Nomase Care Ltd

Nomase Care Ltd - Chadwell Heath

Inspection report

Room 17, 321 - 323 High Road
Romford
RM6 6AX

Tel: 01708933988
Website: www.nomase.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an announced inspection of Nomase Care Limited on 4 June 2018. Nomase Care Limited is registered to provide personal care to people in their own homes.

The 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, the service provided personal care to 74 people in their homes. This was the first inspection of the service since it registered with the CQC.

The service had two registered managers. 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 legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is run.

Some risks to people were not always robustly managed. We found some care plans did not contain suitable and sufficient risk assessments to effectively manage risks. We made a recommendation in this area.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and were aware of the principles of the act. Records showed that one person did not have capacity to make decisions and an assessment of their capacity using the MCA principles had not been carried out. We made a recommendation in this area.

Quality assurance and monitoring systems were in place to ensure there was a culture of continuous improvements. However, this had not identified the shortfalls we found in relation to risk assessments and MCA assessments. The registered manager informed us that they will ensure the systems would be made more robust.

Staff were aware of how to identify abuse and knew who to report abuse to, both within the organisation and externally.

There were arrangements in place to ensure staff attended care visits on time. Staff told us they had time to provide person centred care and the service had enough staff to support people.

Pre-employment checks had been carried out in full to ensure staff were suitable to provide care and support to people safely.

Staff had been trained to perform their roles effectively. Staff had also been trained in specialist training to help support people with complex care needs.

Pre-assessment forms had been completed to assess people's needs and their background before they started using the service. Reviews were held regularly to identify people's current preferences and support

needs.

People were being cared for by staff who felt supported by the management team.

People were supported to access to healthcare if needed.

People's privacy and dignity were respected by staff. People and relatives told us that staff were caring and they had a good relationship with them.

Staff, relatives and people were positive about the management team. People's feedback was sought from surveys.

Complaints received had been investigated and relevant action had been taken. Staff were aware of how to manage complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Some risks assessments had not been completed for people with identified risks.

Pre-employment checks had been carried out to ensure staff were suitable to care for people safely.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

There were appropriate staffing arrangements to ensure staff attended care visits.

Appropriate infection control arrangements were in place.

Is the service effective?

Good

The service was effective.

Staff received essential training needed to care for people effectively.

Assessments had not been carried out using the MCA principles to determine if people had capacity to make certain decisions. Staff had been trained on the MCA and requested people's consent before carrying out tasks.

People's needs and choices were assessed effectively to achieve effective outcomes.

Staff were supported to carry out their roles.

People had access to healthcare services when required.

Is the service caring?

Good

The service was caring.

Staff had positive relationships with people. People and relatives told us that staff were caring.

People and their relatives were involved in decision making on the support people received.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive

Care plans were person centred and included people's support needs.

Staff had a good understanding of people's needs and preferences.

Staff knew how to manage complaints. People and relatives were confident in raising any concerns about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality systems in place had not identified the shortfalls we found during the inspection.

Staff, people and relatives were positive about the management team. Regular staff meetings were held.

People's feedback about the service was obtained from surveys.

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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.

The inspection was carried out on 4 June 2018 and was announced. We gave the provider 72 hours' notice. We announced our inspection because we wanted to be certain that someone would be available to support us. The inspection was undertaken by one inspector and an 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.

Before the inspection, we reviewed relevant information that we had about the provider, including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We also received a Provider Information Return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make. We also sought feedback from health and social professionals.

During the inspection, we reviewed documents and records that related to people's care and the management of the service. We reviewed seven people's care plans, which included risk assessments and five staff files which included pre-employment checks. We looked at other documents held at the service such as medicine, training and supervision records. We spoke with both registered managers, a care coordinator and a care staff member.

After the inspection, we spoke to three people who used the service, six relatives and four care staff.

Good

Is the service safe?

Our findings

People and relatives told us that people were safe. One person told us, "They [staff] know that I am managing, but they always check and say things like, 'have you noticed this, and do you want to have the GP look at that? They are very good."

Staff were aware of their responsibilities in relation to safeguarding people. Staff were able to explain what abuse is and who to report abuse to. A staff member told us, "This is when someone mistreats service users in different ways such as physically, emotionally or financially. If this happens, I will report to my manager and if this continues then I will have to let the CQC know." Staff also understood how to whistle blow and knew they could report to outside organisations, such as the Care Quality Commission (CQC) and the police.

Assessments were carried out with people to identify risks before they started to use the service. Most risk assessments that had been completed provided information and guidance for staff on how to keep people safe and were regularly reviewed and updated. There were risk assessments associated with moving and handling, neglect, urinary tract infection (UTI), falls and infection control. Assessments included the risk and strategies to mitigate risks. A relative told us, "There's always two carers as agreed in the care plan and I've seen them use the hoist which is always done appropriately."

Risk assessments had been completed for people at risk of skin complications. Risk assessments included information on how to minimise risks, such as repositioning people regularly, applying creams and reporting redness in skin to health professionals and management. We saw records for one person who had developed a grade four pressure sore, prior to receiving support from the service and this was now healing. The person required regular repositioning and monitoring of their fluid intake. We saw repositioning charts and fluid intake charts that showed this was occurring. The registered manager told us that by adhering to the risk assessments and working closely with a district nurse, they had ensured the person recovered from their skin complication.

However, we found that some risk assessments had not been completed for people with identified risks. Records showed that some people had specific health conditions, such as Chronic Obstructive Pulmonary Disease (COPD). Risk assessments had not been completed in this area on what actions staff should take if people were short of breath or the triggers that could lead to shortness of breath.

Risk assessments had been completed for people at risk of choking and this included how to ensure people were supported with meals safely. However, this was inconsistent. Records showed that one person was at high risk of choking and there was a recommendation made by a Speech and Language Therapist (SALT) to minimise the risk of choking. However, a risk assessment on choking had not been created with the recommendation made by the SALT. This meant the person may be at risk of harm when eating. The registered manager told us that they would address this immediately.

We recommend that the service follows best practise guidance on risk management.

We checked five staff records to check if pre-employment checks had been carried out. This ensured staff were suitable and were of good character before supporting people. The Disclosure and Barring Service [DBS] is a criminal record check that helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people. Pre-employment checks such as criminal record checks, references, employment history and proof of the person's identity had been carried out as part of the recruitment process.

The registered manager told us the service only prompted people to take medicines and did not administer medicines. Medicines were recorded accurately on people's Medicines Administration Records (MAR) to evidence people had been prompted to take their medicines. Staff had received medicines training and told us that they were confident with prompting people to take their medicines. The registered manager told us that staff were trained in the event they had to administer medicines to people. Medicines were audited by the registered manager as part of spot checks and audits. A spot check is a member of the management team observing care staff when they support people to check their performance. A relative told us, "They prompt [person] to take his medication and there have never been any issues."

People and relatives told us that staff arrived on time and carried out the required tasks. One person told us, "In the morning they are here for two hours between 8am and 10am. They turn up on time, and if they are a little bit late, then it's something with traffic." A relative told us, "Prior to having this company, [previous company] was all over the place. We never saw the same carers twice and the times of the calls were all over the place. Now, there's no need to monitor the log book anymore." A number of compliments had also been received about staff time keeping and comments included, '[Staff members] is always on time, good carer, always happy', 'Quality service, punctual and very polite' and 'The carers are always on time, very good service, always with their uniforms.' Staff told us that they were not rushed in their duties and had time to provide person centred care and support to people when needed.

The registered manager told us that staff were always on standby if staff could not attend appointments. The registered manager informed us that the service had a rapid response team to cover staff that may be running really late or could not attend an appointment. The rapid response team consisted of two care staff members with a dedicated driver. This was confirmed by staff. We checked the staff rota and found staff were given time to travel in between appointments. The registered manager told us that staff were allocated care appointments in certain geographic areas, to ensure they travel less in between appointments. A staff member told us, "We are given enough time to travel." Another staff member told us, "The clients I see are within reasonable travel space." This minimised the risk of missed visits and late calls.

The service had recently purchased a digital monitoring system, which would enable them to monitor staff attendance and time keeping. The service would be alerted if staff did not check in on a visit after a certain time, which allowed them to investigate lateness or missed visits and arrange cover, if needed.

The registered manager told us that there had been no incidents or accidents. There were incident and accident forms available to record incidents. The registered manager told us that if there was any incident, they would analyse this to ensure lessons were learnt and to minimise the risk of re-occurrence.

There were systems in place to reduce the risk and spread of infection. Staff had been trained on infection control. There was information in people's care plans on how to prevent the risk of infection when supporting someone to the toilet or with personal care. Staff were supplied with personal protective equipment (PPE) such as gloves, aprons and sanitisers when supporting a person. Staff told us they disposed of PPE separately when completing personal care. A staff member told us, "They do provide gloves, aprons and shoe covers."

Good

Is the service effective?

Our findings

People and relatives told us staff were skilled, knowledgeable and able to provide care and support. A person told us, "They know what I need doing." A relative told us, "I know they understand [person] needs and do an excellent job."

Records showed that new staff members that had started employment with the service, had received an induction. This involved shadowing experienced members of staff, meeting people and looking at care plans. A staff member told us, "I did shadowing for two days, induction was good." Another staff member told us, "I got an induction, I did shadow and I got further training. Induction was very helpful. Without it, I would not know what to do. It strengthened me." There were shadow training reports that ensured staff were prepared and competent to support people with personal care. Following the induction, staff had received training on the Care Certificate. The Care Certificate is a set of standards that health and social care workers comply with in their daily working life such as safeguarding, infection control and health and safety.

Staff had also received specialist training to ensure people that required complex support received this effectively. Specialist training had been completed on epilepsy, choking, challenging behaviour, dementia, stoma and catheter care. This meant that staff received training required to perform their roles effectively. The registered manager kept a training matrix that included what training staff had completed and when training was next due. A staff member told us, "Training has been fantastic."

Supervision meetings were held between staff and their line managers to discuss staff progress, care standards, identify developments and provide support if required. Staff told us that they were supported in their role. A staff member told us, "[Registered manager] is very supportive and approachable." Another staff member commented, "[Registered manager] has been very supportive." For staff that had been working at the service for over 12 months, an appraisal had been completed. During the appraisal, staff discussed their performance, objectives for the year ahead and learning and development.

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.

Staff had been trained on the MCA and were able to explain the principles of the MCA. The registered manager told us that most people had capacity and there were consent forms that had been signed by people, agreeing to the support provide by the service. In addition, there was signed agreement between the provider and commissioners on the care package people would be receiving.

However, on one record we found a person was not able to make day to day decisions. The registered manager told us that this person did not have capacity. We did not find evidence on how the person's capacity had been assessed and if a best interest decision had been carried out to make a decision on the

person's behalf. There was a decision-making form but it did not cover the elements of capacity; namely can the person understand, retain, and weigh the information, and make a decision on the information they received. The registered manager told us that this would be addressed as soon as possible.

We recommend the service follows best practise guidance on MCA assessments.

Staff we spoke with told us that they always requested consent before doing anything. A staff member told us, "I will always ask for consent." Another staff member told us, "I will always ask because I need them to give me consent before I do anything." A relative told us, "They talk to her [person] all the way through and make sure she's happy with what they're doing or going to do next." Care plans also included that staff should explain what they are doing when supporting people. One person's care plan included how staff should explain what they were doing and reassure the person if they became anxious.

Pre-admission assessments had been completed prior to people receiving support and care from the service. These enabled the service to identify people's daily living activities and the support that people required. This allowed the service to determine if they could support people effectively. Using this information, care plans were developed. The service assessed people's needs and choices through regular reviews. Records showed that changes in people's circumstances had been recorded and used to update people's care plans. This meant that people's needs and choices were being assessed effectively to achieve effective outcomes.

Care plans included the level of support people would require with meals, such as with feeding, the times people preferred to eat and people's dietary requirements. For example, information on one care plan included that the food was to be soft, so it was easier to swallow, otherwise the person would not eat the meal. People were given choices by staff and this was also recorded in people's care plans. For people at risk of UTI, there was information that people should be encouraged to drink six to eight glasses of water and walk for bowel movements, to prevent the risk of UTI. People were given choices with meals. A staff member told us, "You tell the client what is available and they have a choice." Another staff member told us, "We always give them a choice, sometimes I will open their fridge and ask them what they would like." We saw a compliment from a relative complimenting the service who had written, 'The Carers are good always finding a way to encourage my mum to eat'.

Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health. Where staff had more immediate concerns about a person's health, they called for a health professional to support the person and support their healthcare needs. Staff were able to tell us the signs people would display if they did not feel well. A staff member told us, "I will look if their behaviour has changed, I will notice if they were not well. For example, I went to a client recently and they were so quiet and not bubbly like himself. I was worried and I called 999. The ambulance came and commended me as they found something was wrong and took him to hospital." A relative told us, "I know that they will realise if [person] not well and let us know, then we will sort it out." There were records that evidenced that the service had worked with health professionals, which meant that the service ensured people were in the best of health.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. A person told us, "They are very nice people and quite kind, I'm certainly happy with them." Another person told us, "I've just come back from a walk with [name of carer]. It's the first time I've been able to do it and he was so kind and patient with me." A professional told us, "I have found Nomase to be very caring, proactive and will let me know as soon as possible, when there are issues with the clients I have with them."

Staff told us how they built positive relationships with people. A staff member told us, "I do this by talking to them, finding out what their needs are and making myself approachable to them." People and relatives told us that they had a good relationship with staff. One person told us, "I've got a good rapport with quite a few of them now."

People and relatives confirmed that they had been involved in decision making on the care people received. There was a section where people and relatives could sign to evidence that they agreed with the contents of their care plan. A person told us, "My daughter sorted out all the plans for my care at my bedside and it's working pretty well." People's independence was promoted. Care plans included information that people should be encouraged to support themselves as much as they can. On one care plan information included that when showering a person, staff should give the soap and towel to the person to support themselves. Staff told us they supported people to make choices in their day-to-day lives with personal hygiene and care. A staff member told us, "If I was to support them to put on clothes, I let them choose their clothes. We would do everything together like making food, putting on clothes. They make the decisions." One person told us, "I want to carry on doing as much as I can for as long as I can and they help to make sure I'm safe doing it."

Staff ensured people's privacy and dignity were respected. They told us that when providing particular support or treatment, it was done in private. A staff member told us, "I will shut the door and tell person what I will be doing but I will make sure no one is around." People and relatives confirmed this. A person told us, "I don't feel embarrassed with the carers, they support me well, I can't fault them." A relative told us, "Even though I'm her husband, they still keep things private for her, they will just disappear and get on with it. They are very good with things like that." Care plans also included information on how to ensure people's dignity was preserved when supporting them.

Staff gave us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity. We saw that confidential information such as people's care plans and medicines records were stored securely in the office.

People were protected from discrimination within the service. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. A staff member told

us, "I treat them as my client and make sure they are always safe. This is part of my care. I treat them equally." People and their relatives we spoke with confirmed that they were treated equally and had no concerns about discrimination. A professional told us, "The staff are always professional, helpful and willing to work with us on packages that require spiritual and cultural requirements."

Good

Is the service responsive?

Our findings

Staff we spoke with were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. A professional told us, "Nomase appear to be very person focused and will react swiftly to the changing needs of the service provision and the client if there are any changes that need addressing." People and relatives, we spoke with told us that staff were responsive and knowledgeable. One person told us, "They do, they know me." A relative told us, "They respond to requests I make and we have a little book that I leave messages in for them."

Each person had an individual care plan which contained information about the support they needed from staff. One staff member told us, "Care plans are very helpful." Another staff member told us, "Care plans are very helpful, it tells you the best way to look after them." Care plans detailed the support people would require with personal care. They also contained people's family contact details. Plans included people's personal information such as their religion, any health conditions, marital status, major life events and date of birth. Care plans were personalised based on people's preferences and support needs. In one person's care plan, information included that the person had a health condition that meant they were unable to move certain parts of their body. Therefore, staff should be gentle around this area to prevent discomfort and pain to the person.

There were daily records, which recorded information about people's daily routines and the support provided by staff. Staff told us that the information was used to communicate with each other between shifts on the overall care people received and if a particular person should be closely monitored. This meant that staff could summarise the care needs of the people on each shift and respond to any changing or immediate needs.

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information would tell them how to keep themselves safe and how to report any issues of concern or raise a complaint. Staff we spoke to did not know what the AIS was in full but were able to tell us how they communicated with people. However, care plans did not include people's ability to communicate. In one care plan, we found that a person had difficulties with communicating, however there was no information on how staff should communicate with the person. We fed this back to the registered managers, who informed us that they would include this information on the care plan. People and relative's we spoke to had no concerns with staff communication. A relative told us, "[Person] clearly likes [staff member] and he is able to see [person's] signals before anything happens so he can prevent it." Records also showed that compliments had been received from relatives who complimented staff communication with people. One compliment included, '[Staff members] is always on time, very good communication with my wife'.

There was a complaint's register that included the complaints received, response and the action taken, which ensured the management team were able to track complaints and have oversight of complaints

investigations. People and relatives knew how to make complaints and staff were able to tell us how to manage complaints. A relative told us, "All the details are in the folder or booklet they gave us, but I'd just ring the office."

Records showed that the service had received compliments from people and their relatives. Comments included, 'Your support workers are good and they understand my needs and always punctual and are caring', 'The service is very good and the carers are always on time' and 'The carers are good always finding a way to encourage my mum to eat'.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place for quality assurance. Audits were carried out on people's care plans, risk assessments and medicine records. However, this had not identified the shortfalls we found with risk assessments and MCA assessments.

Records were not always kept up to date. We found some risk assessments and people's ability to communicate in care plans had not been completed in full in order to ensure staff had the relevant information to provide high quality care at all times. Keeping accurate records is important to ensure the service had oversight of the support people required and if support had been delivered effectively.

We fed this back to both registered managers, who acknowledged this and informed us that they would ensure that this was addressed as soon as possible. They told us they would make the audit processes more robust to ensure shortfalls can be identified and action taken promptly to ensure people received safe and effective care at all times.

Spot checks of staff supporting people had been carried out and this had been recorded. They focused on time-keeping, communication, health and safety, person centred care, appearance and infection control. This was then communicated to staff and formed part of their supervision. This meant that the service was able to identify what areas staff were doing well in and identify if further development was required, to ensure people received effective care and support.
The service had two registered managers. One of the registered manager had primary management responsibility of Nomase Care Ltd, while the other registered manager managed another branch in another borough. Both registered manager told us that they worked very closely together to share ideas and best practises for both services and covered if one of them was off work.

Staff told us that they were supported in their role and the service was well-led. They felt concerns they had would be addressed promptly by the management team. One staff member told us, "She [registered] is a brilliant manager. If we have any problems, she will sort it." Another staff member commented, "She [registered manager] is very good, always willing." Staff also told us they enjoyed their role. One staff member told us, "I do enjoy this, I like helping people." Another staff member told us, "I enjoy the job. When you go to look after them and you put a smile on their face, that is rewarding."

People, relatives and professionals did not have concerns about the management of the service. A relative told us, "There's a very helpful lady at the office called [name of registered manager], who I think is the manager or the care coordinator. She is very accommodating." A professional told us, "My involvement with NOMASE has been extremely positive, they are always contactable at any hour of the day. They are very accommodating at short notice and will always ensure they support their clients." Another professional commented, "They take directions well and do work well with us. I always recommend Nomase as they are caring and do go the extra mile. I find them to be proactive and well managed."

People's and relatives' feedback were sought through surveys. The survey focused on attendance,

satisfaction, infection control and communication. Comments from the survey included, 'Very happy with the service that my current carers give. They are good at what they do', 'The carers are very caring and supportive' and 'Carers are very good and caring of their jobs. They are cheerful and polite'. The registered manager told us she was in the process of analysing the survey results and implement an action plan to address any comments that may improve the care people received.

Staff meetings were held regularly. The meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes of meetings showed staff held discussions on staffing, notifications, concerns and were able to discuss any concerns or updates as a team. This meant that staff were able to discuss any ideas or areas of improvements, to ensure people received high quality support and care.

The registered manager told us that the service was in the process of purchasing digital software that would enable people's relatives, who may not live with people, to access their care plans and daily records. They would seek people's consent to do this. This would ensure that relatives would be updated regularly on the support people received from the service.