New Age Care Limited

New Age 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
New Age Care is a is a community-based care provider that provides personal care to people living in their own homes. At the time of inspection, the provider told us they supported 65 people but not everyone received a regulated activity.

Forty two people were in receipt of the regulated activity of 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 received care calls ranging from 30-minutes up to 24/7 live in support.

People's experience of using this service and what we found
At our last inspection, we found significant improvements were required around managing people's risks and risks to support safe medicines management, quality of record keeping and quality assurance processes. At this inspection, some improvements in implementing and recording audits and checks had taken place. However, in some cases, audits were not always completed on time and where some audits were completed, the provider had not identified the issues we found at this inspection which could put people at risk of harm. The provider remained in breach of the regulations.

Some care plans continued to require further information to ensure they supported person centred care. Some risk assessments although completed, needed additional information to ensure the overall risks were fully documented. Speaking with staff, this showed us staff knew people's needs and how to manage known risks.

Serious incidents had not always been fully investigated, reported and reviewed to ensure people remained safe. Some safeguarding concerns were not fully investigated and referred to us or other agencies to keep people protected.

People did not always receive their prescribed medicines safely. Systems to support safe medicines practices needed further improvement. Medicine Administration Records (MAR) did not always accurately record what doses people were administered or if those medicines were given in line with manufacturers guidelines. In some examples, people who required 'as and when' medicines did not have a detailed protocol in place to tell staff, when, how and what dose, these medicines should be given safely.

Improvements to monitor and organise staff training, staff development and monitoring staff competency had improved since our last visit.

Whilst we found continued issues related to record keeping and a lack of quality assurance, people and relatives spoke highly of the service they received. People and their relatives told us they had built good relationships with those staff who cared for them, and they explained how the service they received,

supported positive outcomes.

People told us they received their care at the right times and people said they were supported by a consistent staff team.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, we found inconsistencies in the records to evidence where family members had authority to speak on their family members behalf. We also found inconsistencies in how people's mental capacity was supported, especially if a person's capacity to make certain decisions varied.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 05 April 2023) and there were breaches of regulation. Following the last inspection, we requested that the provider sent us an action plan telling us what they had improved. At this inspection, we found the provider remained in breach of regulations.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. The providers action plan told us what they would do and by when to improve.

This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for New Age Care on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safety and oversight of the service at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service

under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

New Age Care

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 Health and Social Care Act 2014.

Inspection team
The inspection visit was completed by 3 inspectors and 1 further inspector worked off site making telephone calls to people and relatives. An Expert by Experience also made telephone to people and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection visit was unannounced. The first day of our inspection was unannounced. We informed the provider we would return to continue our inspection the following day.

Inspection activity started on 9 October 2023 and ended on 16 October 2023.

What we did before inspection
We reviewed the information we held, such as people and relatives' feedback and statutory notifications, as

well as any information shared with us by the local authority and commissioners. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 1 person who received a service to get their experiences about the quality of care received. We also spoke with 7 relatives. We spoke with 9 members of care staff that included office staff who supported the registered manager with audits, checks, care call scheduling, care assessments and care planning. We spoke with the owner who was 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. These included examples of 5 people's care records, as well as associated records that included daily report logs and medicine administration records. We reviewed 4 staff recruitment files, policies and procedures and examples of quality assurance checks and meeting minutes.

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 Inadequate. At this inspection this key question has changed to requires improvement. 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.

At our last inspection we found systems and processes were not good enough to demonstrate risks associated with people's care were effectively managed. This included managing risks associated with safe medicines management. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

Using medicines safely

- People did not always receive their medicines safely and in line with their prescription.
- Staff did not always record or record correctly when medicines were given on a person's medicines administration record (MAR). For example, one person's medicine for August 2023 was to be given in the morning and evening. Records showed it was only given in the morning. For September 2023, this person's MAR had not been completed, yet staff told us they had administered this medicine.
- Some MAR had gaps which meant we could not be sure those people had been given their medicines as prescribed.
- One person had several medicines that were prescribed to be taken in the mornings. Records did not evidence these medicines were always being given as prescribed. Taking medicines as prescribed is essential to ensure effectiveness and minimise negative side effects.
- One person was prescribed a pain-relieving medicine with the prescribing instruction it should be taken at 4-to-6-hour intervals. MAR did not evidence that the required gap was consistently being maintained between doses which could place the person at risk.
- Variable doses of medicines were not recorded clearly so it was not possible to know what dose had been given.
- We saw one example for a medicine to help manage a person's anxiety. This medicine was to be given on an as and when basis, but staff administered this medicine without a safe protocol in place. This meant staff were not always clear when and how to give this medicine safely. We told the registered manager about this and a protocol was put in place, but it was not clear as to what dose to give the person and when. This meant the medicine was not being given in accordance with prescribing instructions.
- We checked how medicines were given to a person who had swallowing difficulties. Staff told us they crushed all medicines and gave with food, yet there was no instructions or guidance from a prescriber to ensure that those medicines were given safely. This was not in line with safe medicines practices and guidelines.
- Some incidents of missed medicines went without investigation. We saw an accident and incident record for a person in June 2023 which recorded they may have had a medicine overdose. However, this was not followed up or investigated to check the person's welfare and what may have caused this or actions to

prevent it from happening again.
● Monthly checks of medicines failed to identify the concerns we found.

Assessing risk, safety monitoring and management;
● Overall, risks to people's health had been identified. However, risk management plans were not sufficiently detailed to ensure a consistent and safe approach by staff when supporting people's needs. For example, where people needed specialist equipment for moving and transferring or to maintain their skin integrity, there was no information about the checks staff should complete to ensure equipment remained in good working order and safe to use.
● One person had an allergy to latex. Care records had not assessed or mitigated the risks associated with this allergy.
● At our last visit we found 1 person did not have a care plan to direct staff in how to manage their diabetes. We found for one person with diabetes, there was no care plan which meant staff did not have important information to know how to manage any high or low blood sugars.
● On 9 October 2023 the provider told us they had supported a person with personal care and a personal care plan needed to be completed. We checked on our return on 16 October 2023 and this had still not been completed.
● We reviewed a care plan for a person who could become very anxious and agitated. This person had a mental health care plan but there was no information to tell staff, how behaviours would present themselves, what approaches worked well and how to manage the behaviours to keep the person safe. A lack of effective risk management meant staff did not have accurate information to manage people's risks safely.
● The provider was not able to demonstrate an effective system for overseeing incidents and accidents to identify any themes or trends to reduce the risk of reoccurrence and share lessons learned. Some incidents such as falls and medicines errors went unrecorded and where not reviewed as part of the providers monthly checks.
● The provider had failed to fully learn from our last inspection which had potential to expose people to potential harm.

We found no evidence people had been harmed however, the provider continually failed to robustly assess all necessary risks relating to the health safety and welfare of people. This placed people at risk of harm. This was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● At our last inspection, the provider failed to complete safe recruitment checks to ensure people were safe and protected. At this visit, we saw improvements had been made.
● A designated staff member was responsible for staff recruitment, and they completed all the required checks to ensure staff were of suitable character. Safe recruitment checks included obtaining written references from previous employers and checks with the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There were enough staff to meet the needs of the people using the service.
● People told us they received support from a staff team who knew them well and who were consistent in their care delivery.
● People raised no concerns staff had missed their calls. If calls were running late, people said they were notified. People and relatives said if they needed to contact someone about care calls, this was supported and there was flexibility to add or stop care calls when needed.

Learning lessons when things go wrong

● The provider's systems and processes were not sufficiently embedded to enable areas of improvement to be identified and acted upon. For example, we identified 2 separate incidents that had not been captured in the provider's overall analysis of accidents and incidents. This meant the provider could not assured they were accurately identifying any trends or patterns or learning needs.

Systems and processes to safeguard people from the risk of abuse

● We were not assured, everyone who received a service was safeguarded. During this inspection we saw and heard of examples where people had raised concerns around their financial vulnerabilities. When people shared concerns with the provider, there were limited or no records to show how those people had been protected. In three examples, the provider failed to notify us of those incidents which was their legal responsibility.

● People and relatives' feedback to us was they felt safe and satisfied with those staff who supported them. Comments included, "[Relative] adores them, they are like daughters to her" and "I know most of them now and if I have a problem they will change the visit to enable me to do what I have to do. They are very flexible, and I feel very confident with them."

Preventing and controlling infection

● People and relatives were satisfied with actions taken by staff to reduce risks of infection.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● We found an inconsistent approach to supporting people who lacked or who had fluctuating capacity. In some examples, people who had capacity, staff supported and for others, staff deferred to family members instead of seeking that person's consent or wishes for certain aspects of their care.
● From speaking with office staff and management there was a lack of understanding in how a person's mental capacity was considered, especially if it fluctuated. There was no formal assessment or best interest meeting to determine the best outcome for that person.
● In one example, a person was deemed to have capacity and their wishes were not respected by the provider. There was a lack of understanding to seek and follow peoples expressed wishes.
● Copies of Lasting Power Attorney (LPA) orders were not always available to confirm if these were for finance, health and welfare. This increased the risk LPAs would not be appraised of appropriate decisions to be made in people's best interests.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed, but those in some examples needed further improvement and details to ensure people continued to achieve effective outcomes.

Staff support: induction, training, skills and experience
● People felt staff were trained and knew how to look after them. One person said, "Yes. I understand they have training courses. They are always thinking of what I need.".
● A dedicated member of staff had been recruited to develop the provider's training programme and ensure

staff had the skills, knowledge and confidence to provide safe and effective care. This member of staff explained, "I think the vision is to make sure everyone has the skills and knowledge to deliver care and support in the way it needs to be delivered and it is person centred."

● A system of observations and spot checks were being implemented to ensure learning was embedded in staff practice. The staff member responsible for training told us, "We do monthly spot checks now and if any concerns are raised by seniors, I will be involved, and we will look at it and any additional training that is required."

● Specific training for supporting autistic people and people with a learning disability was being introduced through the service. For staff who provided support to people with a learning disability, they had received this training.

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

● Where people needed support with eating and drinking, this was recorded in their care plans.

● People and relatives said staff helped support them with meals and drinks and their choices and preferences were respected. One relative said, "They [Relative's] had breakfast and a cup of tea and [Relative] tells staff what they want. Staff always leave a glass of water by the chair where [Relative] sits."

● In some cases, families prepared meals and staff gave the person those meals already prepared, or, staff helped people in they wanted alternatives.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.

● The provider ensured the service worked across organisations to deliver effective care, support and treatment. For example, working with local GP practices, community nurses and local authorities.

● People were supported to live healthier lives, access healthcare services and support. Where people did not have family to support them with appointments, staff made those appointments and where necessary, took people to the appointments.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection, the provider did not demonstrate effective governance, including assurance and auditing systems or processes. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection enough improvement had not been made and the provider remained in breach of regulation 17.

● We acknowledged some improvements had been made, such as improved recruitment practices. However, it was evident there remained a lack of understanding and knowledge to know what the purpose of the audits were and what they did with the findings.
● For example, accident and incident analysis was not always completed and, in some cases, serious events or incidents went unreported. This meant incorrect patterns or trends would not show what was going on within the quality of service. We spoke with the registered manager and business manager and it was clear they lacked consistency in what constituted an incident.
● For example, some medicines errors were reviewed others were not. A serious injury was missed off July 2023 analysis. This meant the provider was not aware of all incidents to take appropriate steps to investigate. Post our inspection, we discussed those concerns with other agencies.
● Medicines audits were not always completed. Where those audits were completed, they failed to identify the issues we found that we have reported on in this report under Safe.
● Issues identified during this inspection were similar to issues we identified at the previous inspection. The provider had failed to follow their own action plan to make the necessary improvements. They told us by May 2023 they would have met their regulatory requirements.
● The registered manager told us care plans and risk assessments had improved but we continued to find some plans of care continued to lack details. In some cases, there was no care plan to manage certain health conditions or tasks. This had not been identified through improved practices and processes.
● There remained no effective system of continuous improvement. There was a lack of effective reporting, investigation and referral of serious concerns to us and other agencies. We found 3 safeguarding incidents that should have been made to us and a serious injury notification. The registered manager said they were not aware we needed a notification.

A continued lack of effective reviews and quality assurance systems had not taken steps to drive improvements through effective governance and quality assurance. The above issues demonstrate a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

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

● The management team through a lack of their own checks were sometimes reactive to issues raised by people and relatives, rather than preventing them from happening. One relative said they felt the onus was on them demonstrate a concern and they didn't always feel believed.

● CQC were not informed when serious incidents had happened which was their legal responsibility to notify us.

● The registered manager had met the legal requirements to display the services latest CQC ratings on their website.

● The registered manager and provider responded positively to our visit and was committed to address the improvements we discussed at the time of our visit.

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

● There was a positive and open culture at the service of wanting to do better. We received mixed feedback from people and relatives when raising a concern. Some relatives told us it was challenging to get some things resolved while others felt the management team responded well to feedback.

● The registered manager explained how they had introduced new systems and checks to improve the service from the last inspection. We could see some improvements had been made, for example better recruitment and some audits had been implemented. The registered manager and provider told us they wanted to continually improve the service.

Working in partnership with others

● The registered manager worked in partnership with other healthcare and external professionals. This included district nurses, GPs and community nurses.

● Management staff attended a recent national care show and signed up to online support and manager forums. The registered manager told us they were willing to learn about new practices and guidance related to care practices and improving standards at New Age Care.

● The provider needs to understand their role and the role of the regulator, as well as the regulations to help drive the changes they want to make.

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

● Staff initiatives to make them feel valued such as 'carer of the month' were in place. The registered manager said they wanted to reward staff for what they did.

● People and staff were involved in the running of the service and understood and took into account people's protected characteristics. People were asked what gender of care staff they wanted to support them. We could see from people's feedback people and staff got on well with each other.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider continued not to adequately assess and protect people from risks. Those risks were associated with how people received their medicines. Systems and processes to check people received their medicines safely were not always effective.

The enforcement action we took:

Warning notice sent

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider continued not to ensure they operated robust quality assurance systems and processes effectively to monitor the service appropriately, including people's safety.

The enforcement action we took:

Warning notice