Notaro Homecare Ltd

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

Summary of findings

Overall summary

About the service: Notaro home care provides personal care to around 250 people. It provides personal care support to people with a range of physical and mental health care needs.

People's experience of using this service: People were supported by staff who they felt were kind and caring.

Feedback was sought by the local authority contracts team however the provider had no system in place to monitor feedback from people, relatives and staff.

Staff had good relationships with regular carers who knew them well, although people, relatives and professionals all felt some improvements could be made to receiving regular staff who knew them well.

People's care plans had risk assessments in place.

Recruitment procedures were completed before new staff began work.

Supervision, appraisals and enabling staff to undertake the care certificate required improving.

Records relating to the recording of medicines administered, cream charts and body maps and having records available to staff required improving.

The service provided a reablement service so that people could receive support to regain their independence following a fall, being unwell or a hospital admission.

People were supported by staff who demonstrated dignity and respect, however improvements could be made to not sharing personal information with other people using the service.

Care plans were personalised and contained important information relating to people's likes and dislikes. One person required their care plan updating with their change in visit information.

Some actions had been identified through audits and an action plan was in place.
Rating at last inspection: Requires Improvement (April 2018)

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we made two recommendations around handling and acting upon complaints and care planning that reflects people's end of life wishes. Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We will review the report on actions the provider intends to take following the inspection. We will continue to monitor the service through the information we receive. We will inspect in line with our inspection programme or sooner if required.

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 effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Notaro Homecare Limited

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one adult social care inspector, and 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. The expert by experience's area of expertise was older people.

Service and service type: Notaro Home Care is a domiciliary care service that provides personal care to people living in their own homes.

The service had a manager however they were not, at the time of the inspection, registered with the Care Quality Commission. They confirmed they planned to be registered manager and be legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was announced.

We gave the service 5 days' notice of the inspection site visit so that consent could be gained for phone calls and home visits.

Inspection site visit activity started on 20 March 2019. We visited the office location on 20 & 21 March to see the manager and office staff; and to review care records and policies and procedures.

What we did:
We reviewed information we had received about the service since the last inspection in April 2018. This included details about incidents the provider must notify us about. Prior to this inspection we did not request a Provider Information Return (PIR). Following the inspection, we sought feedback from the local

authority and professionals who work with the service. We gained views from two of these.

During the inspection we made calls to 10 people receiving the service and we visited three people. We spoke with five carers, four office staff and the manager. After the inspection we contacted five relatives and gained views from one. We reviewed six people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

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 our last inspection in January 2018 we found the provider had made improvements to the recording of Medicines Administration Records (MARs) however improvements needed to be sustained.
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.

Using medicines safely
● People's Medicine Administration Records (MAR) were not always accurate and up to date. For example, we found gaps in people's MARs where medicines had not been recorded as given. We also found where a 'X' or 'O' had been recorded there was no explanation as to the reason the medicines hadn't been given. This is important as, having a clear record of why the medicines had not been given means there is a clear audit trail of reasons.
● MARs charts did not always contain information about people's allergies. For example, one person's MAR's charts had missing information relating to their allergy.
● Where people required topical medicines such as creams there was no body map or guidance in place for staff to follow. This is important as staff require clear guidance on when and where to administer people's creams.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People had mixed views and experience of when they received their visits and if they received their visits from staff who they knew. Some people felt communication could be improved. People told us, "It's a bit annoying when they are late and you don't get a phone call to tell you". One person said, "They can be anything from half hour early to 2 hours late". Another person told us, "Staff generally arrive on time. If they are late then it's down to traffic and they ring her to advise". Another person said, "They are sometimes late. They do ring to let me know if they are running late".
● The service sent people a list of staff they could expect for the coming week. However, people felt this didn't always reflect who visited them. One person told us, "The coordinator is finally giving out rotas, but this is never right. It's always a surprise to see who walks through the door". One member of staff confirmed they felt additional staff were required. They told us, "They are still a bit short staffed at the moment although it's better than it was".
● The service aimed to allocate all visits a week in advance. Co-ordinators were responsible for allocating these visits. We found all visits were allocated for the coming 48 hrs, but some visits still required allocating after this time. One professional felt the service had improved over the last six months. They said, "I would say that the service is much improved over the past 6 months. I have a particular client who had lots of problems with different carers, different times and staff who did not read the care plan. However, care has now been established for morning calls and is working well. It is not so good for the evening calls but is

improving".
● The provider was following safe recruitment procedures. This meant new staff had a full Disclosure and Barring Service check (DBS) completed, references and an interview before commencing employment.

Preventing and controlling infection
● Staff demonstrated using personal protective equipment (PPE) such as aprons and gloves when required however one member of staff failed to dispose of their PPE before signing the person's care file. This meant by not disposing of the PPE following providing personal care, the risk of cross contamination could be increased.

Learning lessons when things go wrong
● Accidents and incidents were reported and recorded.

Systems and processes to safeguard people from the risk of abuse
● People felt safe. People told us, "Yes, I feel safe, they do everything I need help with". Another person told us, "I've got to know them, they are all very trustworthy, I prefer it when I know somebody". One professional told us, Notaro "Pick up extra calls when needed to keep [Person] safe and are responsive with requests."
● Staff received training on safeguarding adults and most were knowledgeable about the procedures to follow if concerns arose. One staff member was only able to confirm they would speak to someone at the Notaro office. They were unable to confirm who else they would report issues to until they were prompted. They did give an example of when they had raised a concern to their manager.
● Referrals were made to the local safeguarding authority when appropriate. Investigations and any actions were taken to safeguard people.

Assessing risk, safety monitoring and management
● Risk assessments were in place for people. These included fire safety and falls risk assessments.
● Risk assessments were also in place for the environment. This included confirming people's emergency shut off valves, such as gas and electric.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- Staff were not always receiving regular supervision or an annual appraisal so that their performance was reviewed. The manager confirmed this was an action they were in the process of addressing.
- There was no system or process in place at the time of the inspection for staff to receive a set of standards called the Care Certificate. This set of common standards is expected for those who provide care to people. However, staff received mandatory training.
- New staff received an induction and shadowing shifts to ensure they were confident before working by themselves. Records confirmed this.
- All staff felt supported and able to raise concerns with the manager and their co-ordinator.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care plans confirmed any religious or cultural needs. Staff had a good understanding or equality and diversity. One member of staff told us, "Treating everyone equal regardless of upbringing, religion, beliefs, disabilities, age, gender, culture and race."
- Staff gained consent before they supported people.

Ensuring consent to care and treatment in line with law and guidance

- 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.
- The service was working within the principles of the Mental Capacity Act (MCA). No-one at the time of the inspection lacked capacity. One of the care co-ordinators confirmed if people lacked capacity they seek the appropriate support from health and social care colleagues.
- People's care plans confirmed if people had an advocate or identified lasting power of attorney, however there was no legal records that confirmed these agreements. By not having a copy of the record means any decision is made without having the authorised agreement within the person's care plan.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported, if required, with a diet of their choice. Staff asked people what they wanted to eat and drink and if they wanted additional drinks left for them. Staff showed people the different meal options.
- Where people had food and fluid charts that recorded the amount they had received improvements could be made in recording the specific quantity rather than recording half a plate or half a bowl.

Staff working with other agencies to provide consistent, effective, timely care

● Advice and support was sought from other professionals such as occupational therapists, social workers, physiotherapists and district nurses. People's care plans confirmed professionals involved.

Supporting people to live healthier lives, access healthcare services and support

● People's care plans had important information relating to specific health conditions. People felt supported by staff with appointments. One person told us, "The carers have called the GP for me in the past". Another person told us, "The carers rang my GP last week as I was feeling under the weather".

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People were supported by staff who were kind and caring. One person said, "They are very kind". Another person said, "The carers are kind and very good". One person however felt that their regular carers were good, but that some carer's attitude wasn't good. They told us, "Most of the carers are wonderful". They went on to say it was just a few that they felt had 'no idea what they were doing'.
- People felt they had developed positive relationships with their carers. We observed staff engage in conversation with people and talk to them about how they were and about their day. One person said, "I like them, I trust them". The person went on to confirm that staff had taken the time to get to know her. Another person said, "They are very pleasant and talkative".
- The service had received several compliments. Compliments about the care received included, 'To all the staff at Notaro, just to say thank-you all so much for looking after [Name], it was much appreciated, and you were all so lovely'. Another compliment said, 'Dear manager and staff. I wish to thank you all for the great care and kindness you showed my dad during his care at home. As a family it meant so much to us that [name & name] could remain together at home. Please forward our gratitude to all those that cared and made my dad smile everyday'.

Respecting and promoting people's privacy, dignity and independence

- Although staff were knowledgeable about maintaining confidentiality of information, during the inspection we witnessed an example where personal information was spoken about in front of another person using the service. The member of staff confirmed the information shouldn't have been shared. It is important for care staff to retain personal information and not to discuss this in front of another people using the service.
- Staff respected people's privacy and maintained people's dignity. One person told us, "I feel that they respect my home. They can see how I like it kept and they respect me by leaving it that way then they go". Another person said, "They really are very good, and they don't treat me like a silly old lady".
- People were encouraged and supported to remain independent. One person said, "They ask me how I like things done, I do not know what I would do without them". Staff gave examples such as encouraging people to wash and dress themselves if they wished.
- The service provided a reablement service so that people could receive support to regain their skills and confidence following a fall, being unwell or a hospital admission.

Supporting people to express their views and be involved in making decisions about their care

- People were asked about their care and support. For example, we observed staff ask what meal they would like and if they required the heating on.

● People felt part of making decisions about their care. One person said, "Staff are approachable they always listen to me, and ask me what I need doing". Another person said, "I meet the manager, to discuss my needs to put into my care plan".

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

On our inspection in September 2017 we found the provider was in breach of not investigating complaints or taking necessary action to prevent similar incidents from occurring. Complaints related to late and missed calls. At this inspection we found some improvements had been made however we have recommended that the provider addresses people's feedback so additional improvements can be made.

Improving care quality in response to complaints or concerns

● People and relative's feedback was that they had been raising concerns with the office about poor care experiences. For example, some people confirmed they were experiencing problems with late visits. One person told us, "I've lost count at the number of times I've complained about it, sometimes it gets better for a few days, but it soon goes back to being erratic". The person said they had met with the previous manager, however they had not meet the new one. Another person told us, "The care varies depending on who visits. It's not really consistent if I am honest - I do not wish to make a complaint but on occasions I can be sitting around half dressed for most of the morning waiting for someone to come and help me to get washed and dressed". One relative said, "My husband rang the office the other day as a carer upset [person] due to talking about their personal problems". They went on to also say that late visits were regularly experienced and on occasions medication was missed.

● The manager confirmed one complaint had been received. This had been investigated and responded to in line with the providers policy, however no other complaints received had been recorded, although people and relatives said they had raised them.

● We reviewed the feedback people had provided as part of the providers quality monitoring. People's feedback confirmed out of 25 responses, four people were unsatisfied with how their complaint had been dealt with. One person was very unsatisfied.

We recommend the provider seeks best practice guidance in relation to identifying complaints and taking necessary action to prevent similar experiences from occurring.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People's care plans were personalised and contained important information such as people's routines, their likes and dislikes, life stories and personal preferences. However, we found one person's care plan required updating as they were only receiving one call a day not the two as recorded in their care plan.

● People were given choice and control. One person told us, "I am given choice if I want a shower or a wash". Another person told us, "Everything is my choice".

● One professional confirmed they found undertaking joint reviews with office staff helpful. They told us, "I have met with [Name] and [Name] on joint reviews and find them both helpful and responsive when I call the office".

End of life care and support

● One person at the time of the inspection was receiving support with their end of life care. Their care plan contained minimal information relating to their funeral wishes and their wishes around how they wanted to have care provided towards the end of their life.

We recommend the provider explores best practice around developing care plans for people receiving end of life care.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

At our last inspection in September 2017 we found the provider was not accurately registered with us and records were not accurate and up to date. At this inspection we found the provider was accurately registered with us and that people had current care plans and risk assessments.
However, improvements were still required to Medicine Administration Records (MARs).

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● We found that people's Medicine Administration Records (MAR) were not always accurate and up to date. For example, we found gaps in people's MARs where medicines had not been recorded as given. As well as no explanation as to the code used for medicines that hadn't been given. We also found MARs charts did not always contain information about people's allergies. Along with no topical medicines body map or guidance in place for staff to follow. Shortfalls had not been idetified through the providers medication audit.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new manager had started two weeks prior to our inspection. The previous registered manager had left. This meant at the time of the inspection the service had no registered manager in post.
● An action plan was in place which had been agreed with the local authority compliance team. Actions required included the manager undertaking staff supervisions, annual appraisals, and some staff files required documentation such as references and a disclosure and barring service check. This meant some shortfalls had been identified prior to our inspection and the manager was working with the local authority to address the shortfalls.
● Some staff were not receiving support to complete a set of standards called the Care Certificate. For example, at the time of the inspection there was no system in place so that staff could undertake their care certificate as required by a basic set of competencies.
● The service had an audit in place for monitoring shortfalls relating to people's care plans. The audit identified missing information and paperwork. Actions were being taken to address these shortfalls.
● The provider had displayed their CQC rating at the service and on their website.
● Notifications were submitted as required.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● People had mixed views on their care experience as some people felt their visits could be inconsistent with who arrived and the timings. For example, one person said, "I've requested a 9am visit but when Notaro took over the calls they are as late as 10.30 / 11am. It's a real pain as my lunch is between 11.30 and 12.00. I would really like to know who's coming and when, it's a real pain not knowing. I don't receive a phone call to advise me if someone is going to be later than 9/9.30am, nor do I get a call if the carer is sick".
● People felt communication with staff was positive. One person told us, "Staff are approachable and eager to learn. They are respectful and take on board the way I like things done." Another person said, "They are very pleasant and talkative".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had been sent a survey from the local authority contracts team however the provider had no survey in place that sought views from people, staff and professionals. The manager confirmed they had plans to address seeking feedback through a satisfaction survey however this wasn't in place at the time of the inspection. Following the inspection the provider confirmed they had collated people's feedback into an improvement plan.

Continuous learning and improving care
● At the time of the inspection the new manager hadn't undertaken any staff meetings. We were unable to find previous meetings held with staff. The local authority action plan confirmed the manager was required to address this shortfall. They planned to hold a meeting with staff soon after our inspection.
● Staff could receive regular updates to people's care, wellbeing and visits, and staff could access this information by logging into their mobile phones.
● Staff felt improvements had been made in the short time the new manager had been in post. One member of staff told us, "No troubles working for the agency. If I have ever had to swap a shift they have always done as much as they can to support me. It's settled down loads and I'm happy".

Working in partnership with others
● The service was working with the local authority contracts and commissioning team to improve the service and people's experience.
● The service also worked in partnership with social workers and other community teams. The manager confirmed there were plans to have a board within the foyer area of the office that would have important information for the community to access.

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 The provider had no effective systems in place that identified shortfalls relating to the recording of medicines, cream charts. 17 (2) (b) (c)