Norvic Healthcare (Anglia) Limited

Norvic Healthcare Anglia

Inspection report

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Date of inspection visit:
22 November 2017

Date of publication:
27 February 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 22 November and was announced.

Following the last inspection on 10 November 2016 we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Well-led to at least good.

This service is a domiciliary care agency. It provides personal care to 29 people living in their own houses and flats in the community. It provides a service to older adults and people who are living with a learning disability.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection on 10 November 2016 we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for good governance and notification of other incidents under the Care Quality Commission (Registration) Regulations 2009. At this inspection we found the provider had taken action to ensure they were compliant with the Registration regulations. We found that whilst some improvements had been made with the governance of the service, there were still concerns about the assessment and monitoring of the safety and quality of the service. The provider was still in breach of this regulation.

The quality assurance system that was in place was not effective at identifying areas for improvement within the service. This was because there was a lack of any in depth examination of the service. Satisfaction surveys were sent to people but the responses were not collated to gain an overall picture of the service.

There was clear and visible leadership in place and staff felt supported by the registered manager. The registered manager was able to be contacted by people and their relatives and made time to listen to people.

Regular staff meetings took place and there was frequent communication in the form of newsletters, phone calls and texts between the provider, management team and the staff.

Working relationship had been fostered and maintained with other services such as local hospitals and the local authority to ensure continuity of care for people.

People's medicines were not always managed in the safest way possible. There were no protocols in place for 'as required' medicines and staff did not have a good understanding of this type of medicine.

Staff had received training in the safe management of medicines and documentation relating to people's medicines was completed fully.

Individual risks to people had been identified but there was little information to guide staff about how to mitigate them. Risk assessments for people's homes had been completed to help ensure the safety of people using the service and the staff visiting them.

There were enough staff to safely meet people's care needs and staff arrived to people's houses on time. Staff had received training in safeguarding and knew how to report any concerns of abuse. There were safe recruitment practices in place and the necessary background checks had been carried out before staff started working in the service.

Accidents and incidents were recorded and these were looked at regularly to identify any patterns or trends.

Processes were in place to prevent and control infection. Staff had received training in infection control and food hygiene and knew their responsibilities in relation to these areas.
People's care and support needs were not always holistically assessed. Whilst there was information in people's care plans relating to their physical health, there was little detail about any mental health needs that people may require support with.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 and whether the service is working within the principles of the MCA and report on what we find. We found that not everyone had an MCA assessment and decisions made for people in their best interests were not always documented. Staff we spoke with had a good understanding of the MCA and knew how to offer people choices.

Staff received training relevant to their role and they were supported to access additional training that would benefit them in their role. Staff were further supported through regular supervisions and appraisals.

People who required support with their meals were supported to maintain a healthy nutritional intake. Relevant healthcare professionals were contacted where there were concerns about a person's health or wellbeing.

Staff were caring and took time to listen to people and involve them in making choices about their care. People were treated in a respectful way and their right to privacy was maintained.

People's independence was promoted and people were encouraged to do as much for themselves as possible.

Care records were updated regularly and people and their relatives were involved in this process. Care plans were updated to reflect people's current needs.

There was a complaints procedure in place and people felt happy to raise a complaint if needed and knew who they would direct their concerns to if needed.

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.

Individual risks to people's health and wellbeing had not been identified and documented.

People's medicines were not always managed in the safest way possible. There were no protocols for 'when required' medicines.

There were enough staff to safely support people. Satisfactory checks were carried out on staff before they commenced employment with the service.

Staff had received training in safeguarding and knew how to report any concerns.

Accidents and incidents were recorded and monitored.

Staff had received training in infection control and food hygiene and knew their responsibilities in relation to these.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's care needs were not holistically assessed and recorded.

People's mental capacity was not always assessed and it was unclear what support people needed to make choices.

Staff received training relevant to their role and were able to access additional training relating to their role.

People were supported to maintain a sufficient nutritional intake.

Staff worked with other organisations to ensure that people received care from relevant healthcare professionals.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in planning their care.

People were supported by staff who were caring and who knew their needs well.

People were treated with respect and their privacy was upheld.

People's independence was encouraged and supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records did not contain information about their emotional wellbeing.

Care records were reviewed on a regularly with people and their relatives.

There was a complaints procedure in place and people knew who to raise any concerns with and felt comfortable in making a complaint.

Preferences for end of life care and treatment were documented.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of effective systems in place to assess and monitor the quality and safety of the service.

People's views about the service were not collated to generate an overall picture of the service.

Staff felt supported in their role and were actively involved in the ongoing development of the service.

The registered manager was a visible presence and was available to speak with people and their relatives.

The staff worked closely with other services to ensure that people received continuity of care.

Norvic Healthcare Anglia

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 November and was announced. This inspection was carried out by one inspector.

We gave the service 48 hours' notice of the inspection visit because the service operates from an office we needed to be sure that the registered manager and care staff would be available to speak with us. The inspection was carried out by one inspector. We spoke with two people who used the service and the relatives of a further two people over the telephone.

As part of the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available for registered manager to complete and we took this into account when we inspected the service and made the judgements in this report.

During the inspection, we also spoke with the registered manager and three members of care staff. We reviewed the care records of three people and the medication administration record (MAR) charts for three people. We looked at three staff records relating to recruitment and training. In addition to this, we reviewed monitoring reports relating to the quality of service being delivered.

Requires Improvement

Is the service safe?

Our findings

The service was not consistently safe. We looked at the medication administration record (MAR) charts for three people for whom staff were responsible for the administration of their medicines. We saw that some people were prescribed PRN medicines. There were no PRN protocols in place. A PRN medicine is a medicine that people are prescribed to take as and when required, for example paracetamol. It is good practice for staff to know the circumstances why the PRN medicine has been prescribed, when to administer it and what the medicine is for. It is also good practice for staff to record this information. This allows for staff to monitor and review people's ongoing health needs and make a referral to a healthcare professional if needed. The absence of any PRN protocols meant that people's use of these medicines was not being monitored. Therefore, timely referrals could not be made to relevant healthcare professionals.

When we asked staff if there were any PRN protocols they did not have a good understanding of what these were and stated that the policy for administering PRN medicines could be found in the policies and procedures file.

Some people using the service required support to take their medicines. One person's relative told us that they thought that staff had a good understating of their relative's medicines and was confident that they knew how to administer them in a safe way. Staff told us that they had attended training in the safe handling and administration of medicines and training records we looked at confirmed this.

We saw from people's care records that individual risks relating to their health and wellbeing had been identified. We noted that there were no risk assessments in place to provide guidance to staff about how to manage and mitigate known risks. For example, we saw that one person was at risk of choking and was on a pureed diet. There was no guidance in their care records to show how the person should be positioned when eating and drinking to minimise the risk of choking. We saw from another person's care record that their initial assessments stated that they were at risk of falls. There was no risk assessment to detail what action was required to minimise the risk of falls for this person.

We spoke with the registered manager about the lack of risk assessments and they started to immediately review people's care records. After the inspection we received a copy one person's updated care record to show what the risks were but they were vague in what support was needed to effectively mitigate the risk. A key was also used to show whether the risk was low, moderate or high. However, it was not clear how people's level of risk is being ascertained.

People and relatives we spoke with told us that they felt safe with staff who provided care to them or their relatives. One person's relative told us, "I have no safety concerns; I trust [the staff]. I would leave [relative's name] with any of them." Another person commented, "Safe? Oh yes, I am safe."

We were told by people and their relatives that there were consistently enough staff. No one reported to us that they had missed any visits and that staff were rarely late. One person told us, "[The staff] would always ring to let me know that they were running a bit late." Everyone we spoke with told us that staff would stay

for the agreed amount of time.

We saw from training records that staff had received up to date training in safeguarding and staff we spoke with told us what signs and behaviours they would look for if they suspected a person was at risk of abuse. Staff were also able to explain the process they would follow to report any concerns and they were aware of outside agencies they could report concerns of abuse to.

We looked at the recruitment files for three members of staff and saw that appropriate references had been sought and a satisfactory check from the Disclosure and Barring Service had been obtained. Staff we spoke with confirmed that they did not start to work for the service before these documents had been obtained by the registered manager.

Accidents and incidents were recorded and the registered manager told us that they would analyse these on a frequent basis so they could identify any patterns or trends. We asked staff how they would report any incidents. One member of staff explained, "We would notify the registered manager and then document the accident or incident in the person's care folder and in the accident and incident book."

We saw from people's care records that risk assessments for their homes had been carried out. This included identifying anything that may pose a risk to the person or staff visiting them. For example we saw that trip hazards such as electrical cables were identified.

Some people required support with making their meals. We saw that staff had attended training in food hygiene. This helped to ensure that people's meals were prepared in a safe way. Staff we spoke with had a good understanding of infection control. One member of staff told us, "We are able to access [personal protective equipment] from the office." This included disposable apron and gloves. This equipment is used to mitigate the risk of infection to the person being cared for and the member of staff.

Requires Improvement

Is the service effective?

Our findings

The service was not consistently effective. People's care needs were not always holistically assessed. We saw that some people who used the service were living with mental health difficulties. We saw from two out of the three people's care records we looked at that there was no information about their support needs in relation to their mental health. This meant that people were potentially not receiving the most effective care due to the lack of guidance about how best to support them with their mental health needs.

People we spoke with thought that staff were well trained to support them. One person told us, "The staff are well trained, yes." Staff completed training relevant to their role. This included training about the conditions people were living with, moving and handling and first aid. Training was delivered either face to face or online. Staff told us that they thought that the training was good. One member of staff commented that the registered manager would support staff to access further training if they wanted to develop their knowledge in a specific area. Staff were further supported through regular supervision with the registered manager. This gave staff the opportunity to discuss their career development and anything they required support with.

All new staff completed an induction period before they start working independently. One staff member told us, "I was given a folder with everything in, policies and procedures and all of that. I also went and shadowed a couple of supervisors so I could meet the clients."

Some people were supported with preparing and eating their meals. One person was on a pureed diet as they had difficulty swallowing. Staff we spoke with knew the person's dietary requirements and we saw from the person's daily notes that they were provided with appropriate food for their needs. However, we noted that there was no information in the person's care plan from the speech and language therapy team that had been provided in relation to what position the person should be in when eating and that fluid should be encourage between mouthfuls of food.

Staff at the service worked effectively with other organisations. Whilst in the office, we heard staff speaking with the local hospital discharge team so they knew when a person was going home and what their care needs would be. We also saw from people's care records that a person's social worker (if they had one) was contacted if there was any change to their needs. For example, a member of staff explained that one person's mental health had deteriorated so they contacted their social worker to arrange an assessment of their care and support needs.

Staff we spoke with told us that if they were concerned about a person's health or wellbeing, they would contact relevant healthcare professionals. We saw that when staff had needed to consult healthcare practitioners, this was documented in people's care records. If a person has a next of kin, then they will inform them. One person's relative told us, "If [the staff] notice that [family member] is unwell, then they'll call me."

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. We checked whether the service was working within the principles of the MCA.

We saw from the care records we looked at that people's capacity had not been assessed. The operations manager told us that this was something that they were looking into as they were aware that not every person who used the service had capacity to make decisions. They showed us some recent guidelines they were referring to whilst developing a new form to document people's capacity to make decisions.

All of the members of staff we spoke with had a good understanding of the MCA. One member of staff explained that some people were unable to make complex decisions but they were able to make decisions about what to wear. For example, they told us that they would hold us two items of clothing and ask the person what they would prefer to wear that day. We saw that there was no reference to people's mental capacity in their care records and what decisions people may need support with and how staff could promote choice. People and their relatives told us that staff would always explain what they were doing and would ask for consent before providing support. One person commented, "Yes, [the staff] always ask me [before providing support]."

Good

Is the service caring?

Our findings

The service was caring. People and relatives we spoke with were positive about the care provided by staff. One person explained, "The staff are caring, very much so. They seem to [care] as they do as much as they can. They always make sure I'm happy before they leave." One person's relative told us that they were pleased with the way that the service had put together a care package for their relative at short notice.

Staff we spoke with were able to tell us in detail about people's care needs. Whilst there was little information about people's personal histories, staff knew people's history and how they preferred their care to be delivered. Staff spoke about people in a warm and enthusiastic manner. We heard staff in the office speaking with people who used the service. We noted that staff spoke to people in a warm and friendly manner and took time to listen to people without rushing them. People we spoke with told us that they felt listened to by staff and that they made time to have a conversation. One person commented, "We have good conversations about the news." One person's relative explained, "The carers have got used to me, they know what we want, they listen."

People, and their relatives, where appropriate were involved in decisions about their care. One person told us, "A member of staff comes over every three months to review [person's] care." We saw that people or their representative had signed their care plan. This demonstrated that people understood what information their care plan contained.

When new staff started working for the service, people and their relatives told us how they were introduced to new staff gradually. One person explained, "If there's [a new member of staff] they will shadow one of my usual carers so I can meet them. They teach the new staff how I like things done."

People and people's relatives we spoke with told us that staff understood how to treat people with respect and uphold people's privacy. One person's relative explained, "[The staff] always speak to [person's name] respectfully and treat them with dignity." Staff explained to us how they would ensure that curtains and doors are closed when they are supporting a person with their personal care.

People were supported to be as independent as possible. One person explained, "[The staff] let me try and do things for myself. All I have to do is ask if I need help with anything." Another person explained to us that they were registered blind and staff would organise their food in a clockwise fashion and explain what food was on their plate. They told us that this helped them to eat independently. A third person's relative told us, "[The staff] take the trouble to listen to [person's name]. They speak to him in a motivating and friendly way, they listen."

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive. Whilst staff knew people's physical care needs well, there was a lack of information in people's care records about their emotional wellbeing. Some people were also living with a mental health disability and we did not see any evidence in their care records about how to support them in maintaining their mental wellbeing.

After our inspection, the registered manager sent us a revised care plan for one person. This was to demonstrate that they had taken a more holistic approach to planning people's care. We saw that the revised care plan identified people's psychological and emotional needs but did not provide sufficient detail about what support that person required when they were experiencing low mood. For example, we saw that they were less likely to eat when they were feeling low. The care plan stated that staff would reassure them. There was no specific guidance for staff to detail what support should be given to help the person to maintain a sufficient nutritional intake.

People's care records were reviewed on a regular basis and we saw that they were updated when people's needs changed.

People and their relatives we spoke with told us that staff would be flexible when it came to changing visit times and duration. One person's relative explained to us that the staff agreed to change a visit time so their relative could attend a hospital appointment.

People we spoke with told us that they had the same staff visit them. One person told us, "Most of the time I get [the same staff], I'm used to who's coming and they know me well."

People were supported to maintain their interests and relationships. One person told us, "When my husband died I felt isolated. [The staff] helped me a lot and helped me to meet other people."

Staff attended to people's needs in a timely manner. For example, we heard a member of office staff speaking with a person about a broken piece of equipment that helped them to maintain their independence. We heard that the staff member was reassuring and made several calls to ensure that a replacement was with the person by the following day. We saw that the staff member would keep the person updated with regular telephone calls regarding the issue. People we spoke with told us that they felt the staff were responsive. One person commented, "[The staff] would come if I need them."

There was a complaints procedure in place and we saw that complaints were dealt with in a timely manner according to the provider's policy. Everyone we spoke with felt able to raise any concerns. One person's relative told us, "I'm happy to raise a complaint if needed."

We saw that people's preferences regarding the end of their life were documented in their care records. We noted that some people had forms in place to show that they did not wish for resuscitation to be attempted in the event of a cardiac arrest

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well led. At our previous inspection on 10 November 2016 we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of effective systems in place for monitoring and assessing the quality and safety of the service. Arrangements for assessing and monitoring risks were not robust. The checks in place did not identify the shortfalls that were found as a result of the inspection. Records were not always complete, including records relating to people's care and staff recruitment. The provider completed an action plan which stated that action to meet the regulation would be completed by 13 February 2017.

We found at this inspection that improvements had been made but we still had concerns relating to the lack of effective systems in place to monitor and assess the quality of care being provided to people. The provider used an independent company to audit the quality of the service being delivered. We looked at the most recent audit and found it was not an in depth evaluation of the service. There was no detailed examination of people's care records or MAR charts to ensure that people were receiving safe and effective care. The audit also failed to identify that people's mental capacity had not been assessed. Whilst we found no gaps in the recording of the care people received, care plans and risk assessments were not specific enough to provide staff with the guidance about how best to support people with their individual needs. We concluded that the system in place to monitor and assess the service was not robust and was ineffective at identifying and managing risks to people.

These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was clear leadership in place. We saw that the registered manager had an open door policy and that staff were comfortable with approaching them with any queries. Staff we spoke with told us that they felt supported by the registered manager. One staff member told us, "If I need anything I just ring the office. [Registered manager] is always there, always got time for a chat." People and relatives we spoke with also told us that they thought the registered manager was approachable and felt listened to.

At our previous inspection on 10 November 2016 we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered manager did not always notify us of specific incidents which is required by law. During our most recent inspection we found that the registered manager notified us of incidents and the provider was no longer in breach of this regulation.

The registered manager told us that they felt supported by the provider and received regular supervisions themselves. This gave them the opportunity to discuss any support they required with their role and any training needs.

The provider regularly sent out satisfaction surveys. We noted that most of the responses were positive,

however, when people had expressed a dissatisfaction with the service, this was not always followed up. We were told by one of the office staff that people were called to discuss any issues but this was not always documented. The responses from the surveys were not collated. This meant that patterns and trends which may highlight any shortcomings in the service were not acted upon.

Regular staff meetings took place and this gave staff the opportunity to be involved in developing the service. Staff we spoke with told us that they found the meetings supportive and it enabled them to get together with other staff and discuss people's care needs.

Staff told us that there was frequent communication from both the registered manager and the provider. This was through text messages, meetings and via a monthly newsletter. We saw throughout our inspection that care staff would visit the office to report any concerns to the office staff who would then take the appropriate remedial action.

The registered manager and staff from the service worked closely with other organisations such as the local authority and local acute hospitals. We saw detailed assessments of people's care and support needs completed by the local authority in all of the care files we looked at. We saw during our inspection that staff would liaise with the local hospitals to ensure a smooth transition for the people when they were returning home.

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 17 HSCA RA Regulations 2014 Good governance Suitable systems were not in place to monitor, assess and improve the quality and safety of the service. Accurate and complete records were not maintained in respect of each person who used the service this included assessments of people's mental capacity. Regulation 17(1)(2)(a)(b)(c)(f)