

# Nurse Plus and Carer Plus (UK) Limited

## Nurseplus UK - Ashford

### Inspection report

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Date of inspection visit:  
20 November 2018  
21 November 2018

Date of publication:  
05 February 2019

### 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 20 and 21 of November 2018 and was announced.

Nurseplus UK – Ashford is a domiciliary care agency. It provides personal care to adults who want to remain independent in their own home in the community. At the time of the inspection not everyone using the service received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection 130 people were receiving the regulated activity personal care. The service is also registered to provide treatment for disease, disorder or injury. However, no one was in receipt of nursing care when we inspected.

At the last inspection on 6 and 7 November 2017 the service was rated overall as requires improvement. Following this we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, responsive and well-led to at least good. At this inspection we found that the rating remained requires improvement. This is the third consecutive time the service has been rated Requires Improvement.

There was a registered manager at the service. 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 2008 and associated Regulations about how the service is run. At the time of the inspection the registered manager was on planned leave and the deputy manager was the acting manager.

At the previous inspection we found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not always administered safely and the provider had failed to ensure care was provided in a safe way. At this inspection some improvements had been made to medicines management but there continued to be concerns relating to the recording of medicines and dating when bottles and creams were opened. We made a recommendation relating to the administration of medicines.

At the last inspection the service we found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, in that systems and processes had been not been consistently effective in identifying shortfalls and driving improvements in a timely way to ensure compliance and make sure people received a quality service. At this inspection, audits undertaken by the service had identified that there continued to be concerns relating to the recording of medicines and actions taken had not resolved all of the concerns. Further improvements were needed to be made and the service remained in breach There continued to be concerns about communication between the people who used the service and office staff.

Risks to people and from the environment were assessed and there was information for staff on how to

lessen these risks. People were protected from the risk of infection and personal protection equipment such as aprons and gloves were available for staff and were used.

People were protected from abuse. Staff had a good understanding on what abuse was and reported concerns when they had them. Concerns were reported to the local authority and CQC and dealt with appropriately. Staff understood the principles of the Mental Capacity Act 2005 and supported people to make choices for themselves.

There were sufficient numbers of staff to cover care calls. Staff were recruited safely and the appropriate pre-employment checks had been carried out. Where things went wrong the service took action where this was needed. Staff had the skills, training and knowledge they needed to support people effectively. Staff received appropriate levels of supervision, underwent competency checks and had an annual appraisal. New staff undertook appropriate training and a period of shadowing.

Where people needed support to eat and drink this was provided. People also had the support they needed to access healthcare services. Staff had the information they needed to share with healthcare services if someone was taken ill.

People were treated with kindness, compassion and respect. Staff communicated well with people and asked their permission before providing care. People's dignity and privacy were respected and promoted. People were supported to maintain their independence and continue to do things for themselves where possible.

People's needs were assessed before they started to receive a service and this assessment was used to plan people's care. People and their relatives were involved in reviews of their care and people were supported to express their views. Care plans were personalised and contained information about people's preferences and cultural and religious needs where people had these.

There was a complaints policy in place which was shared with people who used the service. People knew how to complain, and complaints were recorded and investigated appropriately.

The service was not currently supporting people at the end of their life. The acting manager was aware that they needed to discuss people's end of life preferences if they supported people in the future. Where people had "do not resuscitate" forms in place these were in people's care files. There was also information about any advance decisions people had made about care and treatment.

The acting manager was committed and passionate about the service and had the skills and experience they needed to undertake this position. The acting manager was supported by the area manager and was aware of their responsibilities.

The staff we spoke to told us that they enjoyed their role and were listened to. There were regular staff meetings. Attendance at these meetings had not been high, however, there were plans in place to address this. There were annual staff surveys and surveys for people and their relatives. Where issues were identified these were added to an action plan for completion.

The acting manager planned to access local forums to meet with other managers and share best practice. The service had access to best practice information and guidance which was sent out by the provider.

During this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities)

Regulations. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** 

The service was not consistently safe.

Medicines were not always managed safely.

Risks to people were assessed and there was guidance for staff to mitigate risk.

There were enough staff available to provide the service. Safe recruitment practices were followed.

People were protected from the risk of abuse, staff had the appropriate training and knowledge.

Staff used personal protective equipment as appropriate and people were protected from the risk of infection.

Lessons were learned when things went wrong, and learning was shared with staff.

### Is the service effective?

**Good** 

The service was effective.

People's needs had been appropriately assessed before they received care from the service.

Staff were appropriately supervised and had the skills, knowledge and training the needed to support people.

People were provided with the appropriate support to eat and drink where this was required.

People were supported to access to healthcare professionals when they needed this.

The provider followed the principles of the Mental Capacity Act (2005).

### Is the service caring?

**Good** 

The service was caring.

Staff were kind and caring.

People and their relatives were involved in decisions about their own care.

Staff assisted people to maintain their dignity and privacy.

People were supported to maintain their independence.

### Is the service responsive?

Good ●

The service was responsive.

People's care plans were personalised and contained information on how people liked to be supported.

There was a complaints policy in place and people and their relatives knew how to complain if they chose to do so.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Regular checks of the service was undertaken but these did not always lead to a timely improvement in quality.

Medicines administration records continued to be incomplete.

People, their relatives and staff had the opportunity to feedback about the quality of the service. However, people told us that communication between them and the office was poor, that Care calls were sometimes late, and some people told us that they did not always know who was visiting them.

Staff were happy in their role and felt well supported by the provider and that their views were listened to.

Staff and the registered manager were aware of their roles and responsibilities and notifiable incidents were reported to CQC.

The service worked in partnership with other relevant organisations.

# Nurseplus UK - Ashford

## 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.

We gave the service 24 hours' notice of the inspection visit because the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 20 November 2018 and ended on 21 November 2018. We visited the office location on both days to see the management team and office staff; and to review care records and policies and procedures. On the 21 November 2018 we shadowed a member of staff undertaking lunch time calls and spoke with people who received a service by telephone.

The inspection team consisted of two inspectors and two experts by experience who undertook telephone calls to people who used the service and their relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Due to technical problems, the provider was not able to complete a Provider Information Return. 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 took this into account when we inspected the service and made the judgements in this report.

We sought feedback from relevant health and social care professionals and staff from the local authority on their experience of the service. We contacted Healthwatch, who are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change.

During the inspection, we visited five people in their own homes and spoke with sixteen people and thirteen relatives on the telephone to gain their views and experiences. We looked at fourteen people's care plans and the recruitment records of six staff employed at the service.

We spoke with one of the providers, the acting manager, and five members of staff. We viewed a range of policies, medicines management, complaints and compliments, meetings minutes, health and safety assessments, accidents and incidents logs. We looked at what actions the provider had taken to improve the quality of the service. We also used information from a recent survey of people undertaken by the provider.



# Is the service safe?

## Our findings

At the last inspection on 06 November 2017 the service continued not to meet Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Medicines were not always administered safely, and the provider failed to ensure care and treatment was provided in a safe way. At this inspection we found that the regulation had been met and the service was no longer in breach of the regulation. However, there were some areas that still needed improvement and we made a recommendation about this.

At this inspection we found that the service had made some improvements. However, there continued to be issues relating to the safe management of medicines. At the last inspection people's medicines administration records (MARs) were not consistently completed by staff. At this inspection this had improved but there were still gaps in the MARs which could not be accounted for. A gap in the MARs is where staff did not sign the MARs when the person received their medicine or added a code to indicate that they did not have their medicine and why. This meant that staff were not keeping accurate records which increased the potential risk of errors occurring. There were also gaps where body maps had not been completed so that staff knew where transdermal patches had been placed on people's skin and when these patches were removed. This meant that staff did not know where the person's patch had been placed and increased the risk that the patch was placed on the same area of skin on consecutive occasions which can lead to problems with the person's skin. People's daily records showed that people had received their medicines as prescribed. When we visited people in their own homes none of the creams we looked at had been dated when they were opened. Creams and liquids expire within a certain time of opening. Staff would not have been aware of when the medicine was opened to ensure that it was not used after this time. The acting manager was aware that medicine continued to be a concern and there was a process in place to ensure that staff were retrained, and their competency was checked again after any errors. However, there were times when this retraining was not done in a timely manner and the staff members had continued to administer medicines. This put people at risk of harm.

Immediately after the inspection the acting manager put in place new guidance for the process for retraining. This was to ensure that staff who did not complete the MARs or where there had been errors were retrained and re-assessed quicker or were suspended from administering medicines until this was completed. The acting manager also updated the audit system so that one person had oversight of medicines and the performance of staff delivering these. The process for undertaking spot checks of staff administering medicines was also amended so that spot checks were undertaken more frequently, and all staff were identified as requiring further medicines training.

We recommend that the provider reviews the services medicine administration practice.

The service had a good system to ensure that they kept up to date with what medicine people were taking. Where medicines were to be crushed before administration the service had checked that this was safe to do. Some medicines should not be crushed as it can change how the medicine is absorbed. One person did not have the correct medicine when they came home from hospital staff identified this and supported the person to get the medicine they needed. There was guidance for staff on how people preferred to take their

medicine and what to do if a person declined their medicine. We observed staff supporting people to take their medicine, staff knew how people wanted to be supported and were patient and encouraging where this was needed. Where people used creams, there were body maps in place to ensure that these were applied to the correct area. There was information for staff about 'as and when' medicines, these are medicines people take when they need them such as pain relief. There was guidance on how often these medicines could be taken, what they were intended for and what the person's reaction to taking the medicine might be.

Outside of office hours there was an on-call system so that staff could speak to someone if they needed support or were unable to attend the call. The service had identified people who would be at risk if there was a bad weather event such as snow, and there were procedures in place to keep people safe.

There was sufficient numbers of trained staff with the needed experience and skills to meet people's needs. During the months before the inspection a number of staff had left which had resulted in a shortage of staff. The service had since recruited sufficient numbers of staff to resolve this concern. The provider had a policy of continual recruitment to ensure that new staff were recruited to accommodate growth and to replace staff who left. Staffing numbers were reviewed before the provider agreed to accept new packages of care.

The staff records showed that a robust recruitment procedure was being followed. Pre-employment checks were carried out; these included obtaining a full employment history, identification checks, references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to identify people who are unsuitable to work with adults in vulnerable settings.

People were protected from abuse. Staff had a good understanding of abuse and knew how to identify concerns including identifying when a person was a risk from someone they lived with or abuse through self-neglect. Staff were confident that the acting manager would report any concerns they raised. Staff also knew to report concerns to the local authority if they felt that the acting manager had not addressed these. The management team ensured that safeguarding information raised by staff was escalated to the safeguarding team at social services. They also informed CQC, along with any action they have taken.

Risks to people had been assessed and mitigations were put in place when these were needed. There was information in people's care plans to provide staff with the guidance they needed to support people to manage risks to their health and wellbeing. For example, care plans included risk assessments for moving and handling, medicines, skin integrity and personal care. Where people needed equipment to manage risks safely this was detailed in the care plan and there was information for staff on how to use this safely. We visited people in their homes and found that the equipment detailed in the care plan was an accurate reflection of the equipment being used. Where people had long term conditions such as needing support with continence there was information on how to identify concerns such as infections and what action to take if concerns arose. We observed staff checking people's care plans and daily notes before delivering any personal care to ensure that these had not changed since their last visit.

There were also risk assessments to protect people from risks from the environment and to protect staff. For example, there was a lone worker risk assessment for each person to ensure that staff could work safely with the person alone. The acting manager had system to ensure that hoists and other equipment used by the staff were regularly checked and service appropriately even where this was not the direct responsibility of the service to do so.

People told us that they felt safe using the service. People said, "We are very happy with the care and that's the most important thing"; "I have never felt unsafe or had a concern about the staff sent" and, "I do feel safe

with the staff that come and knowing that someone is coming to check on me."

Relatives told us, "My relative feels safe and happy with them and I feel safe leaving my relative in their capable hands" and, "It all seems to be working well with them and they listen and want to help."

People were protected from the risk of infection. The risk of infection had been individually assessed for each person. These assessments included information on what the risks to a person were and what actions staff needed to take to reduce these risks. Staff had access to personal protection equipment (PPE) such as aprons and gloves and we saw that staff used these. Staff had received training in infection control and knew how to keep people safe. When staff prepared food for people we saw that they knew how to follow the rules of good food hygiene such as changing gloves and covering food when appropriate.

The service had learned from incidents and accidents. These were recorded, investigated and where needed action was taken. For example, one staff member had not undertaken their care calls on one day and did not inform the service. The service was notified by a person and the acting manager arranged for care calls to be covered by other staff which meant people received late care visits. The member of staff received a supervision and was told how this had affected the people concerned. The staff member apologised to the people and their colleagues. The acting manager continued to supervise the member of staff to ensure that the incident did not re-occur and there were no further issues. At staff meetings staff were reminded of how to contact the agency when they are not able to cover their calls. In this way all staff were all aware of how missed calls impact on the people they care for.

Incidents were reviewed for patterns and where these occurred they were analysed to identify trends. This meant that the acting manager could use this information to minimise the risk of further incidents occurring. Lessons learnt were shared with staff at meetings. Where staff could not attend these meetings, they were sent the notes so that they could read what was discussed.

# Is the service effective?

## Our findings

People told us, "I'd give the staff ten out of ten for knowledge and ability to get the job done"; "They are hardworking and yes they all do a good job and know what they are doing"; "I am happy with the staff when they are here, and they all seem to be quite able and willing to help" and "The staff are all professional and know exactly what they are doing I wouldn't question a single one of them."

Staff had the skills, training and knowledge they needed to support people effectively. Training included safeguarding adults and children, infection control, dignity, equality and diversity, nutrition and hydration and health and safety. Staff also had access to learning in other topics such as dementia, mental health, end of life care and learning disability. Staff told us that they thought that the training was good and was "Well structured." At the time of the inspection there were no nursing staff working at the service. Before starting work with people staff undertook the providers own induction training and their competency was assessed. New staff confirmed that they worked alongside experienced staff to have the opportunity to meet people and get to know how to deliver their person-centred care. People told us, "They are certainly well trained, and any new ones will shadow at first"; "They know exactly what they are doing and get on with it as soon as they arrive" and, "I am very happy that the staff are all knowledgeable and fully trained. They do a sterling job on all fronts."

Staff received regular supervisions and an annual appraisal. The supervisors undertook four spot checks a year for each member of staff to check that staff were following safe procedures and were competent. After each spot check staff had a supervision to discuss what was found as well as one supervision in the office every three months. If staff needed extra support or there was an incident the frequency of supervision was increased.

People's needs were assessed before they started to receive a service. One relative said, "When the care was set up they came out to see me and my relative they set out a care plan." The assessment forms were comprehensive and covered all aspects of people's care and needs. The initial assessment included mobility, communication, personal care and support the needed to maintain their health and as well as discussing people's cultural, religious and spiritual needs. The information from the assessment was used to develop the person's care plan. The acting manager told us, "When we are asked to take on a new client, we look at the information and the care that the Care Managers are requesting. If we can meet the person's needs, we visit that person and do our own initial assessment. We then look at matching the available staff who can deliver this person's care needs. If we have suitable staff, only then would we then take the on package of care."

When people needed support to eat and drink safely this was provided. Where people needed support with eating and drinking this was documented in their care plan. There was information on people's preferences such as what they liked to eat and how they took their tea. We observed staff provided good support to people when making food for or with them. One person was being supported by staff to make a meal. Staff checked with the person about their preferences, such as how thick they wanted their gravy and how much gravy they wanted. Staff offered people drinks and encouraged people to eat and drink. Food and drink was

left within people's reach. People told us, "They always make sure I'm well stocked with drinks and check before they leave that I have everything" and, "I can choose my lunch from the fridge they will tell me what's there and then cook it for me." Relatives said, "I leave the food for my relative ready prepared and they will take it through to them wherever they want to eat. They never rush them, but they make sure they eat it and have a drink to go with it. They will always leave them with a cup of tea or coffee or ask them what they fancy on the day" and "They always check that my relative is comfortable before they leave and make sure they have drinks."

Where people had difficulty swallowing there was information from the speech and language team (SaLT) providing guidance for staff on how to support the person to remain safe whilst eating and drinking. Where staff had concerns about people's swallow they had supported the person to access a SaLT assessment.

Some people did not need support to access healthcare, such as making and attending appointments as they managed this themselves or a relative or friend assisted them. However, people told us that staff did provide help when they needed it. One person said, "One time the carer was concerned that I was still in pain after some treatment and so they called the dentist for me and made an appointment and then called my relative to let them know." Another person said, "They would call a nurse or a doctor for us no problem and no hesitation." There were copies of people's care plans in their home and in the office. This meant that staff had access to critical health information about people such as whether someone had a heart condition or epilepsy. This meant that they could share important information with the emergency services if they needed to call an ambulance. When we visited people, we observed that staff always checked that the person was wearing their pendent alarm, where they had this in place. There was a prompt in people's care plans to ensure that staff checked, and this was recorded in people's daily notes.

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 to receive care and treatment with appropriate legal authority. In the community, this is usually through MCA application procedures to the Court of Protection called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found that they were. For example, where people had medicine that was administered covertly the service had checked that this decision had been made with relevant health professionals in the person's best interests. Where people had the capacity to make decisions they had been asked if they wanted relatives to be involved in helping them to make decisions about their care and that this was recorded.

## Is the service caring?

### Our findings

We observed staff treating people with care, compassion and respect. When we visited people, we observed that staff knew people well. People were happy to see the staff and were comfortable in their company. Staff chatted to people and people led the conversation. Staff were aware of the topics that were of interest to people and asked people about their family and lives. Staff and people laughed and joked together. People told us, "The staff have really bothered to get to know us and the care is marvellous in every way we simply could not be here without them"; "It's nice to chat as we go we get on well and talk about anything"; "I would say the best thing about the service is just the care and the way they are respectful and kind" and, "They are patient and kind and talk to me respectfully, they value my opinion."

People and their relatives said, "They are like our friends coming we have a laugh and banter with them"; "We do get on well with all of them they are all kind and caring but it's hard to build a rapport as we see so many different ones"; "I completely trust them with my relative they know my relatives capabilities on a daily basis"; "I would say that the best thing about the service is the care they give is kind, compassionate and dedicated and enables my relative to continue their life out of a care home and put my mind at ease too. A win-win all round" and "They put my relative at ease, so much so that my relative really looks forward to them arriving."

When staff were providing personal care they asked people for permission first and talked with people about what they were planning to do before they did it. One relative said, "The carers really listen, and they understand my relative which is quite something because her needs are quite complex now." People told us that staff respected their privacy and respected their home when they visited. We observed that staff always knocked on people's door or used the bell even when they had their key to let themselves in. When staff were undertaking personal care they ensured that we left the room first and closed the door. People said, "They will pull the shower curtain across if I'm able to manage on my own and just be around if I need to call them" and, "They make sure that the door is closed before they [provide my personal care]." People's records were kept confidential. Records were stored at the main office in a locked cabinet.

People and their relatives told us they were involved the review of their care plan. One person told us, "We both have a care plan and it is up to date someone comes and talks to us about it and make sure everything is working well." People's views were taken in to account and people were listened to. A relative said, "The staff are fully aware of my relatives likes and dislikes but still always check with them and discuss what they would like that day." Another told us, "We have always found them to be polite and listen to my relative and then react in a very appropriate and caring manner."

People told us that staff supported them to do things for themselves where they were able to. People said, "They know me well and knows I'm unable to bend and knows I like to wash certain areas myself and they respect that"; "They will ask me if I want a wash or a shower it's up to me, some will ask how I feel what I can do for myself today"; "They will close the curtains and I hear them asking if my relative can do their own face and hands" and "They listen, they help, and they encourage. You see I like to try to be as independent as I can, so they encourage that by letting me do certain things for myself with a little help if I need it." One

member of staff said, "I always encourage the people I care for to do what they can for themselves, I do this by giving people time and making sure they do not feel rushed. A lot of older people want to keep their independence and it's important as carers that we enable that as much as possible."

There was information about the service for people in the care file in their home. Information included what they could expect from staff, contact numbers and how to make a complaint. The service was working according to the Accessible Information Standard (AIS) and its requirements. AIS is a framework put in place in August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information. For example, information was provided in plain English using clear large print format and, where needed, staff used these documents to discuss and explain information to people.

## Is the service responsive?

### Our findings

Care plans were personalised and included information about people's life history, preferences and what was important to them. For example, there was information on what people liked to eat and drink. There was information on what people liked to do for themselves and what support they needed to do it. One person liked to be supported to check the temperature of their bath water and there was guidance for staff on how to do this. There was detailed information about the care and support people needed at each visit. There was detailed guidance for staff to describe what assistance may be needed and when or how they would know if assistance was needed. There was information in people's care plans about any religious needs they had or if they needed support with cultural needs. People told us, "The staff all know me and my idiosyncrasies" and "They will do extra little things for me like buy me the paper if I ask."

People and their relatives were involved in annual reviews of their care. In people's care plans there was information on who people wanted involved in decisions about their care and how much involvement they wanted relatives to have. Relatives were involved in reviewing people's care plans where people had expressed that they wanted them to be so. One person said, "I am in charge of the care plan bit myself with the help of the carers and we get it all done together." One relative told us, "We were fully involved in writing and re-writing the care plan and things are not set in stone. We frequently discuss my relatives care and make slight alterations to the way things are done if we are all in agreement. So, in a way I suppose it is a continuing and flowing review."

There was a complaints policy in place. The complaints file contained complaints received, any investigation that took place and the findings. The complainant is contacted within three days, is kept inform of progress during any investigation process. The acting manager said its important they remain open and transparent when dealing with a complaint. The agency apologised when their service has not provided the quality of care they strive to provide. The acting manager explained that they do learn from the complaints raised and look at how they can prevent the same concern being made again. Most of the people we spoke to told us that they had not made a complaint. People said, "I do phone the office occasionally, but I have never had cause to complain"; "We do know how to complain but it all seems to be working well so we have no need to" and "I am more than happy with the service, they are a life saver and I have no complaints." One person said, "We do know how to make a complaint and we did do when we were not happy about the carers, but they have sorted it out now and the new lady is very reliable."

The service was not currently supporting people at the end of their life although they had done in the past. The acting manager was aware that they needed to discuss people's end of life preferences if they supported people in the future. Where people had "do not resuscitate" forms in place these were in people's care files and the ones we looked at where up to date. There was also information about any advance directives people had in place. Advanced directives are where people make decisions in advance about treatment they want to refuse if the need arises. These are used when people are no longer able to communicate their wishes.



# Is the service well-led?

## Our findings

At the last inspection on 06 November 2017 the service continued not to meet Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Systems and processes not been consistently effective in identifying shortfalls and driving improvements in a timely way to ensure compliance and make sure people received a quality service.

There continued to be concerns relating to the recording of the administration of medicines for the third consecutive inspection. At the previous two inspections we found that staff inconsistently completed medicine administration records (MARs). At this inspection we found the same concerns. For example, one person was out when staff called to provide care. The medicine administration record (MARs) had not been updated to state that the medicine was not administered and there was no exception report. We also found more than one occurrence where medicine had been administered but the MARs had not been completed and was left blank.

At the previous inspection we found that there were concerns relating to the recording of medicated patches in that staff had not always dated when these were removed. At this inspection we found the same concerns. For example, one person had a medicated patch which was to be placed on the skin. When placing a patch on the persons skin staff used a body map to note where the patch was placed so that it could be placed on a different area of the body next time to reduce the risk of irritating the persons skin. On three occasions staff had not noted where on the person's body the patch had been placed on one occasion it had not been noted when the patch was removed.

Audits of the MARs had been undertaken by the management team. These had not always identified concerns relating to medicines and the actions taken had not resolved all of the concerns. For example, the audit completed by the service had identified that there was no date when the medicated patch had been removed but had not identified that the body map was not complete for 20 July 2018 and the 27 July 2018 and the 10 July 2018 to show where the patch was applied. Where staff needed re-training or medicines supervision this was not always done in a timely way. For example, one member of staff had made a medicine error on 4 June 2018 and did not meet with their supervisor until 13 July 2018. The did not attend a medicine workshop until 16 October 2018 and were not reassessed for their competency until 21 October 2018. During this time the staff member continued to administer medicine.

After the previous inspection the registered manager had sent us an action plan to tell us how they would improve the recording of medicine. This included undertaking monthly reviews to look at how the service could improve medicines. However, the management team was not monitoring the trends of gaps in MARs to see if this was improving and the number of gaps were reducing. This meant the provider was not aware if the actions being taken were leading to an improvement. The action plan for the service had also included undertaking "Regular carer spot checks for medication administration." However, this had not been put in place at the time of the inspection. After the inspection the acting manager wrote to us to demonstrate that these spot checks were put in place immediately after the inspection.

The provider and registered manager failed to ensure quality auditing systems were fit for purpose to provide an effective means of monitoring and improvement. Records were not maintained accurately to make sure people received care and support to meet their needs. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People continued to have varied views regarding the timeliness of their care calls and if they were told who was visiting them. The providers quality assurance processes had not identified these continued concerns. We found that this was an area for improvement. The service logged calls as late where they were 30 minutes late or more. Some people were positive and said "They usually turn up on time and if not, it is only about 10 minutes to half an hour when they could be in traffic or late from the last appointment, nothing to worry about"; "They are usually on time give or take ten or twenty minutes" and "We are given a half hour time slot and I don't think that they have ever strayed from this slot in the seven months that they have been coming here." However, some people told us that late calls had had an impact on them their dignity and independence. One person said, "Once a fortnight at least they say they just can't come until it is too late for us, so I have to tell them not to bother and I struggle to care for my relative myself". Another person told us, "We have never had a missed appointment but sometimes they arrive too early and my relative doesn't want to go to bed at 17.30pm". And one person said, "It can be most embarrassing when they are late, and I am left too long". Some staff told us that they did not always have sufficient travel time between their care visits to be able to travel from one person's home to the next.

Feedback from people was mixed when we asked them if they knew which staff were visiting them. People said, "Occasionally a stranger can turn up who I haven't a clue about"; "I don't always know who is coming, I do get a rota but it can change but I'm fine with that"; "We do not always get introduced to new staff and they just turn up on our doorstep sometimes we do not know those who turn up on our door"; "We always are kept informed over who is coming if there is to be a change to the norm"; "We have and always are introduced to new or different staff"; "The carers are usually on time and I do like to have the same ones as much as possible, but this is not always the case and I am not always informed" and "The staff do change a bit, but they try to let us know if someone different is coming."

At the last inspection we found that communication between the office staff and people had been inconsistent. People told us they had difficulty in contacting the office staff at times. Communication with people was identified as needing improvement in the 2017 branch action plan. Following the 2017 survey of staff and people the action plan was developed which included a number of actions to improve communication. One of the actions that was that they would use communication sheets to record all issues that came into the office via the phone. The acting manager told us that these communication sheets were 'in place for a short amount of time until the branch manager felt comfortable that communication had improved.' However, at this inspection feedback from people continued to be mixed. People and their relatives said, "The staff in the office are polite and helpful it is a very well organised affair"; "I can't think of anything about the service that we are not happy with or unsure about, they are easy to communicate with they listen, and they are there for us" and, "The office is very responsive and always do their best to help if I call and want or need an extra slot or cancel one because I have an appointment." However, other people said, "The communication is dreadful simply awful"; "I am not happy with the office and I never know who is going to turn up"; "I have called the office a few times, but I feel it falls on deaf ears"; "I feel that I have a constant battle with them"; "The office never calls me back and are no good at all" and "I find them very unhelpful if I call and they don't take any notice of me." In the 2018 survey seven people had responded to the question 'How do you rate the communication from office staff?' two of those seven people had rated it poor. However, the survey was still underway.

After the inspection the acting manager wrote to us and told us that people were sent a weekly rota which included information on visit times and the staff that would be attending. The acting manager said 'If there

are changes to the rota sent branch staff will contact clients or next of kin via to inform them of the change, this will then be documented on the notes of the service user". However, the service was not able to demonstrate that this always happened and feedback from people continued to be mixed. Since the last inspection the provider had undertaken three monthly surveys with people. The feedback provided in these surveys did not indicate that there were widespread concerns relating to late calls or poor communication.

At the time of the inspection there was a registered manager in place. 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 2008 and associated Regulations about how the service is run. However, the registered manager was taking some planned absence from the service. The acting manager was being supported by the area manager. We spoke to the deputy manager who had very recently taken up the position of acting manager to cover this period of absence. The acting manager was committed and passionate about the service and had the skills and experience they needed to undertake this position.

Staff had a good understanding of their responsibility to keep people safe. Staff told us that they enjoyed their role and were positive about the acting manager and the culture they were promoting in the office. Staff told us that they felt listened to. Staff had the support they needed to undertake their role. The acting manager said that if there is anything that needs to be discussed with the staff member and they were brought in the office to do this. The meeting would be recorded on a supervision form. If there was any feedback that need to be given this would be given verbally or by letter depending on the circumstances. They also informed staff if a compliment had been received into the office, these compliments were posted on the notice board in the office.

There were regular staff meetings. These meetings were to aid communication and for staff to feedback. Attendance at these meetings had not been high. However, the acting manager had now started to add these meetings to staff rotas so that staff were prompted to attend. Where staff could not attend a meeting, the notes were sent out. There were annual staff surveys and surveys for people and their relatives. Where issues were identified these were added to an action plan for completion.

The service had access to patient safety alerts and changes in legislation which were sent out from the provider. The acting manager planned to access local forums to meet with other managers and share best practice. The acting manager said that their line manager and other agency managers were supportive and happy to share their experiences and learning. The service worked in partnership with healthcare professionals such as the speech and language team and GP's this ensured that there was a multiagency joined up approach to people's care.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths. The provider had notified CQC about important events such as deaths and safeguarding concerns that had occurred.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their ratings in the office area and on their website.

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured that systems and processes had been consistently effective in driving improvements in a timely way to ensure compliance with the regulations.</p>

### **The enforcement action we took:**

We served a warning notice to ensure the provider took action to comply with the Regulation.