

South Norfolk Carers Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service: South Norfolk Carers is a domiciliary care agency that was providing personal care to 96 people at the time of the inspection.

People's experience of using this service:

- Systems and processes in place to protect people from risk of abuse were not robust.
- Risks to individuals were not always assessed or monitored.
- Medicines management was not based on current best practice and there was no systematic way of identifying and investigating errors in administration.
- The registered manager told us that they would organise further training for the medication officer and the introduction of auditing tools to improve medicine management.
- There were enough staff to meet people's needs and people had regular care staff.
- There were procedures in place to help protect against employing staff who were unsuitable to work in the service.
- People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.
- Care needs were not consistently assessed in people's files.
- Staff had received the training they needed to carry out their roles. There was an induction programme in place for all new staff.
- The service worked with other healthcare professionals such as GP's, district nurses and occupational therapists.
- People told us that the care staff were kind and caring. Staff knew people well which enabled them to provide consistent care.
- The service manager regularly rang people to review their care. However, it was not always clear in the files what had been updated as a result of these calls.
- People were supported with end of life care and staff received training as part of their induction.
- Systems and processes in place to monitor the quality of care were not robust.
- There was no system in place to support continuous improvement and learning from mistakes.
- Staff gave positive feedback about managers and said that they were open and approachable.
- The service worked well with the local community to support people's care.

Rating at last inspection: At the last inspection the service was rated as good. (Report published 14 July 2016).

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

Follow up: Going forward we will continue to monitor this service and plan to inspect in line with our reinspection schedule for those services rated requires improvement.

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

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 caring?

The service was caring

Details are in our Caring findings below.

Good ●

Is the service responsive?

The service was responsive

Details are in our Responsive findings below

Good ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

South Norfolk Carers Limited

Detailed findings

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

This inspection was carried out by an inspector, an inspection manager and expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:

This service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults.

The service had a manager registered with the Care Quality Commission. 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. There was a service manager who supported the registered manager in the day to day running of the service and a medication officer who was responsible for overseeing the management of medicines.

Notice of inspection:

We gave the service 48 hours' notice of the inspection visit because managers are often out of the office supporting staff or providing care. We needed to be sure that somebody would be available to support the inspection.

What we did:

Before the inspection we looked at all the information that we had about the service.

- This included information from statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.
- We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
- We also contacted professionals working with the service for their views.

During the inspection

- We spoke to the registered manager, the service manager and eight support staff.
- We spoke to 12 people who used the service and 4 relatives.
- We reviewed five people's care records.
- We looked at the medicine administration records (MAR) and supporting documents for 11 people.
- We looked at records relating to the governance and management of the service.
- After the inspection we asked the registered manager to send us further documents which we received and reviewed.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: 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. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong.

- Systems and processes in place to safeguarding people from the risk of abuse were not robust. There was a central record of safeguarding held by the registered manager, however this did not contain all safeguarding records.
- In one person's file there was reference to an investigation in relation to money that had gone missing, but it was not clear from the records in the file whether there had been police or safeguarding involvement and what the outcome had been.
- Not all risks relating to people using the service had been assessed. For example, one person had no falls risk assessment or skin care risk assessment or medication risk assessment despite these being identified as areas of concern in the initial overall assessment. Another person who walked with a frame had a falls risk assessment form in their file but this had not been fully completed. This meant that staff did not have guidance to mitigate the risk of falls for this person.
- There were no systems and procedures in place to monitor when things went wrong. There was a folder for incident and accident records but there were no records in the folder for 2018.
- There were incidents that were reported through the daily notes. For example, a person had a ring that went missing, another person had a skin tear when staff were assisting with moving and handling, but these had not been recorded as incidents in the central record.
- Where there were safeguarding concerns that had been reported to the local authority safeguarding team, there was no record of the incident in the incident log.
- Safeguarding referrals were not always reported to the Care Quality Commission as a Statutory Notification. It is a legal requirement that services report safeguarding incidents to the CQC.
- The provider had files to keep records of safeguarding referrals and another file for incidents and accidents but were not following their own procedures to keep records up to date in these files.
- As a result, the registered manager did not have oversight of, or review all safety incidents and near misses to learn from mistakes and prevent things going wrong in the future.

The lack of systems and processes to identify risks and monitor safety incidents means that the registered manager could not effectively safeguard people using the service. This is a breach of Regulation 12 (2) (a) and (b) of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines management was not based on current best practice. There was no systematic way of identifying and investigating errors in administration.
- Care staff recorded administration of medicines on a medicine administration record (MAR).

- Some errors had been identified, resulting in a professional conversation with the member of staff involved.
- However, we identified three occasions where there was no signature on a MAR chart to indicate that the medicine had been given. The only record of the missed signatures was a professional conversation with a staff member in relation to one of the errors. There were no records of the errors having occurred which would identify whether these were recording errors or occasions where people had not been given their medicine.
- The medication officer reported the number of errors, verbally each month to the service manager and the service manager reported these to the regional quality and compliance manager. The regional quality and compliance manager had not identified that these audits were not been carried out correctly.
- For medicines that were taken 'as and when required' (PRN) there were not always protocols in place to give guidance to staff on how and when people should take these medicines.
- Where there were PRN protocols in place these did not always contain enough detail. For example, one protocol said it was for the 'relief of indigestion.' However, it did not say if the person was able to tell the care staff themselves if they had indigestion. The medication officer said that this person had fluctuating capacity and therefore at times may not be able to identify these symptoms themselves.
- The medication officer or senior care staff sometimes picked up medicines for people from the pharmacy. They also disposed of medicines that were not used. There was no system in place to monitor the receipt and disposal of medicines and monitor of stock levels.
- There was a row on the MAR chart to record the quantity of medicines left after each administration but this was not being completed by care staff.

The lack of systems and processes in place to monitor medicines was a further breach of Regulation 12 (2) (g) of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager showed us forms that the provider had for the auditing of medicines as well as for stock control of medicines. They had a separate form that they should use for the recording of medicine errors which should be reviewed separately as part of medicine management. The registered manager said they were not aware that the medication officer was not following these procedures.
- They told us that the medication officer would undergo further training including spending time with a medication officer at another service to learn how to implement the systems and processes.
- Staff had received training in medicines management and could describe how to administer medicines in the way that they had been prescribed.
- People told us that they felt safe. One person said, "I had a fall and my [relative] felt I needed some care now, so I feel safer now." A relative told us, "Yes [relative] is safe with them, they're very solicitous, they handle [relative] well and are reassuring when doing so, they are very good at spotting things too, like sores or if [relatives] heel needs a clean-up."
- Staff told us, and we could see from records that they had completed safeguarding training. They could identify the different types of abuse and understood how to report concerns.

Staffing and recruitment

- The registered manager told us that it had been difficult to recruit staff in the past but that this had improved recently.
- People told us that there were enough staff and that they had regular care staff. One person told us, "They informed me there had been a change of care staff"
- Rotas were prepared by the administrator in the office using an electronic system. The administrator told us that they check every day to make sure that there are no calls to cover. If calls needed covering they would ring round the existing staff and the registered manager told us that all office staff had up to date

training and covered calls if necessary.

- We could see from the records that there were procedures in place to help protect against employing staff who were unsuitable to work in the service.

Preventing and controlling infection

- Staff had attended training in the prevention and control of infection and could describe how to control the spread of infection.
- The provider made equipment such as gloves and aprons available for care staff to help with the control of infection.

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

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

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

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- We checked whether the service was working within the principles of the MCA.
- People were identified in their files as living with dementia. One person's referral documentation stated, "memory loss and slight confusion," but there were no mental capacity assessments in their file or records of best interest decision making.
- One person's file stated that the person's partner signed to consent on their behalf but there was no record to say what their legal status was that enabled them to do this, although the service manager said that they had lasting power of attorney. There were also no mental capacity assessments or best interest records for this person.
- Staff were therefore working under the assumption that people had capacity so were at risk of not ensuring that decisions were consistently made in people's best interests because they had no guidance, and this had not been assessed.
- Staff had attended training in mental capacity but could not always describe accurately the principles of the MCA and how their training impacted on the way in which they ensured that people were able to consent to their care.

Systems and processes did not support people to consent to their care. This is a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Care needs were not clearly assessed in people's files.
- In cases where people had an assessed need there were not always care plans to provide guidance for staff on how to support the individual. For example, one person who was identified at risk of falls and pressure areas had no corresponding assessments and care plans to provide guidance for staff.

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

- Some people were supported with the preparation of food. This included snacks such as sandwiches or microwaved meals.
- Where people's food and fluids were monitored or they had special requirements there were no separate

care plans.

- □ One person for example had thickener, the care plan said that they had one scoop but no corresponding amount of liquid. The person had a relative who was often there to provide guidance for staff. However sometimes the relative went out and there was no care plan to guide staff on how to prepare the person's drinks. The service manager told us that this was on the prescription on the tin and generally it was regular staff caring for the person who knew how to prepare the thickener.
- □ Another person had their food and fluid monitored on a chart, but there was no care plan explaining why this was monitored or providing guidance for staff. The service manager told us that this had been monitored during hot weather because care staff had been concerned that the person was not drinking enough.
- □ Where people had been assessed as at risk of poor nutrition or dehydration there was no system in place to monitor the food and fluid records to make sure that people reached their targets.
- □ Care staff told us that they completed food hygiene training.
- □ Allergy information was held in people's files, and staff were also given summary information with their rotas which included any allergies of people they were down to support.

Staff support: induction, training, skills and experience

- □ There was an induction programme for all new staff which involved face to face training, e-learning as well as shadowing more experienced staff.
- □ One staff member told us that in the last six months the provider had created a 'buddy' system. They felt that this helped new staff settle in better. They told us, "After new carers have done training, then they come round and shadow train with myself or the other buddies for two or three weeks until they feel confident that they can go out on their own. Buddy's go over to the office and are given information about what to do... Now new staff have to be checked on for first three months and they can ring us at any time with any questions or help."
- □ The service manager and team leaders carried out regular 'spot checks' on staff to observe them carrying out their care tasks and then followed the observations with supervision to give them feedback.
- □ The provider used an electronic system to monitor when staff training was due to be renewed. Training included dementia, dignity, moving and handling, person centred care, equality and diversity.

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

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

- □ We could see from the records and staff told us that they worked with other healthcare professionals.
- □ There were letters in files from health professionals such as GP's or occupational therapists.
- □ One member of staff told us, "If someone's pressure area was getting worse I would phone the district nurse. It depends on if the person is on their own, or mention it to their partner so they phone the doctor"

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity

- People told us that the care staff were kind and caring. One person told us, "They are so helpful, sometimes we have coffee together which is nice and a little 'natter,' we have little jokes they are great, they even feed the birds for me." Another person said, "I get on with all of them they are very friendly. I talk to them like I would do my friends, they are very good."
- Staff told us that they liked to chat to people to get to know them. One staff member told us they, "Find out what people's hobbies are, be inquisitive." Another said, "While doing care you talk to them about their personal life, it's surprising how many funny stories you hear. I looked after someone who was a test pilot in the war, he had so many stories."
- Staff respected equality and diversity. One staff member said, "treat them all as if they are your own mum and dad and how you would want to be treated yourself"

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

- People and relatives told us that they were involved in their care. One relative told us, "They are easy to talk to and will do anything I ask them to."
- Staff told us that they always ask people before they provide care and make sure that they know what they are going to do. "Ask them what they would like us to do as well as what is in the care plan are they happy and feel settled?" Another member of staff said that they, look through the care plan and ask them what they would like us to do, communicate with them that's the best thing."

Respecting and promoting people's privacy, dignity and independence

- Staff could describe how to maintain people's privacy and dignity. One male care staff described how if they were providing care to a female who required two care staff, and the other care staff was female they would let them take the lead when doing personal care. Another care staff said, "Use a towel to cover other parts of the body (that you are not washing) and think about how we would feel in that situation."
- Care staff made sure that they gave people choice to maintain dignity. One care staff said, "Give them choices, don't deprive them of their liberty, for example if we give someone a tablet ask them first and check they are willing. They have the right to refuse."
- Staff described how they promoted people's independence. One member of staff said, "Don't do things for them ask them if they want to do their face or whatever for themselves. It's not doing things for someone it's maintaining their independence that's the ultimate goal."

Is the service responsive?

Our findings

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

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

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

- We could see from the records that the service manager regularly contacted people either by phone or face to face to discuss their care. However, there was no evidence to show how, or which parts of care plans were updated as a result of these reviews. For example, one person had a quality review in October 2018, care plans had been updated in December 2018 but there were risk assessments with no date, and an assessment of skin viability dated October 2017.
- The registered manager told us this was because the forms were completed electronically with just one date at the front, but then split up when they were put into the files.
- The registered manager showed us a new format that they were introducing which made reviews of care plans clearer with each section dated separately and individual review dates.
- Staff received a summary print out with their rota with the main details of the support each person they were due to visit required. These were updated with changes in care needs.
- The staff were responsive to people's needs and knew people well, but there was no evidence to show when this was updated in care plans.
- People told us that visits were arranged at times to suit their needs. Most people said that visits happened on time. One relative said, "Time wise they are pretty reliable, usually arrive within 15 minutes of the scheduled times, they always contact me if they are running late so we know they are on their way." Another relative said, "Most of the time they are punctual, if they are running late I would say 50% will phone ahead. Its good, they try and get the same carers, they really to keep certain ones coming, that helps with feeling secure."

Improving care quality in response to complaints or concerns

- The service had a complaints procedure in place.
- People told us that they knew how to complain most people said that they had not needed to complain. One person said, "No complaints at all, they are brilliant and excellent carers...I've never contacted management cos I don't need to, I have a phone number though."
- One person told us that they had to contact the office because the care staff, "Hadn't got a clue, [name] just stood there...then another one came along, she just stood around not really doing anything too, I don't like complaining but the management said you did the right thing, they did sort it out for me, apart from that everything is fine now."

End of life care and support

- The service supported people who were approaching the end of their life.
- Staff completed end of life training as part of their induction and the registered manager told us that for those who express an interest they can access further training.

- There was an end of life team who worked regularly with people on end of life care and the service worked closely with the CCG and Marie Curie and other professionals when supporting people at the end of their life.

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

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

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality auditing systems were not robust. The registered manager was not aware that audits and stock control forms in relation to medicines management were not completed.
- The Quality Audit by the regional quality manager had not identified gaps in the auditing by the service manager and registered manager. For example, they had completed an audit of the medicines management but had not identified that the correct procedures were not being followed.
- Audits of the customer files had not identified gaps and inconsistencies across care plans or missing risk assessments.
- The registered manager told us that they had assumed that the correct procedures were being followed for medicine management.
- There was no clear system in place for monitoring accidents, incidents and near misses. We identified incidents from daily records, such as people's property going missing but there were no incidents reported.
- There were no incident reports corresponding to safeguarding concerns that had been raised and no incident reports relating to medicine errors.
- The registered manager had a folder which should contain all the incident and accident reports but there were no reports for 2018. In people's files we saw individual incident forms but these had not been reviewed by the manager and copies placed in the central record.
- The safeguarding folder included one safeguarding referral for 2018. The registered manager then found records for a further two safeguarding referrals that had been made.
- The report that the service manager sent to the regional quality and compliance manager, stated that there had been a safeguarding incident in February 2019 but this was not held in the safeguarding folder. When we asked the service manager why this was they told us that it had been reported to social services but not taken forward as a safeguarding. However, there was no record to clarify this outcome.

The lack of robust quality assurance meant people were at risk of receiving poor quality care and should a decline in standards occur, the provider's systems would potentially not pick up issues effectively. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us that they would be reviewing the way in which they recorded safety incidents and near misses to ensure that they were able to learn from them in the future.
- Safeguarding incidents had been recorded on safeguarding forms, however only one out of three safeguarding incidents had been reported to the Care Quality Commission in a Statutory Notification in 2018.
- The registered manager showed us the forms that had been completed by the previous service manager to report the incidents but these had not been received by the CQC. The current registered manager was unable to find a record of these having been sent.

Failure to notify the CQC of safeguarding incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulation 2009.

- Staff gave positive feedback about the new service manager. One member of staff said, "We've got a new manager and she seems to be getting things sorted out."
- Staff said that they felt listened to and that managers were approachable.
- The registered manager told us that their ethos is to provide high quality home care to enable people to remain at home as long as possible.
- They said that the local village has a community feel to it and a lot of carers live locally. In the bad weather everyone pulled together and if someone lived locally to a customer then they would walk to the person's house. This had enabled them to continue to provide services during the snow when many people were cut off.
- Staff told us that they felt supported by management. Several mentioned improvements with the new service manager. They attended regular supervisions and team meetings where they felt they could raise issues and were listened to. One staff member said, "We've got quite a new manager and she seems to be getting things sorted out. – [name] she is quite approachable and seems to be sorting out anything we ask her to do at the moment." Another member of staff told us that managers, "Listen to what we say - yes they do and they will let us know the outcome of things as well."
- Several staff commented that there is a good team spirit and morale is good. One staff member said, "In the five years I've been doing it I have always felt appreciated"

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

- The provider carried out a quality questionnaire with people using the service every year. People were asked for comments on the care they received and where they felt improvements could be made if possible.
- Staff were aware of plans for the future development of the service.

Working in partnership with others

- The service worked as part of the local community. Some people were supported to go into the community as part of the care that they received.
- The service worked in partnership with a range of healthcare professionals when caring for people.
- The service had links with specialist organisations such as Marie Curie for supporting people at the end of their life.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>The provider did not notify the Care Quality Commission of safeguarding incidents. Regulation 18 (1) (2) (e).</p>
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Systems and processes did not support people to consent to their care. Regulation 11(1).</p>
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not provided in a safe way. Not all risks to people's safety had been assessed or practical action taken to mitigate such risks. There were no systems in place to identify and monitor safety incidents in order to prevent them from happening in the future. Regulation 12 (2) (a) and (b).</p> <p>There were no proper systems and processes in place to monitor medicines management safely. Regulation 12 (2) (g).</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>There was a lack of robust systems in place to</p>

monitor and improve the quality of care.
Regulation 17 (1), (2) (a) (b) (c) and (f).