Anaya Corporation LTD

Kare Plus Portsmouth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Kare Plus Portsmouth is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older and younger adults who may be living with a disability or sensory impairment. At the time of inspection, the service was delivering personal care to 48 people living in their own homes.

People's experience of using this service:
Insufficient improvement had been made since our last inspection. Medicines management remained unsafe. People's medication records did not always reflect that they were administered safely. It was not always clear that people received their medications as prescribed. Risk assessments continued to lack enough information to provide direction for staff, or information about how to reduce risks.

The registered manager had conducted some quality assurance audits to monitor the running of the service. However, these were not always effective, records did not always reflect these were used to monitor, assess and improve the quality of the service being delivered.

Despite this people's relatives told us they felt their family member was safe. There were some systems in place to protect people from the risk of abuse and potential harm. Staff were aware of their responsibility to report any concerns they had about people's safety and welfare.

People's relatives and staff knew the registered manager and felt able to speak to them if they had any concerns. The registered manager demonstrated a willingness to make improvements and had recently employed a staff member who would be responsible for carrying out monthly audits.
Rating at last inspection: The service was rated Requires Improvement at their last inspection. (Report published 7 November 2018)

Why we inspected: At our last inspection we found Kare Plus Portsmouth was in breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they had not ensured the safe management of medicines, risks for people had not been assessed and plans implemented to reduce these and governance was poor meaning issues of concern were not being identified. We served a warning notice to the provider requiring them to be compliant with Regulation 12 by the 25 January 2019 and issued a requirement notice for regulation 17. We carried out this focussed inspection to check whether Kare Plus had acted to meet the warning and requirement notices issued at the inspection in November 2018.

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

Follow up: We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and because this is the second consecutive time the service has been rated as requires

improvement we will request a clear action plan from the registered person on how they intend to achieve good by our next inspection. We may decide to meet with the provider following receipt of this plan. We will continue to monitor all information received about the service to understand any risks that may arise and to ensure the next inspection is scheduled accordingly.

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

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

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Kare Plus Portsmouth

Detailed findings

Background to this inspection

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

The focussed inspection took place to review the providers progress in relation to a warning notice that was issued following the last inspection which was published in November 2018.

This inspection focussed on Safe and Well-Led domains.

Inspection team:
This inspection was carried out by one inspector.

Service and service type: Kare Plus is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults and younger adults who may be living with a disability or sensory impairment. At the time of inspection, the service was delivering personal care to 48 people living in their own homes. Not everyone using Kare Plus Domiciliary Care Agency received a 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 consider any wider social care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the provider 24 hours' notice of the inspection site visit to ensure that the registered manager would be present, and to ensure people's consent was gained for us to contact them for their feedback.

What we did:
Prior to the inspection we reviewed any notifications we had received from the service. A notification is

information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

This inspection included speaking with two relatives, four members of staff, the registered manager and one professional. We attempted to speak to people however, many were unable to speak to us and some requested that we did not contact them. We requested contact details for more people from the registered manager however we did not receive this information. We reviewed records related to the care of five people. We reviewed recruitment files for two staff. We looked at records relating to the management of the service, policies and procedures, quality assurance documentation and complaints information.

We asked for further information following the inspection including the end of life policy and supervision policy and these were received. We also asked for information about bespoke training that staff had completed. We received an example book showing what additional training staff undertook however, the provider did not have a matrix identifying who had completed this additional training.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● At the last inspection published in November 2018 we identified that the registered person failed to do all that was reasonably practicable to mitigate risks. Risks to the health and safety of service users receiving care or treatment were not always assessed and monitored. We served a warning notice on the provider which required them to be compliant by 25 January 2019. Insufficient improvement had been made and we found the same concerns at this inspection and the provider remained in breach of this regulation.

● Risks to people had not always been assessed, monitored or mitigated effectively. Whilst a 'Personal Care Assessment and Delivery Plan' was in place, this was not always effective and lacked detail. It considered areas such as the environment, COSHH, continence care and skin care. However, the detail required to support people safely was lacking.

● The oversight of risk was poor, and the provider failed to identify individual risks to people. For example, one person was at risk of a potentially life-threatening condition, if not recognised and treated appropriately. There was no detail in the support plan to guide staff about the signs, symptoms and potential risks of this condition. The risk management plan provided insufficient guidance for staff as it only stated, 'Care workers are to report any concerns immediately to emergency services and to the office.' There was a generic information sheet which gave information about the condition. One staff member told us they understood this condition and said, "I know what to do if anything happens." However, when asked what the risks associated with this condition were, they told us, "Off the top of my head I am not too sure, I haven't been in there for some time." They did tell us they had a training booklet for this health condition. Despite asking the registered manager on two occasions to provide details of bespoke training that staff had completed this information was not received. We received an example book showing what additional training staff undertook however, the provider did not have a matrix identifying who had completed this additional training. This same person had a variety of health conditions which required support, for example, tracheostomy, muscle spasms, four hourly intermittent catheterisation, kidney stones, manual bowel evacuation and had a PEG fitted which was used for some nutrition and some medicines administration. A PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus. This person also used bedsides. Two staff members we spoke to told us they would look for risks to a person in their care plan. The care plan told us this person had these conditions however, they lacked detail and there was not always a risk assessment in place in relation to them. This meant staff did not have enough information to minimise risks for this person.

● Another person lived with bowel cancer, asthma and allergies to some medicines however the 'Care Assessment and Support plan' lacked detail and there was not always a risk assessment available to guide staff on what to look for and when to act.

● There was not enough information to guide staff members when delivering support to people, including how to reduce identified risks. This meant that the risks to the health and safety of people had not been

assessed or mitigated.
● One person was supported with their catheter bag. There was no information in the care and support plan to guide staff on how to do this. The same person was supported with transferring using a sliding board. This person's care and support plan also stated, 'Please offer me reassurance and encouragement because I have been known to fall.' There was no risk assessment or plan to reduce the risk in relation to falls. This meant that the risks to the health and safety of people had not been assessed or mitigated.
● We spoke to the registered manager about this who told that it was "disappointing" that we were finding different concerns than were raised at the last inspection. However, the concerns found at this inspection were regarding the assessment and management of risk, as found at the previous inspection.
● There was a failure do all that was reasonably practicable to mitigate risks for people. Risks to the health and safety of service users of receiving the care or treatment were not always assessed and monitored.

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

Using medicines safely
● At the last inspection we identified that, 'how and when people's medicines needed to be administered' was not always clear and that people's records did not always reflect how the service was meeting people's specific health conditions and managing risks that this might present with. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this focussed inspection we found that although medicines errors had improved further improvement was needed and this remained a breach.
● Some people were supported with their medicines by care staff. Care plans did not give enough information for staff to be able them to understand what support would be required. For example, one person's care plan stated, 'Nifedipine, in cupboard in emergency bag. This is to be taken with autonomic dysreflexia. Follow guidance in MAR chart and from medication training.' However, there was no medication called Nifedipine on their MAR chart. There was no PRN protocol in place in relation to this 'as required' (PRN) medication. This meant guidance to support staff in the management of a potentially life-threatening situation was either inaccurate or not available. The registered manager told us they would look into this and have it added back onto the MAR chart, they said when a PRN medication has not been requested for some time it can get removed from the MAR chart. This had not been picked up on medicine audits.
● People's MAR charts had been returned to the office for auditing or review however, this was only checked monthly. There were gaps in people's MAR charts where medicine had either not been given or had not been signed.
● Where errors were noted this had been addressed with staff however, this could be as late as four weeks after the omission had occurred. One person had been prescribed antibiotics three times a day there were two gaps on this MAR chart where it should have been signed as being administered but hadn't been. The daily notes identify that the two gaps for the morning medication were administered at 1105 on the both days. However, there are no times recorded on the Kare Plus designed MAR charts. The MAR charts identify administration times as, 'Morn, Lunch, Tea and Bed.' This meant that people were at risk of either not receiving their medicines as prescribed or being re-administered medicines that had already been received if staff followed the MAR chart before reading the daily support notes. The medicines audit for this person for the month of March 2019 stated, 'No Errors', meaning this had been ineffective in identifying and addressing concerns.

A failure to have the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All staff had received current and up to date medication administration training and were reassessed when medicine errors were made. Medicines errors were reduced since the last inspection however medicines were still not managed effectively.

Learning lessons when things go wrong

● The registered manager told us about a system that they had put in place in response to an incident. This helped to reduce the risk of it happening again. The registered manager told us they discussed shared learning at meetings and shared learning via emails to staff. However, learning was not always identified, and documents had not always been robustly updated.

Systems and processes to safeguard people from the risk of abuse

● At the last inspection we saw the service had procedures in place to minimise the potential risk of abuse or unsafe care. Staff understood their responsibility to report any concerns they may observe to keep people safe. Staff felt confident that if they reported a safeguarding concern to the registered manager that they would act on it. At this inspection we found effective processes continued to be in place.

Staffing and recruitment

● At the last inspection we saw that safe recruitment practices were in place. At this inspection we found that safe recruitment practices continued to be followed and the provider employed enough staff to meet people's needs.

Preventing and controlling infection

● Suitable measures continued to be in place to prevent and control infection. Personal protective equipment (PPE) was available to staff, including gloves, aprons and alcogel.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At our previous inspection published November 2018 we found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they did not have effective quality assurance processes in place. At this inspection we did not find enough improvement had been made and the provider remained in breach of this regulation.
- Although there were some quality assurance processes in place these were found to be ineffective and did not pick up on the issues identified during this inspection.
- Audits were completed in relation to care plans, daily logs and medicines. These audits were not clear, and the action plan was basic. For example, a 'customer file quality audit' took place on 8 January 2019 for 11 people. This identified several areas requiring improvement. The action plan for one-person stated, 'annual update to be completed' however, there was no date for completion and it did not specify who was responsible for the update. There was no update to identify if this action had been taken or not. Another person's action plan simply stated, 'New client, new care plan' and a further person's action plan stated, 'No updates recorded.' The same applied to two other people's records. Although an audit had taken place there was no evidence that a detailed action plan had been completed and the actions carried out. This meant that the staff were at risk of working with information that was out of date and people may be at risk.
- Whilst some governance was in place (for example house visits and service user feedback), the oversight of the provider was poor. The lack of oversight meant that concerns with records and risk management had not been identified. The registered manager expressed disappointment at the findings and said work would start on improving this going forward.
- Medicine audits were unclear and did not detail what was being checked. For example, there was no detail about the type of error or actions taken when the same member of staff repeated an error within two weeks of it occurring. Several staff had made errors on more than one occasion and this had not been identified on the audit.
- We spoke to the registered manager about these errors and she told us that these were mostly staff not signing the MAR chart however medicines had been given. They had identified this by reading the daily support notes. The lack of clarity on the medicine's audits meant that it was not possible to identify trends in different types of error or confirm that people were receiving their medicines in line with their prescription.
- There was a failure to maintain accurate and fit for purpose care records. These included missing or incomplete, care plans and risk assessments that were not detailed. There was a risk that if accurate and contemporaneous records were not put in place, this could negatively impact on people's

health, safety and well-being.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager advised us they had recruited a staff member who will be responsible for conducting audits on records, and thereafter this will take place monthly.
● We found that the registered manager, senior staff and care staff continued to have clear lines of responsibility and were knowledgeable about their roles.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager told us they complete a yearly family survey. They told us, "The responses come to me, I go through them to see if there are any trends." However, family members were not always aware that there had been a survey. For example, one relative, when we asked if they had been involved in a feedback survey or had had a questionnaire to complete about the service, told us, "No, I haven't heard of it, no I don't think so, no." The registered manager told us, "We haven't shared feedback."
● People's relatives told us they were involved in decisions. One relative told us, "They always do what [person] wants always" and another relative told us, "Everyone is very helpful and very pleasant."
● The service worked in partnership with other organisations to support care provision and service development.
● Staff told us they felt listened to and could influence change within the service. Team meetings were held, and the minutes demonstrated meetings were used in part to share ideas and suggestions on how the service could be improved.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
● People and their families were involved in developing their care plans. One relative told us, "It appears to be run well it works for us, the staff that come, if there is anything I ask them to do they are more than capable and more than willing to help."
● Records demonstrated that when staff performance fell below standards action was taken to address shortfalls and support the staff member to develop and improve their performance.
● The registered manager had a good understanding of the duty of candour. This is where we ask providers to be open, honest and transparent about their service. When incidents had occurred, which caused harm to people, the registered manager had reported these to appropriate health and social care professionals. The service's previous inspection rating was on display in the office for visitors to read. The previous report was also on the provider's website.

Working in partnership with others
● At the last inspection published in November 2018 we found the provider worked with other health and social care professionals in line with people's specific needs. This enabled the staff to keep up to date with best practice, current guidance and legislation. At this inspection we found the provider continued to work effectively with other health and social care professionals.

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 There was a failure do all that was reasonably practicable to mitigate risks for people. Risks to the health and safety of service users of receiving the care or treatment were not always assessed and monitored. There was a failure to have the proper and safe management of medicines.

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of the service and to send a report to the Commission monthly.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records.

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of the service and to send a report to the Commission monthly.