

Cera Care Operations Limited

Cera - Old Stratford

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

Cera- Old Stratford is a domiciliary care agency providing personal care to people living in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of inspection 113 people were receiving personal care.

People's experience of using this service and what we found

Risks to people had not always been recorded and assessed. Care plans and risk assessment had missing information. Records of care tasks to mitigate risks were not always completed.

Systems required to ensure effective oversight of the service was not always in place or effective. For example, the systems in place to ensure medicines were recorded and administered appropriately had not identified some of the concerns found on inspection.

Medicine management required improvement. Records were always completed fully. However, people told us they received their medicines as prescribed.

People did not always know what staff were coming or what time staff would arrive. Call times varied dependant on the person's priority based on risk. Staffing levels were low, and the provider was in the process of recruiting new staff.

People were supported by staff who received appropriate training, understood safeguarding, had been safety recruited and wore personal protective equipment (PPE) to reduce the spread of COVID-19.

People, relatives and staff were asked to feedback on the service. However, not all staff felt involved in the service. For example, not all staff were able to attend staff meetings to understand what changes or improvements were being made or to share information between the staff team.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 9 April 2021) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider was still in breach of regulations.

Why we inspected

We received concerns in relation to people not receiving care calls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cera-Old Stratford on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risks and management oversight at this inspection.

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

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Cera - Old Stratford

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection was completed by an inspector and an 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.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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

This inspection was unannounced.

Inspection activity started on 19 October 2021 and ended on 3 November 2021. We visited the office location on 19 October 2021, calls were made to people on 25 and 26 October 2021 and information was requested from the registered manager on 1 November 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with eleven people who used the service and eleven relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, regional director, regional trainer, care coordinator and care workers.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.



Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant 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 our last inspection the provider had failed to mitigate risks. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvements and were still in breach of regulations.

- Staff did not always have the information recorded to provide safe care. Not all known risks for people had been identified and recorded. For example, two people did not have details regarding their health conditions. This put people at risk of not receiving safe care.
- Records of care tasks were not always completed to evidence risks were mitigated. For example, when a person required exercises to reduce the risk of fluid build-up, or when a percutaneous endoscopic gastrostomy (PEG) is turned to reduce the risk of it becoming embedded into the stomach wall. (A PEG is a tube that is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.) There were no assurances these tasks had been completed to reduce the risks to people.
- Equipment was not always used safely. One person told us, "Sometimes they [staff] have forgotten to put the brakes on (the equipment used for mobility) which could have resulted in serious injury." A staff member told us, "Equipment can still be a risk. One person fell as the staff member did not use the equipment properly."

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. This is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had risk assessments and strategies in place for risks relating to medicines, moving and handling, environment, skin pressure damage and COVID-19.

Using medicines safely

At our last inspection the provider had failed to ensure strategies to mitigate risks had been completed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had made enough improvements and were no longer in breach of regulations.

- Medicine records required improvement. There were multiple gaps in the recording of administering medicines for people and body maps for creams were not always completed. This put people at risk of not

receiving their medicines as prescribed. However, people and relatives told us they received their medicines appropriately.

- Staff received training in medicines management and understood the processes in place.
- Staff had protocols in place to follow for people's 'as required' [PRN] medicines; to understand why, how and when to give the medicine and the dosage required.

Staffing and recruitment

- People and relatives told us they didn't always know which staff were coming and staff were often late. One person said, "Sometimes they [staff] come at the wrong time and don't phone to let us know." Another person told us, "I have different carers each time; I would prefer the same carers. I do not have a schedule."
- Staff told us they often did not have enough time to travel to people's homes. This meant staff were often late or calls were shorter than required. One staff member told us, "There are not enough [Staff], staff are expected to work on days off and we are always running behind on call times." Another staff member said, "We are often short staffed, it delays people's care."
- Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions
- Staff received appropriate training to ensure they understood and could fulfil their roles and responsibilities.

Systems and processes to safeguard people from the risk of abuse

- Staff understood safeguarding procedures and received training in recognising and reporting signs of abuse.
- Safeguarding policies and procedures were in place to protect people from forms of abuse.
- The registered managers were aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.

Preventing and controlling infection

- People and relatives told us staff always wore appropriate personal protective equipment (PPE).
- Staff accessed regular COVID-19 testing.
- The provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

- Incidents and accidents were analysed and any trends and patterns identified were shared with staff.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had made some improvements. However, they had not made enough improvements and were still in breach of regulations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Audits on medicines were not always effective. For example, audits did not identify if a body map for creams was not in place or when incorrect information had been recorded regarding medicines administered. Audits had identified multiple missed signatures on various people's medicine records. However, actions were not always sufficient when staff made multiple mistakes.
- Systems and processes were not in place to identify safe care was being completed. For example, there were no audits completed to ensure care tasks linked to risks were being completed. We found information was not recorded within people's records to evidence these tasks were done.
- Systems and processes to ensure care plans and risk assessments were kept up to date and relevant required improvement. Audits had not identified the issues found relating missing information within care plans or risk assessments. A staff member said, "Staff cannot always access people's care plans when on a visit."
- People and relatives told us they felt the management of the service required improvement. One relative said, "The right hand does not know what the left hand is doing. They send some staff shooting all over the place; the organisation skills require improving." A person said, "The office doesn't communicate with each other; it is like talking to a brick wall. the problems with the company are getting me down, I feel very distressed. I never get an apology from the office."
- Staff, people and relatives told us the management of call times was insufficient. One staff member said, "Staff can 'log into' a call even if they are not at the person's home, the management know this, and nothing is done." People and relatives told us that call times were not always sufficient to meet people's needs.

We found no evidence of harm to people. However, the provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood, and would act on, their duty of candour responsibility, however, no incidents had occurred which would require action or investigation in this regard.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People, relatives and staff were asked regularly to feedback on the service. One person said, "We get asked for feedback during care plan reviews." A relative told us, "We get phone calls or visits asking for feedback, the last being within the last six months."
- Not all staff felt involved in the service. The registered manager arranged team meetings to discuss updates and information sharing. However, not all staff were able to attend due to the short notice.

Working in partnership with others

- Referrals to external professional such as, doctors, speech and language therapists and occupational therapist were completed as required.
- The registered manager submitted notifications to the CQC in a timely manner, including submitting statutory notifications about the occurrence of any key events or incidents involving people they supported.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks.</p>

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.</p>

The enforcement action we took:

Warning Notice