Cera Care Ltd

Cera - London

Inspection report

4th Floor, Elizabeth House
39 York Road
London
SE1 7NQ

Tel: 02033196511
Website: www.ceracare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Cera operates across different regions. We inspected the London location where eighty people were using the service at the time of this inspection.

This inspection was at short notice, which meant the provider and staff did not know we were coming until 48 hours before we visited the service. This inspection took place on 18 and 21 May 2018 This was the first inspection of the service since initial registration in December 2016.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and a small number of younger adults living with a disability or long-term health condition.

Not everyone using Cera receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene, taking medicines and eating. Where they do we also consider any wider social care provided.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the CQC 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 noted improvements were required to obtaining verification of staff experience and references that demonstrated the previous experience that staff claimed to have. The provider informed us of the immediate action they had taken in response to this, which included removal of staff experience and qualifications from care staff profiles if these could not be verified.

The provider's policy was to accept previous DBS checks for new staff if these had been undertaken within three months of staff commencing work with the agency. This was taking place.

Staff told us they received training to support them with their role when they joined the service and on a continuous basis, to ensure they could meet people's needs effectively. Staff training records confirmed this and there was an emphasis on staff obtaining the Care Certificate. The provider's staff supervision records were hard to follow and we have recommended that action is taken to address this. Clarification was required regarding staff understanding of supervision, which the provider informed us was being acted upon because of our feedback during this inspection.

There was a potential risk we identified in respect of staff who lived on site with the people they cared for. This risk was associated with care staff, in one case, feeling that breaks were not sufficient and they were sometimes tired. We raised this with the provider as although no negative impact upon people had resulted it was evidently a matter for pre-emptive consideration.

The provider started operating in 2016 and it has made technological innovation a core factor in service delivery. A digital platform is used which enables care staff to record care visits which can be used immediately and which people using the service can access. Similar technology is used in other areas of the service and there are plans to widen technological use to further record visit data and to introduce artificial intelligence to assist care staff and people using the service.

People using the service and their relatives told us they felt safe. People were looked after by staff who knew them and gave them the time and attention they required.

Risks associated with people's care needs were assessed, and the action needed to minimise risks was recorded and were updated regularly. Staff were aware of the potential risks that people may face.

The service complied with the requirements of the Mental Capacity Act (2005) and consultation took place to help protect people's human rights.

Staff respected people's privacy and dignity and their individual preferences. The people using the service were from a variety of different cultures and backgrounds, however the majority were white British.

People were encouraged and supported to maintain their independence with no more than the necessary support from staff that was required to help them retain their independence.

People received regular assessments of their needs and the service worked co-operatively with people's families and other health and social care providers.

People who used the service, relatives and stakeholders had opportunities to provide their views about the quality of the service. The provider worked to ensure that people were included in decisions about their care. People's views about how the service was run were respected and taken seriously.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Staff profiles needed development to make sure that experience claimed was correct. And staff references needed more checking during the recruitment process. Another potential risk of staff possibly becoming over tired when living with people to provide care was raised with the provider.

The staff assessed people's individual risks associated with their care to mitigate or reduce risk and to ensure people's safety.

Care staff were trained in keeping people safe from harm and they knew they had to report any suspected signs of abuse to ensure people's safety.

Medicine administration was managed in a safe way. Medicine Administration Records listed the details of the medicines that were administered.

Is the service effective?

Good

The service was effective. The provider was able to evidence that staff supervision was taking place regularly. However, the recording of staff supervision was difficult to follow and needed a clearer tracking system.

The registered manager and care staff considered mental capacity assessments to identify if any person lacked capacity. Action was taken to address any capacity concerns.

Care staff received an induction when they started work with the service which included training about any specific support individual people may require. All care staff had completed, or were completing, the care certificate.

People were pro-actively supported with their dietary and nutritional support needs by the service. Staff supported some people to access community based healthcare.

Is the service caring?

Good

The service was caring. People were treated with respect and

staff maintained privacy and dignity.

People were encouraged to have input into their care and their views were respected. We were informed by people using the service and relatives that care staff treated them well and were kind.

Is the service responsive?

Good

The service was responsive. People's care needs were assessed and care needs were kept under review with any changes being responded to.

A complaints policy was available and was also given to people and relatives when the service began. People usually felt able to raise questions they had with agency staff.

Is the service well-led?

Requires Improvement

The service was not always well led. The service had effective systems in place for monitoring the standard of day to day care and learning from events that occurred but needed to develop systems to cover staff supervision, staff recruitment and live in care.

The registered manager could show us how they sought people's views and checks they had in place to keep the quality of the service under review.

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Detailed findings

Background to this inspection

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

This inspection took place on 18 and 21 May 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by two inspectors and an expert by experience who telephoned a selection of people using the service and their relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses care services.

Before the inspection we reviewed the information, we held about the service, which included any notifications of significant events and other contact the provider may have had with the Care Quality Commission.

During our inspection we spoke with one person using the service as other people preferred we contacted a relative which we did for seven of these people, others we contacted were not available to speak with us. We also spoke with five care workers (and received e mail feedback from five other care workers), two care co-ordinators, the lead nurse, the head of personnel, the head of training, the operations director and the registered manager. We also contacted five care commissioning group and NHS trusts who purchased publicly funded care from the service we but had no feedback from any of these.

We gathered evidence of people's experiences of the service by conversations we had with them and their relatives and reviewing other communication that the service had with these people, their families and other care professionals.

As part of this inspection we reviewed eight people's care plans and care records. We looked at the induction, training and supervision records for eight care staff and the training and supervision records for all the care staff team. We also reviewed other records such as complaints information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with, or their relatives, told us they felt safe with the care staff that supported them. One relative told us they had concerns about the number of different staff used when care was first provided but since that time the agency had responded and they felt their relative was now safe.

Another relative told us their relative felt, "completely safe. The carer really understands and I interviewed the carer over the phone and after that I was convinced she was right." A third relative told us "Care is fine and safe. They arrive on time. I wouldn't part with them for the world. The same carer comes which my [relative] likes".

The provider had a safeguarding adults' policy and flow chart with guidance for staff on the steps to follow if they had concerns about the safety of anyone using the service. This policy and procedure was kept under review by the clinical governance group, formed of senior managers of the organisation. This explained types of abuse, capacity issues, consent to information sharing and steps to be taken in cases where allegation of abuse related to any staff working for the agency. This was detailed and clearly described the responsibilities of the agency and all staff working for Cera. Staff confirmed that they had received training about keeping people safe from harm and how to report any concerns that may arise. Care staff were also provided with a pocket guide about adult safeguarding, which we saw. This guide provided information to care staff about the principles of safeguarding, types of abuse and what staff had to do in response to any concerns.

Two safeguarding concerns had been raised with the Care Quality Commission (CQC) since the service was first registered. The provider could show that these had been responded to appropriately and full details of the action taken to address, in cooperation with other safeguarding professionals, was available.

We looked at eight staff recruitment records. These checks included a Disclosure and Barring Service (DBS) criminal record check. The provider checked documents, such as a passport or driving licence, to verify a person's identity and home office permission if required to work in the UK. The recruitment officer stated they do accept DBS checks from other providers if they had been taken up with a previous employer within three months of joining Cera. The procedure was then that staff were then required to undertake a further DBS check with Cera.

We asked the recruitment officer responsible for staff profiles why two staff profiles included information on staff length and the type of experience which had not been verified. One was described as having 18 years of experience in different areas of care work and another as having a nursing qualification although they were not employed as a nurse. The recruitment officer agreed that based on information in these people's references they could not say what experience the staff had. The officer admitted that the information in staff profile was based on what the staff had said. People using the service were provided with skills and knowledge information about staff on which to choose who worked with them. The officer agreed that this could potentially cause a risk that people might select staff that may not have the skills or experience they were looking for.

We asked the registered manager to explain why these specialities were placed on the staff profile. The registered manager said there was possibility the people had some experience but admitted the word specialities should not be used in this context. We did not identify any staff providing care in specialist areas that were not evidenced. We were also subsequently informed by the director of operations that "We have removed any information from the care staff profiles that has not been robustly evidenced."

In some cases references were not given by professionals of previous employers but by friends or work colleagues on the same employment position, for example other care worker colleagues or business partners. We raised this with senior managers for Cera and were subsequently informed that, where staff should be able to provide previous employment references this was being followed up.

Each member of the care staff team had received one day of medicines training by the agency's registered nurse. The training was followed with two competency tests and skills assessment and this was seen on staff records. The registered nurse employed by the agency told us there were monthly medicines audits, required on 25% of people receiving medicines. This meant that people's medicines were reviewed three times a year, and we viewed the last six months of these, as well as a quarterly audit analysis. All errors were recorded and rectified, most being recording issues rather that misadministration errors. Action taken in response was also recorded.

Risk assessments were clear, detailed and specific to the needs of people who used the service. The service had common risk assessments such as falls, manual handling and medicines. These risk assessments then went on to describe other risks associated with people's day to day needs. The risk assessment policy did not state the minimum frequency of risk assessment update but did refer to this being ongoing through identified changes in care needs. This took place through care plan reviews which were carried out a maximum of every three to six months. This was described as done through using information gathered through care recording and other day to day contact with people using the service [or their relatives] and care staff. Risk assessments were reviewed, which we saw, and were updated at any time that people's care needs and any associated risk had needed to change.

Staff told us they had plenty of time to travel between calls if they had visits to different people on the same day. They also told us they had enough time to complete their tasks as each visit was scheduled to last at least an hour at a time. A relative told us that recently staff had been arriving late and we explored with the agency what they knew or had done in response. A care co-ordinator admitted that this could be an issue but the agency was working on introducing a system to ensure staff are where they say they are. Staff needed to check in through application on their phone that they arrived at a person's home. If staff had not checked in within 15 minutes the system would trigger an alarm which would go straight to the registered manager. With the current system we could not say that data regarding missed visits and lateness was fully accurate as staff were using their own mobiles and there was no other means of tracking that staff had arrived at present. In the meantime, the provider advised us that checks were made to make sure care workers had arrived on time, spot checks looked at arrival times and regular wellness checks were made to people using the service which included questions about care worker punctuality. However, this will become more effective when the GPS tracker is introduced. We noted, however, that when complaints about late or missed calls had been raised, on eleven occasions in the last twelve months, this had been followed through. Each event had prompted a full response and apology by the provider, including what would be done to address the circumstances of each late or missed visit to minimise a risk of recurrence. A review of complaints had been undertaken in May 2018 and we were provided with a copy of this. This included the issues of missed or late calls and outlined the action being taken to address this.

Staff rotas, which we viewed, were prepared a month in advance. Most visits were covered by the same staff

so rotas were used to allocate new calls or cover planned absences. Care coordinators had easy access to information, via an online matching system, about all staff that were known to people or had relevant training and who were available to cover calls while regular staff were away on planned absences, for example holidays.

During our conversations most staff did not highlight any concern regarding the rota system. However, we looked at three examples of rotas for live in staff. Breaks were discussed at the point of assessment which included information about whether a person could be left on their own when staff had their break. Staff were entitled to a two-hour continuous break a day, however, these were not formally scheduled and often were subject to agreement with the person, the family and availability of other workers. This might work if a person's needs were not very complex and if there was a good relationship between the people and the staff. However, if a person's needs were more complex and breaks were subject to availability of other staff and this risks a situation when they could work many hours and they had no time to rest. No incidents had been reported because of this, however, it is important that the provider pre-empt this potential risk of live in staff being overly tired due to insufficient breaks from work. We raised this with the senior management team to review and address any concerns raised about suitable rest breaks for live in care staff.

Staff received hygiene and infection control training. Personal protective equipment such as gloves and aprons was readily available for staff when carrying out personal physical care tasks. The majority of relatives told us that staff always wore gloves and aprons when assisting their relative with physical care.

Good

Is the service effective?

Our findings

People received care and support from care staff who had training to carry out their roles and responsibilities. All staff were booked for induction before they started working with people, which care staff confirmed. The induction included four days of training including Dementia awareness, Mental Capacity Act, whistle blowing, equality and diversity, Cera values and the last day was medicines training.

Following their employment induction all staff were enrolled to complete the Care Certificate. These were common standards used for inducting staff into care services and ensuring they had the necessary core skills to carry out their duties using 15 core standards. Staff had 12 weeks to complete it. The training coordinator said, "Cera thinks it is good practice to complete Care Certificates even if all staff are already experienced." On the Cera's system and in staff files we saw evidence that staff completed or were in the process of completing their care certificate. Additional training was provided depending on the specific care needs of people that care staff would be assigned to support. One example was peg tube use for eight staff who may need to assist people with this. A Peg is a tube that is inserted into people's stomach through which they receive nutrition. We were informed that no-one required this assistance at present. Managing diabetes training was also provided by the agency's registered nurse.

Cera had newly introduced an online learning suite where staff had access to training. The training coordinator had access to reports so they could see which staff completed, or still needed to complete, their training. We saw a training matrix which had clear details on training completed by staff. The training coordinator who we spoke with told us, "Providing training to people means we have control over ensuring the right staff support people."

The provider's policy stated that all staff should receive supervision and that supervision was both formal and informal including one to one and group sessions. Staff had different understanding of how often they thought supervision should take place. One said every three months, another every 5- 6 months and another now and again. The staff supervision records we saw at the inspection and afterwards, were hard to follow because of the different types of sessions staff had and the way they were tracked. We recommend that the service seeks advice and guidance from a reputable source about the supervision recording to make clearer and easier to follow.

All staff received yearly appraisal of their skills, which we saw evidence of on staff files. The appraisal matrix stated that all but one member of staff had completed or had their appraisal during a qualifying period of 12 months since commencing work with the agency. We informed the senior management team of the care worker whose information was not up to date to address this.

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this was in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS), however, DoLS does not apply in a service of this kind.

Care plans that we looked at showed that consent to care and support was being obtained. Where people using the service were unable to provide this consent it was sought and obtained from a relative, advocate or health and social care professional on their behalf. This was carried out using best interest's decision-making procedures and lasting power of attorney when this was applicable.

Where care workers were required to assist people to prepare a meal they had training to do this. A relative told us, "There's a food chart of what she eats. [Relative] has to be prompted to eat on time and they also have to prompt her to drink which they do". Another relative told "They sort evening meals out and a choice is given. My [relative] feels as though the staff are trained well."

People were registered with their own GP and staff supported people who were unable to attend the surgery themselves or arrange home visits. Details of people's appointments were documented on care plan records for reference and included known medical histories, which was the case in all care plan records we examined. Not everyone using the service required this support although this was more relevant for people who had live in care staff supporting them. We saw examples in the records of when people had been assisted to make medical appointments, to attend appointments and seek advice. We spoke with a member of staff who told us about a project they were involved with to share medical history information, with people's consent, with the 111 NHS advice line. This work was ongoing and was designed to assist people to seek advice via the 111 services to make information more readily accessible. The aim was to assist with the 111 responses with advice or calling for emergency assistance if required.

Good

Is the service caring?

Our findings

Almost all of the people who spoke with us were positive about the service and their experience of care staff being caring and supportive. A person using the service said, their carer is "Phenomenal. She gives outstanding care and goes beyond the call of duty."

A relative told us, "They [care staff] are all very pleasant. They know his likes and dislikes. They respect our decision [as a relative] they also treat him with dignity. They are kind and respectful." Another relative told us "He [relative] is very independent and staff respect that. He doesn't like to complain but can sometimes has trouble understanding the carers as he has a hearing aid and that some of the carers don't speak clear English so there is a "slight language barrier." We raised this comment with the senior managers at the agency to respond to.

These comments showed that people's experience of using the service, or having contact with it, was that the care staff and the service were caring about people and were respectful.

People's individual care plans included information about their cultural and religious heritage, daily activities, communication and guidance about how personal care should be provided. In conversation with care staff it was evident that they knew what should be done to respect and involve people in maintaining their individuality.

We asked people using the service and their relatives if they had been involved in decisions about care planning and if they had seen their care plan, understood it and been allowed to sign to agree the plan. People said that they had been involved in decision making and their views were listened to. Those we spoke with, and their relatives, raised no concerns about their rights to dignity, privacy, choice and autonomy.

People's privacy and dignity were respected and maintained. Staff we spoke with could explain the way they worked with people and focused on people's needs being individual and that their role was to respect individuality and beliefs. All staff we spoke with told us they cared for the same people who use the service. They felt this helped to develop positive relationship with people who used the service and feel positive about their work. Some of their comments included, "I like working with the same client it helps continuity of care and when you support this person it does not feel like work anymore. I always have the same clients, depending on how long the package of care lasts for" and "I have one client. I work long shifts and I have plenty of time to do what I need to do. I have time for breaks."

Good

Is the service responsive?

Our findings

The agency had an online care planning/recording system that had been used by staff, the management team and people who use the service. Staff had access to an "app" (application) which allowed them to make real time records immediately after care was provided. Additionally, any changes to people's care were immediately recorded on this system and could be seen by staff supporting people.

Staff spoke positively about this system and they though it made their work easier, quicker and allowed immediate sharing of information so appropriate action could be taken to support people. They said, "Cera has a very good online application. I can log in and read everything that someone else wrote. I can check if there are any changes", "Cera has very useful application. It is useful because it is online and daily reports can be seen immediately by managers. You can also submit it to specific person, for example, a nurse or the manager and they can act immediately."

A relative told us" They ring and check everything's ok. We haven't had a review yet but I don't use technology really". Another relative said, "A lady came and went through with information with my [relative] and myself very sensitively. It was a quick process; they identified a carer that afternoon. The care started about 3 days later. It was very well done." A third relative told us they could not recall having an assessment when they first contacted the agency but did have one as the care of their relative started.

The eight care plans we looked at showed that everyone had a care plan and/or assessment from the placing public authority as well as the agency. If people were requesting the agency's care service privately the service carried out their own assessment of need and developed a care plan. Assessments and care plans were undertaken in consultation with people using the service with relatives also being involved if required. Care plans were clearly recorded and information was readily and easily accessible. The care plans gave guidance to staff on how to support each person and about the independence and ability that each person maintained. Care plans and risk assessments were subject to ongoing monitoring and review.

Care staff were aware of the information which needed to be recorded such as accidents, incidents, risk management and safeguarding and were aware of their reporting channels. Care staff recorded information about what they had supported people with on each visit, or at what specific point in the day if the care worker lived on site. We looked at samples of these records for four people over a three-month period. These records showed what support had been provided and included additional information about specific events or aspects of care if required. The records were sent electronically to the agency and two senior managers took joint responsibility for reviewing the records and following up, for example if changes to support needs were highlighted, as required.

Each member of staff we had contact with demonstrated by their comments that they took their caring role seriously. People working at the service felt accountable for the way that care was delivered.

There was a complaints policy which clearly outlined what the provider would do to listen to and respond to complaints. People and relatives were provided with information on how to make a complaint when they

began using the service. From the feedback that we received above it was evident that people had felt able to raise concerns. There had been, apart from complaints about missed or late visits, other complaints about invoicing and the number of staff required for each visit. These had been resolved with the people concerned.

The agency was in the process of developing a palliative care training in partnership with Marie Curie Cancer Care. They aimed to introduce the training in June 2018. The service did not specialise in providing end of life care although did support people who were using community based palliative care services.

Requires Improvement

Is the service well-led?

Our findings

Relative's told us "I talked to them about having a substitute carer, had a chat with them and felt like the office had respected and listened to our wishes", "The office is "very available, they don't let me know every little change but if there's a problem, they let me know" and its "managed well and efficiently." One person raised a query about changes to office staff and invoicing which they were unclear about.

There was a registered manager in post. They were supported by care co-ordinators, field care assessors, a lead nurse as well as personnel and administrative staff. They were in regular communication with each other and we observed this during our inspection. Meetings were held each Monday to review what had occurred over the weekend and priorities for the service in the coming week. In addition to this the senior management team held a quarterly clinical governance meeting as well as an advisory board. The clinical governance meetings, the most recent minutes of the meeting at the end of February 2018 we viewed, described the areas discussed and current performance of the service and any action required.

Staff told us they usually felt well supported by their direct line managers. Care staff contributed to how the service was run, through staff team meetings and regular training sessions. The staff we spoke with knew their roles, the lines of accountability and what was expected from them. We were told by staff that "Yes, the agency is well led. Everything is organised, nothing has ever gone wrong", "I feel supported. They always ask if I am ok. When I ask for anything they do it straight away" and "Yes, I think the agency is well managed. Everything is online and it makes things easier. Managers follow our suggestions."

There were systems in place to monitor the service. For example, the manager and other members of the management team carried out audits across a range of areas. These included medicines, care plans, monitoring staff training and staff performance. There were also systems in place for regular review of day to day care needs and audits of care plans, risk assessments and medicines management all took place. However, improvement was required to the quality monitoring systems to address the matters we identified at this inspection. These were the need to improve the recording system for staff supervision, the need to review live-in care worker breaks, the need to revise the staff profiles, the need to review the obtaining of employment references for care workers and how that linked to the recruitment process.

The use of technology was a key factor in service delivery. The provider has started operations with the aim of bringing technology and innovation to the domiciliary care sector. A digital platform was used which enabled care staff to record care visits for immediate use. The provider was using data captured from visits to build intelligence to make care provision more effective and cost efficient for people using the service and care staff. All parts of the service were to be covered by digitalisation and a hand held device was to be introduced bringing artificial intelligence for care staff to use to assist them to provide care to people using the service. The provider had extensive plans to innovate in all aspects of the service and make links with partners within the health and care industry.

The provider predominantly provided a service to people who funded their own care, although in some cases people were publicly funded. Relationships with outside agencies and stakeholders were managed. A

three-monthly spot check visit system was in place along with regular contact with people, including a quarterly survey to ask about their experience of care. The latest quarterly survey showed that 93% of people were either satisfied or very satisfied with the care service provided to them.

The service had appropriate, up to date policies and procedures in place which were available to staff to guide on various areas of their work. The policies included safeguarding people from abuse, equal opportunity, medicines management, equality and diversity and complaints.

The provider undertook learning from case study reviews, for example falls, palliative care and the use of the organisations database artificial intelligence system and how this could capture key information. Learning points were described and action that would be taken from this learning to make improvements.