Nationwide Care Services Ltd

# Nationwide Care Services Limited (Derby)

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

This inspection took place between 4 and 7 of March 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. Phone calls to people were completed on 4 March 2017 and we visited the premises on 4 and 5 March. We made phone calls to staff between 5 and 7 March 2017.

The service provides personal care and support to people who live in their homes in and around the Derby area. At the time of this inspection 61 people received support from the agency, 48 of whom received support with their personal care needs.

The service is required to have a registered manager. 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 registered persons could not demonstrate medicines were managed safely and administered as prescribed.

The registered persons could not demonstrate people received care that was safe and consistent as care plans and risk assessments were not always in place. Monitoring of people's health was not always completed in line with the provider's own guidance.

The registered persons could not demonstrate all the required pre-employment checks had been completed on staff employed at the service.

Staff received training, however staff did not always follow good practice guidance in relation to medicines and their knowledge of other areas relevant to peoples' care was not always in place.

Not all staff understood local safeguarding procedures and potential safeguarding incidents had not always been recognised and referred to the local safeguarding authority.

Not all staff were confident the support they received from their managers had been effective at resolving concerns or improving services.

Most, but not all people and their family members thought staff were caring; some staff practice did not always support the care and welfare of people.

Care was provided in ways to respect people's privacy and promote their dignity. People were involved and felt listened to when their care was discussed. People's care was reviewed with them, however this did not always lead to their care plans and risk assessments being updated when their care needs changed.

Complaints were not well managed or always investigated appropriately. Concerns and complaints were not used to improve the service. Not everyone felt confident to raise concerns.

Systems and processes designed to assess, monitor, improve and reduce risks in the quality and safety of services were either not in place, or where they were in place they were not effective. Actions taken to improve services had not always resulted in improvements. Staff were not always confident support from their managers would lead to improvements. Not everyone felt the service was led with an open style of leadership.

Policies and procedures did not always ensure quality services for people.

The registered persons could not demonstrate accidents and incidents were always recorded as appropriate and that any subsequent investigation and actions to reduce future risks had been taken.

Other healthcare professionals had not always been informed of changes to people's needs in a timely manner.

The provider had a policy in place on the Mental Capacity Act 2005. We found mixed evidence on whether people's rights had always been upheld and their views respected.

There were sufficient staff deployed to meet people's needs.

People received care with their nutrition and hydration needs. Staff provided care and support to help people with their meals and drink in a way that met their known preferences.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspection is added to reports

after any representations and appeals have been concluded.

## 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.

Medicines were not managed safely. Records of medicines administered were not always complete. Required pre-employment checks on staff had not always been completed. Care plans and risk assessments were not always in place. Sufficient staff were available to meet people's needs.

### Is the service effective?

**Requires Improvement**

The service was not effective.

Staff practice was not always in line with good practice; staff knowledge of areas relevant to their job role was not always adequate. Not all staff felt the support they received was effective. The provider had a policy in place for the Mental Capacity Act 2005 (MCA). People were supported to have good health and nutrition.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Most, but not all people and their family members thought staff were caring; some staff practice did not always support the care and welfare of people. People felt staff promoted their dignity and respected their privacy. People were involved in planning the care and support they required and their views and were respected.

### Is the service responsive?

**Requires Improvement**

The service was not responsive.

Although people knew how to complain, not all people felt able to complain without repercussions. Complaints were not well managed and opportunities to learn from complaints were not taken. Care plans and risk assessments were not always updated when people's needs changed. The views of people and their preferences, including their cultural views were respected.

## Is the service well-led?

Inadequate

The service was not well-led.

Policies and procedures did not always assure quality services, and were not always followed. Audits on the quality and safety of services were either not in place, or were not operated effectively. The management and culture of the service had not always been viewed as open and able to improve from feedback.

# Nationwide Care Services Limited (Derby)

**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 between 4 and 7 March 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. The inspection team included one inspector and an expert by experience who spoke with people on the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at all of the key information we held about the service. We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

In addition, during our inspection spoke with eight people and two people's relatives on the telephone. We also spoke with the registered manager, the area manager and four carers.

We looked at three people's care plans and reviewed other records relating to the care people received and how the agency was managed. This included risk assessments, quality assurance checks, staff training and recruitment records.

Inadequate

# Is the service safe?

## Our findings

Medicines were not managed safely. We found staff had assisted one person with their medicines for a two week period, however no medicines administration record (MAR) chart had been put in place for staff to record what medicines this person had taken. Nor had the person's care plan, risk assessment or their consent form for staff to assist them with medicines, been updated. This meant there was no record of what medicines staff had assisted the person to take, or had been declined over this period of time. One of the medicines was required to be taken in a specific way and without a care plan or risk assessment in place the provider was unable to provide assurances this had been given in this way.

A MAR chart was in place for staff to record they had applied this person's prescribed skin creams as required. However, this person's records stated staff did not provide any assistance with medicines and there was no care plan or risk assessment for medicines administration. In addition, the person's consent to care form had also recorded they did not require support with medicines. The provider's medication policy stated staff were to follow a care plan with regard to creams and lotions, and a person's consent obtained and recoded. We spoke to the registered manager about why the provider's medication policy had not been followed. They confirmed it had not been followed on this occasion and a care plan should have been in place for the person's prescribed creams.

Information on what medicine people required and when, was transferred onto a standard MAR chart used across the service. In addition, handwritten entries of people's prescribed medicines and the prescriber's instructions had been added onto MAR charts. We asked the registered manager what checks were in place to ensure the information had been copied accurately from the person's prescription. They told us there were currently no checks in place. They told us they recognised this way of working did not take steps to reduce potential medicines errors and reduce risks to people; they told us they would introduce checks to reduce any potential medicine errors and risks to people the week following our inspection.

We saw one person had started an antibiotic medicine; there was no separate care plan to explain why they had started on this medicine; however their records stated they had previously had hospital admissions from urinary tract infections. The MAR chart stated they were to receive one tablet, four times a day. Out of seven days, there were six occasions no record had been made to record whether this medicine been given, or offered and refused. For another occasion, staff had recorded 'other' however had not made a record to explain what this meant. The effectiveness of antibiotics is reduced when they are not taken as prescribed. The provider could not provide assurances from their records of medicines administration that this person had received their antibiotic medicine as prescribed.

This person's MAR chart also showed staff had recorded a prescribed medicine for this person was 'not available.' They had recorded it was not available for six consecutive days. We asked the registered manager what staff should have done. They told us staff should have reported it to the office so more medicine could have been arranged. They showed us a record of where staff had done this. However, staff had not reported this medicine was not available until the fourth consecutive day of the person not receiving their medicine. There was no care plan to say what this had been prescribed for, however the medicine is known to treat

high blood pressure, coronary artery disease, and angina. We checked what the side effects were when doses of this medicine were missed; these stated a person's blood pressure or chest pain could get worse. This could lead to serious problems, such as a stroke or heart attack. The service were not taking all reasonable steps to reduce the risks associated with medicines as staff did not report in a timely manner when people's medicines were not available.

The MAR charts we reviewed had numerous errors on them. These included ineligible entries where records had been overwritten or crossed out; gaps where staff had not made an entry to record whether the medicine had been given or offered and refused. We were aware of incidents of when medicine had not been available for people. Under the provider's medication policy the staff member is required to record the incident. These had not been completed. The registered persons were not able to assure us accidents and incidents were recorded and investigated as appropriate; nor were they able to assure us all reasonably practical steps to reduce risks were identified and taken.

In one person's daily records, staff had recorded they hoisted the person 'into the air for 20 minutes. Records showed this occurred almost every day, and on one occasion the person had been hoisted in the air for one 20 minute period and a separate 10 minute period. Hoists are equipment designed to lift and transfer people safely. We were concerned a person had regularly been lifted and left in 'the air' for periods of up to 20 minutes. The provider had identified a hoist was used for this person; however the provider's specific manual handling assessment also asked what support was needed, including step by step instructions. This had not been completed. Although use of the hoist was included in the details of the person's morning call and evening call, there was no care plan in place for the use of the hoist. There were no records to show how the practice of the person being hoisted into the air for 20 minutes by staff had been risk assessed or care planned. We asked the registered manager where this practice had originated from and they were not able to tell us. The registered persons were not able to assure us this person was receiving safe care and we asked the registered manager to make a safeguarding referral to the local authority.

Other equipment was used by staff when they provided care to help people move. For example, records of people's daily care showed staff used a slide sheet to make one person comfy in bed. However, there were other records that stated staff had made the person comfy, or had rolled the person in bed and these did not record a slide sheet was used. The slide sheet was not identified in their care plan, or on their moving and handling risk assessment. This meant there was no written assessment for staff to refer to for when to use the slide sheet for this person. The person had a grade two pressure area and any incorrect moving and handling could contribute to the deterioration of their skin integrity. Without a care plan or risk assessment in place the provider could not provide assurances all staff provided consistent safe care, which had been assessed and had been based on best practice when repositioning this person.

Daily reporting sheets showed one person received daily catheter care. The provider's information on what records staff were required to keep, stated catheter logs should be completed when the catheter bag is changed and to monitor the levels of fluid output. There were no catheter monitoring logs completed for this person who used a catheter. This meant staff were not adequately recording and monitoring people's catheter output in line with the provider's policy.

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

We looked at how the provider recruited and managed staff. Staff we spoke with told us they did not start work until the registered manager had checked their references and obtained information from the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and to

prevent unsuitable staff working with people. However, recruitment records we checked showed one person's start date was two weeks prior to the provider obtaining information from the DBS. The provider's recruitment policy stated that whilst staff can be employed at any stage of the DBS checking process, they are not permitted to undertake any unsupervised work. There was no evidence on the person's file to show they had only undertaken supervised work until their DBS check had been received. Recruitment procedures did not take all steps to ensure people who were employed were suitable to work at the service.

In addition one person's application form showed a gap in employment history of 18 months. Registered persons are required to obtain a satisfactory written explanation of any gaps in employment history so as to help them make safer recruitment decisions. The provider's recruitment policy stated any gaps in employment history must be explained and fully documented during the interview. This had not been completed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe with the staff and the care they provided. One person told us, "I feel safe with the staff; if I didn't I wouldn't let them in." Another person told us, "I feel safe with the staff as they really know how to do the job properly." Although staff told us, and records confirmed they had been trained in safeguarding, not all staff we spoke with were aware of how local safeguarding procedures could help keep people safe. In addition, during our inspection we became aware of one incident reported to the registered manager that had not been recognised as a potential safeguarding issue and had not been referred to the local safeguarding authority. Not all steps had been taken to reduce the risks of preventable harm and abuse to people.

People told us there were enough staff to provide them with a service; however some people had experienced some difficulties prior to our inspection. One person told us, "When I first started to have care from my present care company there were a lot of issues with timings and who was coming; it was a shambles but over the last few months everything has got better and it all runs like clockwork; I couldn't ask for better." One family member told us, "[My relative] needs two carers and when new staff are in training three come so they can learn the ropes."

Staff we spoke with told us there were enough staff and enough time allowed for them to provide care to people. The registered manager told us they had experienced a period of time prior to our inspection when there had not been enough staff. They had since recruited more staff and told us there were now enough staff to provide care for people. At the time of our inspection people were supported by sufficient staff.

Requires Improvement

# Is the service effective?

## Our findings

Staff told us, and records confirmed they had completed training on different aspects of care before they provided care to people. Staff told us this had been useful. However one staff member told us, "The training was helpful and I really enjoyed it; They were very strict on the training, but no-one follows it." They went on to tell us their concerns that good practice in medicines management was not always followed when this care was provided to people. In addition, staffs' knowledge in some areas of training varied. One staff member was not aware of the local safeguarding procedures and staff commented, that areas such as the Mental Capacity Act 2005 had been covered, "Very briefly." We were concerned the training provided had not always ensured staff fully understood the areas relevant to their job role, and staff practice in relation to medicines management was not in line with good practice.

Staff told us they had either received a supervision meeting or a senior member of staff had observed their practice on a 'spot check'. Records showed supervision meetings had been held with staff and spot checks were in place on whether staff attended calls on time, used gloves and aprons and were helpful and pleasant to people. However, staff had mixed views on the support they received. One staff member told us the registered manager and office staff were, "Very good at helping out." However other staff told us they had not seen improvements when they had raised concerns over people's care and they felt less confident over the support offered as a result. One staff member also told us they had experienced periods of time when the on-call phone had not been answered. Although some processes were in place to support staff in their role, not all staff felt the support was effective.

People told us they were comfortable with the care staff and the way they provided care. Staff we spoke with told us they talked with people about their care before this was provided. Records of people's daily care showed staff respected people's views if they refused some parts of their care. For example, we saw one person told staff they did not want, on one occasion, to be assisted to move and staff respected their view. However, we also saw one complaint had raised concerns over where one member of staff had not respected a person's views. We were concerned this person's rights had potentially not been upheld and we asked the registered manager to make a safeguarding referral for this person.

Records showed people saw other healthcare professionals when needed to help them maintain good health. However, records also showed an occasion where a healthcare professional had not been informed of a change to a person's health condition in a timely manner. Although staff supported people to access other healthcare services, this was not always done within an acceptable timeframe.

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 so that they can 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. The service had policies in place that covered the MCA and making decisions in a person's best interests. The registered manager told us no-one lacked the capacity to consent to their care at the time of our inspection; however the polices and form to assess a person's capacity were in place should these be needed at a future point. Records showed people had signed to give their consent to their care plans; however this had not always accurately reflected the care that was provided. For example one person's consent form did not reflect staff provided care with this person's medicines.

People told us they felt staff cared for them effectively. One person told us, "I couldn't be treated any better by any of the carers." Another person told us, "My care is first class." People also told us any new staff were introduced by more experienced carers. They told us this helped them to understand what care the person needed.

People who received care with their meals and drinks had sufficient to eat and drink. One person told us, "I like chapattis and so I asked the managers if I could have an Asian carer as some of the others couldn't help me make them; It is really good now they come." Another person told us, "I am never left without being able to have a drink within easy reach." Family members were also satisfied with the care their relatives received over food and drink. One relative told us, "Mum seems quite happy with the food she receives from the care staff." Staff we spoke with told us they would always ask people what meals they wanted and would leave people a drink within reach in between calls. Records showed people's preferences for food and drink had been discussed with them. People received sufficient to eat and drink.

Requires Improvement

# Is the service caring?

## Our findings

One family member we spoke with told us they felt one staff member could be abrupt to their relative. Two members of staff also told us about two separate occasions where they felt other staff had not always shown care and consideration for people's well-being. Both of these separate occasions were to do with the supply of people's medicines. On one occasion, staff were concerned medicines had not been offered to the person as prescribed, even though they were available. On the other occasion a person's medicines had not been arranged on time; staff were concerned a senior staff member had commented, "Another week [without medicines] is not going to hurt them." Although people felt staff had a caring attitude, some staff practice was reported not to always support the care and welfare of people.

People told us they felt staff were caring. One person told us, "Angels are what they [staff] are; I couldn't manage without them." Another person told us, "I do think the staff have the right attitude for doing the job they do; some of the men are just great." While another person told us, "I am never rushed by the carers, even though sometimes they run short of time; it's as though I am the only person in the world; it makes me feel special." During our inspection we heard staff talking with people on the telephone. Staff were courteous, polite and friendly.

People told us staff promoted their dignity and privacy. One person told us, "When I am being showered I am kept covered so as to protect my dignity." People also told us staff encouraged them to be as independent as possible. Staff we spoke with told us they took steps to respect people's privacy and dignity. One staff member told us they always made sure doors were closed and curtains closed whenever they assisted a person with personal care. Care was provided to respect and promote people's dignity and privacy.

People told us they knew about their care plan and felt their views were listened to. One person told us, "[My care plan] is updated if anything changes with me." People also said where they had made a choice to receive female care staff, this choice had been respected. Staff we spoke with told us they always asked people for their choices and understood it was important to support people's choices in their care. Records showed care plans had been discussed with people. For example, we saw people had been asked about their preferred choices for any meals and drinks. People were involved in planning their own care.

Requires Improvement

# Is the service responsive?

## Our findings

One family member we spoke with told us they did not want to report a concern as they felt this may single out their relative as a, "Trouble causer." Other people we spoke with told us they did not have any reason to complain, and should they need to complain, they would feel confident to and knew how to do so. One person said, "I've never had a problem with anything, but if I did, I wouldn't hesitate to contact the office." People received information on how to make a complaint if they needed to and there was a policy and procedure in place to manage and investigate any complaints received. However we were concerned that not everyone we spoke with felt they could complain without the worry of repercussions.

We reviewed five complaints made since January 2017. One complaint recorded the person was 'distressed' by what had occurred. Another complaint referred to 'known problems' with one member of staff. Other complaints were about late or missed calls. We were not assured these had been investigated appropriately. Although the registered manager told us they had investigated the complaints, these investigations had not always been documented. The registered manager's response to the complainant also did not make any reference to how their complaint had been investigated or resolved. In addition, the registered manager confirmed they had not kept the original letter they had sent to the complainant. There was also no date on the concluding letter sent to the complainant. This meant the registered manager could not provide assurances the responses given were in line with the timescales set in the provider's own complaints process.

The provider's complaints process stated, a complaints log must be kept by the registered manager and they were to identify what actions, if any, were required to avoid complaints of a similar nature, as well as recording outcomes and actions taken. We reviewed how the registered manager had summarised the outcomes for the complaints received in the complaints log. Where the registered manager had investigated and found evidence of late or missed calls, they had recorded 'no evidence of late or missed calls.' We discussed this with the registered manager who agreed their summary of the complaints investigated in the complaints log had not been an accurate reflection of their findings.

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

Most people told us they were contacted on a regular basis and asked whether they were satisfied with their care. One person told us, "The office rings every couple of weeks to see if I am okay." Another person told us, "I think my care plan is reviewed about every six months; in fact it's just been done last week." Records showed reviews of people's care had been held; however when changes had been identified this had not always led to updated care plans and risk assessments. Although people were able to contribute their views through reviews of their care and support; there was a risk they would not always receive responsive care. Care plans and risk assessments were not always updated when people's needs changed.

People we spoke with told us staff knew them well and understood their views and preferences. One person told us, Sometimes I think the care staff know me better than I know myself." Records showed people's

choices and preferences were known, for example people's preferences for food and drink were recorded. Another person told us how they appreciated a carer who understood their cultural needs. They said, "All the carers are great but being able to have a carer of my own nationality is brilliant." People's views and preferences, including their cultural views were known and respected.

Inadequate

# Is the service well-led?

## Our findings

Checks on the quality and safety of services were either not in place, or were not operated effectively. For example, we were told MAR charts were audited when they were returned to the office. We reviewed the audits completed on two people's MAR charts. These stated there had been some missed entries. The audits had not identified the seriousness of the missed entries. For example, they had not sought to understand why there were gaps in a course of antibiotics, or why a medicine prescribed to help with heart conditions had not been available for six consecutive days. The audit had not identified some entries were illegible and some entries had been overwritten and crossed out. Nor had they identified that not all staff signing for medicines on the MAR chart were identified on the staff signature list. The registered persons could not provide assurances that risks were reduced, or action taken to improve the safety of medicines as the audits had failed to identify and take action on these errors.

The audit also stated medicines error forms had been completed and staff had attended medication refresher training. We asked to see the medicines error forms and the records to show staff had been on the training identified in the audit. However the registered manager told us no medicines error forms had been completed and staff had not as yet, attended their refresher training. The registered manager agreed the actions recorded as completed had been written in an inaccurate way as they stated actions had been taken when in fact they had not. This meant audits had failed to identify all the errors made in medicines management and when they had identified errors, actions had not been taken to improve those errors.

In addition, we were aware of incidents that should, according to the provider's medication policy have resulted in the completion of an incident form. Staff also made us aware of other issues that again should have been reported with an incident or accident form. The registered manager told us there were no accident and incident forms completed. Policies to report accidents and incidents were not always followed; the absence of any accident and incident forms for incidents meant the registered manager was not able to assess and identify actions to take to reduce further risks. Systems and processes designed to reduce risks to people were not always operated effectively.

We asked how care plans and risk assessments were updated. The registered manager told us care plans and risk assessments were checked and updated as part of reviews of people's care. However we found this did not happen. This was because we found one person identified a change in their care needs at their review meeting. They told the staff member they now received care to help them with their medicines. However this did not result in any changes to their care plan or risk assessments; despite staff being aware of changes to people's care needs, no new care plans and risk assessments were put in place.

The registered manager told us they were three months behind in processing medicines error forms they were required to send to the local authority. They also told us there were delays to the processing of some people's invoices for the care they had received. Information was not always processed without undue delay. This meant analysis and actions to improve the quality and safety of services had not always been identified and taken in a timely way.

The provider had a range of policies to manage the quality and safety of care provided. However, we found these policies, and the associated systems and processes to deliver the policies were not effectively established or operated. For example, the provider had a quality assurance policy in place. This stated all people would have a full risk assessment and a needs assessment completed. In addition, it stated people would have an individual plan of care and support. We found risk assessments and care plans had not been completed for equipment in use, such as bed rails and pressure relieving equipment. Risk assessments and care plans were not always in place for medicines management, continence and pressure area care. The provider had failed to ensure risk assessments and care plans were in place to identify, assess, monitor risks and identify improvements to people's health, safety and welfare.

The provider's complaints policy also stated monitoring of complaints was an important aspect of their quality assurance process. It allowed them to identify trends and issues that could be addressed and so lead to improvements for people. We were not assured this quality assurance process had been effectively operated. This was because the registered manager had not always taken the appropriate actions to act on the feedback received. Concerns and complaints were not being used as an opportunity for the registered persons to learn and improve care to people. Complaints were not well managed.

We reviewed complaints from people and found the registered manager had investigated where people had stated they had received either late or missed calls. The registered manager had found some evidence of missed and late calls on some, but not all occasions. We asked the registered manager what quality checks were in place to provide assurances calls were provided within the timeframes set by the provider. The registered manager told us no monitoring of call times, late or missed calls had been in place; this was despite information from complaints investigations indicating sometimes calls were not always delivered to the timescales expected. The area manager and registered manager told us this would now be implemented.

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

The service is required to have a registered manager and a registered manager was in post. The registered manager was aware of their responsibilities and had submitted some, but not all statutory notifications to CQC when required. Notifications are changes, events or incidents that providers must tell us about. Not all statutory notifications were submitted as required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager told us systems and processes to check on the quality and safety of services had not been in place when the service started; they told us they had struggled to implement systems and processes as the service developed. They told us this was because they had spent a lot of time on care calls themselves before more care staff had been recruited. The registered manager told us they had not received any supervision or induction from the provider; although they told us the provider had been given updates on the problems in the service on a regular basis.

The area manager told us they had been recruited by the provider to make improvements to the service. The area manager told us they had started in post three weeks prior to our inspection and no audits had been completed on the quality and safety of services prior to our inspection. The area manager told us they would now be introduced. They told us they had produced an action plan prior to our inspection that identified what improvements were needed and what actions were required; the area manager added further areas for improvement to the action plan following our inspection feedback and also confirmed actions were to be

taken urgently in response to some of the issues identified.

Staff told us and records confirmed, spot checks were completed at people's homes on staff conduct and their performance; the person was also asked whether they were happy with the care, if they knew how to contact the office and whether they received their weekly rota. The spot checks we viewed on staffs' performance were positive. However where a person had stated they did not receive their weekly rota, there was no evidence to show how this had been communicated to the office for an improvement to be made.

Not all staff we spoke with shared the view that the registered manager and senior staff were open and approachable. In addition, some staff told us when they reported concerns about people's care and medicines, they received no feedback and no improvements were made. One staff member told us they felt their concerns had been, "Brushed under the rug." Not all people felt the service had been led with an open management style that used feedback to improve services.

People we spoke with were on the whole happy with the management team and told us they knew how to contact them. The registered manager was supported by the new area manager; they told us their role was to support all the managers at the different Nationwide Care Services offices. However they told us they would be at the Derby office for the next month to support the registered manager and to implement the improvements in their action plan. The registered manager was also supported by a care coordinator, an administrator, senior carers and care staff.

Staff we spoke with told us they enjoyed their role. One staff member told us, "It's lovely; everyone's really nice; I love working for them." Most staff we spoke with were aware of team meetings and records confirmed these were held. These meetings helped to provide support and provided staff with an opportunity to raise and discuss any issues. For example, we saw staff discussed one person's pressure area care and were reminded to report any broken skin to the office.

People we spoke with told us they were satisfied with the service they received. One person told us, "I couldn't ask for any better care." A relative told us, "I am so happy with the care [my relative] receives; I now don't need to worry that they are not going to be safe at home when I am not there." The service had recently collected people's views on the service through a survey type questionnaire. The registered manager told us these would be analysed and any improvements that could be made from people's feedback would be put into an action plan to develop the service. People's views were gathered and people had the opportunity to be involved in the way the service operated.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>Statutory notification were not always sent when required. 18 (1) (2) (e) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>Complaints received were not always investigated and the necessary and proportionate actions were not always taken. Systems to identify, receive, record, handle and respond to complaints were not operated effectively. 16(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The information specific in Schedule 3 was not always available. 19(3)(a) |

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<br><br>Care and treatment was not provided in a safe way. Care and treatment was not provided in a way that assessed the risks to the health and safety of people and all reasonably practicable actions were not taken to mitigate risks. The proper and safe management of medicines was not in place. 12(1)(2)(a)(b)(g) |

**The enforcement action we took:**

We took action to restrict new admissions to the service. We issued a requirement for the provider to send us monthly reports on the progress they had made towards improving the service.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems or processes to assess, monitor and improve the service, and mitigate risks to the health, safety and welfare of people were not operated effectively. 17(1)(2)(a)(b) |

**The enforcement action we took:**

We took action to restrict new admissions to the service. We issued a requirement for the provider to send us monthly reports on the progress they had made towards improving the service.