

Nomase Care Ltd

Nomase Care Ltd - Chadwell Heath

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Nomase Care Ltd - Chadwell Heath is a domiciliary care agency based in the London Borough of Barking & Dagenham. The service provides personal care to adults in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

At the time of the inspection, the service was supporting 56 people with personal care.

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

We continued to find that robust systems were not in place to ensure staff attended calls on time. Robust risk assessments were not in place in relation to people's health conditions to ensure they received safe care at all times. Medicines were not being managed safely.

Pre-admission assessments and care plans were not robust to ensure people's preferences with support and care were captured. Care plans lacked evidence that people were being involved in decisions about their care.

Robust quality assurance systems were not in place to identify shortfalls and take prompt action to ensure people received safe and effective care at all times.

Pre-employment checks had been carried out to ensure staff were suitable to support people. Staff had completed essential training to perform their roles effectively and felt supported in their roles. People had choices during mealtimes and were supported to access healthcare services. People were encouraged to be independent and to carry out tasks without support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Feedback was sought from people and staff.

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

Rating at last inspection

The last rating for this service was requires improvement, published 27 January 2022 and there were 5 breaches of regulation specifically on Regulations 9 (person-centred care), 11 (need for consent), 12 (safe care and treatment), 18 (staffing), and, 17 (good governance). At this inspection, not enough improvement had been made, the provider continued to be in breach of regulations 9, 12, 18 and 17 for the for the second time.

Why we inspected

We undertook this inspection to check if there were improvements regarding the concerns we identified at the last inspection and if the service was compliant with the requirement notices on Regulation 9, 11 and 12 and warning notices we served on Regulation 18 and 17.

The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last inspection report, by selecting the 'all reports' link for Nomase Care Ltd - Chadwell Heath on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to risk assessments, medicine management, staffing, person centred care and good governance.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures

The overall rating for this service is Inadequate and the service is therefore in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

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?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Nomase Care Ltd - Chadwell Heath

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection was carried out by an inspector, a CQC pharmacist specialist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

We announced the inspection and gave the provider 72 hours' notice. This was because we wanted to make sure the registered manager would be available to support us with the inspection.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We also reviewed the information we already held about the service and provider. This included their last inspection reports, enforcement notices and notifications. A notification is information about important events, which the provider is required to tell us about by law. We used all of this information to plan our inspection.

During the inspection

We spoke with 4 people that used the service, 9 relatives, the registered manager, the service manager, 2 care coordinators and 5 care staff.

We reviewed documents and records that related to people's care and the management of the service. We reviewed 6 care plans, which included risk assessments and 5 staff files, which included pre-employment checks. We looked at other documents such as training, medicine and quality monitoring records.

Is the service safe?

Our findings

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

At the last inspection, this key question was rated as Inadequate. At this inspection, this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure medicines were being managed safely as we found protocols were not in place for as required medicines to ensure this was administered safely and covert medicines were being administered incorrectly. We also found risk assessments were not in place for people at risks of falls and dehydration and also on their health conditions. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the service continues to be in breach of regulation 12.

- Risks were not always managed safely because risk assessments had not been completed in full for some people to ensure they received safe care at all times.
- There were risk assessments in place for people at risks of dehydration, falls, depression and skin integrity. This included measures on how to keep people safe.
- Risk assessments had not been completed in relation to people's health conditions. For example, some people had specific medical conditions that may place them at risk such as history of stroke or heart disorder or current conditions associated with breathlessness. Risk assessments had not been completed in these areas to ensure staff were aware on how to support them safely if their health was to deteriorate.
- For one person's care plan, we looked at their nutritional assessment, which included they may cough or choke when being supported with meals. There was no risk assessment what staff should do if the person was to choke. We also found hospital outcomes, which showed the person may be risk of choking and this had not been assessed.
- Failure to complete risk assessments in these areas meant that there was a risk people may not receive safe care at all times.

Using medicines safely

- Medicines were not managed safely.
- Medicine Administration Charts (MAR) showed gaps on 6 peoples MAR charts with no information on why these medicines were not administered, which meant there was a risk these medicines were not given placing people at risk of harm.
- We saw numerous discrepancies in medicines records held for people. For example, the medicines risk assessment document often had different medicines listed when compared to the MAR chart such as the dosage and frequency on some risk assessments did not match the information on people's MAR chart, which placed a risk people may not be given medicines safely.
- MAR charts did not always include all the information staff needed to give medicines safely. Therefore,

there was no assurance that these medicines were given safely such as for people using nicotine patches there was no information on the rotation of patches.

- There was a protocol in place for the use of a 'when required' medicine, however it was not detailed. It did not have information on when to offer the medicine. The provider was in the process of improving the information in the 'when required' protocols at the time of this inspection.

The above concerns meant that risk assessments were not completed in full to demonstrate the appropriate management of risks and to ensure support and care was always delivered in a safe way. Medicines were not being managed safely to ensure people received their medicines in a safe way. This was a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure robust systems were in place to ensure staff attended calls on time. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice with a deadline for compliance.

Not enough improvement had been made at this inspection and the service was not compliant with the warning notice we served at the last inspection.

- Systems that were in place to monitor time keeping ensuring staff attended calls on time continued not to be effective placing people at risk of harm. The service used an online call monitoring system to monitor staff timekeeping and attendance. Staff logged in and out of visits electronically. This showed they had attended and left their visit after carrying out personal care.

- Records showed the planned time that staff were supposed to attend call visits. Staff monitoring data continued to show a number of calls had not been attended on time, in a number of cases staff being over an hour late. We also found staff were not being given time to travel in between appointments, which meant that they would be late for calls.

- People and relatives told us that carers did not arrive on time. A person commented, "I have observed that they [staff] are late most days and times of the 3 visits I get. The most infuriating thing is that they, the carers or Nomase don't let me know if and when the carers are going to be late." A relative commented, "We are experiencing carers visiting any time of the day. Morning visit should be 7.15am to get [person] up and ready for college. But we have had carers arriving as late as 1pm. We are not informed of lateness." Another relative told us, "Carers seem to turn up late every day for all 4 visits by at least half an hour to up to 1 hour late. Today the carer arrived at 9am when the visit should be 7.45am. It is so important that [person] has regular carers and regular meals as it affects [persons] digestive system."

- Relatives also told us carers did not stay the required times. A relative told us, "Over the past few weeks when [persons] main carer has been on leave, the carers have just come when it suits them and stay only for the shortest of times. It should be a one-and-a-half-hour morning visit. Most carers don't even stay the hour, if they turn up." Another relative commented, "I would say never the carers do what they want to do and leave. The morning visit is for 45 minutes and some carers stay this time some don't, they cut corners."

The above concerns meant that effective systems were not in place to ensure people received safe high-quality care in a timely manner. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

- Records showed that relevant pre-employment checks, such as criminal record checks, references and proof of staff's identity had been carried out. This ensured staff were suitable to provide safe care to people.

Learning lessons when things go wrong

- Systems were in place to learn from lessons following incidents.
- Incidents and accidents had been recorded with details of action taken. Lessons had also been learnt following incidents to minimise the risk of reoccurrence.

Systems and processes to safeguard people from the risk of abuse

- Records showed that staff had been trained in safeguarding and understood how to safeguard people from harm. A safeguarding and whistleblowing policy was in place. Whistleblowing is a person who informs a person or relevant authorities regarding abuse or unlawful activity.
- People and relatives told us people felt safe when staff supported them. A person told us, "Yes, I do feel safe. I think they are quite experienced and seem to be able to use the hoist ok." A relative commented, "Yes, I imagine [person] feels safe. The carers have got to know [person] well."

Preventing and controlling infection

- Systems were in place to reduce the risk and spread of infection.
- People and relatives told us that staff wore personal protective equipment (PPE) such as gloves and aprons when supporting them. A person told us, "Yes, staff do wash their hands before and after tasks. They wear aprons, masks and gloves and place them in the bins outside."
- People and relatives told us that staff wore PPE when supporting them and followed good infection control practices. Staff confirmed this. A staff member told us, "We have enough PPE and have been trained on controlling infection."

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Robust systems were not in place to assess people's needs and choices.
- Pre-assessments had been carried out to ensure the service was able to provide person-centred support to people in some areas. However, we found the assessments were not comprehensive in capturing people's preferences with personal care and risks in relation to their health conditions.
- A relative told us they are waiting for an assessment and a care plan was not in place. They told us, "We are waiting for an assessment to be able to devise a care plan and we have been waiting now 2 months. So, no care plan and we have to tell the carers what needs to be done."

The above concerns meant that robust pre-assessments systems were not in place to ensure people received safe person-centred care at all times. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection, the service had failed to ensure staff sought people's consent prior to delivering care and MCA assessments had been completed to determine capacity in specific areas. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of Regulation 11.

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Systems were in place to obtain consent from people to provide care and support.
- MCA assessments had been completed to determine if people had capacity to make certain decisions. Where people did not have capacity, best interest decisions were made on their behalf.
- Staff had received training on the MCA and were aware of the principles of the act.
- Staff told us that they always requested people's consent before doing any tasks. A staff member told us, "Yes, we need to ask for consent, always." People and relatives confirmed this. A person commented, "Yes they do (ask for consent) even though I have the same routine each day." A relative told us, "I can only say what I have observed and carers do not ask [relative] for her consent."

Staff support: induction, training, skills and experience

- Staff had been trained and supported to perform their roles effectively.
- Staff had completed essential training and refresher courses to perform their roles effectively such as on safeguarding, infection control, manual handling and basic life support. A staff member told us, "They do give good training, I have just finished NVQ Level 3 on caring role. It is very helpful."
- Staff were supported in their roles. Regular supervisions had been carried out with staff and yearly appraisals were completed to check on their progress. Staff told us they felt supported. A staff member said, "[Registered manager] is very very good, I am supported."

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People were supported to eat and drink to maintain a balanced diet
- Care plans included the level of support people required with meals or drinks and their likes and dislikes. A staff member told us, "We always give them [person] choices on what they would like to eat."

Supporting people to live healthier lives, access healthcare services and support

- Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health.
- Records showed the service worked with professionals such as GPs to ensure people were in the best of health.

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

At our last inspection, we made a recommendation for the service to follow best practice guidance on ensuring people are involved in decisions about their care. Care plans lacked evidence people were involved in their care planning and people and relatives told us some staff did not include them on decisions about their care.

- Care plans did not include if people had been involved in decisions about their care. Although a template had been made to confirm people agreed with their care, this was incomplete. The registered manager told us this would be completed and submitted an action plan to address this.
- People and relatives told us staff involved them with decision when supporting people. A person commented, "They ask me and give me choices." A staff member told us, "I involve people with decision when supporting people or give them choices."

Ensuring people are well treated and supported; equality and diversity

- People and relatives told us staff were caring. A person told us, "Yes, care staff are kind caring and do listen to me." A relative commented, "The people [staff] who visit are very friendly. [Person] hasn't had any carers who are not nice."
- People were protected from discrimination within the service. The registered manager and staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. Care plans include people's backgrounds and belief's and information on how to meet these needs had been included.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity were respected when they were supported by staff.
- Staff told us that when providing support with personal care, it was done in private. A staff member told us, "I need to cover [person] properly, that windows and doors are shut. We knock on people's door before entering." A person commented, "Yes, they do. They treat me very well with dignity and respect. They protect my privacy by covering me with a towel." A relative told us, "Yes, they [staff] are very respectful and they do treat [person] very gently."
- Staff gave us examples of how they maintained people's dignity and privacy, not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal

information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity.

- Staff encouraged people to be independent. Care plans included information on areas people were independent and where they needed support.

Is the service responsive?

Our findings

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

At the last inspection this key question was rated Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of Life care and support

At our last inspection, the provider had failed to ensure people with dementia received person centred care and people's ability to communicate was not recorded. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made in this area and the service continues to be in breach of Regulation 9.

- At our last inspection care plans had not been completed for people with dementia to include their level of dementia and how support can be personalised to ensure they received person-centred care.
- At this inspection, we found improvement had been made in this area. Information included how people with dementia can be supported with personalised care.
- However, we found inconsistency with people's preferences with personal care had not been recorded. Some people's care plans included people's preferences on how they would like to be supported with personal care such as with showering. However, for some people their preferences were not recorded and this was generic, which meant they may not receive personalised care. A relative told us, "We have had so many new carers who do not know [persons] routine and often they don't even introduce themselves. It is not acceptable. Often, I am left to do all the tasks for [person], which is not easy for me as I am not well."
- The service was not providing end of life support to people.

The above concerns meant that care plans had not been completed accurately or personalised to ensure people received high quality person-centred care. This was a continued breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's ability to communicate was recorded in their communication care plan, to help ensure their communication needs were met.

Improving care quality in response to complaints or concerns

- The service had a complaints procedure. Records showed complaints had been recorded, actioned and resolved. A log was kept of complaints and when a response was sent with the action being taken. Complaints were also being analysed for patterns and trends.
- The registered manager told us people were made aware of the complaints process and were aware of how to make complaints. Staff were able to tell us how to manage complaints.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure robust audit systems were in place to identify shortfalls and take prompt action to ensure people received safe person-centred care at all times. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the service was not compliant with the warning notice we served at the last inspection.

- Robust quality assurance systems continued not to be in place to ensure shortfalls were identified and prompt action taken to ensure people received safe and effective care at all times.
- We also found audits were carried out on aspects of the services, which included medicines, care plans, staff call logs and on staff files. However, these audits continued not to find shortfalls we found with medicines, care plans, risk assessments and staff time keeping.
- We found continued widespread shortfalls in relation to a number of areas such as with risk assessments, medicines management, staffing and care plans. We also found the systems in place to protect people from harm and abuse were not robust. There were shortfalls identified with the service not robustly assessing people's care and support needs prior to accepting care packages.
- People and relatives were not positive about the service. A person told us, "To be honest no, it's not well managed." A relative commented, "No I don't think so. From top down the manager should insist on carers being on time. There is no respect for us to be able to make arrangements in the day." Another relative told us, "There is little communication between the office and us. We are not contacted if carers are running late."

This meant the service had failed to ensure that adequate quality assurance systems were in place to identify shortfalls and ensure people received safe care. This was a continued breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

- Staff told us they were clear about their roles and were positive about the management of the service. One staff member told us, "I have no concerns with them [Nomase Care Ltd]. Everything is going well."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- Staff meetings were held to share information. The meetings kept staff updated with any changes in the service and allowed them to discuss any issues or areas for improvement as a team.
- People's beliefs and backgrounds were recorded and staff were aware of how to support people considering their equality characteristics.
- The service obtained feedback from staff and people about the service through telephone monitoring.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager was aware that it was their legal responsibility to notify the Care Quality Commission of any allegations of abuse, serious injuries or any serious events that may stop the running of the service and be open and transparent to people should something go wrong.

Working in partnership with others:

- The service worked in partnership with professionals to ensure people were in good health.
- The registered manager gave us an example of good partnership working where they supported one person whose mobility improved considerably through support and working with professionals. Records showed that the service worked with professionals when required.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider was doing everything that is reasonably practicable to make sure that people who use the service receive person centred care. Regulation 9 (1)

The enforcement action we took:

Impose condition to restrict care packages without prior written authorisation of the CQC.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users and ensure medicines were being managed safely at all times. Regulation 12(1).

The enforcement action we took:

Impose condition to restrict care packages without prior written authorisation of the CQC.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider was not robustly assessing, monitoring, improving the quality and safety of the service users and mitigating the risks to ensure people were safe at all times. Regulation 17(1).

The enforcement action we took:

Impose condition to restrict care packages without prior written authorisation of the CQC.

Regulated activity	Regulation
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Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider was not deploying sufficient numbers of staff to ensure people received support in a timely manner.

Regulation 18(1).

The enforcement action we took:

Impose condition to restrict care packages without prior written authorisation of the CQC.