

Nationwide Care Services Ltd

Nationwide Care Services Limited (Dudley)

Inspection report

Trafalgar House
47-49 King Street
Dudley
West Midlands
DY2 8PS

Tel: 01384211444

Website: www.nationwidecare.org

Date of inspection visit:

18 April 2016

19 April 2016

Date of publication:

08 June 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

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

This inspection took place on the 18 and 19 April 2016 and was unannounced. This was because we had received some anonymous concerns about the way the service was being managed so we did not announce our inspection visit with the provider. This was the first inspection since this service was registered July 2015. Nationwide Care Services Limited (Dudley) provides personal care and support to 84 people that live in their own homes.

There was a registered manager in post, but they were not based full time at this location. The registered manager did visit the office during our visit and we did have a brief discussion with him. The service was managed on a daily basis by a branch manager who advised that they were supported by the registered manager. The branch manager was present during our inspection.

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.

Recruitment procedures were not robust to ensure all the required information was obtained before people commenced employment.

People did not always receive a reliable and consistent service, as some people had experienced late and missed calls.

The registered manager had failed to meet the requirements of their registration with the Care Quality Commission as we found a number of incidents that had occurred within the service that had not been reported as required.

Quality assurance systems were not effective and had not identified the shortfalls we found during this inspection.

You can see what action we told the provider to take at the back of the full version of the report.

Staff had received training and knew how to report and deal with issues regarding people's safety.

People told us they received their medicines as prescribed, but the medicine records were not always completed to demonstrate this.

Risk assessments and care plans had been developed with the involvement of people. People had equipment in place when this was needed, so that staff could assist them safely.

Staff understood that people have the right to refuse care and that they should not be unlawfully restricted.

People received care from staff that were respectful and caring and ensured that people's privacy and dignity was maintained. People had someone they could talk to if they were not happy about the service they received.

Feedback was sought from relatives about the service provided to their family member.

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 safe.

Recruitment procedures were not robust and did not ensure all of the required checks were completed before staff started work.

People did not always receive a consistent and reliable service.

People felt safe and staff understood their responsibilities to keep people safe and protect them from harm.

People told us they received their medication as required, but the records did not demonstrate this.

Requires Improvement ●

Is the service effective?

The service was effective.

People's needs were met by staff that had received training to ensure they had the skills for their role.

Staff ensured they obtained people's consent before providing support.

Good ●

Is the service caring?

The service was caring.

People were supported by staff that were kind and caring.

Staff ensured that people's privacy, dignity and independence was respected and promoted.

Good ●

Is the service responsive?

The service was responsive.

The support people received met their needs and preferences.

People felt confident that any concerns they raised would be listened to and action would be taken.

Good ●

Is the service well-led?

The service was not well-led.

The quality assurance systems were not effective and did not identify the shortfalls in the service.

Systems were in place to enable people and their relatives to provide feedback about the service they received.

Requires Improvement 

Nationwide Care Services Limited (Dudley)

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.

This inspection took place on 18 and 19 April 2016 and was unannounced. The inspection was undertaken by one inspector.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found that the PIR had not been completed in full and therefore we were not able to use this information when we made the judgements in this report. We looked at the information we held about the service. This included the notifications that the provider had sent us about incidents at the service and information we had received from the public. We also contacted the local authority who monitor and commission services, for information they held about the service. We used this information to plan what areas we were going to focus on during our inspection.

We spoke with ten staff members, including the branch manager, whilst we were at the office, and four on the telephone. We spoke to the registered manager when he visited the office during the first day of our inspection. We spoke with eight people and three relatives by telephone to gain feedback about their experiences of using this service. We received feedback from one social worker about the care people received. We looked at a sample of records including six people's care plans, seven staff files and staff training records to identify if staff had the necessary skills and knowledge to meet people's care needs. We looked at the provider's records for monitoring the quality of the service to see how they had responded to issues raised.

Is the service safe?

Our findings

Prior to our visit we received information of concern about the recruitment processes being followed at this service. These concerns were referred to the local authority and we were aware that the provider was working with them to make the required improvements. We found the recruitment procedures in place were not robust and had not ensured that all of the required recruitment checks had been undertaken before staff had commenced employment. We saw that staff had completed application forms but we found gaps in their employment which had not been explained or followed up on as required. We saw that staff had Disclosure and Barring service (DBS) checks completed. The DBS is a check undertaken to ensure staff are suitable to work with people. However we found that risk assessments had not been undertaken or recorded to detail the safeguards that had been put in place to protect people from risk, when some staff had commenced working with and supporting people before their DBS check had been received. We also saw that no risk assessments had been undertaken or recorded where issues of concern had been raised following the receipt of staff member's recruitment checks. Staff files contained two references which we saw had been validated. Since the concerns had been raised about the recruitment processes we saw that audits had been undertaken and as a result improvements had been made to the recruitment processes, focussing on risk assessments that had not been undertaken. However we saw that these audits did not identify all of the shortfalls that needed to be prioritised and addressed to ensure all of the required information was in place.

People we spoke with told us they usually had the same team of staff that provided their support. One person said, "I usually get the same staff, which is important to me. The service have improved in this area as before I didn't get that consistency but now I do". Another person told us, "I have support from the same staff apart from when they are off sick or on holiday and then I may get someone different". Another person told us, "I usually get the same staff, and sometimes the staff are late and I have had missed calls in the past". We did receive feedback from other people about late and missed calls. Most of these people told us they had complained to the service about this, and we saw this had been recorded on the complaints log. However other people had not raised this with the provider. We discussed these issues with the branch manager who confirmed that a new system had been implemented to monitor the staff whereabouts and the times they attended calls. The branch manager confirmed that action has been taken which had included disciplinary action in relation to the staff shortfalls with the service being delivered and we saw evidence of this.

Staff we spoke with told us their rotas were now the same each week and they visited the same people. One staff member said, "I now have a consistent rota which is only changed when we have staff off due to holidays or sickness". The branch manager advised that they were recruiting care staff on an on-going basis, and that they had sufficient staff to meet the needs of the people they were currently providing a service to.

Some people required assistance with their medication. People we spoke with told us they were satisfied with the support provided. One person told us, "The staff give me my medication and make sure I take it". Another person said, "The staff remind me to take my medication". The staff we spoke with confirmed they had received training and the records we looked at confirmed this. They also told us they felt confident to

administer people's medication.

We looked at some completed medication records that had been returned to the office. We saw that there were gaps in the records where staff had not signed to confirm that the medication had been administered. We also saw on one record that the dosage had been amended, but no explanation was recorded as to who had made this amendment and why. We were advised by the branch manager that audits were due to be undertaken on these records and that discrepancies would be investigated and action taken. However we saw that no systems were in place to report and alert the branch manager to these shortfalls sooner by staff who had attended the next visit. We did see evidence of audits on records that had been reviewed when they had been returned to the office. Action was recorded where shortfalls had been identified which included discussions with staff members about their performances.

People we spoke with told us they felt safe with the staff that supported them. One person said, "The staff help me with my mobility which makes me feel safe as I know they are there to help me, and this is reassuring". Another person said, "I feel safe when the staff come and support me I have no concerns". Relatives we spoke with had no concerns about the way support was provided. One relative said, "I think my family member is in safe hands". Another relative said, "I have no concerns and if I did I would soon take action".

Staff we spoke with had an understanding of their responsibilities to keep people safe, and they confirmed they had received training to ensure they were able to recognise when people may be at risk of harm. All of the staff we spoke with was aware of the procedures to follow if they felt someone was at risk of harm or abuse. However some staff were unsure about the external agencies they could contact if they had any concerns. One staff member told us, "I have had safeguarding training and if I thought that a person was at any kind of risk I would report it to the branch manager". Another staff member said, "I would feel confident to raise any issues".

We saw from people's care records that risk assessments had been completed which identified any risks due to their health and support needs. These assessments included information for the staff to follow to minimise the chance of harm occurring. We were told by staff, people who used the service and their relatives that where people required a hoist to move them from one place to another, two staff were always provided to ensure that this was done safely. We saw that risk assessments had been completed on the environment to ensure any risks to the person or staff had been minimised where possible. For example risk assessments included information about pets, and uneven steps to the property.

Is the service effective?

Our findings

People told us that they were happy with the care they received and that staff were "helpful" and "supportive". One person told us, "The staff help me to do the things I cannot do myself." Another person told us, "The staff are lovely, and nice, I am happy with the support I get". A relative we spoke with told us, "The staff have improved and we are satisfied with them. But we think some staff need more training as they do not seem to know what they are doing and they need direction from us. But on the whole we are satisfied". This feedback was discussed with the branch manager who agreed to look into the issues raised.

Staff told us they received training, as part of their induction. One recently recruited staff member said, "When I started I went to head office and completed a week of induction training. This was good training and I think it gave me the skills and knowledge about how to do my job. I also had the opportunity to shadow more experienced staff before I started to deliver care myself". The staff member reported that doing all this meant they felt confident when they went out on their own for the first time. Another staff member said, "I had training when I first started in lots of different areas and we had to answer questions to make sure we had learnt from the training. I also shadowed experienced staff members so I was able to see people's routines and meet people before I provided their care". The branch manager confirmed that the Care Certificate had been introduced and incorporated within the induction process. The Care Certificate is a set of standards designed to assist staff to gain the skills and knowledge they need to provide people's care.

We looked at staff files and we saw that training records were in place to demonstrate the training staff had undertaken. Staff we spoke with told us they received regular supervision to discuss their role and any issues they had. They confirmed they could contact a senior or the branch manager at any time if they needed help or advice. The branch manager confirmed that a system was in place to undertake annual appraisals for staff when they had worked with the service for a year.

The branch manager told us how they aim to recruit staff to meet the specific needs of individuals using the service. We saw that people were asked their preferences as to the gender of the person providing their care and this was recorded in their care records. Where people had requested support from female staff only, we saw that this was facilitated. Where people's first language was not English we saw that staff who were able to understand and communicate with people in their preferred language were supporting them where possible.

People and their relatives confirmed that they had been consulted about how they wanted to be supported and, when possible, people had signed their care records to indicate their agreement and consent. We saw that the branch manager had made changes to the way people were supported in line with their expressed wishes. This included changes to call times and the staff who provided support.

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Although staff were not familiar with the terminologies Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguarding (DoLS) we found that staff knew that they should not restrict people in any way and that they should ensure that people consented to their care and support. A staff member told us, "I always ask before I provide support to people to make sure they are okay with it". Another staff member told us, "I ask permission first before I provide care especially when supporting people with personal care". People we spoke with confirmed that staff asked their consent before providing care. One person said, "The staff ask me for my consent and they do as I say". Training records that we looked at confirmed that staff had received MCA training as part of the safeguarding training that was delivered. However when we asked staff about this training they were unsure if they had completed this training. Nearly all of the staff we spoke with said they would benefit from further training to ensure that they were fully aware of the principles of the MCA and best interest decision making.

People who needed support from staff to prepare meals confirmed they were supported in the way that they preferred. We saw that information in relation to people's dietary requirements was recorded in their care plans. Discussions with staff members demonstrated they were aware of any specific risks when supporting people to eat a meal or to have a drink. People told us that staff left drinks and snacks out for them when they had requested this.

People we spoke with confirmed they accessed health care support independently or had support from their family members. Staff we spoke with knew the procedures to follow if someone fell ill or had a fall during their visit. One person said, "I know if I needed medical support the staff would arrange this". A relative told us, "The staff would take action if they needed to". A social worker told us that staff were proactive in ensuring a person's healthcare needs were monitored and any concerns were reported. We saw that staff followed healthcare professional recommendations and completed monitoring charts of fluid intake. The records also demonstrated that staff moved people to provide pressure relief as recommended.

Is the service caring?

Our findings

People we spoke with made many positive comments about the staff that supported them. One person said, "The staff I receive support from are caring, kind and friendly and I think they do their job well". Another person said, "The staff I get are excellent, and provide good care, I am very happy with the support I receive". A relative we spoke with told us, "The staff are kind, caring and polite we have no concerns".

People we spoke with told us they felt involved with their care and that staff listened to them. One person said, "The staff help me with the tasks I need help with and they always ask if I am satisfied and if I needed help with anything else". People told us how important it was to them to receive support from a consistent team of staff. One person told us, "I used to get many different staff providing my support but now things have improved and I pretty much get the same staff. This means a lot to me, as I can get to know them and they can get to know me. This makes it so much better".

Staff demonstrated a good understanding of people's needs and were able to tell us how they cared for people in a dignified way. They were able to describe to us how they would respect people's privacy and dignity when providing personal care to people. One staff member said, "When providing personal care I always ensure the curtains and doors are closed and the person is covered". Staff we spoke with understood the importance of promoting people's independence and enabling them to be self-managing. One staff member we spoke with said, "Our aim is to maintain people's independence and to enable them to do things for themselves". A relative we spoke with said, "The staff are respectful and ensure my family members dignity is maintained at all times".

The branch manager confirmed that she was unaware that anyone supported by them was using an advocate service. She also said they did not have any information about local advocacy services but she would contact people's social worker if she had any concerns about people. Advocacy can support and enable people to be involved and make decisions; Some people who may have difficulty speaking out, or who need support to make their own, informed and independent choices about decisions that affect their lives find advocacy invaluable.

Is the service responsive?

Our findings

People we spoke with confirmed the support they received from staff met their individual needs and preferences. One person said, "The staff give me the support I need, I am satisfied". Another person said, "I am very happy with the care I get, they help me when I need them to". A relative told us, "I think the staff provide the support that we have asked for".

People and the relatives we spoke with confirmed that an assessment was undertaken before the service was provided. One person told us, "I had a visit from the office staff who came and asked me lots of questions about what support I needed". Another person said, "I had an assessment completed and I have a care plan which tells the staff the support I need". The records we looked at confirmed that assessments and care plans had been completed and included information about people's past history, and preferences.

Staff we spoke with were knowledgeable about people's needs, preferences and routines. They were able to describe to us how they met people's care needs and how they supported people to express choices and maintain their independence by encouraging them to do as much for themselves as they could. One staff member told us, "We always ask people what support they want. We are led by them and the tasks they want support with".

Where people had specific cultural or language requirements, the provider had made efforts to find suitable members of staff that could meet these needs. The care plans included information about people's cultural and religious needs as well as their preferences.

People we spoke with were aware of the complaints process and most of them felt that concerns were addressed and action taken. One person said, "I have had to complain as staff were not coming at the time I agreed. The branch manager sorted this out and took action with the staff and now I receive support at the times I want and need". Another person told us, "I would speak to the branch manager if I had any issues and I am confident they would be sorted out. I have not had any reason to complain as I am happy with the service".

We saw that a complaints procedure was available in the pack that people received when they first started using this service. The complaints procedure included a list of agencies people could approach for support to make a complaint, or if they were not happy with the way the complaint had been responded to. We saw that a system was in place to record the complaints the service had received, and we saw all complaints had been responded to. We found that where issues from complaints needed to be addressed they were discussed with individual staff members, raised at staff meetings or information was sent to staff in the form of staff memos to ensure that the required changes were made.

Is the service well-led?

Our findings

We received information of concern from anonymous sources prior to this inspection. We looked into the issues that were raised. We found that the provider had taken action to address the performance of some staff which had impacted on the service that people received.

The registered manager was not based at this service and did not manage the daily running of the service. This was managed by the branch manager who told us she was supported by the registered manager. We were advised that the registered manager completed audits to monitor the way the service was being delivered, the audits had failed to identify issues related to recruitment and missed calls. We asked to see these records, and we were advised these would be forwarded to us following our inspection as they were not available at the time of our visit. We did not receive these within the requested timeframe following our inspection.

The provider and registered manager had failed to notify us about incidents that had occurred and affected people who used the service. We reviewed the notifications received from the service and we found that a number of incidents had not been reported. As the incidents related to allegations of abuse and to people who used the service, the registered manager had a legal responsibility to report these in accordance with their registration with the Care Quality Commission (CQC). We spoke with the branch manager about why these incidents had not been reported and they advised they were not fully aware about which incidents had to be notified to CQC. However, we found that the incidents had been referred to the local authority as required by the safeguarding procedures to protect people from harm. The branch manager confirmed that the notifications would be submitted to us retrospectively, and since the inspection we have received these.

We saw that effective systems were not in place to ensure that records were completed or had been updated to underpin and guide staff on the support they should provide to people. For example we found that protocols were not in place for staff to follow when supporting people with behaviours that challenge. We found that some people who were prescribed 'as required' medicines did not have supporting information in place to guide staff in the signs and symptoms which might indicate people needed their medicine. We also saw that information about how people took their medicine was not recorded in their care records for staff to refer to. However discussions with staff demonstrated that they had the knowledge about people's needs despite the lack of written guidance. We found that some people used bed rails, and information relating to the staff support needed with this aspect of care was not recorded in people's care records. Risk assessments and consent for the use of bed rails was not in place for all of the people who used these. People and the relatives we spoke with confirmed that they had consented for this equipment to be used when they were assessed by a healthcare professional. We also saw that where people lacked capacity this information was not clearly reflected in their care records to guide staff when providing support, and to make it clear that support was being provided in people's best interests.

We saw that there were systems in place to assess and monitor the quality of the service people received, but these were not always effective. We received feedback from people that they had received missed or late calls. We saw that there was a missed calls folder but this did not include all of the missed calls the

service had received concerns about. The branch manager advised that this information was recorded in the complaints log or on individual electronic records. Therefore it was not clear how many missed calls the service has had and the action taken in response to each incident. However the branch manager was able to show us records to demonstrate some of the action that had been taken in response to some of these incidents, and this included disciplinary action, and issues had been raised in staff meetings. The provider has also recently implemented an electronic call monitoring system to monitor staff whereabouts and alert the branch manager if staff had missed a visit or were running late. The branch manager told us this would enable her to monitor how the service is delivered more effectively. We saw audits to monitor the care plans, medication records and recruitment information had not identified shortfalls so that improvements could be made in a timely way.

The systems in place were not effective in assessing and managing risks and improving quality. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People we spoke with told us they thought the service had improved recently and they thought it was being managed satisfactorily. People and the relatives we spoke with said, that any issues they had raised had been responded to to their satisfaction. One person said, "The office staff and branch manager are approachable and they listen and do their best to sort any issues out". A relative we spoke with told us, "The branch manager is friendly and approachable and I think she is doing her best to manage this service. She has taken action and made improvements where needed".

We received mixed feedback from the staff about the way the service was managed. Some staff told us the service was now being managed well. Other staff told us improvements could be made with the communication processes, and some staff did not think the management team were open and transparent. Staff did not always feel able or empowered to share their ideas about the way the service was delivered. All staff thought action was being taken to improve the way the service was managed and delivered. All the staff we spoke with told us they enjoyed their job and were dedicated to ensuring people received 'good care'.

People and the relatives we spoke with told us their feedback had been sought about the way the service was delivered. One person told us, "I have completed a couple of questionnaires and have provided feedback over the telephone about staff member's performance". Another person said, "I have been asked what I think and I have told them and this has led to improvements so it works".

We saw in people's files the records of these telephone calls and questionnaires that had been completed. We saw that a report and analysis of the feedback the provider received had been completed. We saw that 'spot checks' on staff were undertaken and the action taken in response to these was recorded where performance issues had been identified.

The service had a whistleblowing policy and procedure, but not all of the staff we spoke with was aware of this policy. Whistleblowing is the process for raising concerns about poor practice. We saw that where concerns had been made action had been taken to ensure people were safe.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service were at risk of inappropriate or unsafe care because the provider did not have effective systems to assess, manage and monitor risks. Regulation 17 (2) (a)