NDH Care Ltd

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Inspection report

Keys Court
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Birmingham
Tel: 0787725301
Website: No website at this time.

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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

Overall summary

This inspection took place on 14 and 21 January 2016. We gave the registered manager 48 hours notice of our visit, to ensure that office staff and records could be made available, to enable staff that provide care to people in their home could be made available to speak with us, and for us to make arrangements to speak with people using the service and their relatives.

This was the first time we had inspected NDH. The agency registered with us in August 2015, but we were informed the service had only been fully operational and delivering care for three months.

NDH provides care and support to 18 people living in their own homes. At the time of our inspection most of the people needing support did so because of needs relating to their older age, or mental ill health.

There was a registered manager in post who was present for the inspection. 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.

Summary of findings

People were not always safe. People that required full support to manage their medicines had not all been supported by staff with the appropriate skills or knowledge. Records of medicine management were not always adequate to provide evidence people had their prescribed medicines at the correct time.

Staff were supported by a consistent team of staff who they liked. Systems to reduce the chance of missed calls were not entirely effective, and left people at risk of having their care needs unmet.

Staff were aware of the types of abuse people receiving care at home could experience. Staff had been provided with training to ensure they would recognise this and be able to report it.

Staff recruitment checks had been robust. New staff had received induction, training and support to ensure they were confident to meet people's needs. Staff had been provided with a variety of basic awareness training courses which promoted safe working practices.

People were supported to maintain good health. Staff were aware of people's specific needs and the support they required. Changes in people's needs had been identified and action taken to ensure the person received the additional support they required and that their care plan was reviewed.

Staff were aware of how to promote people's independence and choices. People's rights to refuse care and treatment were not overridden.

People told us they were happy with the support they received to prepare food and drinks.

People were supported by staff that showed kindness and compassion, and worked to uphold people's privacy and dignity.

The registered manager was keen to improve the service and take action in response to people's feedback. There was a complaints procedure in place. Complaint investiagtions had not always been effective at fully resolving the concerns or making the changes required to reduce the likelihood of a re-occurance.

Our inspection identified that the agency was still in the process of developing and was not yet fully established. The inspection identified that while some people received good care that met their needs, this was not consistently the experience of every person using the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People could not be confident that they would always receive their medicines safely or that adequate records would be maintained.

Systems to ensure there were always staff available to support people were not completely robust, and occasions had occurred when calls had been missed.

Most people told us they felt safe. People were supported by staff who knew them and knew how to support them safely.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff had limited knowledge about the Mental Capacity Act 2005, and were able to describe ways they promoted people's rights and independence.

Staff had received an induction, training and on-going supervision. Staff mainly had the skills required to support people, and further training was planned.

People told us they were pleased with the support offered to them with eating and drinking and staying healthy.

Requires improvement

Is the service caring?
The service was caring.

People received support from staff that cared about them, and who demonstrated kindness and compassion.

Good

Is the service responsive?
The service was not consistently responsive.

Complaints investigations had not always been robust and people had not always been satisfied with the outcome.

Staff were aware of people's individual needs and preferences, and described how they worked to promote these.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Systems and processes were not all fully developed. Mechanisms for checking quality and safety required further development to ensure people consistently experienced a good service.

Requires improvement

Summary of findings

The registered manager was keen to receive feedback, and to take action to develop and improve the service.	

NDH Care Ltd

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 14 and 21 January and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to give notice to ensure arrangements could be made for us to speak with office staff, care staff and people that use the service.

The inspection was undertaken by one inspector. As part of planning for the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We reviewed the information we had to plan the areas we wanted to focus our inspection on. We also contacted the local authority who commission services from the provider for their views of the service.

While at the agency office we spoke with eight members of staff. We looked at the care and medicine records for three people. We checked three staff files to ensure staff had been recruited using robust processes. We looked at the systems the registered manager had developed to provide assurance that the service was safe and meeting people's needs and wishes. After the office visit we contacted all of the people using the service and their relatives. We spoke at length with five people and thirteen of their relatives.

Requires improvement

Is the service safe?

Our findings

All of the people receiving care from NDH staff told us they felt safe, and many expressed feeling particularly secure and comfortable with the staff member that provided the majority of their care. People told us, "I have a really good carer. She does whatever she can to help me, and I never feel concerned or afraid" and, "I have the confidence with my carer to push myself and build back up my confidence and skills." The majority of relatives we spoke with also told us they felt people were safe. Their comments included, "We have a particularly good carer who has genuine concern for my mum" and, "The staff who comes to us is nicely protective and concerned about my mother." Other relatives we spoke with gave examples of concerns they had, that did not give them confidence that their relative was safe. Their comments included, "I don't feel my relative is safe at all. I have concerns about: the care, if the carer stays the right time, her medicines, and what she has to eat and drink. I know that not all the records are correct. They do not always use the key safe properly. I'm not confident at all that she is safe." We raised these issues with the registered manager to ensure urgent action was taken to improve upon this situation.

Staff we spoke with described the support they provided to people to administer their medicines. Some people required staff to prompt or remind them to do this. We found that staff knowledge, staff training and the records were adequate for providing this level of support. Some other staff were fully responsible for administering medicines. Their training and the records of medicine administration were not adequate to show this level of support was being undertaken well, or by staff with the required skills and knowledge. Failing to safely manage and accurately record the medicines administered is a breach of the Health and Social Care Act 2014. Regulation 12.

In December 2015 we received information informing us that staff had not all been subject to robust recruitment checks. We spoke with the registered manager who explained the action he had already taken to improve upon this situation. We looked at the records for three members of staff. Each of their files showed checks had been made to ensure they were suitable to work in Adult Social Care. We asked staff about their recruitment process and they confirmed that an interview and recruitment checks were made before they were offered a position. The manager explained that checks had been made but that records to show this had not been available to local authority staff when they had visited in December 2015. The registered manager was aware of the requirements relating to recruitment and was able to provide evidence that new staff currently being recruited were subject to full and robust checks before being offered work. Records were available to show this.

The agency had an electronic programme that they used to support them in planning calls and allocating staff to people. We found that for the majority of the time this worked well. People reported pleasure that they had consistent carers and that they were usually informed of any changes in advance. Positive feedback from people included, "I have had no missed calls, and she phones if she is going to be late" and, "She has never been late. She couldn't come once and we had someone else. It was fine. They called us." Other people told us that they had experienced missed calls. Their feedback included, "Yes, I have had one missed call. I didn't know about it and no one else came. I muddled through" and, "The girl is very good. She couldn't come recently, she did tell me the day before, but no one else came." Looking at records completed by the agency, we found evidence of a further two missed calls. We looked at the systems in place that would alert the manager to a potential missed call. We found shortfalls within the systems and evidence that effective communication had not always taken place. The manager had already identified some of these issues and had taken action to improve upon this. Action was commenced during our inspection in response to our findings to further improve upon the situation.

We spoke with eight members of staff who were all able to describe the types of abuse people receiving care in their own home may experience, and the action they would take should they witness or suspect this had happened. Training records showed that staff had received basic awareness training about adult abuse and information was on display in the office reminding staff of the action to take and who to contact if they needed this. The manager had reported potential abuse to the local authority as is required. We looked at the action taken by the manager in response to one allegation of abuse. Records and a discussion with the manager identified that an appropriate investigation into these concerns had taken place.

Requires improvement

Is the service safe?

Staff we spoke with were able to describe the action they took to help maintain people's safety. Staff described how when working in people's homes they would check for new or emerging risks within the home such as problems with appliances or flooring. Staff described how they observed people for changes in their needs or conditions that may indicate further support was needed or that a change to their plan of care was required to help the person stay safe.

Requires improvement

Is the service effective?

Our findings

In December 2015 we received information that alerted us that staff may not all have the skills and experience required to provide care and support to people safely. We asked the manager about this, and were informed that not all staff had received an adequate induction or training before starting work, and training had subsequently been delivered to address this. Staff we spoke with told us they had attended a three day course to achieve the 'Care Certificate.' This is a basic induction programme that newly appointed staff must undertake to ensure they are aware of how to provide safe and compassionate care. The registered manager was able to demonstrate that other basic, awareness training had been delivered, and describe his plans for further development and training of the staff team.

We spoke with staff about their induction. They described that they had been supported by a senior carer to get to know a person prior to taking responsibility for their care. They told us, "I did some shadow shifts. This made me feel a safe carer and meant I went out the first time feeling good. This was good for the people I support" and, "When I went out alone, I felt confident." The majority of relatives we spoke with told us they were pleased with the carers ability to meet the needs of their relatives. Comments included, "I didn't know she was new until she told me. She gave the impression of being very experienced" and,"Mum has Alzheimers, she is not always easy or co-operative. The staff have developed ways to meet her preferences and she responds well to that. It is a delight now to see her clean, fresh and smartly dressed." When relatives expressed concerns about the ability of staff to meet people's care needs we looked at this further. We found that while staff had sought advice and were receptive to development and learning new skills, the staff were not all suitably skilled at the time of the inspection. The registered manager agreed to take action to improve upon this and to liase with the people involved.

Some people's care needs included receiving help to prepare and eat a meal. People we spoke with told us they were pleased with the support they received and their comments included, "She helps me prepare a meal in the evening. She comes in and says, 'Shall I give you a hand? What would you like me to do?' I couldn't wish for a nicer girl" and, "She sets the meal out really nicely." Some relatives explained that when the care had started, staff had not always made food that people enjoyed, or staff had wasted food products. Everyone reported that over time this had improved. Two relatives told us that their relative had gained weight. This was a planned goal of them receiving care and support.

Staff we spoke with were able to describe the actions they took to ensure people stayed healthy. One member of staff was able to describe the needs relating to a person living with diabetes. They were aware of the signs to look out for that may indicate the person's condition was changing. Another member of staff explained the action they had taken to maintain good catheter care. All the staff were able to describe how they met the needs of people who could be confused. Many of the relatives we spoke with described how staff had contacted them to alert them to a change in the person's health, which had enabled them to access further medical help. One relative told us, "Every day staff come in and wash him, cream him and make sure he is comfortable. It is very good."

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.We checked whether the service was working within the principles of the MCA.

The knowledge of the manager and staff about the Act was very limited, and was identified as an area requiring further development. However all staff were aware of the needs to seek people's consent before providing care, and shared examples of how they did this. Staff told us, I usually say, " Can I help you?" or "What you would like me to do for you?" Another staff explained that she tried to let the person guide her. This meant people's rights to refuse care and treatment were not overridden. The registered manager was working co-operatively with other health professionals when changes or concerns were noted regarding people's mental well-being.

Care documents we viewed contained 'consent forms' that had been signed by a relative of the person receiving the

Requires improvement

Is the service effective?

service. The registered manager was unable to explain why they had done this. There was no evidence to support that the relative had authority to sign for the person, or that the person lacked capacity to do this for themselves. The registered manager agreed to seek advice regarding this, and make any necessary changes to their practice.

Good

Is the service caring?

Our findings

People consistently told us they were pleased with the way they were supported by staff. Comments included, "I have a very good carer. She does what ever she can for me. A really nice girl" and, "She is amazing, we never want her to leave." Relatives we spoke with told us, "[name of staff] is really lovely with my parents. She has worked out how they tick" and, "She has a lovely way with him. Chats to him all the time. He looks forward to her coming, he's got used to her." Relatives who had raised concerns with us about some aspects of the care being delivered praised the relationships that had been built up between people and staff over time.

The staff we met spoke with compassion and enthusiasm about the people they supported. Comments from staff included, "Every day I am getting to know the people a bit better. This improves their care" and," Slowly I am building up trust with the people I go to. Then it stops being a job and starts being great." One member of staff explained that a person she supported often needed more time than she had been allocated by the social worker. The member of staff told us that she had explained this to the registered manager and had been told, "Do your job properly, don't rush her. Take as long as she needs." The registered manager had raised the need to review the length of the person's call with their social worker.

Staff described the ways they were helping people to be as independent as possible. Their comments included, "I support and reassure people to do as much for themselves as they can." Care plans we viewed prompted staff to look for ways to help people maintain and re-develop their independence.

Staff we spoke with were able to describe ways they maintained people's privacy and dignity. This included being mindful when people had to use temporary bedroom or bathroom facilities for example when they were unable to manage the stairs. Staff described how they closed doors or curtains to protect people's dignity from other people in their home, or from being seen through ground floor windows for example.

Requires improvement

Is the service responsive?

Our findings

Our inspection identified that NDH was a new and developing service. We had been made aware of some serious shortfalls by the Local Authority in December 2015, and further shortfalls that people had experienced were explained to us when we spoke with people using the service and their relatives.

The majority of people described the positive action taken by the registered manager and agency staff in response to their concerns and were able to confirm that in the past four to six weeks things had improved. Comments included, “We did have problems at the beginning-it has improved now. I would go as far as to say I am very happy” and ,”Initally we did have concerns. A few difficult things to sort out. Now we have one main carer, my mum really likes her. She will text or call if there are any difficulties. I feel they responded well to my concerns.” Some relatives described still feeling concerned and frustrated that their issues had not been acted upon. One relative shared with us the way they had communicated with senior agency staff about the shortfalls in their relatives care. They had not received call backs at the agreed times and changes had not been made as expected. We spoke with the registered manager about this. He was realistic about the issues that people had experienced, and the action they had taken to try and improve upon this. The registered manager explained the further action he would take in response to the specific feedback we shared with him.

There was a procedure by which people could raise complaints. Three complaints had been received since the agency had started providing care. While a senior member of staff had looked at each of the issues raised their investigation was not robust or wide reaching. It had failed to pick up some of the issues surrounding the exact matter of complaint. The action taken in response to the complaint was then not always adequate to fully resolve the concerns or make the level of change necessary to prevent a re-occurance.

All the feedback we received from people and their relatives provided evidence that the care people received was very individual to them. We saw that care plans were tailored to each person, and detailed people’s preferences, religion and culture. Information about each person and the needs they had was gathered during an assessment before care was delivered. We saw the information had been developed and updated as people’s needs changed or staff got to know people better. At the time of our inspection the care staff team were all female. The registered manager explained that he had current care qualifications and skills and had provided care himself, if a person had requested or required a male member of staff.

Requires improvement

Is the service well-led?

Our findings

NDH care registered with CQC in August 2015. The registered manager told us that they did not start providing care until October 2015. Our inspection identified that the agency was still in the process of developing and systems and processes were not yet fully established. The inspection identified that while some people received good care that met their needs, this was not consistently the experience of every person using the service. The registered manager had been successful at recruiting some care staff that were particularly skilled and some of the relatives we spoke with felt the success of their relatives package of care was down to the tenacity and commitment of individual staff and not always attributable to the planning and delivery of the service. Comments included, "Our particular carer has been over and above. The admin people are okay but they do what needs doing and nothing more."

The registered manager had developed and implemented some systems to check on the safety and quality of the service. The inspection identified that these were limited and not yet fully established. This had resulted in people not always receiving the care or support they required. Failing to have systems and processes in place that are established and effective is a breach of regulation 17 of the Health and Social Care Act 2008. Regulation 17.

The registered manager was open to the feedback we shared and demonstrated a desire to improve the service. It was positive that significant action had already been taken in response to concerns identified in December 2015, and that during the inspection action was taken in response to feedback as it was shared. One member of staff told us, "One good thing about [the registered manager] is that as soon as he knows something is going wrong, he takes action to sort it out and fix it." A relative we spoke with told us, "Any little things are dealt with straight away. The senior care staff came out the same day and now the issue is fully resolved."

Staff we spoke with told us the registered manager was supportive and that they were able to raise any concerns about their supervisors or the care of people and this would be addressed. Staff knew about the whistle-blowing process and felt confident to use this to keep people safe knowing that they would not face any repercussions. One member of staff told us, "The manager has an open door, he works in an open way. I would be happy to whistle blow here. To be honest he would want to know and do something about it."

Staff told us they had regular supervisions. Staff had been visited during care calls to ensure they arrived at the expected time, stayed for the full duration of the call and that the person was satisfied with the care given. Staff told us they felt supported and could ask for help. Their comments included, "The senior is easy to deal with, she is experienced. She will call you back quickly and help you with any problems."

The registered manager was aware of their responsibilities to notify the local safeguarding authority of concerns about people's safety and we saw evidence that this had been done. They are required to send these notifications by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The management of medicines was not always adequate. Records did not provide evidence that people had received the prescribed medicines at the correct time, or that it was administered by staff with the necessary qualifications.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were inadequate systems in place to monitor the safety and quality of the service.