is enough staff. We have had some sickness lately but between us we cover all the care calls."
●The staff rota was planned three weeks in advance and care workers received their rota in advance. The registered manager told us that sixty percent of care calls had an allocated care worker. Where people

received a live-in carer, the carer was permanent and support was provided by the service to cover the carers annual leave and breaks during the day. The registered manager told us that when people did not have a permanent live-in carer, a team of carers were rotated on a two-week basis.

●The deployment of care workers took into account people's individual care needs alongside equality and diversity needs. For example, the registered manager told us how some care workers were unable to work Saturday evenings due to attending church. The registered manager told us how these considerations were factored into planning the rota.

●The provider was in the process of transferring to an electronic system whereby care workers would log in and out of care calls. This system would enable the provider to monitor the arrival and departures of care workers from care calls in live time. Whilst this system was being embedded, care calls were regularly audited to ensure care workers arrived at the allocated time and staying for the duration of the time allocated.

Preventing and controlling infection:

●Care workers received training in infection control and food hygiene. Care workers told us that personal protective equipment (PPE) was readily available.

●Care workers were observed to be mindful of infection control when visiting people in their own homes. They washed their hands upon arrival and carried anti-bacterial gel and wore PPE when appropriate and required.

Learning lessons when things go wrong:

●Accident and incidents were managed safely, and lessons learned to improve the care people received.

●Since January 2019, the service had experienced two missed calls. The missed calls had not recorded or reported as incidents. However, learning had been derived from the missed calls. The registered manager told us, "We identified that the missed calls were the result of mis-communication between the office and the care worker. When making changes to a care call this is being communicated via telephone, we now always check that the care worker has time to take the call. Previously, we were communicating this message between care calls and the care worker probably wasn't taking in the message."

●Following a safeguarding incident whereby confidential information was stolen, the provider reviewed their policies and procedures around paperwork and confidentiality and changed to a paperless system.

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

Requires Improvement: 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

●The provider was not consistently working in line with the principles of the Mental Capacity Act (MCA).
●Where relatives had signed people's care plans, the provider had failed to determine if they had the appropriate legal authority to do so, such as lasting power of attorney (POA) for health and welfare. For example, one person's care plan referenced that a relative held 'POA' and they had signed the care plan and consent forms. The registered manager was unable to demonstrate whether the relative had POA for health and welfare and that the person lacked capacity to sign and understand their care plan. We brought these concerns to the attention of the registered manager and subsequent to the inspection, the registered manager confirmed that copies of POA had been requested and were now on file.
●Care plans considered if people had the mental capacity to make decisions. However, when this was recorded as 'no', subsequent mental capacity assessments had not been completed to assess whether the person was able to consent too and understand their care plan.

Failure to work in line with the principles with the Mental Capacity Act 2005 was a breach of Regulation 11 – Need for Consent, Health and Social Care Act 2008 (Regulated Activities) 2014.

●Whilst decision specific mental capacity assessments were not in place, care workers understood the importance of gaining consent from people to enter their home and provide personal care. One care worker told us, "I always seek a client's approval."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

●People's care needs were assessed before the service commenced supporting them.
●Care workers provided us with examples of how people wanted to be cared for, including the choices they were making around their daily routines and personal care.
●The provider ensured care workers supported people in line with their assessed need. Care workers told us how they attended the local hospital for training on how to safely support someone in preparation for their

discharge home.

Staff support: induction, training, skills and experience:

●People were supported by care workers who had completed an induction and training programme before they started to work with them. Care workers spoke highly of the induction programme and support they received when they first joined the company. One care worker told us, "I shadowed a colleague for a week which was really helpful."
●During care worker's induction and shadowing, feedback from people was sought to see how the care worker was progressing during their induction.
●The provider had a strong focus on training and assessing care worker's competency. Training topics included moving and handling, safeguarding, stoma care, risk assessments, catheter care and health and safety. Care workers confirmed they were regularly asked if there was any additional training that may be helpful to them. One care worker told us, "In every supervision they ask about training. I've recently asked for end of life training which they have organised for me."
●The provider recognised the importance of effective supervision. Care workers received supervision every three months alongside a yearly appraisal. Care workers spoke highly of the support they received. One care worker told us, "Supervision is extremely helpful."
●Where care workers had not been meeting the requirements of their role, disciplinary procedures were in place, so issues could be addressed promptly, and plans put in place to improve their practice.

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

●People were protected from malnutrition and dehydration.
●Care workers supported people with food preparation and with eating if required. People spoke highly of the support they received from care workers. One person told us, "They encourage me to eat."
●Care workers were observed supporting people to eat and drink with care and compassion. They asked people what they would like to eat and provided a variety of options whilst also empowering people to come into the kitchen and chose for themselves. When leaving care calls, care workers ensured people had a hot and cold drink to hand.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives:

●People were supported to maintain their health and relatives told us they were regularly updated if there were changes in their family member's health and wellbeing.
●Care workers knew what procedures to follow if they had concerns about people's health. Care workers competency around the procedures in the event of an emergency was also assessed and reviewed.
●People told us that care workers supported them to attend appointments, such as GP and hospital appointments.
●Care workers, the registered manager and the provider worked in partnership with healthcare professionals to ensure people lived healthier lives. One care worker told us, "We noticed that one person's walking was getting bad and they didn't have any equipment in place. We contacted the Occupational Therapist (OT) who supported the person to get some walking aids. Their walking has much improved."

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

Good: 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 spoke highly of the care workers that visited them. One person told us, "They are brilliant."
●The management led by example, this was by working hands-on and motivating care workers to deliver good care. The caring nature of the service was shared by all care workers.
●Care workers spoke about the people they supported in a caring manner and it was clear from conversations with office staff that they knew people well. One care worker told us, "One person I go to, likes their routine. We've learnt the routine really well now. They also enjoy talking about the weather and travelling." It was clear that care workers had spent time getting to know people, their hobbies, interest and routines.
●Care workers worked to ensure people were treated equally and that their protected characteristics under the Equality Act were respected and promoted. Care workers supported people to attend their local church and where people were no longer able to attend, the provider organised for local priests to attend people at home.
●Where people requested a male or female care worker, this was respected. Care workers were mindful of people's religious and spiritual needs and supported people to practice their faith. The registered manager told us, "We supported one person who wanted to attend day centre but none of the local day centres spoke their language. We found a day centre that did, and care workers supported them to attend."
●People spoke highly of the little things that care workers did for them. One person told us, "During my evening call, they turn my bed down for me. It's so luxurious. It's those little things that make me feel less lonely."

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

●People we spoke with were able to express their views and make decisions about the support and care they received. People were aware of their care plan and regular reviews took place to ensure people remained happy with the care. For example, following one care review, it was identified that the person required additional support with bathing. A bath call was subsequently added to the package of care.
●Relatives and people spoke highly about communication from the office which enabled them to be fully involved and understand the decisions made about their care. During the inspection, office staff were heard contacting people advising that their care worker may be late due to traffic.
●Care workers supported people living with communication needs to be fully involved in decisions about their care. The registered manager told us how care workers devised communication cards for people to enable them to day to day decisions about their care, what they wanted to do, eat and wear.

Respecting and promoting people's privacy, dignity and independence:

● People's privacy and dignity was respected. Care workers recognised the importance of respecting and promoting people's dignity when providing personal care. One care worker told us, "We check that people are happy for us to close the door and curtains. I also ensure people's top half is covered when supporting them to wash their bottom half."

●Care workers encouraged people's independence and promoted people to do as much for themselves as possible. One care worker told us, "We try and motivate people to help them to keeping doing things for themselves. As the saying goes, you don't use it, you lose it. We try and keep clients as independent as possible." One person told us, "They encourage us to be independent."

Good

Is the service responsive?

Our findings

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

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

●Care plans were in place which included information on the support required at each care call, the person's interests, hobbies and aspirations. For example, one person's care plan outlined the tasks required to be completed at each care call. It also detailed their interest in politics.
●The provider recognised the importance of supporting people to access the local community and enabling people to improve their quality of life. The nominated individual told us, "We focus on quality and ensuring that people access the community and have a good quality of life."
●People and their relatives spoke highly of the care workers. They told us that the care workers demonstrated compassion, empathy and kindness. One person told us, "They keep me company."
●One person told us, "We have a good chat and laugh when the carers come in." Care workers understood that the purpose of the care calls was to provide people with companionship and not just to complete the tasks listed in the care plan. One care worker told us, "Every day we support people. We always go above and beyond to what's stated in the care plan. The other day I was supporting someone to buy gifts for their loved one."
●Care plans reiterated the importance of asking people if there was anything else they required during the care call. We observed this in practice. One-person care's plan identified that they enjoyed going for a walk if the weather was nice. Care workers told us that since the weather was picking up, they were regularly supporting this person to go out for walks.
●Care workers regularly provided companionship to people and supported people to access local day centres, go shopping and swimming. One person was a huge train fan and care workers supported them to go on a train outing.
●People's birthdays were recognised and celebrated. The provider told us that for one person's birthday they called them in the morning and asked what they would like to do that day. Care workers subsequently went out for afternoon tea with them to celebrate their birthday.
●The service worked to the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans considered if the person required the care plan to be provided in pictorial format or larger print. For people living with sensory loss, read aloud emails were in use to keep them updated about their package of care.

Improving care quality in response to complaints or concerns:

●A complaints policy was in place which was accessible to people.
●Relatives and people felt comfortable to raise any concerns they had and were confident any issues would be dealt with. One relative told us, "I wouldn't hesitate in raising any concerns." One person told us, "The

office staff are easy to get hold of if I need to raise any concerns."
●Since January 2018, the provider had received 11 complaints. These complaints had been reviewed to identify trends, themes or patterns.

End of life care and support:

●At the time of our inspection, care and support was being provided to one person who required end of life care. The registered manager told us, "Anticipatory medicines are in place and their wishes around where they would like to pass away have been discussed." Care plans included information about people's wishes in relation to end of life care.
● Care workers had access to policies and procedures surrounding end of life care. End of life care was also discussed during care worker's induction and additional training was also available to staff.

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

Requires Improvement: 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:

●The quality and auditing system needed to be developed further so findings could be collated, and actions taken to drive improvement.
●Audits were undertaken on a regular basis, however, these failed to identify shortfalls. For example, MAR charts were checked on a monthly basis. These quality checks looked for any omissions in recording but failed to identify that the management and recording of medicines was not consistently in line with best practice guidelines. For example, that risk assessments were not in place when medicines were being left out.
●Risk assessments and care plans were reviewed during yearly and six-monthly reviews. These reviews assessed whether the person was happy with the care and if their package of care was meeting their needs. However, the reviews failed to assess and identify whether risk assessments and care plans were accurate and fit for purpose. For example, we found some information held within care plans to be lacking in detail. Risks relating to health conditions were not always in place, so staff did not had guidance to refer to when supporting people with some health conditions.
● One person's MAR chart identified they were required to use a nebuliser (inhaler). Their care plan referred to them requiring a nebuliser but failed to explain why and how to safely support the person. A member of the office team advised that this person was discharged from hospital with the nebuliser. This information was not documented in their care plan and guidance was not available on how care workers should safely administer the nebuliser.

We recommend that the provider seek guidance and support around quality assurance and audit processes.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

●The service was a family run business and had been in operation for 20 years. The registered manager and provider told us, "It's our twentieth anniversary this week and we are holding a summer party to celebrate."
●The registered manager and provider identified that they valued quality of care rather than quantity. The registered manager told us, "We are working to full capacity at the moment and therefore we are not accepting any new packages of care as we don't want to compromise quality."
●There was an organisational structure in place and care workers understood their individual

responsibilities and contributions to the service delivery. Care workers knew of the provider's values and we saw they upheld these values when supporting people.

●Care workers spoke highly of working for Classic Home Care Service Limited. One care worker told us, "This is the best agency. The manager is so supportive, and they are always checking in and asking if there's anything else they can do." Another care worker told us, "I'm very happy and the clients seem very happy."

●People told us they were happy with the care provided and how the service was run. One person told us, "I'm very happy." Another person told us, "It's marvellous."

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

●Feedback was regularly sought from care workers, relatives and people. An annual survey was sent to people to gain their feedback. The results from the 2018 survey demonstrated that people felt the care was excellent. Comments from the survey included, 'Allows me to stay at home.' and, 'A reliable service.'

●The care workers survey results found that 56% of care workers felt their shift hours were good and 44% felt their hours and shift patterns were excellent.

●The registered manager and nominated individual demonstrated a commitment to engaging and involving people and care workers. The registered manager told us, "We moved office to enable more people and relatives to visit the office and be more involved. Since moving office, we have more and more people visit the office."

●Care workers spoke highly of the support they received and confirmed they were regularly asked for their feedback.

●The registered manager fully considered people's and care worker's equality characteristics when scheduling care calls. When care workers were fasting as part of Ramadan, the registered manager swapped their care calls to enable them to continue working whilst respecting their religious beliefs.

●Care worker team meetings were held on a regular basis. These meetings provided care workers with a forum to discuss ideas, practice and raise any queries. Minutes from the last meeting held in February 2019 reflects that training was discussed, ID badges, leaving calls early and MAR charts.

Continuous learning and improving care. Working in partnership with others:

●Call monitoring and spot checks were carried out to assess the quality of service being provided. Spot checks considered if the care worker was wearing the correct uniform, if they arrived at the scheduled time and departed at the scheduled time.

●There was an 'out of hours' system in place which supported staff should events arise outside of office hours. Care workers told us they felt confident getting hold of office staff in the event of an emergency.

●A business continuity plan was in place which was in the process of being updated by the registered manager. This considered the actions required in the event of an emergency, such as office staff being unable to attend the office.

● The registered manager and care workers worked in partnership with healthcare professionals to promote positive outcomes for people. One care worker told us, "One person was refusing us entry and we were concerned for their safety. We contacted social services to seek their advice and guidance."

● Links with the local community had been established. The nominated individual told us, "Last summer, we had a cupcake day and raised money for the Alzheimer's society. We've also grouped together with other local businesses to raise money for charity."

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant persons. When the service user is 16 or over and was unable to give such consent because they lacked capacity, the registered provider failed to act in accordance with the 2005 Act. Regulation 11 (1) (2) (3).