Mr Lloyd Myrie

Ocean Care

Inspection report

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

Summary of findings

Overall summary

This inspection took place on 6 August 2018 and was announced. At our last inspection in May 2016, we were not able to give an inspection rating as people using the service did not wish to speak with us so we were unable to make a judgement about the care they received. Our last inspection did not identify any breaches of legal requirements. At this inspection we rated the service, 'Requires improvement' overall and identified three breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. 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 our inspection, one person received the regulated activity of personal care from the service.

The person lived in their own home and told us they felt safe using the service. However, systems were not always clear to help the person manage their finances safely and we shared this information with the local authority after our inspection for further consideration. The person's risks were known to their carer, (the care manager) who had supported them for a long time, and the person told us they received their medicines on time. However, records relating to this were not always accurately maintained and monitored to ensure the person always received safe support.

Systems to assess, monitor and improve the quality and safety of the service were not always effective and checks were not always carried out as planned. The provider could not evidence that staff supporting people were fit and of good character. They told us they had recruitment processes in place to help them recruit staff safely however some documentation was not available to evidence this.
The provider was aware of how to identify and report safeguarding concerns and there were sufficient numbers of staff available to care for the person.

The person made their own choices about their care and told us their choices were respected. The person told us they were satisfied with their care. They were supported to access further healthcare support as needed and to have meals of their preference. The care manager felt supported in their role and was familiar with the person's needs. The provider had arranged some guidance and training for staff, however the provider did not always keep track of staff training plans and requirements.

The person told us their carer was kind and caring, and we saw they had a good rapport. The care manager understood how to help promote the person's dignity. The person told us they felt able to complain and the provider had a system in place to ensure complaints would be addressed. However, the person was not supported to be involved in discussions and decisions about their care as far as possible. Care plans did not always fully reflect the person's choices and support needs.

We received positive feedback about the service and the person told us they were happy with their care. The provider referred to some current good practice guidelines and understood their responsibilities to the Commission.

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 consistently safe.

Systems and processes did not ensure the person was always supported with their finances safely. Safe recruitment procedures were not in place.

The person told us they felt safe using the service. The person's risks and needs, including medicines support, were known to the provider and care manager, however not always reflected and monitored through care planning.

There were sufficient numbers of staff to care for the person.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The person could make their own choices about their care and told us their choices were respected.

The person told us they were satisfied with their care. The person had further access to healthcare support as needed.

Staff felt supported in their role and told us they had received training. However, the provider did not have a process to review the support and training providing to staff after their induction.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The person was not actively involved in discussions and decisions about their care as far as possible.

The person told us their carer was kind and caring. They had a good rapport.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care planning processes did not fully reflect and effectively monitor the person's needs and preferences.

The person told us they could complain if they needed to. The provider had a complaints process and no complaints had been received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to assess, monitor and improve the quality and safety of the service were not always effective.

We received positive feedback about the service and the person told us they were happy with their care.

The provider had referred to some current good practice guidelines.

Ocean Care

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.

During our inspection, we looked at how the provider managed people's finances due to previous information that we, and other relevant partner agencies had received about the safety of the service. Our inspection found those concerns had not been fully addressed by the provider and this put people at risk. After our inspection, we shared this information with relevant partner agencies for further review and consideration.

This inspection was announced. We gave the provider notice of the inspection site visit because it is small and we needed to be sure that the manager and people involved with the service would be available.

Inspection site visit activity took place on 6 August 2018. It included a visit to the home of a person using the service, and the office location on see the manager and office staff; and to review care records and policies and procedures. On 7 August 2018 we made phone calls to others involved in the service. The service currently supports one person living in their own home.

This inspection was completed by one inspector. As part of our inspection planning, we looked at other information held about the provider, for example, incidents or events related to the service which the provider is required by law to notify us of. We also sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also used information the provider sent to us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection, we spoke with two healthcare professionals who regularly visited the person, the provider and the care manager who regularly supported the person. We looked at records related to the

person's care, three staff recruitment files and other systems in place related to the quality and safety of the service. After our inspection, the provider sent us additional information we had requested as part of our inspection processes.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2016 our inspection found this service was safe, for example, care staff knew how to keep people safe from harm, and medicines were managed safely. At this inspection, we found continued positive practice, however improvements were required to ensure people's risks and finances could always be managed safely. We have rated this key question, 'Requires improvement'.

The provider had not recruited staff recently or since their registration with the Commission. The provider told us they would ensure character reference checks and checks through the Disclosure and Barring Service (DBS) were completed before staff started in their roles. However, documentation for two previously recruited staff members did not demonstrate this. For example, one staff member's DBS check was not available to view and the provider told us they had not kept this documentation. The second staff member's start date was prior to their DBS and reference checks however the provider advised they had only completed induction tasks during this period. The provider did not have all documentation available to demonstrate consistently safe practice and could not be sure that staff providing care were fit and of good character.

Failure to establish and operate recruitment procedures and to keep required information related to persons employed is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection, the provider had been instructed by relevant partner agencies including the local authority, to review how they helped people using the service to manage finances. This was because the provider did not have clear systems to protect people from the potential risk of financial abuse. Our inspection found those concerns had not been fully addressed by the provider which put the person using the service at continued risk. Systems were not in place to demonstrate this person was always safely supported with their finances, and that the person's wishes and support related to this were regularly reviewed. For example, the care manager told us they promptly gave receipts to the office so they could be recorded and checked to confirm the person had been supported safely. However, our sample of records found this had not always been done, for example for two months leading up to our inspection, this information had not been collected or reviewed by the provider. After our inspection, we shared this information with relevant partner agencies for further review and investigation.

Systems and processes were not established and operated effectively to prevent abuse of people using the service. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us staff had received safeguarding guidance as part of their induction and training delivered by the local authority, however there was no record of this for all staff. The provider could tell us the types of abuse people could experience and the appropriate agencies and authorities to report concerns to. The care manager also knew who to report concerns to and told us they had received safeguarding training to help them identify possible signs of abuse.

Although the person's risks were known to the provider, their risk assessments did not clearly outline the person's changing needs and how identified risks could be effectively assessed and mitigated. The person told us they had previously fallen over, however this had not been logged as an incident or considered in their care planning. The care manager told us the person had been referred for further support to help prevent falls, and they had a personal alarm to help them seek emergency support in the event of another fall. The person's care plan did not always contain other risk assessments where relevant, for example, related to the person's health care conditions. Risk assessments should be completed and reviewed regularly to outline how to support the person to safely manage those risks. Further improvements were required to ensure records reflected the person's risks and how to safely manage these to support staff knowledge in this area.

The person using the service told us they felt safe, and there were sufficient numbers of staff available to support them. The provider and care manager, who regularly supported the person, were aware of the person's risks and support needs. This helped them share information with relevant healthcare professionals to promote the person's health. The person was supported by a regular and familiar carer, the care manager. The care manager showed awareness of the person's risks associated with their support needs and how to help keep them safe.

The person told us they received their medicines on time. A healthcare professional told us prescriptions were picked up in a timely way so the person had the medicines they needed. The care manager helped the person manage their medicines. The person's care records provided current information about the medicines they took. Medicines administration records (MARs) that were available for us to sample did not contain any gaps, however the provider had not checked more recent records within the last two months of our inspection as planned. This meant they could not monitor the person's medicines support and identify any changes.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in May 2016 our inspection found the service was effective, for example, care staff told us they felt supported in their roles and the person was supported to access healthcare services. At this inspection we found similar findings however improvements were required because the provider did not have clear systems relating to the Mental Capacity Act 2005 (MCA). We have rated this key question, 'Requires improvement'.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The person could make their own choices about their care and told us their choices were respected. The care manager told us they supported the person to make their own decisions, for example, they said the person wanted fish and chips for lunch and we saw they had this. The person went out when they wanted, for example to the shops, with the support of a staff member.

Improvements were required however because the provider had not documented the person's decision about their personal finances, or ensured this aspect of their support was regularly reviewed. The provider had not followed recommendations set out by the local authority and other relevant partner agencies, in relation to this. The person's care plan did not clearly reflect the agreement they had made with the provider about the management of their finances. The provider had also not updated the person's care plan, or explored further the occasional concerns they told us they had in relation to the person's capacity to make specific decisions. The provider had not ensured the person would always be supported to make decisions in line with the requirements of the MCA.

The person was supported to access further healthcare support as needed. During our visit, the care manager told us the person had complained of a headache. The care manager recognised the possible cause of this and how to help the person feel better. A healthcare professional told us the care manager had regularly supported the person to seek support when they were unwell. This had led to some changes to the person's medicines which the care manager felt had improved the person's health. The care manager told us they supported the person to exercise, as recommended by another healthcare professional to promote the person's health.

The care manager prepared meals for the person and told us they encouraged the person to choose healthy, nutritious options. They prepared meals of the person's choice although sometimes the person fancied a surprise so the care manager decided. We saw the person was encouraged to drink plenty given the warm weather and the care manager was mindful of helping the person stay cool.

The person told us they were happy with their support and felt the care manager supported them well. The care manager told us they felt supported and told us how they helped meet the person's needs, for example when they became unwell. The provider told us that as part of the induction process, staff had received guidance in mandatory areas including safe moving and handling, and health and safety, and they had encouraged staff to attend available training from the local authority. The care manager told us they received training and spot checks which they found helpful to know they did their job effectively. The provider told us they had offered some training and current good practice guidance to staff however this was not always recorded and monitored as part of their quality assurance processes, for example there was no current training matrix available to view.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in May 2016 our inspection found this service was caring, however at this inspection, we found improvements were required because the provider had not ensured the person was actively involved in discussions and decisions about their care as far as possible. We have rated this key question, 'Requires improvement'.

The person had previously been asked to complete feedback surveys about their experience using the service. There were no records of surveys in recent years and the provider told us they had chosen to visit the person and ask about their care instead, for example when they completed a spot check. This did not always give the person an independent opportunity to talk about their care and spot checks had not regularly taken place. Although the provider told us they asked the person for their views on the service during spot checks, this did not provide the person with the opportunity to have independent discussions and advice in relation to their care and treatment should they have required this, for example, from an advocate. The provider told us the person had previously received advocacy support but this had not continued and the provider had not kept a record of the advocate's details in case the person required their support.

The provider told us the person had previously expressed a preference about their care, and although the provider had acted on and respected this choice, the provider had not reviewed the person's decision as part of their care planning to ensure this decision continued to promote the person's safety and independence. This meant the person was not always supported to express their views and be actively involved in decisions about their care as far as possible.

The person told us the care manager was kind and caring, and we saw they had a good rapport. The person smiled and laughed at times in response to the care manager. The care manager reassured the person when they became upset and we saw they took time to explain things to the person, for example, how they supported them, when the person received post and why we had visited. The person told us they had friends who lived in the same building who they sometimes met with and saw at social events they went to. The care manager had got to know the person well and knew about their past and preferences.

The person had been asked for their views and feedback about their care and was supported to make decisions. The care manager told us the person had thought about going away for a break with friends, and showed us how they helped the person with decisions about other plans they had. We saw the care manager understood how the person wanted to be supported.

The care manager explained ways they promoted the person's dignity and privacy, and followed the person's preferred routines for personal care. We saw they checked the person was comfortable and gave them a napkin to use during their meal. The care manager only assisted the person when they needed and let the person know what they were doing and checked this was okay with them beforehand. The care manager spoke discretely about the person's support needs and showed awareness of maintaining their privacy.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in May 2016 our inspection found this service was responsive, however at this inspection, we found improvements were required to the provider's care planning processes. We have rated this key question, 'Requires improvement'.

The person told us they were satisfied with their care and we saw examples of how their expressed preferences had been met. However, the provider had not ensured appropriate processes were followed in relation to the person's care to ensure their needs were always safely met. For example, although the provider and care manager were aware of the person's support needs and expressed preferences for their care, the person's care plan did not fully reflect their needs and had not been accurately updated. The provider had not ensured all appropriate measures were followed to support the person safely, including those recommended by the local authority about the person's finances. In another example, the provider told us they knew the person's wishes related to end-of-life, however the provider had not documented these in their care plan. The provider told us they would do so and showed consideration and sensitivity about having approached this topic with the person.

The person had been supported for a long period of time by the provider and their needs and preferences were known. The person's care plan reflected how they wanted to be supported in relation to their personal care, which they had signed. The person told us they were happy with their care. A healthcare professional who often visited the person told us, "[Person] is always looked after very well and seems very happy."

Our discussions with the care manager showed they understood the person's preferred routines and preferences, for example, related to personal care and the person's religious preferences. The care manager knew the person well, their life prior to receiving support through the service and their social links. We saw they respected the person's choices. Daily care notes completed by the care manager were respectfully written and reflected how the person had been supported.

The provider had not received any complaints. The person told us they would feel able to complain. We asked if they felt able to share any concerns with their care manager and the provider and they commented, "Twenty years", which reflected they had known their care manager for that long and accordingly would feel comfortable doing so. The provider had a complaints process in place which would help them review and respond to any complaints they received.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2016 we found this service was well-led, however at this inspection, we found improvements were required because systems and processes were not always effective. We have rated this key question, 'Requires improvement'.

Systems to assess, monitor and improve the quality and safety of the service including the person's experience were not always effective. Regular checks to review aspects of the person's care, including their support with medicines and finances, were not carried out as planned to help monitor the quality of their care and identify any safety issues. For example, the provider had not collected and reviewed the person's daily care notes for June or July 2018 and could not demonstrate earlier audits had always been completed.

The provider told us they had completed spot checks to review the safety of the person's support, and shared current guidance and training opportunities with staff. However, the provider did not have a current training matrix or other ways to monitor and assure themselves that staff had received up to date training to meet people's needs.

Although the care manager and provider were familiar with the person's support needs, records related to the person's risks and choices had not been accurately maintained. For example, risk assessments were not in place where relevant for example related to the person's health conditions, falls risk or the safety of equipment they used. Although the person had been involved in their care planning, we found the provider had not explored other means to independently and regularly check their views and experiences of the service, or to ensure the person always had access to any support they needed to make decisions about their care.

The provider had not fully addressed previous guidance and requests by the local authority to ensure the person's finances were managed safely. This did not help protect the person from the risk of financial abuse. Shortly after our inspection, we shared this information with relevant partner agencies for further review and consideration.

The provider failed to establish and operate effectively, systems and processes to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The person told us they had been supported by the provider for several years and they were happy with their care. The person told us they felt safe and they were support to seek healthcare support when they were unwell. Healthcare professionals told us they felt the person was well cared for. The care manager told us they felt supported and could contact healthcare professionals or the provider if they had any questions or concerns.

The provider had referred to current good practice and policies, and demonstrated how they had developed some processes since the last inspection. The provider showed an understanding of their responsibilities to

the Commission and had submitted their Provider Information Return to support our inspection processes as requested. The provider understood their requirements to notify the Commission about specific events and incidents.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of people using the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effectively, systems and processes to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to establish and operate recruitment procedures and to keep required information related to persons employed.