Notaro Homecare Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 18 & 28 September 2017 and was unannounced on the first day. It was carried out by two adult social care inspectors, over the two days.

Notaro Homecare is a domiciliary care agency. It provides personal care to people living in their own houses in the community. At the time of the inspection the agency was supporting approximately 250 people who received personal care in their own home.

There was a registered manager in post at the time of this 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.

We carried out a responsive inspection due to concerns we had received about the service. The provider had taken a number of additional care packages at very short notice and this had impacted on the service delivered to people. Concerns included various complaints about missed and late visits, missed medicines, not receiving a rota or knowing what care worker was visiting. We inspected the service against two of the five questions we ask about services: is the service safe and well led.

We undertook our last full comprehensive inspection in April 2017. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link on our website at www.cqc.org.uk

People were experiencing missed and late visits. This included not receiving support with their personal care, meals and medicines.

The provider was not ensuring their registration was accurate following the agency moving offices. Following the inspection we issued a letter and the provider submitted an application which was being processed.

People were not always familiar with staff supporting them and people felt their choice was not always taken into account.

People's care plans, risk assessments and medicines administration charts were not always complete and accurate to reflect people's support needs.

The provider was currently experiencing shortfalls with staff and was using agency to support this shortfall.

The provider had experienced IT and phone line problems this had affected the running of the service. We had not received these notifications without prompting their action.

The provider's complaints procedure was out of date and did not ensure people were familiar with the complaint procedure and who to go to.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering the action we are taking and will produce a further 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?

Inadequate

The service was not safe.

People were not always receiving their care and medicines when required due to late and missed visits.

Support plans and risk assessments were not always accurate and up to date reflecting people's individual care needs.

People were not always receiving support from staff who knew them or were familiar with their individual needs.

The provider was using agency staff due to not having enough staff to meet people's needs. The rostering of people's care was undertaken each day which meant people were not always aware of who was visiting and when.

People spoke of poor communication with the service. This was due to the service having problems with the phone lines and the computer system.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider was not ensuring they were registered as required we issued a letter following the inspection confirming immediate action needed to be taken.

People's care plans and medicines administration records were not always up to date and accurate.

People were unhappy with their care and the provider's complaints policy was not current and up to date. People and relatives felt they were not being listened to.

The agency had expanded in size within a short period of time this had impacted on the quality of care. The local authority and safeguarding teams were monitoring the risk to people.

Notifications were not always being made when required relating

to events that stop the service.

Notaro Homecare Ltd

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.

This inspection took place on the 18 and 28 September and was unannounced on the first day. It was carried out by two different adult social care inspectors each day. On the second day of the inspection we visited people in their own homes and looked at records.

The inspection was prompted due to various complaints, notifications and concerns that had been raised about the safety of the service. People were experiencing late or missed calls. We inspected the service against two of the five questions we ask about services: is the service safe and well led.

Before the inspection we reviewed the information we held about the service. We looked at notifications we had received from the service, share your experience forms and complaints.

During our inspection we spoke with the registered manager, the director of care. We also spoke with four people and seven relatives or friends about their experience of the care they received. Following the inspection we were sent safeguarding minutes from the local authority relating to the poor care people were experiencing.

We reviewed the service's computer system and rostering of calls, daily reports and local authority safeguarding minutes. We reviewed three people's care plans and risk assessments and medicines administration charts.

Inadequate

Is the service safe?

Our findings

We undertook this responsive inspection as we had received concerns that people were experiencing poor care and treatment. At this inspection we found people were receiving poor care and treatment. People were not always receiving their medicines and personal care as required due to missed and late calls along with receiving visits from staff who were unfamiliar with their needs.

People and relatives were unhappy and upset about their poor care experiences. Prior, during and after this inspection we received feedback from people that they were unhappy about the care they were experiencing. They confirmed this was due to missed and late visits, inconsistent staff including agency staff, medicines not administered as prescribed, missed meals and poor personal care experiences.

People did not feel safe as they were not always receiving support from staff who were familiar with their care needs. They also felt they were not always receiving accurate care. People and relatives confirmed the service was using agency staff which made them feel anxious and worried. People also felt care was not always provided by staff who were familiar with their care needs and wishes. They told us, "I don't know who is coming through the door. In the middle of July it all started to go downhill. There is a different carer every day" and "I don't feel safe with them. I don't know who they are …it could be anybody." Another person told us, "They are not the same carers a lot of agency workers that don't know where things are, I have to keep repeating myself". Another person said, I've got a male carer and I don't like male carers". Another person told "Regular people (meaning staff) in the morning are lovely, it's the nights that are worst visits." They also confirmed that staff should be undertaking physio although this has not happened since receiving care from Notaro. They said, "Staff are not doing physio either." This planned care was confirmed in their care plan. They had also experienced several missed or late visits and at times had to wait for the second member of staff to arrive.

"One relative told us, "Agency staff don't have a clue, the staff this morning didn't know what to do. We don't have a clue who is coming through the door, my stress levels are terrible and my [Spouse] is crying a lot because I am stressed." One person's friend told us, "[Name] hasn't had a list of carers, yet the area manager confirmed they would get one". Another relative said, "I haven't received a rota since mid-July we never know who is coming through the door".

The registered manager and director of care said that they were using agency staff to support with the delivery of care. The quality performance manager following the inspection confirmed, 'Due to insufficient staff numbers following the transfer of care packages from a number of providers without the corresponding staff transferring to Notaro to continue to deliver this care.' A daily report was being sent to the local authority confirming sickness and use of agency. This was so the local authority could monitor the service and identify quickly any changes. Within the report sent on the 2 October 2017 it showed 14 staff were not at work and the reasons why. It also confirmed that a total of nine staff were supporting from an external agency to cover various shifts. We found agency staff were travelling long distances to support people and this was often at short notice. One person told us staff came from, "Exeter, Newport or Wales". The registered manager confirmed they had experienced difficulties recruiting in certain areas. There was a

recruitment drive in place and vacancies were advertised on job boards, through word of mouth and social media. The agency also had a recruitment manager who was dealing with the vacancies. The quality performance manager following the inspection confirmed, 'However there is a significant lead time to employing new care workers as all staff are required to complete a full week of class room training followed by shadowing with experienced staff in the community and receipt of a clear enhanced DBS'.

The process in place to allocate people's support to a member of staff in advance of each week was inadequate. The registered manager showed us the "Care Planner" system which was used to allocate people's support to a member of staff. They said that each geographical area had been split and allocated to an operations executive. An operations executive allocates people's care visits to care staff. All three operations executives were responsible for allocating 700hrs of care a week. We reviewed all three geographical areas for any visits that still required allocating the same day. We found, 'Group A', had 26 outstanding visits that required allocating to staff for people's tea time and evening visits. 'Group B' required three visits that required allocating to staff for tea time and evening visits. 'Group C', required 10 visits that required allocating to staff for tea time and evening visits. The registered manager confirmed they were likely to need support from agency staff to cover these visits but until they had allocated the visits to their own staff, they would not know how many agency staff were required.

We asked to see what calls were left to allocate for the rest of the week. The registered manager showed us the amount of work each geographical area had allocated. 'Group A had 49% allocated, Group B had 40 % allocated and Group C had 48 % allocated. This showed that over half of the support needed by people did not have a member of staff allocated. They said from the middle of the week the rest of the calls were either unallocated or needed confirming on the system.

People were not always receiving their medicines when required. This was due to missed or late visits. For example, three people we visited told us they had not received their medicines as required. One person required support with applying six different creams. Their care plan confirmed care staff were responsible for applying their creams. Their relative confirmed there had been seven missed visits within 16 days. They had also experienced their visits were late on one occasion there was only one hour between the morning and lunch visits. Records confirmed this. The person's MAR chart recorded the creams prescribed but these were not being recorded as administered and there was no body map or guidance for staff on what cream was needed and where. Another person had no record to confirmed they had been administered their eye drops as required. Their medicines risk assessment confirmed 'I am able to apply all creams and eye drops'. This did not reflect the support the person required as they confirmed they needed assistance with their eye drops. They told us, "I had no eye drops for 3 days. The carers give me my eye drops". Their MAR records confirmed they should have received them 56 times in September 2017 when their records confirmed they had received them 39. This meant on 17 occasions they had not received their eye drops as prescribed. Another person required assistance with their medicines twice a day. Their relative confirmed on occasions care staff had failed to administer a muscle relaxant and a sleeping tablet. Their relative also confirmed on occasions they had administered medicines due to the care staff forgetting. Their MARs records confirmed a morning tablet had not been administered on one occasion within the month of September 2017. On four occasions their muscle relaxant tablet hadn't been administered. On eight occasions their sleeping tablet had no record of being administered. There was also no record of another prescribed medicines being offered or refused on 16 occasions. The person's MARs chart also gave no clear instructions on what this medicine was for or how often it was required.

Prior to and following the inspection we continued to receive confirmation that people were not always receiving their medicines when required. We requested following the inspection information from the agency with how many people had been identified as not receiving their medicines as prescribed. They

confirmed on 20 occasions people had not received their medicines as prescribed. One person had missed seven different types of medicines on four occasions. Between the first and second missed medicines was three days and the third and fourth was four days. The tablets missed included those for depression, nerve pain, blood thinning and for the prevention of seizures.

People's care plans did not contain up to date and accurate information including support plans and risk assessments. Records were not current and up to date reflecting people's care and who was responsible for providing that care. This posed a risk that people would not have their needs met especially with the numbers of staff who were not familiar with them. We found care plans contained out of date and missing information relating to people's personal care, incontinence needs, skin care and diabetes. For example, one person's care plan recorded they required three visits a day. Their care plan stated their morning call was for 45 minutes and they required the following support. 'Need support to carry out personal care, empty leg bag and prepare breakfast'. The person confirmed staff were usually gone within 30 minutes and that they did most of their care themselves apart from their eye drops. Daily care records confirmed staff were not providing any care but sweeping floors, cleaning and tidying. This person required support with their continence and eye drops but at times had not been administered their eye drops. We reviewed another person's care plan when we visited them. It had no risk assessment relating to the risk of their skin developing pressure ulcers or that they sat on a specialist cushion to prevent their skin from breaking down. They also confirmed they were having dressings applied by the district nursing teams to the areas where their skin had broken down. We found no guidance for staff to follow relating to this person's continence needs. Another person's care plan confirmed they were diabetic. We found no guidelines or support plan with how the person managed this and what support staff should be providing. This meant people's care plans were not current and up to date ensuring staff had accurate guidelines to follow relating to people's individual needs. Due to the provider using agency staff that were unfamiliar with people's needs. People were not always receiving care as required.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and care director were being supported by an external member of staff recommended by the Local Authority. They were supporting the agency to allocate people's visits into confirmed runs. This was so people's visits could be allocated on the system without the operations executive having to undertake this manually for each visit. One operations executive showed us how they had started to work out what days of the week staff worked which would enable them to allocate people's visits to staff who worked that day. The provider following our inspection sent us a report of the concerns which had been received each week. One week as many as 68 concerns had been reported. Concerns included, missed visits, complaints and safeguarding concerns. The concerns within October had been improving with the last week in October there being nine concerns received. The local authority were monitoring these concerns daily and a weekly meeting was also being held to review the agency's situation.

People and staff were experiencing problems with communication. For example, the agency had experienced computer and phone problems. This had affected people being able to call the agency along with how visits were allocated to care staff. On one occasion the phone lines had been out of order from 7:30 am to 10:30am. People had been unable to contact the office during this time. One person told us, "I once range up 14 times before the phone was answered." Although contingency plans had been put in place with external calls going through to a different number people still reported being unable to contact and communicate with the office. This meant the systems in place had been ineffective. During this time people might have been unable to raise concerns relating to missed and late calls due to being unable to raise these concerns directly with the office.

Requires Improvement

Is the service well-led?

Our findings

We undertook this focussed inspection as we had received concerns relating to the safety and management of the service. The provider had taken a number of new care packages over a short period of time and with short notice.

The service was not consistently responsive to people's complaints to improve the care provided. Prior to the inspection we had received various complaints from people, staff and relatives about the care they were receiving. People and relatives told us they did not feel listened to and felt their concerns were not being acted upon. One person said, "It (service) has all gone to pot. It is so unorganised" and "I don't feel listened to … nothing changes." Complaints, included, missed and late calls, not having carer staff that people knew, care plans not reflecting people's individual needs, missed medicines and personal care. The provider's complaints procedure had no confirmation of who to complain to or what people could expect including timescales. We fed this back to the registered manager for them to action. One person confirmed where they had raised a complaint this had been responded to and they had started to experience an improvement in the care they received.

Following the inspection we continued to receive a high number of complaints. Some people and relatives confirmed they had been unable to raise these complaints directly with the service. This, they felt, was due to phones and emails being unanswered. Where people and relatives were happy for us to do so, we shared their complaints with the registered manager for them to investigate and take any necessary action.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had not ensured their registration was accurate following the agency moving offices. This was due to the provider moving offices to a new location. Although we had received an application to change the provider's address we had not received an application to change the location address. At our last inspection in April 2017 we had also identified the provider was not accurately registered. This meant the agency was not accurately registered as required by law. We issued a letter to the registered manager and nominated individual who then submitted an application.

The provider was not ensuring records relating to record keeping, care planning and risk assessments and medicines were accurate and up to date to ensure people's care needs were met. For example, we found one persons' care plan had support plans and risk assessments that dated back to January 2015. This had been completed by a different care provider not Notaro who were providing the care to the person. We also found the person had incomplete MAR records for August and September 2017. These records contained significant shortfalls that had not been identified by the provider as part of the monitoring of the service. All four MAR charts that we reviewed had incomplete and inaccurate recording which meant it was unclear if people had received their medicines or that the medicines had been administered as required. We fed this back to the registered manager for them to action.

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

During the inspection the director of care and the registered manager discussed with us changes since the last inspection. This included the agency expanding and taking on additional work from seven other providers in the North Somerset area. They stated within a short period of time the agency had taken on packages of support from other providers and had tripled in size. The quality performance manager confirmed following the inspection, 'The timing of these transfers was outside the agency's control as outgoing providers gave notice on care packages and/or closed their businesses in North Somerset at short notice.' During the transfer of these hours from other providers they had experienced higher than expected levels of staff sickness, inconsistent staffing rotas that were handed over, less staff than expected transferring to them and packages of care requiring covering in rural areas where there was limited staff deployed. This had resulted in people experiencing a significant reduction in the standard of service delivered and the service was being monitored daily by the local authority. The director of care provided a daily update to the local authority. This update included, staff not at work, the use of agency, any missed calls, the management arrangements and the allocation of visits. Once a week the agency had a meeting with the Local Authority who were reviewing the current situation and progress made. At the time of the inspection the service had identified those individuals who they were unable to continue to provide support and care to. At the time of the inspection the director of care confirmed there were no plans to take on any more packages of support. They confirmed they were discussing these arrangements with the local authority.

The provider is required by law to notify us of events that had occurred at the service. We found not all notifications were being made when required. For example, prior to the inspection we had received information that the service had experienced difficulties with the phone lines and IT systems. This had affected the running of the service. We contacted the registered manager who confirmed that they had experienced problems with the phone lines and computer systems. This had affected the running of the service that day. We prompted the registered manager to notify us of this event including any action they had taken. Following our inspection we reviewed information we held about the service and found this notification had not been received from the provider.

The registered manager had sent us various notifications where people were experiencing missed and late visits. These included people not receiving support with their medicines, skin care, continence care and personal care. Missed and late calls were being monitored daily by the local authority contracts and commission and social work teams. These missed and late calls were also being raised by the agency through to the local Safeguarding team.

At the time of the inspection the service was managed by a registered manager. During the inspection the registered manager confirmed they were in the process of deregistering with us. They confirmed a new manager was being inducted and trained and they would be submitting a new application to become registered manager. We wrote to the registered manager and nominated individual following our inspection. We confirmed a new application for the registered manager and changes to the location were required.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not being effectively identified and resolved and people were experiencing similar and identical issues to their original complaint.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not ensuring accurate records were being maintained relating to people's care plans, risk assessments, medicines administration records.

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 People were not always receiving their care and support in line with their individual care needs. Medicines were not being administered as required.

The enforcement action we took:

We have issued a warning notice. They must become compliant by 20 November 2017.