

Nestor Primecare Services Limited

Thomas Place

Inspection report

Thomas Place
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Date of inspection visit:
05 September 2018
06 September 2018
07 September 2018

Date of publication:
17 October 2018

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

The inspection took place on the 5, 6 and 7 September 2018 and was announced.

Thomas Place provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Not everyone using Thomas Place 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. At the time of the inspection, there were 25 people receiving the regulated activity.

This was the first inspection of the service since their registration with the CQC on 14 November 2017, following a change in provider. The service's office was based at the site of the extra care unit.

There was no registered manager working at the service. 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 and associated Regulations about how the service is run. We were supported during the inspection by the care delivery director and the field care supervisor. The provider had employed a manager who had started working at the service in June 2018. At the time of our inspection, they had not started the process of applying to be the registered manager with the Care Quality Commission. The provider was in breach of their registration by not having a registered manager in post.

People told us they felt safe living at Thomas Place. People were protected from the risk of abuse, staff had received training and were knowledgeable about what to do in the event of a safeguarding concern being raised. The manager had notified the local authority of safeguarding concerns but they had failed to submit notification to CQC.

On the day of the inspection, we observed and people we spoke with told us there were sufficient numbers of staff deployed to support them. However, following the inspection, we received mixed feedback from people and key professionals involved with the service. People told us staff were often rushing and they did not always know who was coming to provide them with support. Key professionals told us people often reported late calls.

We have made a recommendation about this in the report.

Staff knew and understood their roles and responsibilities. Staff had received training relevant to their roles

and received regular updates. Staff were supported through planned one to one supervisions to discuss their training and development. Staff meetings gave staff the opportunity to voice their opinions. The provider's policies and systems promoted safe recruitment practices.

Where required, people were supported to manage and take their medicines as prescribed. Staff received training in medicines administration and had access to the provider's policy for further guidance. Competency checks were routinely carried out by senior staff.

People's needs were assessed before they started using the service and support plans were person centred.

Risks to people were assessed, monitored and were reviewed regularly or when people's needs changed. People were involved in decisions about any risks they may take.

People were treated with kindness, respect and compassion. Staff respected people's privacy when supporting them.

People were supported to maintain good health and were referred to healthcare professionals when this was required.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. The service worked with external professionals, such as district nurses, GPs, occupational therapists and speech and language therapists as and when needed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People who used the service and their relatives were aware of how to make a complaint. Complaints were recorded, investigated and responded to in line with the provider's policy.

People, relatives and staff were consulted about the quality of the service. People told us management and staff were helpful and approachable.

People were protected by the prevention and control of infection; staff had access to personal protective equipment and completed food hygiene training.

There were quality assurance systems in place, which were used to promote continuous improvement. Accidents and incidents were reported and analysed to identify any patterns or trends to help reduce the likelihood of the incident or accident happening again.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of section 33 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version 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.

We observed sufficient numbers of staff were available to support people on the day of the inspection, however, people fed back to us that they often felt rushed and did not always know who was coming to support them.

People were supported with their medicine as prescribed. Staff had received training and guidance and their competency had been assessed by senior staff.

Risks to people had been assessed and there was guidance for staff to follow to keep people safe.

The provider followed safe recruitment practices.

Staff knew signs of abuse and had received training to ensure people were protected from harm.

Is the service effective?

Good 

The service was effective.

Senior staff conducted assessment of people's needs prior to the start of the service, which helped inform the planning of their care and support.

Staff worked within the principles of the Mental Capacity Act 2005.

People were supported by staff who were clear on their role and responsibilities. Staff received support through induction, supervision and appraisal.

People were supported to access healthcare services where needed, and to maintain a balanced diet where this was part of their assessed needs.

Is the service caring?

Good 

The service was caring.

Staff were kind and caring and treated people with respect.

Staff were knowledgeable about people they were supporting and aware of their personal preferences.

Staff encouraged people to maintain their independence as much as possible.

People were supported to express their views and were encouraged to participate in the decision-making process about their care and support.

Is the service responsive?

Good ●

The service was responsive.

Support plans were personalised and reflected people's physical, mental, emotional and social needs.

People were involved in the planning of their care and support.

The provider had a complaints policy and procedure in place. People told us they knew how to raise a complaint and were confident that any issues they raise would be addressed.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

The provider had not registered the manager with CQC.

The provider had failed to notify CQC of events and incidents.

The provider had systems in place to seek feedback from the people using the service and their relatives in order to help identify areas for improvement.

The provider had systems in place for monitoring the quality and safety of the service.

Staff had meetings to communicate and share updates or changes to people's care needs.

Thomas Place

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 comprehensive inspection took place on 5, 6 and 7 September 2018 and was announced. We gave the service short notice of our inspection to ensure that people using the service could decide if they wished to receive a visit or a telephone call from us and to ensure we had the correct contact details for people and their relatives.

The inspection was carried out by one inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Inspection site visit activity started on 5 September and ended on 7 September 2018. On 5 September, we visited the office to review the documents associated with the running of the service and we visited people that used the service. On the 6 and 7 September, we made telephone calls to people, their relatives and external health and social care representatives to gain their feedback on the service.

Before the inspection took place, we looked at information we held about the service including registration information and statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law. On this occasion we did not ask the provider to send us a provider information return (PIR). This is information we ask providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information with us that they felt was relevant, during and following the inspection process.

During our inspection we spoke with the care delivery director, field care supervisor and three care staff. We spoke with eight people who used the service and three relatives. We looked at a range of documents and written records including three people's care records, three staff recruitment records and information relating to staff training and the auditing and monitoring of service provision.

Following our inspection, we spoke with the manager of the service via telephone and we gathered further feedback about the service from health and social care professionals who worked closely with the service.

Is the service safe?

Our findings

People told us they felt safe living at Thomas Place. One person said, "I feel safe living here. I trust the staff." Another person told us, "It is a safe place to live. They can see who is coming in and going out. People have to buzz to come in the building during night time."

The service had policies and procedures in place for safeguarding adults. Staff had access to the local authority safeguarding policy, protocol and procedure. Staff received training in safeguarding which was delivered as part of the provider's induction. This helped staff improve and update their knowledge and skills in protecting people from harm and abuse. People and staff were confident that the manager would listen to them and act on any concerns they raised. When we spoke with staff they were clear about their safeguarding responsibilities and how they could raise concerns. They told us what actions they would take if they suspected abuse. One staff said, "If I have any concerns I know I can speak to the manager or contact the local authority." Staff were also familiar with whistleblowing procedures and were confident in its use.

People we spoke with stated they knew who to speak with if they had any concerns. Where concerns were raised about people's safety or potential abuse, the service was aware of the need to report concerns to the local authority but they failed to report this to the Care Quality Commission. We discussed this with the care delivery director on the day of the inspection and they confirmed they will discuss with the manager and senior staff at the service so future notifications are sent to CQC without delay.

Failure to notify CQC of these events is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

On the day of the inspection, we observed and people told us that staffing levels were sufficient to meet their needs and to support them safely. However, following our inspection we contacted people and key professionals involved with the service and we received mixed feedback from them. Three out of eight people told us they were unhappy with the frequent lateness and lack of communication related to this. One person said, "They are rushing about; that's what I don't like." Although they went on to say, "They answer calls straight away. They come up within a couple of minutes." Another person said, "This morning I did not get my call until 9am and this is too late for me. I did not know who was coming and I like to know who is coming to support me." Key professionals involved with the service told us, "Calls are very late or being missed and are not for the correct length of time." Other comments included, "People always come to us and report 'missed calls'. We always then direct this immediately to Allied healthcare staff via their branch office" and, "Staff are often very pushed for time with too many calls to do."

We brought these concerns to the attention of the provider and at the time of writing this report, they confirmed that where calls were late, due to high levels of staff absence during peak holiday periods, these were within 30 minutes of the scheduled calls and they were actively recruiting to ensure sufficient staffing levels at all times.

Comments from other people included, "I get all the support and care I need. I know who is coming and they

let me know if they are running late" and "I have lived here for few years, I don't have any problems. I am happy here." Staff we spoke with did not raise any concerns regarding staffing levels. One staff told us, "It is a busy environment however, I give each person the time they need and I make sure I chat with people."

We recommend that the provider seek guidance from a reputable source in relation to reviewing staffing levels to ensure staff are deployed effectively and to improve communication about changes in order to meet people's needs.

There were safe recruitment procedures in place which enabled the provider to check the suitability of staff to support people. The provider carried out a range of pre-employment checks before confirming staff employment. This included Disclosure and Barring Service [DBS] checks. The DBS restrict people from working with vulnerable groups where they may present a risk and provide employers with criminal history information. Applicants had completed an application process, which included completing an application form and attending an interview. Other pre-employment checks included requesting references from previous employers and exploring any gaps in employment.

People were supported in accordance with their risk management plans. Risk assessments were specific to each person and had been reviewed to ensure they held up to date information. The risk assessments promoted and protected people's safety in a positive way. People were involved in decisions about risks, for example, moving and handling, managing their medicines and daily routines. Risk assessments were reviewed and updated following a change in people's needs. For example, a person who had a fall; they had their risk assessment reviewed in line with advice from healthcare professionals and this was discussed with staff on how to best meet their needs going forward. Guidance was provided to staff on how to manage identified risks, and this ensured staff had all the guidance they needed to help people to remain safe, without restricting their freedom.

People were protected against the risk of infection by the prevention and control of infection hazards. Staff completed health and safety, food hygiene and infection control training. Staff had access to personal protective equipment (PPE) and we saw that staff used this as needed. Staff understood the importance of reporting outbreaks of flu and vomiting to the manager, so they could cover their work to prevent the spread of infection.

There were systems in place to manage medicines. Staff had access to training, including refresher training in managing and administering medicines to ensure people received their medicines as prescribed. People told us they received their medicines at the appropriate times and how they preferred. For example, one person told us they prefer to take their medicines with a glass of milk, which staff always give to them. People told us staff routinely asked them if they needed any pain relief medicines.

Medicines were checked daily by staff and audited monthly by the management team. Medicines were also spot checked by senior staff as part of the provider's quality assurance system. Medicine administration records [MAR] records were completed accurately. There were body maps in place for staff to record topical medicine administration. The care delivery manager told us and records showed that any medicine errors were investigated to identify areas for improvement and to learn lessons. Where identified, staff were required to attend further training and subjected to competency checks to ensure they were fully trained and supported.

Lessons were learnt when things went wrong in the service. Accidents and incidents had been recorded and investigated appropriately by the manager. Actions taken were also recorded, for example, any referrals made to external healthcare professionals. Senior management had oversight of all accidents and incidents

which occurred in the service. The manager monitored and analysed the accident and incident records to identify trends, triggers and common themes. This helped preventing any risk of re-occurrence. Lessons learnt were shared with staff in supervisions and staff meetings. Where appropriate, learning was also shared with people.

The service had plans in place for a foreseeable emergency. This provided staff with details of the action to take if the delivery of care was affected or people were put at risk. People had individualised personal evacuation plans (PEEPs) to enable them to safely exit the building in the event of an emergency. The housing provider was responsible for maintaining the fire safety of the building and people's flats. The service worked with the housing provider to ensure essential checks, such as emergency lighting, fire alarm and fire-fighting equipment, were undertaken regularly. Staff were trained in fire procedures as part of their induction and had access to refresher courses. This helped ensure they kept their knowledge and skills updated.

Is the service effective?

Our findings

People told us they received care and support from staff who were competent, skilled and knowledgeable. One person said, "The staff are very good, they know what they are doing." Another person told us, "I trust all the staff, they know their job. I don't need to tell them what to do." A relative told us, "The staff are good here. You can't fault them."

The provider undertook an initial assessment with people before they started providing a service. The assessment checked the care and support needs of each person so the manager could make sure they had the required levels of staffing and skills required to care for the person appropriately. People, their relatives and representatives were involved in the assessment process to make sure the manager had all the information they needed.

The initial assessment led to the development of the support plan. Individual support plans were detailed, setting out guidance to staff on how to support people in their preferred way. Staff had detailed information within the support plan to support people well. One member of staff said, "The support plan is detailed and we can access these anytime we need. We are kept informed of any changes." Support plans covered aspects of people's daily routines, care and support needs. This included people's background information, cultural needs, religion, marital status and sexuality.

Where people required support with nutrition and hydration this was detailed in their support plan, for example, whether people needed prompts or full assistance with preparing their meal. People were complimentary on the support they received from staff. One person said, "They help with all my meals, including breakfast. They do it nicely." Another person told us, "They always make me a nice cup of tea when they come. They made sure I had plenty of drinks when it was very hot." Staff were aware of people's individual dietary needs and their likes and dislikes. They worked with and followed guidance from external health care professionals where this was required. For example, one person received input from speech and language therapist [SALT] as they were at risk of choking. Staff were clear on how to support the person and followed the guidance and assessment in place.

Support plans contained information about any healthcare needs people had, as well as contact details for their GPs and any other relevant healthcare professionals involved in their treatment. People told us that most of the time they, or their relatives managed their healthcare appointments independently. Staff told us they monitored people's health and where concerns were noted about people's health, staff made contact directly with healthcare professionals or reported the concern to the office. For example, where there were declines in people's mobility needs, the service made contact with GPs and occupational therapists to request reviews and made referrals for additional equipment, such as standing aids and walking frames.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. Applications to deprive a person who is supported in their own home need to be made to the Court of Protection (COP).

We checked whether the service was working within the principles of the MCA 2005. The manager and staff understood the principles of the MCA 2005 and people we spoke with confirmed that staff asked for consent before they provided care or administered medicines. People supported had capacity to make decisions and where they did not; action had been taken by the service to ensure relevant parties were involved in making best interest decisions. At the time of our inspection, there were no applications made to the Court of Protection.

Staff confirmed they received an induction when they started in their roles and we saw the provider had a training programme in place which covered areas including safeguarding, medicines administration, infection control, health and safety, and manual handling. Training consisted of practical sessions and e-learning. New staff were required to attend an induction programme, which followed the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of learning and have their competency assessed before working independently. Staff were also expected to complete a shadowing period before they could work on their own. Staff received support through supervisions and appraisals. Staff we spoke with were positive about the training and development opportunities they received. One staff said, "We are expected to complete training regularly. Training is helpful as it helps keep us updated."

Is the service caring?

Our findings

People and their relatives told us they received care from staff who were caring, kind, compassionate and respectful. One person said, "The staff are good. They help me. They are wonderful." Another person said, "They are all very hard working and caring."

Staff told us they enjoyed their job roles and working at Thomas Place. One staff said, "I love my job. I love coming to work knowing I am making a difference to people's lives." Another staff said, "I like helping people and I get to learn so many things from them too." Staff we spoke with talked about people they supported in a caring and respectful way. They demonstrated good knowledge of the people they supported and had built strong relationships with them. Staff were aware of people's life histories and family backgrounds, the things they enjoyed doing and the friends and family they were in regular contact with. This information helped them interact with people in a familiar and friendly way. For example, we heard one staff member talking to a person about their relatives who were visiting them over the weekend.

We observed staff engaging with people in a relaxed and caring manner. For example, on the day of our inspection, we saw staff regularly check on people's well-being when meeting them in communal areas of the building or when they came to the office, and responding promptly in a friendly way to any queries people raised with them. It was clear from these interactions that people were comfortable with the staff supporting them.

People told us they were involved in decisions about the support they received from staff. One person told us, "They know me well but they still ask me how I want things done." People's care records provided up to date information for staff to follow on how to meet their individual needs. This helped staff understand what people wanted or needed for their care and support. People and their relatives told us that they had a support plan and that staff were aware of this and followed this. One person told us, "They follow my care plan. This was reviewed recently."

Support plans identified that people should be encouraged to do as much as possible for themselves to maintain their independence. For example, one support plan stated, 'Please encourage and involve [person] in all tasks that they can manage as [person] is very independent.' Staff promoted personal choice and independence by ensuring that people were involved in their care and support. One staff told us, "I encourage people to take part in all their care and support, as much as they can, so they don't lose their skills and independence."

People's privacy and dignity was protected and promoted. Staff described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains when delivering personal care and ensuring that people were covered up as far as possible. One staff told us, "I always knock on people's door and call out before I go in." People and relatives told us they were satisfied with how their privacy and dignity was respected by staff.

People could express their views about their lives with staff and others involved in their care. Where

required, they had support from staff, their relatives, friends or external representatives. Staff were aware of how to refer people to advocacy services if people needed this support. An advocate is an independent person who can help people express their needs and wishes, support them to make decisions and represent their interest.

People's personal records were stored securely which meant people could be assured that their personal information remained confidential. Staff understood about confidentiality and were discreet. All confidential information and records were kept securely in the office. Electronic records were password protected and accessible to authorised personnel only.

Is the service responsive?

Our findings

People and their relatives told us they received a personalised service. They said they had been involved in planning their care so the support provided could meet their needs. They told us they could talk to staff if they had any concerns.

Support plans were personalised and had been developed from initial assessments of people's needs. These covered a range of areas including personal care and daily routine, medicines, nutrition and hydration, communication and mobility. They included information regarding people's likes, dislikes, their views and preferences in the way in which they received support, as well as descriptions of their preferred routines when attended by staff. Where changes were identified, people's support plans were updated promptly and information about this was shared with the staff.

Staff told us the support plans provided clear guidance to help them assist people with the required care and support such as assistance at mealtimes, washing, dressing and mobility. Each person had a schedule of their call times along with tasks that were to be undertaken on each visit. Support plan reviews had taken place as planned and these had been recorded. People and their relatives were involved in the reviews. Daily records were also recorded against each care and support area, detailing matters such as how people were feeling, personal care received, their dietary intake and social contacts.

Staff encouraged people to keep contact and maintain relationships with their relatives and friends to help protect them from social isolation and loneliness. Relatives told us they were free to visit their loved ones at any time and there were no restrictions. People benefitted from an on site diner facility, where they often met with other people to have a chat and enjoy meals together.

The service followed the guidance in the Accessible Information Standard when assessing people's needs. The care delivery director told us relevant information would be made available in large print, braille or other formats for people with visual impairments or sensory loss, where required. The Accessible Information Standard makes sure that people with a disability or sensory loss are given information in a way they could understand.

There was a system in place for people to raise concerns if they were unhappy about the service they received. The provider had a complaints policy and procedure in place and people were made aware of this when they joined the service. This provided people with information about who to contact if they had a complaint and who to contact outside of the service if they were unhappy with the response given or action taken by the registered provider. People told us they felt comfortable in raising complaints with staff or the provider. One person told us, "If I have a concern, I can always speak to the staff or office. They will sort it out."

The service maintained a complaints log which contained details of any formal complaints received, as well as the action taken by the manager or staff to investigate the issues and their response. Complaints had been managed in line with the provider's complaints procedure. The manager shared learning with the staff

team, in staff and one to one meetings, with the aim to make improvements at the service.

Is the service well-led?

Our findings

The service was not always well-led.

The service did not have a registered manager. The current manager had started to work with the service in June 2018 and at the time of our inspection, they had not yet applied to register with CQC. The provider had failed to apply to register the manager they had employed with CQC.

This was a breach of section 33 of the Health and Social Care Act 2008.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. When we spoke with the manager they demonstrated a clear understanding of their role and responsibilities in relation to notifying CQC about important events such as deaths, serious injuries and DoLS authorisations, however, they had failed to notify CQC of a safeguarding concern which occurred in the service.

Failure to notify CQC of these events is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

People spoke positively about the management of the service. People and their relatives told us they have met and knew the manager. They said they were confident in the management team. One person said, "I know there is a new manager. She is friendly, you can talk to her." Another person said, "The new manager is good. If I have any problem, I ring the office and it is sorted."

Staff told us they were happy in their roles and felt supported by the management team. One staff member said, "I can speak to the manager at any time. They are very supportive and flexible." Staff told us that communication between staff within the service was good and they were made aware of significant events and updates. Staff used a communication book to share important information about people's health and wellbeing. Staff felt that they could speak up at meetings and that management listened to them. The care delivery director told us meeting minutes were circulated to staff to ensure that all the staff worked well together as a team. One staff said, "I like working here. We all help each other, we are a good team."

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported and dealt with appropriately. Staff told us that they would escalate concerns to CQC as well as the local authority. Effective procedures were in place to keep people safe from abuse and mistreatment.

The provider sought people's views on the service through meetings, surveys and feedback during spot checks on staff performance. People we spoke with told us they would not hesitate to contact the manager or senior staff at any time. One person said, "If I have any problems, I know I can contact the office and speak to the manager." The provider had also conducted a recent survey and the care delivery director confirmed they were in the process of analysing the results and putting an action plan in place to help drive improvements.

Key professionals involved with the service fed back to us that they felt communication within the service could be improved as they often experienced delays in receiving a response to their correspondences and there was a general lack of communication to ensure smooth running of the service provided to people. We brought this to the attention of the care delivery director and manager, who were keen to work with the professionals concerned and implement changes to ensure people experience good standards of care.

We looked at the arrangements in place for quality assurance and governance. The provider had oversight of the service and carried out quarterly audits. The provider's quality assurance team carried out annual compliance audits and any areas for improvement were recorded in an action plan, which was monitored centrally. This helped the provider check people were receiving the care and support according to required standards. The manager completed monthly audits to monitor how the service was operating and to drive forward improvements. A range of checks were undertaken. These included care records, staff records and medicines. Any areas for improvement were recorded and discussed with staff. Accidents and incidents that involved staff or people who used the service were monitored to ensure trends and triggers were identified.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of a safeguarding concern which occurred in the service.