Nationwide Care Services (Dudley) 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 March 2017 and was announced. The service had been registered with us previously and was rated as Requires Improvement. There has been a change to the provider's legal entity and this was the first inspection since this service was re-registered in July 2016.

Nationwide Care Services Ltd (Dudley) is a domiciliary care service registered to provide personal care to people within their own homes. They provide support to people on a long term basis and to people who have been discharged from hospital and who receive a re-enablement service. At the time of our inspection 80 people were using the service.

The service had a registered manager but they were not based full time at this location. The service was managed on a daily basis by a branch manager who advised they were supported by the registered manager. The branch manager was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provision of medicines was not monitored effectively within the service to ensure people received their medicines when they needed them. People did not always receive a reliable and consistent service as they had experienced late and missed calls.

Staff had received training and were aware of the types of abuse people may be at risk of and knew the actions to take if they suspected someone was at risk of harm. Recruitment processes were in place to reduce the risk of unsuitable staff being employed by the service.

Staff received an induction and on-going training to ensure they had the skills and knowledge for their role. People were supported with meals where required and staff had some knowledge of people's dietary requirements. People and relatives told us that staff sought consent before providing their care. Staff monitored the health and wellbeing of people and knew the action to take if someone became unwell.

People and their relatives told us that staff were kind and treated them with respect. Most people felt staff ensured their dignity was prompted when providing personal care. Care records contained information about people's abilities, preferences and support needs, but these were not reviewed in a timely manner.

A complaints system was in place but complaints were not always recorded or responded to in a timely manner. Although feedback was sought from people, and their relatives the action recorded to address the shortfalls had not been effective in ensuring improvements were made.

The provider failed to provide evidence that they had a clear oversight of the service through regular auditing and effective quality assurance systems.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provision of medicines was not monitored effectively within the service.

People had experienced delays in receiving the support they needed.

People felt safe when being supported by staff who knew how to identify and act on concerns of abuse.

Recruitment checks were in place to ensure people were supported by suitable staff.

Is the service effective?

Good

The service was effective.

Staff received training and support to enable them to fulfil their role.

People's consent was sought before their care was provided.

People were supported with their meals where required and their healthcare needs were monitored.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff were kind and treated them with respect.

People and their relatives said staff encouraged them to be independent.

Systems were in place to support people to access advocacy services where required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints procedure in place but not all complaints had been recorded and investigated.

Care plans contained information about people's abilities, preferences and support needs, but these were not reviewed in a timely manner.

Staff were knowledgeable about people's needs.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

The provider failed to provide evidence that they had a clear oversight of the service through regular auditing and effective quality assurance systems.

The branch manager was described as approachable, open and transparent and staff felt supported by her.

Nationwide Care Services Ltd (Dudley)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 March 2017 and was announced. We gave the provider 24 hours' notice that we would be visiting the service. This was because Nationwide Care Services Ltd (Dudley) provides a domiciliary care service, and we needed to make arrangements to speak with people using the service, staff and have access to records. The inspection was undertaken by an inspector and an expert by experience who completed telephone calls to people and their relatives to gain feedback about their experiences. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The form was completed and returned so we were able to take the information into account when we planned our inspection. We reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us. We also contacted the local authority who monitor and commission services, for information they held about the service. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We spoke with 10 people, nine relatives, seven care staff, the recruitment coordinator, two administration staff, the branch manager and the nominated individual. We looked at a sample of records including eight people's care records, four staff recruitment files and staff training records. We also looked at records that related to the management and quality assurance of the service, such as complaints, rotas and audits.

Requires Improvement

Is the service safe?

Our findings

Some people who received care from the service required support with their medicines. People and relatives provided mixed feedback about the support they received. One person told us, "My medicines have been missed on the odd day, but this is not a major issue for me due to the medicines I am prescribed". Another person said, "I am given my medicines and the carer makes sure I have my bracelet alarm on". Records of incidences with medicines were recorded and investigated when these were reported by the person or their relative. We saw from these records the action the branch manager had taken to address any issues with staff not following procedures. This included retraining of staff.

Medication administration records (MAR) were completed by staff in people's homes and then returned to the office base each month. We reviewed the medicines records for four people from previous months and found that there were gaps where staff had not signed to verify that the medicines or creams had been administered. We saw that these gaps had been identified in an audit that had been completed on these records but the action to address these shortfalls was not always recorded. Records also showed that staff were using codes on the medicines records but they did not always record the reasons why medicines were not administered. Body maps were not in place to direct staff on the location the creams should be applied. Staff we spoke with knew where to apply creams on people. Staff told us they had received medicine training as part of their induction. We found that following their training an assessment of their competence to administer medicines safely had not been completed on most of the staff. The branch manager advised that action would be taken to address this.

People and their relatives told us they did not always receive a reliable and consistent service. For some people this impacted on them not being supported to receive their medicines as prescribed. A relative said, "The call times are a nightmare. There is a one and half hour window given to the agency, for each call, to ensure the medication is given at the right time but the carer turns up early and that means there is a potential risk of me overdosing on medicines if I took them". A person told us, "My regular carer is on time, but if they are away then the care is at different times. I have only been missed once and I had to phone the office, they sent someone out eventually". We discussed these issues with the branch manager who was aware of some of these issues due to a recent safeguarding concern that had been raised about similar issues. The branch manager advised that action would be taken to review people's call times and the rotas especially when support with medicines was provided to ensure there was sufficient time in-between visits for people to receive their medicines safely.

People and their relatives told us there appeared to be staffing issues due to the inconsistencies of the staff that provided their support. The branch manager advised us that they were able to meet their contractual requirements with the staffing levels that they currently had. She confirmed that they were recruiting for new staff to ensure they had sufficient cover for sickness and annual leave. The branch manager advised that where possible they aimed to ensure people had regular carers and she acknowledged that this needed to be improved upon.

People who used the service told us they felt safe when staff supported them in their home. One person

said, "I do feel safe and the carers are respectful of my home. Another person told us, "Oh yeah I trust the carers completely, they are respectful to me and to my home". Staff we spoke with told us they had received training in safeguarding people and understood the action to take if they had any concerns that someone was at risk of harm. One staff member told us, "I have received training and I would report any concerns to the branch manager". Another staff member said, "I would always report my concerns to the branch manager and I know that action would be taken". Records we looked at showed that the branch manager had taken the appropriate action where concerns had been raised.

Staff we spoke with all demonstrated their knowledge of how to respond to any emergencies or untoward events. Some staff provided us with examples of the action they had taken in these situations. This included contacting emergency services for assistance.

People and their relatives told us assessments had been undertaken to ensure any risks associated with their care had been identified and reduced. A relative told us, "The carers have to use a hoist and so there are two that come together. There have never been any accidents". Another relative said, "There have never been any accidents the carers support [person's name] to move from the chair to the walking frame, and then to bed". Staff we spoke with had a good understanding of how to identify and support people to manage risks. One staff member said, "There are risk assessments in people's homes and we get told about any risks to people such as moving and handling and if people need their skin checking". Another staff member told us, "I have read the care records and risk assessments so I know what risks there are. I also check the home for any risks and if I see anything or have any concerns I tell the manager". Records showed that risk assessments had been carried out in areas such as mobility, skin condition, and the home environment. These gave staff information on what risks had been identified and the strategies to manage these. We saw that a system was in place to record any accidents or incidents that had occurred.

Staff told us they had provided all of the required recruitment checks before they had commenced working with people. One staff member said, "Before I started supporting people I had to have checks done such as references and a police check". We reviewed staff recruitment files and we found that staff had Disclosure and Barring service (DBS) checks completed and references. The DBS is a check undertaken to ensure staff are suitable to work with people. We found three files that did not contain a full employment history and gaps in employment had not been accounted for. The recruitment coordinator advised us that he was currently auditing all of the files to ensure they contained all of the required information and that immediate action would be taken to address these shortfalls. We received information following our visit to confirm that these gaps had now been explored and accounted for.

Good

Is the service effective?

Our findings

Most of the people and their relatives told us they felt the staff had the skills and knowledge for their roles. One relative told us, "The staff seem to know what they are doing. Sometimes three staff come here, one is shadowing". Another relative said, "Staff may have had training but some staff lack knowledge in some areas about older people's needs. The staff do go to the house and shadow if they are new".

Staff we spoke with told us they had received an induction prior to starting work to enable them to gain the skills and knowledge for their role. This induction involved a week's training completing the care certificate, and shadowing more experienced members of staff. The Care Certificate is a set of induction standards designed to assist staff to gain the skills and knowledge they need to provide people's care. One staff member told us, "I had an induction which was classroom based which was good and we covered a variety of areas. Sometimes I found that the hoist they used in the training is not the hoist in people's homes so I have told the branch manager about this". Another staff member said, "The induction training gave me the basic knowledge and skills for my role, and the shadowing opportunities were good". Records we reviewed confirmed that new staff completed an induction.

Staff told us they had access to on-going training to support them in their role. One staff member said, "We have had updates which is good as it refreshes our knowledge. Another staff member said, "We do get training which is specific to the needs of the people I support such as catheter care". We found that staff did not have specific training in relation to providing re-enablement services to people, but they had received verbal instructions about supporting people to gain their independence. The branch manager confirmed that she would speak with the training department to arrange for this training to be provided. Staff files contained evidence of the training they had undertaken.

Staff we spoke with told us they felt supported by the branch manager. One staff member said, "She is good and I know she will answer the phone and provide advice". Another staff member said, "I have not had formal supervision for a while but I know I can go to the branch manager when I need to and she will support me".

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and we found they were.

People and their relatives told us staff sought consent before providing their care. One relative said, "The staff always ask before they do anything and tell [person's name] what they are going to do". Another relative told us, "The staff are always talking to [person's name] and asking their permission before they do anything".

Although some of the staff were not familiar with the terminologies Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguarding (DoLS) we found that staff knew that they should not restrict people in any way and that they should ensure that people consented to their care and support. A staff member told us, "We covered this briefly in our induction, and I always make sure I gain people's consent before I support them. If they said no I would respect that and tell the office". Another staff member told us, "I ask permission first before I provide care". Training records confirmed that staff had received MCA training as part of their induction. All of the staff we spoke with said they would benefit from further training or group discussions to ensure they were fully aware of the principles of the MCA and the impact this legislation has on their role. The branch manager advised that this would be considered.

Some people received support with meal preparation. People and their relatives told us they were satisfied with the support staff provided. One person told us, "The staff get my breakfast, just toast and tea and lunch is a sandwich of my choice". A relative told us, "The staff make breakfast and a sandwich at tea time. They give [person's name] a choice from what is in the house".

Staff we spoke with had an understanding of the level of support people needed and about any specific dietary requirements people had. One staff member told us, "I always ask people what they would like to eat or drink and I always leave a drink of their choice and a snack if they want one before I leave". Records we reviewed contained information about people's dietary requirements and the support they required with meals. We saw that staff monitored people's fluid and food intake where this was needed and completed the appropriate records.

People we spoke with confirmed they accessed health care support independently or had support from their family members. Staff we spoke with knew about people's health care needs and described the actions to take if someone became unwell. One staff member said, "If someone felt poorly I would, with their permission contact the GP and their relative to make them aware. If it was an emergency I would just dial 999".

Good

Is the service caring?

Our findings

Most of the people and their relatives told us that staff were kind, and caring in their approach. One person said, "I have a regular carer who is very reliable, gentle and caring". A relative told us, "The carers are excellent". Another relative said, "[Person's name] tells me that some of the carers sometimes ask if they are comfortable and if there is anything else they can do. That shows me that the carer cares it is about letting someone know you care". We did receive some comments that staff were not always gentle when applying creams to people and that some people felt that staff rushed them when providing care. This feedback has been shared with the branch manager to address.

People told us the staff involved them in their care. One person said, "We have a lovely relationship. The carer knows what I like and will just do". Another person told us, "I like the way the regular carer helps me with personal care, and the evening call tucks me up at night". People and their relatives confirmed that they had records in their home which staff completed. One relative said, "There is paperwork in the house that the carers fill in every time. When I read what has been written it is correct". Another relative told us, "It is written in every day and another family member will check it once a week". This demonstrates that staff complete the required records detailing the support they have provided and the well-being of the person following each visit.

People and their relatives told us that they were satisfied with the way staff communicated with them. One person said, "The carers listen to me and act on what I say". Another person said, "The staff are respectful at all times". A relative told us, "The carer is always chatting to [person's name] during the personal care and making them laugh". We did receive some comments about the language barrier between people and staff where English was not their first language. These comments have been shared with the branch manager to address. Staff told us that most people were able to communicate verbally and that where people could not communicate, they were aware of people's body language and facial expressions to ascertain if they were happy with the support provided. One staff member told us, "I always talk to people and make sure they are involved in what tasks I am undertaking".

Most of the people and their relatives we spoke with told us their privacy and dignity was maintained by staff and that staff used their preferred name. One person said, "The carers are lovely, they are respectful". Another relative told us, "Carers speak nicely to [person's name] they like them all and they are gentle and kind and very good with [person's name]. We did receive some negative feedback from a relative who told us, "One of the new carers left the kitchen blinds open with the light on doing personal care. [Person's name] sleeps in the kitchen so anyone could see, some of the staff are just not thinking". This feedback has been shared with the branch manager to address. Staff we spoke with told us how they cared for people in a dignified way. One staff member said, "I give people private time when they are using the toilet or commode and I make sure they are covered when providing personal care".

Staff we spoke with knew the needs and preferences of people who they provided consistent care to. One staff member said, "I have been supporting [person's name] for a while now so I know their needs, and preferences and how they like things to be done. This is important to them and can make all the difference".

Staff knew about people's life histories and their hobbies. One staff member said, "It is important that you get to know people, so I ask them or their family members about what they have done in their life and their interests". We found that most of the records we reviewed contained some information about people's preferences and about their background, to enable staff to gain an insight to their lives.

People and their relatives told us that staff encouraged them to be independent. One person said, "The staff always encourage me to do as much for myself as I can". Staff we spoke with understood the importance of promoting people's independence and enabling them to be self-managing. One staff member we spoke with said, "I always ask people to try and do things for themselves so they do not lose their independence. When I am supporting people who have just come out of hospital I try and reassure them and give them time to do little things to build up their confidence". We did receive some feedback suggesting that staff needed to be more mindful of people's abilities. One person told us, "The carer wants me to lift my leg higher than I can so I tell the carers to be considerate about my age". This feedback has been shared with the branch manager to address.

The branch manager told us she would be able to signpost or provide information to people if they needed to use the services of an advocate. She advised that she did not know of anyone that currently used the services of an advocate. Advocacy is about enabling people who may have difficulty speaking out, or who need support to make their own, informed decisions that affect their lives.

Requires Improvement

Is the service responsive?

Our findings

Most of the people and their relatives told us that prior to receiving a service an assessment was completed to discuss people's care needs and their preferences with regards to their care. For some people the care was arranged by social services. We received mixed feedback about the care and call times agreed during the assessment process to what was then delivered. One relative told us, "When this agency took on the package I feel they agreed the call times and care without having the staff to support the package. The call times were different and it was all over the place. It was important for [person's name] to have the same call times to keep some continuity". Another person told us, "I had an assessment and agreed the call times but these are not always provided". Records showed that assessments were completed with the person and their relatives where applicable. However when we checked the times the service was delivered with people's care records we saw people did not always receive the service in accordance with what was recorded in the assessment and care plan. People that received a re-enablement service received an assessment undertaken by the local authority who then shared this with the service. We were advised that the times of the calls for these people were more flexible unless people required support with their medication.

Not all of the people and their relatives we spoke with were able to tell us if they had a recent review of their care. One person said, "Sometimes the carer's think of a way of doing things that is better but it never changes a lot". Another person said, "The care plan details belong to someone else. The carer told the office and the office sent out another plan and this one was wrong too. So I am waiting for this to be sorted out. It said on the care plan that I used incontinence pads and I don't". This feedback was shared with the branch manager to address. The branch manager was unable to comment as to why the information in the care plan was incorrect but she confirmed it did not contain confidential details of another person. We saw from the records we reviewed that people whose needs had significantly changed or in response to a complaint or safeguarding issues had their care and their records reviewed with them. For some people a review had not been undertaken with them for over a year. The branch manager acknowledged that reviews were overdue and confirmed that action would be taken to review people's needs, and to ensure the service was delivered in accordance with their needs and preferences.

Staff we spoke with demonstrated a good knowledge of people's care needs and how people liked their care to be provided. One staff member said, "When you support the same people you get to know them and how they like things to be done, which makes all the difference to them. Some people like things done in a certain order". Another staff member told us, "I know the needs of the people I support and about their likes and preferences. Not everything can be written down".

People and their relatives were aware that a complaints procedure was in place. One relative said, "At the start I was always complaining about something, the agency office and I are on first name terms. I speak to the manager in the office". Another relative told us, "I sent in a letter of complaint but it was not answered in writing". We reviewed the records held about complaints and saw that not all of the complaints that had been made had been recorded. We saw one complaint recorded where no outcome was recorded. These complaints had been received prior to the branch manager being in her position so she was not able to offer

an explanation for these shortfalls. We found the complaints that had been received recently had been investigated by the branch manager and the outcomes recorded and shared with the complainant. The branch manager told us about the improvements that had been made to the service following receipt of these complaints so that lessons could be learnt. This included staff receiving further training, and performance issues being addressed by the branch manager.

We saw that the service had received some compliments from people and their relatives. Comments included thanking the staff for the care provided, and of their kindness.

Requires Improvement

Is the service well-led?

Our findings

We found that improvements were required in relation to how the service was managed. People and relatives told us they were not sure who the manager of the service was. One person said, "Not sure who it is I don't have a name". A relative told us, "No I don't know who the manager is". Staff told us that although there was an on-call system in place they did not know who the person was and that they were not supportive. One staff member told us, "The on call system needs improving, we don't' know who is it that covers and they usually do not know the people we support so they do not provide any advice or guidance in situations. The attitude displayed by the on-call person can be negative at times. Another staff member said, "The on-call person is not supportive and they do not pass messages on or sort cover out when people telephone in sick which affects the people we support". We also heard from staff that sometimes the on-call person did not answer the call, or staff had to continually call until the phone was answered for support. Staff told us that the communication between the office and staff required improvement as staff did not receive messages about people's needs in a timely manner. One staff member said, "The communication needs to be improved sometimes we are not informed when people go into or are discharged from hospital, or when there are changes to people's needs". Another staff member told us, "I have reported concerns or issues to management and then we do not get told an outcome of what is happening so we are left in the dark. It would be nice to have some feedback".

Systems in place failed to ensure that people received a service that met their needs. For example people experienced late and missed calls and for some people this meant support could not be provided with their medicines because there had not been sufficient time allowed in between the call times. People told us they did not receive a telephone call informing them that staff would be late or if there would be a different staff member attending due to sickness. The systems in place for assessing and monitoring the quality of the service were not effective and placed people at risk. We saw that some audits had been completed but these did not demonstrate how shortfalls would be addressed in relation to medicines. We found that a system for reporting medicines shortfalls was not in place for staff to report issues in a timely manner to enable these to be addressed. Staff did not receive regular supervision or spot checks to ensure they were competent in their roles and had opportunities to discuss their roles and development. Systems in place failed to ensure that records were in place and accurately maintained. For example, information was not available to guide staff when to administer 'as required medicines' or in relation to how staff should communicate with people who were unable to communicate verbally.

We saw that feedback had been sought from people that used the service in July 2016. The feedback provided had not been analysed to identify trends but we were able to see a list of the comments people had made at that time. Some people had made positive comments about the service they received and said they were "Satisfied and happy with the service". Some people had shared areas for improvement and this included timing of the calls, lack of communication from the office, and lack of continuity of the staff. We saw that an action plan has been written to address these concerns. We discussed with the branch manager the effectiveness of this action plan due to the feedback we had received from people, which had highlighted the same improvements were still required.

The registered manager had failed to notify us about incidents that had occurred and had affected people who used the service. We reviewed the records at the service and found an incident had not been reported to us. As the incident related to a safeguarding issue, the registered manager had a legal responsibility to report this to us. The branch manager confirmed that the notification would be submitted to us retrospectively, and since the inspection we have received this.

The provider failed to provide evidence to us that they had a clear oversight of the service and it was clear they were not effectively monitoring its quality or effectiveness.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The branch manager has been working at this service since September 2016. Previous to this the service had two other branch managers that worked at the service for short periods of time. We were advised that the registered manager who did not manage the service on a daily basis visited the service regularly and provided support to the branch manager.

Staff told us that some improvements have been made since the current branch manager had been in her role. A staff member said, "The branch manager is trying her best to sort things out, and she is supportive and I know I can go to her with issues". Another staff member told us, "The branch manager is good I hope she stays and we get some consistency as there have been lots of changes. She is supportive open and honest". The branch manager acknowledged the shortfalls that we had identified and gave assurances that improvements would be made.

Staff all confirmed that a whistleblowing procedure was in place and that they felt confident to raise any issues they had. One staff member said, "Yes I am aware of the procedure and I would raise any concerns about my colleagues if I needed to, people come first". Whistleblowing is the process for raising concerns about poor practice.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2) (a) (c) (e) (f) HSCA 2008 (Regulated Activities) Regulations 2014 The systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on the regulated activity were not fully effective.