Nash Healthcare Ltd

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Inspection report

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Date of inspection visit:
10 September 2020

Date of publication:
28 October 2020

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
Nash Healthcare Ltd is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection 14 people were receiving personal care provided by the service.

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.

People's experience of using this service and what we found
We found all required staff recruitment checks had still not been completed on staff, before they delivered people's care. This continued to put people at risk of receiving care from those who may not be suitable to work with vulnerable people. The provider's monitoring systems had also not identified that their recruitment policy had not been fully implemented and therefore risks in relation to recruitment had not been managed effectively. We found other improvements had been made to the provider's quality monitoring which had resulted in improvements to record keeping. Notifications of the deaths of people using the service had not been submitted to CQC to ensure we were able to check if the correct actions had been taken.

People were protected from harm and abuse through the knowledge of staff and management. Risks to people's safety were identified, assessed and appropriate action was taken to keep people safe. Staff followed infection control procedures to protect people. People's medicines were safely managed. People and their relatives told us they felt assured that care visits would take place and staff would contact them in the event of any late calls.

Rating at last inspection and update
The last rating for this service was requires improvement (published 3 August 2019) and there were two breaches of regulation. This service has been rated requires improvement for the last two consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of these regulations. We also found a new breaches in relation to Notifications of deaths of persons using the service.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 29 May 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve Regulation 17 Good governance and Regulation 19 Fit and proper persons employed.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion 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 Nash Healthcare Ltd 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 repeated breaches in relation to Good governance and Fit and proper persons employed. We also found a new breach in relation to Notifications of deaths of persons using the service.

We issued a warning notice in relation to the repeated breach for Regulation 19 Fit and proper persons employed.

Please see the action we have told the provider to take at the end of this report.

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 the information we receive about the service. We will return to visit as per our inspection methodology to follow up the provider's progress in relation to their compliance with necessary regulations. If we receive further concerning information we may inspect sooner.

We will continue to work alongside the provider and commissioners of the service. We will meet with the provider and ask for an action plan to understand what they will do to improve the standards of quality and safety moving forward.

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.

Nash Healthcare Ltd

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
This inspection was carried out by one inspector.

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. Inspection activity started on 9 September 2020 and ended on 25 September 2020. We visited the office location on 10 September 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought and received feedback from the local authority. We requested the contact details of people using the service, their representatives and staff. We spoke with two relatives of people using the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included three people's care records. We looked at six staff files in relation to recruitment procedures. 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. We spoke with one person using the service and four relatives of people using the service. We contacted a further five people using the service or their relatives but we were unable to speak with them. We also spoke with two members of staff by telephone, we contacted three other members of staff but were unable to speak with them. We received feedback via email from a social care professional and one member of staff. We contacted three other members of staff and four social care professionals but we did not receive a reply from them.

Requires Improvement

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.

Staffing and recruitment

● At our previous inspection we found appropriate recruitment checks had not always been completed on staff, before they delivered people's care. This put people at risk of receiving care from those who may not be suitable to work with vulnerable people. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● At this inspection we found safe staff recruitment procedures were still not being fully followed. We examined six staff recruitment files, five out of the six showed shortfalls with the staff recruitment procedures. Relevant checks had not always been made where staff had previously worked with vulnerable adults or children. This was required in order to ensure applicant's previous conduct made them suitable for the role of caring for people using the service. The provider was not following their own staff recruitment procedure in this respect.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe staff recruitment procedures were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported through consistent staff support. Staff were organised into teams based on the areas where people lived which enabled staff to familiarise themselves with people's individual needs. People told us they felt assured that they would receive their care and knew the staff who visited them. Where calls were delayed people and their relatives would receive notice of this.

Systems and processes to safeguard people from the risk of abuse

● People were protected against abuse. Staff received training on safeguarding adults and were aware of the procedures for reporting any safeguarding concerns.

Assessing risk, safety monitoring and management

● At our previous inspection we found risk assessments showed no evidence of having been reviewed to ensure the actions in place remained effective in managing people's risks. Risk assessments were generic in their wording so not personalised to the person's specific risks or needs. This put people at risk of receiving

inappropriate or unsafe care due to a lack of accurate information about people's risks and care needs in their care records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection we found improvements to people's risk assessments. These had been reviewed on an ongoing basis and also through care plan reviews carried out with the involvement of people using the service and their representatives. People had risk assessments in place for identified risks such as the safety of the environment, falls and moving and handling.
● Where applicable, plans were in place in the event of staff being unable to gain entry to people's homes.

Systems and processes to safeguard people from the risk of abuse
● People were protected against abuse. Staff received training on safeguarding adults and were aware of the procedures for reporting any safeguarding concerns.

Using medicines safely
● Where medicines were administered by staff, the medicine administration records were checked during spot check visits by senior staff, to ensure staff were maintaining these correctly and people were receiving their medicines as prescribed. Staff were trained to administer people's medicines.

Preventing and controlling infection
● Staff had received training in infection and food handling. Further training in infection control and hand hygiene was planned. Infection control procedures had been updated in response to the current pandemic and guidelines communicated to staff.
● Checks were in place in ensure staff were following infection control guidelines such as using personal protective equipment (PPE) and where appropriate, were following food hygiene practices. The registered manger reported sufficient stocks of PPE had maintained in response to the current pandemic.

Learning lessons when things go wrong
● The registered manager reported there had been no accidents or incidents since our previous comprehensive inspection. If an accident was to occur, appropriate action would be taken including recording and consulting health care professionals if required. Accidents would be audited as part of the monthly audit.

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.

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 ensure regulatory requirements were 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 we found quality monitoring systems were not always effective in identifying shortfalls in the service provided. Insufficient quality monitoring had resulted in shortfalls such as insufficient recruitment practices, and lack of maintenance of records. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At this inspection we found the systems in place to monitor compliance with regulatory requirements were still not effective. Although we found record audits had been effective in driving improvements to record keeping and the maintenance of people's care records, we found ongoing shortfalls in the service provided in relation to recruitment, which had not been identified. Systems had not identified that regulatory requirements relating to obtaining information prior to employment about the conduct of staff in previous care related positions had not been met. In addition, notifications relating to deaths of people using the service had not been submitted to us and this had not been identified.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective monitoring of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We checked how many deaths had occurred to people using the service since 1 August 2019 which would have required a notification to us. CQC monitors important events such as the deaths of people using the service through the notifications sent to us by providers. There had been four deaths where we should have received a notification. We had not been notified of any of these deaths so we could check if the correct actions had been taken.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

● We also found the service's website was not correctly showing the rating from our previous inspection. Following our inspection the provider to took action to ensure the rating was clearly displayed on their

website.

● Systems were in place to monitor times of calls to people to ensure people received their care as planned.

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 was aware of the duty of candour responsibility to be open and honest with people and their family when something had gone wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People's relatives told us if they contacted the office about any issues, they were satisfied about how these were resolved.

● Staff were positive about the management of the service. They told us they felt supported by the management who were available to contact when needed.

● The registered manager and the provider received regular updates from a local care provider's organisation which they described as being helpful during the current pandemic.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Surveys of the views of people using the service and their representatives had been carried out. Recent responses had been positive although the registered manager described how they would respond to any comments about the service requiring action.

● The agency worked in partnership with commissioners of health and adult social care to provide people with care in their own homes.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The registered person had not notified the Commission of deaths of people using the service which occurred whilst service were being provided in the carrying on of a regulated activity. Regulation 16 (1) (a)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks associated from Ineffective quality and risk monitoring of the service. Regulation 17 (2)(a)

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 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks associated from unsafe staff recruitment practices. Regulation 19, 1 (a) 2 (a) 3 (a)

The enforcement action we took:

We issued a warning notice in respect of continued shortfalls in the provider's staff recruitment procedures.