S U V Healthcare Ltd

Kare Plus Milton Keynes and Bedford

Inspection report

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02 August 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection took place on 25 July, 26 July, 31 July and 02 August 2018.

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 adults. At the time of inspection, the provider was supporting five people with personal care.

Not everyone using Kare Plus Milton Keynes and Bedford receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

There was a registered manager in post. 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.

At our last inspection on the 16 May 2016, we were unable to rate the service. Although the service was providing support to one person, there was not sufficient information available to us to fully assess how safe, effective, caring, responsive and well-led the service was. At this inspection we found that the service 'Requires Improvement'.

The quality assurance processes in place to monitor the quality and safety of the service and drive improvement required strengthening. Audits had not identified gaps in the information provided on medicines administration record charts (MARs) or gaps in the recording of medicines administered to people.

The system in place for the management of complaints required strengthening to ensure complaints were dealt with in a timely manner.

People were not always adequately assessed for their risks and did not have plans of care in place to mitigate their known risks. People's care plans and assessments did not always reflect the support people required to meet their health needs.

People at risk of malnutrition did not have their nutritional needs assessed to ensure that they were supported to maintain an appropriate diet. However, staff knew people well and people were provided with the support they required to prepare their meals and maintain a balanced diet.

Staff demonstrated their understanding of MCA and the need to ensure that people's care and support was provided in the least restrictive way. However, there was a lack of recorded MCA assessments and best interest decisions in place for people. The registered manager had not identified that the principles of the

MCA had not been implemented appropriately; there was a risk that care would be provided to people that was not in their best interest.

Staff induction training and some on-going training was provided to ensure that staff had the skills, knowledge and support they needed to perform their roles. However, staff would benefit from regular updates of practical manual handling training.

Staff were well supported by the registered manager, and had regular contact with them.

People received safe care. Staff understood their responsibilities to keep people safe from harm. Safeguarding procedures were in place and staff understood their duty to report potential risks to people's safety.

There were arrangements in place for the service to make sure that action was taken and lessons learned when things went wrong, to improve safety across the service.

The staff recruitment procedures ensured that appropriate pre-employment checks were carried out to ensure only suitable staff worked at the service. References and security checks were carried out as required. Staffing levels ensured that people's care and support needs were safely met.

People were involved in their own care planning and were able to contribute to the way in which they were supported. People received support from a regular team of staff, who knew them well. Staff treated people with kindness, dignity and respect and provide their care based on their needs and wishes.

Staff supported people to access support from healthcare professionals, and supported them to maintain a healthy lifestyle. The service worked with other organisations to ensure that people received coordinated and person-centred care and support.

At this inspection, we found the service to be in breach of one regulation of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Full details regarding the actions we have taken can be found at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Improvements were required to the recording of people's medicines.

People did not have appropriate risk management plans in place for their known risks.

Recruitment practices ensured that people were safeguarded against the risk of being cared for by unsuitable staff. Staffing levels were sufficient to provide people with safe support.

Staff were clear on their roles and responsibilities to safeguard people.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems were not implemented to ensure that people's capacity to consent to their care and support was assessed.

People's health and nutritional needs were not consistently assessed and recorded.

People were supported to access relevant health and social care professionals to ensure they received the care and treatment that they needed.

Is the service caring?

Good

The service was caring.

Positive relationships had developed between people and staff. People were treated with kindness and respect.

Staff maintained people's dignity and there were measures in place to ensure that people's confidentiality was protected.

People were involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans did not provide staff with all the information they required to meet their needs.

There was a complaints policy in place but this had not always been adhered to.

People's care was personalised and responsive to their needs and choices.

Is the service well-led?

Requires Improvement

The service was not always well led

The quality assurance processes in place required strengthening to ensure sufficient oversight of the service.

A registered manager was in post; they encouraged a culture that was positive and supportive of people and staff.

People, their relatives and staff were encouraged to contribute to the running of the service.

Kare Plus Milton Keynes and Bedford

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.

Inspection activity started on 25 July and ended on 2 August 2018. It included a visit to the office location on 25 July to see the registered manager and office staff; and to review care records and policies and procedures. We also visited people in their own homes, spoke with a person's relative on the telephone and spoke with care staff.

The inspection was announced. We gave the service 48 hours' notice of the inspection as we needed to ensure that staff were available to support the inspection. The inspection was undertaken by one inspector.

Prior to the inspection, the registered manager had completed a Provider Information Return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR on the 12 April 2018, we took this into account when we made judgements in this report.

We reviewed the information we held about the service, including information sent to us by other agencies, such as Healthwatch; an independent consumer champion for people who use health and social care services. We also contacted commissioners and asked them for their views about the service. Commissioners are people who work to find appropriate care and support services for people.

During this inspection, we visited four people at home and spoke with one person's relative on the telephone. We spoke with four members of staff, including care staff, the office manager and the provider. The registered manager was unavailable at the time of the inspection, but we spoke with them following the

inspection site visit and they provided further information to support the inspection. We looked at records relating to the personal care and support of four people using the service. We also looked at three staff recruitment records and other information related to the management oversight and governance of the service. This included quality assurance audits, staff training and supervision information, staff deployment schedules and the arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

There was a system in place to manage the administration of people's medicines. However, we found that medicine administration record sheets (MAR) were not consistently being completed in line with current guidance. For example, some did not contain important information about the person such as their date of birth or whether they had any allergies. They also contained confusing information regarding the role of staff in providing people's medicines. For example, we saw that staff were taking full responsibility for administering one person's medicines. However, the record that they were signing to indicate they had administered the medicines referred to prompting the person with their medicines rather than administering their medicines. We discussed this with staff and they were clear that the person's care plan directed them to administer the person's medicines. Records that we checked confirmed this. There were also gaps in records of medicines that had been administered to some people. In response to our findings the registered manager has undertaken a review of the audit process in place for medicines, to ensure that there are sufficient measures and checks in place to monitor the quality and consistency of medicines records. All staff received training in the administration of medicines and had their competency regularly checked.

Staff did not always have the information they required to ensure people's support was provided in a safe way. Some people did not have appropriate risk assessments and risk management plans in place to manage the risks present in their lives. For example, one person required a high level of staff support to move; they did not have a moving and handling assessment in place to inform staff how to support them safely. This person was also at risk of their skin breaking down, but no skin integrity risk assessment had been completed. They told us that they were usually supported by staff who knew them well and had a good understanding of how to support them correctly. When new staff were introduced, they came with regular staff to learn what to do before providing care on their own. However, on one occasion when being supported by a new member of staff, they had to tell the member of staff how to support them to move. This meant there was a risk that this person's support would not be provided in a safe way.

Other risks to people had been assessed and staff provided with clear instructions on how to keep people safe. For example, we saw assessments in people's care files that identified risks associated with people's home environment and trips and slips. Where risks had been identified appropriate controls had been put in place to reduce and manage the risk; these control measures took account of people's choices and independence.

Staff had received training in infection control. However, two people told us that although staff wore disposable gloves and washed their hands regularly, they did not wear protective aprons when supporting them with personal care. We discussed this with the provider who stated that all staff were trained in the correct use of personal protective equipment and had access to a supply of disposable aprons. They agreed to discuss the correct use of personal protective equipment with staff to ensure that they were aware of their responsibilities.

Safe recruitment procedures were carried out by the service. We looked at staff files, which showed that all

staff employed had a criminal records check, and references and identification had been obtained before new staff started working at the service.

People, their relatives and staff told us that there were enough staff to provide their care and support. One person said, "They [staff] always come on time unless there's an emergency [elsewhere]." Another person said, "They [staff] are usually spot on for time." A member of staff said, "I have time for my calls, they are not back to back, there are normally gaps between. If ever I'm running late I ring [registered manager] and the person to let them know."

The people we spoke with told us they felt safe with the staff supporting them. One person said, "They [staff] are very trustworthy, I feel very safe and trust all of them." Another person told us, "[Name of staff] is brilliant, I feel safe with [Name of staff]." Staff understood their responsibilities in relation to keeping people safe from harm. Staff we spoke with had a good understanding of safeguarding procedures, and knew how to report abuse. One member of staff said, "Any concerns I would consult with [registered manager], I could also go to CQC."

All staff understood their responsibilities to record and investigate any accidents and incidents that may occur. Where incidents had occurred within the service, these were reviewed by the registered manager and action taken as necessary. Staff told us that the manager regularly communicated with them regarding any concerns. This ensured that staff worked in a consistent way and made improvements to practice where needed.

Requires Improvement

Is the service effective?

Our findings

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. In domiciliary care settings, this is under the Court of Protection.

We checked whether the service was working within the principles of the MCA. Systems were not implemented to ensure that people's capacity to consent to their care and support was recorded. Staff told us that some people supported by the service were not able to consent to all aspects of their care. However, there was no record of mental capacity assessments being undertaken or best interest decisions being made on behalf of people. We discussed the need to have systems in place to ensure compliance with the MCA with the registered manager. Following the inspection, they provided information to demonstrate how they would ensure people's mental capacity would be assessed when needed.

Staff had received training in the MCA and were able to demonstrate an understanding of some of the key principles of the MCA and described how these informed their practice. They told us how they supported people to make their own choices and asked for people's consent before providing their support. We observed staff seeking people's consent before providing their support, we saw that people were asked what they would like to do and what they would like to eat and drink. Staff told us that they made sure to give people choice, wherever it was possible.

People's care needs were assessed to identify the support they required. People confirmed that the registered manager met with them and had in depth discussions about their needs and wishes. However, not all of this information was recorded in people's care plans. Some people had specific health and medical needs that were not identified in their care plan. We saw that one person was regularly receiving an injection from the district nurses, but the reason for this injection was not identified in their health needs assessment. There was a risk that staff would not have appropriate information to ensure that people's support was provided in the correct way. The provider and registered manager need to ensure that all information about people's health needs are recorded in their care documentation.

Where needed, people were supported by staff to have sufficient food and drink. However, where people were at risk of malnutrition suitable nutritional assessments and care plans were not in place. Staff told us that one person had been unwell and had lost weight, there was no record of a nutritional assessment being undertaken and no plan of care in place to provide staff with clear guidelines on how to support the person to meet their nutritional needs. However, staff knew the person well and were able to describe in detail the food the person liked and how they encouraged them to eat a balanced diet; staff told us that the person was now putting on weight. Staff also described how they always spoke to people about their food choices and gave different options.

Staff received an induction before working alone with people; shadowing experienced staff until they were competent to provide people's support. One person said, "We had a new carer, she came in with [name of staff] to be shown what to do, [name of staff] has been coming a long time." Newly recruited staff completed the Care Certificate, which covers the fundamental standards expected of staff working in care.

Staff received on-going training to enable them to confidently and competently support people. One member of staff told us that they had completed a range of courses, including practical training in how to move people safely and a range of courses online. We saw records of staff training, including basic mandatory training such as fire safety, health and safety and safeguarding people from abuse. Staff also received training to support their understanding of the needs of the people they were supporting; for example, training in understanding dementia. Records showed that some staff required training in practical manual handling as they had only undertaken training that covered the theory of manual handling. This was discussed with the registered manager who immediately arranged for this training to be provided.

Staff said they were well supported in their job role. One member of staff said, "I meet [registered manager] in the office for a catch up all the time, we talk about the clients and my work. I'm happy with that." Staff also told us that the registered manager visited people's homes to monitor their work. One member of staff said, "[Registered manager] comes out every now and then and observes us working."

Records showed that the registered manager used a variety of types of supervision to oversee staff's work performance and enable open communication. These included observations of staff as they carried out their duties, spot checks and 'drop in chats' where the registered manager recorded informal discussions with staff. There were few records of planned one to one supervision and no records of appraisal.

We recommend that the provider implements a regular, planned programme of supervision and appraisal. This will ensure that both the member of staff and their supervisor are able to prepare for supervision meetings and reflect on previous meetings and progress.

The service worked and communicated with other agencies and staff to enable consistent and person-centred care. People had input from a variety of professionals to monitor and contribute to their on-going support. For example; occupational therapists and district nurses.

People's healthcare needs were monitored effectively by staff. People were confident that staff would support them to get medical assistance if required. One person said, "Staff have sent for the doctor for me twice. It was nothing serious but staff thought I wasn't one hundred percent and sent for the doctor." During the inspection we observed staff liaising with one person's relatives to ensure that appropriate arrangements were in place for them to attend a hospital appointment. People had regular access to healthcare professionals and staff responded appropriately to acute changes to people's health and well-being.

Good

Is the service caring?

Our findings

The service had a supportive and caring culture and people told us they had positive, caring relationships with staff. People and their relatives were complimentary about staff and valued their relationships with them. One person said, "They [staff] are always pleasant and helpful, there are no problems whatsoever with them. You get so you look forward to seeing them." Another person said, "They're fine, I get on well with them, they're all very, very helpful." One person's relative told us, "[Name of staff] goes the extra mile for [person's name]."

Staff worked with the same people consistently and got to know them well. People felt that the service was personalised and that they were treated as individuals. One person said, "[Registered manager] has said, if we need anything extra just to give her a call." They also told us that when they had experienced a late visit due to staff illness, the registered manager had bought them "a big bunch of flowers." They felt that this showed a genuinely caring attitude towards them. All the staff we spoke with confirmed that they worked with people consistently and were able to get to know their needs and preferences.

People told us that staff were flexible and adaptable and provided their care in the way they wanted. As well as supporting people with their personal care, staff helped out with other activities that were important to people. For example, one person had a pet dog, staff walked the dog for them as they were not able to do this themselves. The person told us it meant a great deal to them that staff were willing to do this as part of their support visit. Staff spoke positively about their work and were knowledgeable about the people they supported. They told us what was important to people, their likes and dislikes and the support they required.

Staff understood the importance of promoting equality and diversity, respecting people's cultural and religious beliefs, their personal preferences and choices. People were asked for information about any specific cultural or religious requirements as part of their pre- assessment. This information was available in people's care plans and staff had a good understanding of people's individual wishes.

People and their relatives consistently told us that they had been fully involved in the decisions about how their care and support would be provided. People were aware of their care plan and told us that they had been involved in discussions about how their care would be provided. One person said, "I have a care plan and I told them [registered manager] what should go in it." People had signed their care documentation to indicate their agreement with their care plan and consent to staff providing their support.

Staff understood the importance of respecting people's privacy and dignity when providing people's support. One member of staff said, "I always talk to people while I'm helping them, explain what I am going to do." We saw that staff interacted with people in a respectful manner and involved them in choices and decisions.

Confidential information regarding people's care was stored securely and only shared with people's consent on a need to know basis. Staff understood the importance of confidentiality and understood the

circumstances in which information could be shared.

People were supported to be as independent as they were able to be; staff encouraged each person to achieve as much as they could by themselves. One person told us how staff supported them with personal care, encouraging them to do as much as they could for themselves but providing help where needed.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not always detailed enough to provide clear instructions to staff on how to provide care to meet people's individual needs. Some people's care plans did not contain sufficient information regarding how staff should support them to maintain their health and wellbeing. One person told us that although they had been involved in discussions about their care plan, when they had read it before signing, they had realised that some information about their home environment was incorrect. They had asked the registered manager to amend this before they signed; they said, "I sat down with my [family member] and checked it all, I won't sign it until it's right."

We looked at the care plans of two people who had diabetes, their care plans did not provided staff with clear guidance on the support they required to manage this. Another person had a urinary catheter (A urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag). The person's care plan did not contain sufficient information to guide staff in the support they required. We discussed our concerns with the provider and registered manager, they understood the need to improve the accuracy and detail of information in people's care plans.

We reviewed the complaints log and saw that one complaint investigation had not been concluded nor the outcome provided within the timeframe stated in the provider's complaints policy. The provider was not able to give a suitable explanation for the complaint not being dealt with in line with their complaints policy.

People and their relatives said they knew who to speak to at the service if they had any complaints. One person said, "We know any problems we can ring [registered manager]." Another person said, "I'd speak to [registered manager], but at the moment it's ok, I have no complaints."

People and relatives, we spoke with said that when people's care was being planned they were fully involved. Support plans contained individualised information about how people wanted their support to be provided. For example, one person's care plan provided staff with guidance on how the person's personal hygiene routine could be used to support them to carry out exercises that would benefit their health and wellbeing. The registered manager carried out follow up reviews to make sure people were happy with the care they were receiving and to ensure that the service was meeting their needs.

People's support plans contained information about their history, values and beliefs, cultural needs and preferences and religious and spiritual needs. Staff knew this information and used this to deliver personalised care and support.

People told us that they received care and support that was personalised and responsive to their needs. One person said, "They [staff] always ask if there's anything else before they go, I never feel rushed. They sometimes put the bins out for us, we don't have to ask, they're very conscientious." Another person enjoyed sitting outside in the sunshine watching the world go by. We saw that staff supported them to apply their sun screen and ensured they had plenty of cold drinks so they could enjoy their time outside.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded bodies to ensure people with a disability or sensory loss can access and understand information they are given. The provider was able to access information regarding the service in different formats to meet people's needs, for example large print. We saw that people's care plans contained information about their communication needs.

At the time of the inspection, no people using the service were receiving end of life care. The service understood the importance of providing good end of life care to people and supported people to have conversations about their wishes for the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Improvements were required to the quality assurance systems in place to monitor the quality and safety of the service. The registered manager and the provider did not have the oversight of the service they needed to ensure that the service was of sufficient quality. For example, there was no consistent auditing of care documentation in place. If audits had been regularly undertaken, gaps in the information provided in people's care plans, health information, nutritional assessments and risk assessments would have been identified and could have been addressed.

The registered manager had carried out some audits to monitor quality and safety however, these were not always effective in identifying shortfalls and driving improvements. For example, medicines audits had not identified that improvements were required to medicines record keeping. We discussed the concerns identified during the inspection with the registered manager and provider, who recognised the need for a comprehensive system of governance.

Staff demonstrated their understanding of MCA and the need to ensure that people's care and support was provided in the least restrictive way. However, there was a lack of recorded MCA assessments and best interest decisions in place for people. The registered manager had not identified that the principles of the MCA had not been implemented appropriately; there was a risk that care would be provided to people that was not in their best interest.

The system in place for the management of complaints required improvement and had not resulted in a timely resolution to complaints. Although a complaints log was in place, the provider had not ensured that complaints were investigated and people provided with an outcome to their complaint in line with the provider's complaints policy.

This constitutes a breach of regulation 17(1): Good governance of the HSCA 2008 (Regulated Activities) Regulations 2014.

The culture and atmosphere of the service was open and friendly, which led to a transparent and supportive culture. People and their families were asked for their feedback through surveys and care reviews. We saw the findings of a recent survey that reflected that people were satisfied with the service. One person told us, "We filled in a questionnaire, we gave them one hundred percent." During the inspection, people and their relatives provided positive feedback about how the service was run. One person said, "I would give the service nine out of ten."

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (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.

The registered manager was available to people and staff and had a good awareness of all aspects of the

running of the service. One person said, "We want you to know, we are very happy. We can talk to [registered manager] about anything we need to." A member of staff told us, "[registered manager] is supportive, each new person we visit, [registered manager] comes to see us and we have everything explained to us."

Staff meetings took place, which covered a range of subjects. Staff told us that the meetings were helpful. One member of staff said, "We have a meeting every two months or so, we discuss the clients and our work." We saw minutes of meetings held, and these reflected open discussions about, people using the service, staffing rotas and training."

Staff demonstrated their knowledge and understanding around such things as whistleblowing, safeguarding, equalities, diversity and human rights. The supervision process and training programme in place for staff ensured that staff received the level of support they needed and kept their knowledge and skills up to date.

The service worked in partnership with other agencies when required. The registered manager had provided information as requested to support safeguarding investigations. The registered manager also shared information as appropriate with health care professionals involved in people's care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance processes in place required strengthening to ensure sufficient oversight and governance of the service. Improvements were required to records related to people's care needs, health needs and medicines.