U.K. International Nursing Agency Ltd

UK International Nursing Agency Limited Dom Care

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection took place on 22 and 30 January 2015 in response to concerns that had been raised to us. At our last inspection on 16 January 2014 we found the service was meeting the requirements. Since our last inspection the service has registered to provide accommodation in addition to personal care in the community.

UK International Nursing Agency Limited provides accommodation and nursing care for up to 7 people who have nursing needs or are living with dementia. There were 2 people living at the home when we visited with a further 4 people supported in the community with personal care needs.

Summary of findings

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection there had been no applications made to the local authority in relation to people who lived at the service. The manager and staff were not familiar with their role in relation to MCA and DoLS.

People's safety was being compromised in a number of areas.

There were insufficient numbers of staff available to safely support people's needs.

Incidents that required reporting to the Care Quality Commission had not been made.

Peoples medicines were not stored or managed safely, however staff had received appropriate training

Staff were not clear on how to identify and report any concerns relating to a person's safety and welfare. The manager had not responded to all appropriately. Restraint had historically been used to control a person without ensuring the appropriate authorisations and procedures had been followed.

Staff did not follow the requirements of the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions.

Staff were not recruited through a robust procedure and were not provided with regular professional development to ensure their knowledge was up to date.

Staff knew people well and provided support in a timely manner. There was sufficient food and drink available and people were assisted to eat and drink in a calm and sensitive way.

People had access to a range of health care professionals, such as chiropodist, mental health team and a doctor. People saw a doctor regularly and people were referred when there were concerns with their health.

There was not an effective system of regular auditing, review and action to ensure people received a quality service that kept them safe.

People's feedback including staff had been sought; however it was not always acted upon.

We found the requirements of the standards were not being met. On the 30 January 2015 in response to our concerns we asked the provider to impose a voluntary suspension of new people using the service.

We have referred our findings to the local authority safeguarding and commissioning teams.

Summary of findings

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 is not safe.

There were not enough staff available to provide safe care to people.

Staff were not knowledgeable about signs of abuse or how to report this. Not all staff had received training for safeguarding adults.

People's medicines were not managed safely

People had begun work prior to the provider receiving a copy of the criminal records check.

Inadequate

Is the service effective?
The service is not effective.

Staff told us they felt supported by the provider; however staff, particularly clinical staff did not receive formal supervision or induction. Training for some staff had elapsed or not been completed.

When assessing people's capacity to make decisions, staff had not acted in accordance with the Mental Capacity Act 2005.

The environment of Mayapur House required maintenance and adaptation to suit people's needs.

We have made a recommendation about supporting people with dementia at mealtimes.

Inadequate

Is the service caring?
The service is caring.

People were cared for in a sensitive, kind and caring manner.

People's dignity and privacy was promoted and people's independence was respected.

Good

Is the service responsive?
The service is not responsive.

Care plans and risk assessments had not been developed or reviewed for areas of identified need.

People and their relatives were not involved in decisions about their care.

People felt they could approach the manager with any concerns or complaint.

There was a good provision of activities that promoted peoples hobbies and interests.

Requires Improvement

Summary of findings

Is the service well-led?

Inadequate

The service is not well led.

There was not a registered manager in post.

Notifications that are required to be sent to the Care Quality Commission had not been sent.

There was a lack of systems in place that audited and reviewed the quality of service provided.

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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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to look at the overall quality of the service.

This inspection took place on 22 and 23 January 2015 and was unannounced. The inspection team consisted of one inspector.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. We contacted the commissioners of the service and five healthcare professionals to obtain their views about the care provided in the home. We reviewed information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. Additionally we reviewed information we had received that raised concerns about the care people received in the home.

During the visit, we were unable to seek the views of people to fully understand their experience due to their complex needs. However we spoke with two relatives, two staff members, the newly appointed manager and the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

There were not enough staff available to provide care safely. Upon our arrival at 7.45 in the morning we were greeted by the provider. They told us they had completed the night shift alone and had completed the sleep in shift. They told us that two staff were required, one waking night shift and one as a sleep in. We asked to see a copy of the rota and saw that where two staff were required on a night shift there had only been one for over a month. Invariably this was the provider. The provider had worked the previous day, and continued to work on the day of our inspection. When we returned on 30 January, we were once again greeted by the provider who had carried out the sleep in shift. They had worked in the home without a break since the first day of our inspection.

Day shifts were covered by the provider and one carer; however the carer was not available on the two days of our inspection until nearly 11am. This meant that only one staff member was available to support people where the provider had assessed that the people needed two staff members to meet their needs. We observed that when one person required care and support to be provided this meant that staff had to leave a second person unattended to support them. The staffing levels had been set by the provider and agreed with the funding local authority that had placed the people.

We observed throughout both days of the inspection that the provider was interrupted with phone calls relating to both the home and a recruitment agency they operate. When this happened they were unable to exclusively support the needs of people. We observed one person having to wait seated with the provider in the office whilst requiring support. This meant that people who were identified as requiring two carers to provide support only received one, putting them at risk of unsafe care.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at people's Medicine Administration record (MAR) charts. The MAR chart or associated care plan did not detail the person's, or people's personal preference about how they wished to receive their medicines. We also found that there was no protocol for people that were prescribed pain relief medicine. There was no detail as to when this medicine needed to be given. This meant that people were at risk of not getting appropriate pain relief medication when they needed it as there were no instructions or guidance for staff on when and why to administer this medication.

MAR charts we looked at had been completed when people's medicines were administered.

We saw there were no gaps and omissions in the MAR chart. However we noted that one person had not had their prescribed dose of a controlled medicine at 8pm the previous evening. As this medicine had been prescribed to help aid with their sleep and stabilise their behaviour, this meant this person may have been unnecessarily agitated or restless.

We were informed prior to the inspection that one person had not received their medicine and that this had been disposed of. We checked MAR records which demonstrated to us they had received this as prescribed. However when we looked at a second persons MAR record we noted there was a vast number of additional unaccounted for medicines. These medicines had not been booked into the persons own stock and were surplus to requirements. The provider told us they had planned to keep them, "In case of an emergency if [Person] runs out of ones in the blister packs." During our inspection these were returned to the pharmacy, however medicines had been dispensed from them and were not accounted for.

We observed that the medicine cabinet that held controlled drugs was not secure. We saw that the door to the room was open at times and the key was hanging from the lock. This meant that staff, visitors or people had access to medicines that may harm them.

Regular temperature checks were not completed of the medicines room. This meant that staff could not be assured that medicines had been stored within safe temperature parameters. During our inspection the provider told us they had ordered a thermometer and would measure the room temperature once received.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to people when identified had not been recorded or reviewed. For example, one person was asleep in their wheelchair throughout the night. They had been in front of an armchair which they had used to rest their legs on so they could lay out. The bed was propped up against the

Is the service safe?

wheelchair to stop it falling backwards. However, there were no assessments in place for this, and consideration had not been given to the use of profiling beds, crash mats or bed rails. When asked about this the provider said, "I am worried they will get tangled in the rails, so they wouldn't be a person for rails." We saw from care records that no assessments had been completed for this person. People did not have risk assessments completed for them to identify and minimise risks to their health and well-being.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we asked to see copies of incident and accident reports to see how risk was reported and managed. The provider told us that these were not kept as incidents and accidents did not occur. However, we became aware of two safeguarding concerns that were required to be reported to CQC. Neither incident had been as required. The provider told us they had submitted these as required but were unable to provide us evidence such as emails. We also reviewed the information we held about the home and found no notifications for any accident, incident or notification had been received since registration.

People's relatives told us they felt their relative was safe living at the home. One relative told us, "I am happy now [person] is there. They look so happy and I have no concerns, they have really improved since being with [provider]." Staff told us they had recently received training in safeguarding vulnerable adults. However training records showed that some training had elapsed or not been provided. We spoke with the only other staff member on duty who was unable to tell us how they would respond to allegations or incidents of abuse. They were not aware of external agencies they could contact such as the Care Quality Commission or Hertfordshire County Council for example. People were not provided with information about how they can remain safe, and contact details for organisations to contact if they had concerns were not displayed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked the recruitment files for three members of staff. We saw that for each staff member an application and curriculum vitae had been completed. The provider had taken copies of people's identity and where appropriate copies of their visa to ensure they were entitled to work. Where staff had declared relevant qualifications there were copies of these available.

However, the provider told us that they required two professional references, and for one staff member there was only one. Dates of employment given in application forms contained gaps in people's employment history which had not been explored. We looked at the criminal records checks that were undertaken and found the provider had not satisfied themselves people were suitable to work unsupervised prior to them starting. Criminal records checks for two nurses', who were supplied by the provider's own agency, had been submitted from a previous employer. The dates of the check preceded the start date at UK International Nursing Agency. One of these checks was completed on 29 January 2015 in response to our inspection. However the provider confirmed to us that they had started on 03 November 2014. This meant that the provider had not satisfied themselves that people were suitable and safe to work with elderly people prior to them commencing work. The provider has subsequently sent to the commission confirmation that appropriate checks have been taken.

This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

Staff did not have effective supervision, appraisal or training. Staff who started work undertook a five day induction which included reviewing organisational policies, and completing training. However the provider told us that only the care staff received an induction, which the nursing staff did not. The competency of the care staff was assessed in areas such a moving and handling, however nursing staff did not undergo the same assessment. Where staff declared training they had received in previous employment, verification had not been seen. This meant that the provider could not satisfy themselves that staff had the necessary skills and experience prior to providing care.

Staff spoken with told us they felt they could approach the provider if they needed support. One staff member told us, "[Provider] is good, I didn't know about care before starting here, but [Provider] is training me well." We asked the provider if staff received a supervision and appraisal to discuss their performance and review the development. They told us they did not. We asked how the nursing staff were supported as the Nursing and Midwifery Council (NMC) require clinical supervision to be regularly carried out. The provider told us they had not supervised their nursing staff. This meant that staff and nursing staff had not had the opportunity to reflect on individual cases to change or modify their practice and identify training and continuing development needs.

We looked at the training records for staff. We saw that a range of training had been provided to staff both by the provider and also by community organisations. Training delivered to staff was wide ranging and varied and included areas such as mental capacity, medicines, food safety, safeguarding, moving and handling and infection control. However in numerous examples training had elapsed. For example, moving and handling, infection control, health and safety and safeguarding. We also saw where the provider had identified training for staff to undertake, this had not been completed. For example in areas such as moving and handling, mental capacity and infection control.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

Staff gained consent from people before delivering any care. Staff gave examples of where they would ask people for consent in relation to providing personal care and support. We saw several instances of this happening during the day.

People had not had their capacity assessed in line with the Mental Capacity Act 2005. The provider told us that they and staff had attended training about the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. They told us they would therefore know how to make a Deprivation of Liberty Safeguard application if needed.

The provider told us that people lacked capacity to make decisions in relation to their care and health needs. However an assessment of people's capacity to make decisions about their care, health needs and day to day preferences, had not been recorded. The principal of the MCA 2005 is that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. An assessment of mental capacity is specific for each individual decision at any particular time and must be regularly reviewed. Where decisions

had been made for people assumed to lack capacity then their best interests were not considered and the provider had not acted in accordance with the MCA 2005.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection no applications had been made or been authorised by the local authority. In one person's care record we saw a GP had requested the provider to make a DoLS application in August 2014. This had not been applied for as suggested. People's freedom was restricted as the front door and bedroom doors were locked.

The provider also told us that they would not let people leave the home unaccompanied. They told us that bedroom and house doors were closed at night as they were concerned people may harm themselves. People were not free to access communal areas of the house such as the dining room or lounge. They said, "If people tried to leave I would stop them and explain they are not safe to go outside alone and they are disorientated. At night people may wander into other people's rooms or hurt themselves so it wouldn't be safe to have the doors open." This meant

Inadequate

Is the service effective?

that the provider was depriving people of the liberty without a proper assessment and authorisation. Therefore they were not following the legal requirements of the MCA 2005 DoLS.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People's needs were not met by decoration and design of the home. The roof top garden had hazards which included sharp railings, glass and an un-gated emergency staircase which presented a risk of harm to people using the service. One of the two downstairs shower rooms ceiling was covered in plastic as it had a leak however this shower room was still being used until we asked for it to be taken out of action. Upstairs were five bedrooms that the provider intended to use for people. However there was no lift or suitable way to assist people with mobility needs upstairs, for example a stair lift. Two of the bedrooms had an en-suite "Jack and Jill" bathroom which is an interconnected bathroom accessible from each bedroom. This may mean that people's dignity and privacy is compromised. We found that people's bedrooms lacked their personal items and were bare and unwelcoming. The communal areas of the home had not been decorated to support people with dementia with items to stimulate and orientate people. The floor in the lounge was a ceramic tiled material which was slippery and outside the staff office we continually tripped against a poorly installed ramp in the floor. Both posed a risk that people may fall who are unsteady of their feet. In one bedroom water pipes had been installed, however where areas of the wall were exposed this left sharp edges that may injure the occupant. Throughout the home were areas of poorly repaired and maintained walling and skirting boards that required redecoration.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People were unable to tell us their experience of the food provided to them; however we saw that staff provided a range of drinks and snacks throughout the day. We saw from the menus that people were provided with a wide range of meals that also met their cultural needs. Meals were freshly prepared each day, and were altered at short notice if people changed their minds. We observed the lunch meal being provided to people. We saw that staff were patient and kind when assisting people, and gave them sufficient time to eat their meal. People were offered further helpings, and when eating where provided a constant supply of refreshments. From our observations we saw that people enjoyed the food provided to them. However staff did not engage people with conversation and the dining room lacked a sociable and relaxed atmosphere.

Records of people's weights had been maintained and reviewed regularly. One person's relative said, "Since [relative] has moved to Mayapur House they have put on weight and look so much healthier." Where people required additional support from healthcare professionals such as the GP or dietician this was sought promptly.

However, menus were not provided in a format that people could understand. For example, where people have memory problems they may not be able to recall the choices available. Where people have difficulty with their sight, then small printed words may be difficult to read. The dining room also was not conducive to people living with dementia as the size of the table did not allow full access for people with wheelchairs and walking aids. We recommend that the service finds out more about supporting people at meal times in line with current best practice, in relation to the specialist needs of people living with dementia.

People's day to day needs were met by a small team of staff who knew them well. We saw that people had access to a wide range of health professionals which included GP's, hospital consultants, mental health teams, social work teams and specialist clinics. Letters from GP's demonstrated that people were taken for regular health reviews and where referrals were needed, these were made swiftly. We observed that staff spoke to people and explained to them why they needed to see a healthcare professional and checked they were happy with this. We saw that when the carer came on shift the provider took time to inform them of people's needs to update them.

Is the service caring?

Our findings

People's relatives told us that the staff were very caring and felt staff treated people with kindness and compassion in their day-to-day care. One person told us, "[Provider] is very caring to [relative] since being here [relative] has begun to speak which they never did when they were in the previous home. I don't have any concerns about how [relative] is cared for, [provider] is excellent with [relative]." A healthcare professional told us, "It's like a little family unit; people certainly get a good level of care from a very caring and knowledgeable owner."

We saw throughout our inspection that people were supported by staff who knew them well. Both the provider and staff we spoke with were knowledgeable about people's care needs and how to respond to people in an individual manner. We saw staff interpret people's needs and provide care such as personal care in a pro-active manner. It was clear from our observations that staff had built up a detailed knowledge of people's needs by working with them on a daily basis.

When staff assisted people they gave explanations in a way that people were able to understand, such as pointing, gesturing or clearly giving people a variety of options. For example one person was seen to be agitated so staff took the time to offer reassurance and sat with them to understand how they could support them. We saw that the staff member spent time with them then offering them a shower and took time to assist them with getting dressed. They then sat and ate breakfast together whilst watching television.

There was no advocacy service information present in the home, however the provider demonstrated to us where they had referred a person back to their social worker for independent management of their financial affairs.

Relatives spoken with told us they felt able to visit the home any time and felt welcomed by staff when they did. One person told us, "I don't visit regularly and don't say when I am coming but [provider] is always welcoming when I turn up. Last time we all went out for lunch to discuss [person's] care. In fact, if I haven't been up for a bit [Provider] calls me to remind me to visit."

Through our observations people were treated in a dignified manner. Staff gave examples of how they would provide privacy and dignity to people. They said they would cover people when providing personal care and made sure the doors and curtains were closed. We then observed that when providing sensitive personal care staff did so in a sensitive manner behind closed doors.

We observed numerous positive interactions between staff and people, for example staff knocked before they entered the room of a person who used the service and respected their wishes to remain in bed until later.

Is the service responsive?

Our findings

Relatives we spoke with told us they had not been involved in the planning of the care or asked how their family members should be cared for. They did not know if care plans were in place. People's care plans did not contain evidence that people or their relatives had been involved in decision making about their care or treatment. Care plans rarely contained personalised information that described to staff how people liked to receive their care.

People had not been involved in contributing to the assessment of their needs or the planning of their care or treatment. People had not been consulted about how they could be enabled to remain as independent as possible or how they wished to be cared for. The care plans had not all been updated to reflect people's current care and health needs and where they had been reviewed people or their relatives had not been encouraged to contribute to the reviews. Staff were not all able to describe people's needs or how they should respond to those needs.

Where people displayed behaviour that challenged for example, this guidance was not always detailed enough for staff to deliver appropriate care. There was no direction or guidance for using distraction techniques, or how to identify any triggers. This had resulted in restraint being used to manage a challenging situation. However, for this there was no assessment, care plan or direction. We noted that care plans for areas such as communication, eating, sleeping, mobility, personal care and medication had not been developed. People's care plans were a mismatch of professional's correspondence from hospital, the GP, mental health teams or social workers; however staff had not taken this information to develop specific plans for supporting people. We could not determine whether there had been an appropriate assessment of needs, care planning or risk assessments completed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives we spoke with told us they knew how to make a complaint. One told us, "[Provider] is who I would go to, and I know if I was unhappy they would get it sorted quickly." However, there was no information displayed about making a complaint, and also no information about organisations that people could complain to. The provider told us that they had not received a complaint for the previous twelve months.

People had provided feedback to the provider by regular questionnaires. We looked at several examples of recently completed questionnaires. People had noted they knew how to complain, and their views were sought regarding their care, staffing and overall satisfaction. One section asked how the service could improve. People had noted consistently that they would like to be involved more through meetings and that the training for staff could be improved.

People were supported to engage with individual activities with the support of staff. For example the provider showed us how they had spent extensive time supporting and encouraging a person to communicate using memory prompts. They had done this with the person's relative through talking about their memories which had enabled the person to speak fluently at times. The persons relative said, "It was amazing, in the previous home [person] didn't speak, but with [provider] the change has been amazing. They talk for hours about things [person] is interested in and record it to play it back again and again." We also saw that where one person liked fabrics and sewing as this resonated with previous employment, staff encouraged them to use a variety of textiles and fabrics.

Is the service well-led?

Our findings

When we visited the service did not have a registered manager in post. The provider was acting as the manager and had identified a replacement. This new manager was in the process of completing their registration with the Care Quality Commission and visited during the inspection to complete this.

We saw there were systems and audits in place, for example infection control, medicines, environment and equipment checks. We asked the provider to tell us about the quality assurance systems which were in place in the service. They told us that the system of internal audits had not been completed recently as the registered manager had left and they had been struggling to cope without a manager in post. They showed us copies of audits which confirmed they had not reviewed the quality of the service. However, concerns that had been identified had also not been reviewed and managed. For example, feedback from people regards regular meetings and staff training had not been reviewed or actioned.

We found there was no system in place to monitor the quality and effectiveness of care plans to ensure that people received safe and appropriate care. The lack of such a system was reflected in our findings regarding some of the care records we reviewed as a system had not identified the lack of care plans.

Where accidents and incidents had occurred we did not see any analysis to assure us that any action had been taken to learn lessons from these incidents. We also found two records of serious injury in which a notification should have been submitted to the Care Quality Commission

(CQC).

There was no formal system in place to assess and monitor staffing levels. We did not see how the dependency of each person was identified within their care plan to determine the level of support they required. There was no evidence this was used to calculate staffing levels within the home. We found staffing levels were inadequate which were not attributed to the lack of a manager as suggested by the provider. They had not taken action when required to maintain staffing levels set by the provider.

The provider told us that they had not held staff meetings within the service. The last documented set of minutes was for October 2012. This meant that staff did not have a formal opportunity to discuss the management of the home, or to raise concerns or suggest improvements.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Daily records did not detail the care people received or provide any background to concerns noted. For example, one record noted, "[Person] woke up again with hallucination and confusion.? epileptic seizure, asking for her [Relative] and other family members." There was no mention of how staff supported the person, or what action was taken other than providing them with a cup of tea. Where it was suspected and noted that they may have suffered an epilepsy episode, no further documented evidence was available to demonstrate the actions taken. We found the same lack of clarity and detail was missing from all people's records. Where there were care needs that had been identified, a care plan and risk assessment had not been completed. For example, where people had difficulty with orientation, they had not had a risk assessment completed for their mobility, risk of falls, or accessing dangerous areas such as the kitchen. This meant that a full and accurate an accurate record in respect of each service user had not been developed to ensure people were protected against the risks of unsafe or inappropriate care and treatment.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we spoke with staff, they were unable to provide us with the vision or values that the provider required. Staff were aware of their responsibilities in relation to providing care, but were not able to tell us about the ethos within the home. As there had not been team meetings or supervisions held for staff, they were unable to challenge the previous manager or provider about practise within the home.

Relatives and staff felt they were able to approach the provider with concerns if they felt they needed to. Comments included, "I would go straight to [provider] I am not afraid to speak my mind," and "[Provider] takes things very seriously when it affects Mayapur House so I am comfortable with speaking with them."