Newday Healthcare Professionals Ltd

Suite 21, Dragon Enterprise Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 8, 9 and 24 June 2016 which was unannounced; the inspection team consisted of one inspector on all three days.

Newday Healthcare Professionals Limited provides care services to people within their own homes. Care services include personal care, a sitting service and domestic services. The service provided are either through private arrangement or social services funding. The service covers Southend on Sea and Essex at the time of our inspection the service was providing support to 25 people all in the Southend on sea area. The service was first registered with the Care Quality Commission on the 6 June 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service had 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.

Views about staffing levels were mixed and some people felt that there was not enough trained and experienced staff available to meet their needs. We also found that people or their relatives were not fully involved in planning and making decisions about their care. The service was not responsive in identifying and meeting people's individual care needs.

The manager could not demonstrate how the service was being run in the best interests of people using the service. Arrangements in place to keep the provider up to date with what was happening in the service were not effective. As a result there was a lack of positive leadership and managerial oversight. Systems in place to identify and monitor the safety and quality of the service were ineffective as they either did not recognise the shortfalls or when they did there was a lack of action to rectify them.

Staff did not have the skills and experience, and they were not deployed effectively to meet the needs of people. We found that staff did not always have enough time to spend with people to provide reassurance, interest and stimulation. There was a lack of knowledge around supporting and caring for people living with dementia including understanding how it affected people differently and how each individual should be cared for to promote their wellbeing as far as possible.

Although relatives told us that staff treated people with kindness, we found that the way the service was provided was not consistently caring. Staff did not always demonstrate a caring attitude towards the people they supported and some failed to promote people's dignity or show respect to individuals. The majority of interactions by staff were routine and task orientated.

Whilst staff were able to recognise poor practice, suitable arrangements were not in place to respond appropriately where an allegation of abuse had been made.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected against the risks associated with medicines because the Registered Manager did not have appropriate systems in place to manage and monitor medicines safely.

Although staff knew how to recognise and respond to abuse correctly, not all people felt safe and we found that the arrangements to keep people safe were not robust. Individual risks had not always been assessed and identified

The recruitment process was not robust in ensuring that staff were safe to work with vulnerable people.

Is the service effective?

Inadequate

The service was not effective.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service. Staff training provided did not always equip staff with the knowledge and skills to support people safely.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans generally lacked personalisation.

Records did not always evidence that people had been involved in their care.

Staff knew people and their needs well, and could describe people's preferences and how they wished to be supported

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs.

Not all people's care records were sufficiently detailed or accurate.

Effective arrangements were in place for the management of complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight of the service as a whole.

The quality assurance system was not effective because it had not identified the areas of concern and there were no plans in place to address them.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 8, 9 and 24 June 2016, was unannounced and carried out by one inspector.

We looked at notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at safeguarding concerns reported to CQC. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

We spoke with five people who used the service, four of their relatives, three staff and the registered manager who is also the provider. We looked at records in relation to nine people's care, six staff recruitment folders, and the systems in place for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

We found that the arrangements for the management of medicines were not safe. Medication Administration Records (MAR) sampled showed that these had not been consistently completed to indicate that medication had been given as prescribed as we found several unexplained gaps and omissions in recordings.

One person was prescribed Warfarin, an anti-coagulant medication. We found that from 28 March 2016 to 31 April 2016 that on eight occasions there was a risk to the person as it was not possible to determine if they had received their medication as prescribed as it was not recorded on their MAR sheet. Looking through the warfarin drug therapy records we found several gaps, lack of clarity and variation of when Warfarin dosage had been changed in accordance to the international normalized ratio (INR) results issued by the anticoagulant nurse once every week.

Too much or too little Warfarin is dangerous. If a person gets too little Warfarin there is a significant risk of them having a blood clot, which could result in them having a stroke or a pulmonary embolism. If someone gets too much Warfarin they run a risk of bleeding which can place the person at risk of having a stroke.

Looking through the same person's care plan from the Local Authority (Southend Borough Council) it stated that the service was to administer medication to the person, however we were informed by relatives and the person that at least some of the staff would leave medication in an egg cup on the side for the person to take at a later time. Having done this, some of the staff would sign that they had administered medication, which is incorrect and poor practice.

We were informed by relatives of the person that there was the potential that the person could be forgetful with regards to taking his medication, hence the request for the care package to incorporate the administration of medication. Staff were therefore not ensuring that this person received their medications as prescribed and placing their health at risk.

Our concerns were not limited to one person as we found another person's MAR sheet from 25 April 2016 to 30 May 2016 showed that on six occasions there were no recordings indicating if the person had received their medication as prescribed. In a further person's MAR sheet from 4 April 2016 to 25 April 2016 it showed that on eight occasions there were no recordings indicating if the person had received their medication as prescribed. As result of these record omissions there was no way to confirm that people were receiving their medication as required.

We found in another person's daily visit notes from 22 January 2016 to 21 June 2016 that it was noted that staff were administering prescribed medication however there were no instructions nor was there a record of this arrangement in the person's care plan or a MAR sheet. A relative also informed that periodically staff would administer antibiotics due to a recurring water infection however there was no evidence to suggest a care plan, risk assessment or MAR had been in place at the time of the antibiotics being administered. We found that the service had not consulted nor informed the Local Authority of the changes to the person's

needs and the need to amend care plans so as to incorporate the administration of medication which meant there was a risk of the person not receiving their medication as prescribed.

Staff involved in the administration of medication had not received appropriate training and there was no evidence to show that they had had their competency assessed at regular intervals despite the manager informing that they had checked the competency with staff on a regular basis. When we spoke to the manager they were unable to provide any records to evidence that staff had been trained and had their competencies assessed to ensure that they were administering medication appropriately to people. The manager spoke of carrying out spot checks on staff and medication records completed by staff however this could not be evidenced during the inspection, in addition the manager reported that no formal medication audits had been completed in the last six months. This meant the manager was not periodically reviewing records to ensure that staff were completing records appropriately and accurately.

We also found that the service did not have PRN protocols in place to show why, when and how to administer prescribed 'as and when' required medication. This could mean that people do not receive their medication appropriately and safely because staff do not have clear instructions.

Although staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, we found that appropriate arrangements were not in place to manage risks to people's safety. Information relating to the specific nature of the risk to the person and the steps to be taken by staff to alleviate the risk were not robust or recorded. Of the nine records we reviewed, we found one person's care package had commenced six months prior to our inspection but only had a risk assessment that had been partially completed. During this time the person's needs had changed and they had been taken into Accident and Emergency with a suspected medication overdose. Records we viewed could not evidence if the person or their relative had been involved with discussing changes in these risks. The records did not include any reference to discussion with people.

People were not receiving their calls and visits at the times needed to meet their needs safely and as required. One person's Care Visit daily Report Sheets we found that on the 8 March 2016 only two calls had been recorded and 16 March 2016, again only two calls had been recorded instead of the three calls which the person had been assessed for by the Local Authority. The person's relative informed, "In the early hours of the 9 March 2016 I received a phone call from my relative stating that they had not received their evening call and had waited until 2am however no care staff attended to their needs". Relative went on to say, "Our relative should have had a call at tea time but waited just in case staff were running late, however no communication was made by the service or staff who were meant to attend." The relative informed that the tea time call was to support the person with meal provision and assistance to bed; this meant the person was left with no meal and in their chair until they relative came to assist them to bed.

We also found that on the19 June 2016 another person's report sheet showed that there had been no recordings of care staff visiting on that day. The person relatives also raised concerns around care staff not turning up at the weekends and bank holidays. These concerns were also raised by a further person and relative, who also informed us that over the last two months of May and June 2016 they noticed call times were getting later by two hours especially for the morning calls and staff were rushing calls, not staying for the allocated time as assessed and contracted by the local authority. One relative said, "My relative prefers to get up early in the morning around 7am or 8am at the latest, however we have started to notice that staff have been attending the morning calls around 10am and at the weekends it could as late as 11am." This meant the person was being left without support for long periods of time. We spoke to the manager about the above concerns, the manager informed that due to the increase in people the service was supporting they had not been able to meet people's specified times as the service was still working on employing more

staff to meet the needs of people which was proving difficult at present.

Despite staff telling us they had completed safeguarding training with the manager when they commenced employment, we found that not all staff had received training in safeguarding adults from abuse. Staff were able to identify how people may be at risk of different types of harm or abuse and what they could do to protect them. The service had a policy for staff to follow on 'whistle blowing' and staff knew they could contact outside authorities, such as the Care Quality Commission (CQC) and social services. Staff were certain that their concerns would be taken very seriously by their managers. We saw a poster displayed in the office of the local area safeguarding teams contact details. The manager showed us their safeguarding procedure but we noted that there was no documentation of how many staff had seen or read it. We asked the manager if they had notified the safeguarding team following the missed call and missed medication incidents, they confirmed a referral had not been made and were not aware that referrals needed to be made, however would action this after the inspection. This meant that incidences of potential risk of harm had not been investigated and reported appropriate which could place people's safety at risk.

All of the above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our inspection we were concerned about the amount of staff available to meet people's needs. We found that improvements needed as people were at risk because of inadequate staffing levels. There was not enough skilled staff to keep people safe and meet their needs at all times. The manager was unable to confirm how staffing levels for the service were calculated. There was no systematic approach to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances. The manager added that recruitment for additional staff was underway but was proving difficult. Staff's comments about staffing levels at the service were varied. Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others informed us staffing levels were inadequate to meet people's needs and that this could be stressful especially at the weekends as most staff that worked during the week were not always able to work during the weekends, which meant weekend staff were having to carry out more calls to people due to the drop in staffing numbers. One staff member informed, "At the weekends we are not always able to get to people at the times specified in the care plans, and when we do get to people we are rushing so that we are not late for the next call."

From the three staff we spoke to we were unable to clarify who was still working in the service as one member of staff informed, "Since the service relocated to Southend in December 2015 I have not worked for the service and I am currently working for another service which is close to where I live". Another member of staff informed, "I occasionally work weekends but I haven't worked for the service for a few months now." When we spoke to the manager they informed that due to the slow growth of the service prior to December 2015 they had not always been able to offer all staff work so had kept records of staff for when the service grew.

The manager was unable to provide worked rotas from previous weeks and months, however provided us with planned rotas which showed that all calls had been covered. The manager stated that this can always change as staff may cancel at the last minute leaving the manager to either cover the shift themselves or ask the services bank staff to cover but this is all dependent on them not working elsewhere.

We found the service to have not carried out all the necessary checks on staff before commencing employment with the service. Despite the manager informing us that they had completed all the necessary checks, we found this to not be the case. Seven staff records we reviewed showed that some staff did not

have up to date Disclosure and Barring Service checks (DBS). Records confirmed that most had commenced employment using DBS from previous employment dating back over a year. The service had not completed nor requested up to date Disclosure and Barring Checks. For example we noted a staff member had a DBS issued in August 2014. Within this record it indicated that this staff member had been cautioned for a concerning offence previously however no risk assessment appeared to have been done prior to this person beginning work, or since, and no up-to-date DBS had been requested, we also noted that the service had not requested any references from their previous employment. It was not clear if any steps had been taken to assess and, if appropriate, mitigate any risk that may be associated to this person's employment with the service and working with vulnerable people.

In addition, during a conversation on the 24 June 2016 with the manager, they informed us that the service employed seven bank members of staff, none of whom had received an induction, or undergone any training. They had also not had the necessary employment checks completed. As a result of the above the service failed to evidence that staff employed were of good character, had the qualifications, competence, skills and experience which are necessary for the work to be performed by them and the service did not have the information required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of all persons employed.

All of the above is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service effective?

Our findings

We found that all staff employed by the service had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. All staff records we reviewed contained no evidence of staff having supervision, appraisals or up to date training or induction. Despite the manager and staff informing us that staff had regular informal and formal supervision they were unable to evidence this during the inspection and also in response our urgent action letter dated 28 June 2016.

The service did not have up to date training records for six of the staff working in the service, when we spoke to the provider/registered manager we were informed that most of the staff held training from previous employment. Looking through staff folders we found most of staff had not completed training for some time some training certificates dating back to 2011 and 2014 through previous employment. The provider had taken no steps to assure themselves that this previously completed training by staff was appropriate and sufficient to ensure their up to date knowledge to provide good care.

The Manager and staff we spoke with informed us that they had completed online training however staff records we reviewed we could not evidence this was the case. The manager also informed us that they had carried out most of the staff's training using the Care Certificate Workbook however acknowledged that they did not hold the necessary qualifications to do so safely. We also noted that all the staff working in the service did not have an induction record in place despite staff reporting they had completed an induction. With the lack of evidence available in regards to staff supervision, training and support the service was not able to demonstrate how the service were assured that staff were suitably qualified, competent, skilled and experienced to perform their duties and how they had supported staff to ensure on-going development and review of their work and skills.

The manager informed they had been unable to provide any records or planned schedules for staff supervision, appraisals and training records for staff working in the service, and this had been due to the rapid growth of the service, limited office support and care staff which left the manager focusing on delivering a good service to people and had not had time to update staffs records.

All of the above is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 found staff at all levels lacked knowledge on the Mental Capacity Act and Deprivation of Liberty Safeguards despite staff having attended training provided by the service. Staff did not understand the legal requirements of the Mental Capacity Act. Staff reported having done online training on the Mental Capacity Act however could not explain how or when it would be used.

Staff at all levels lacked knowledge on the Mental Capacity Act and Deprivation of Liberty Safeguards despite staff having attended training provided at the service. Staff did not understand the legal requirements of the Mental Capacity Act. 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.

None of the care records we examined contained forms to assess service users' capacity to make day-to-day informed decisions. There were also no records of best interest decisions being made in the interests of the individual. Where some peoples' capacity may be in question, the service had not involved the person or others in order to ensure that a best interest decisions was made. For example, we found the service had not assessed two people's ability to make an informed decision about their medication despite them being assessed by the local authority as being at risk of getting confused with their medication.

All of the above is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People said they were supported by staff to have enough food and choice about what they liked to eat. The manager informed that they would regularly monitor people's food intake and to ensure that people had a balanced diet. The registered manager told us, "We are in regular contact with relatives, district nurse and GP to monitor people's weights and wellbeing." Relatives informed that the service supported their relatives to have enough food and drink of their choices and staff would also inform them when food would be running low. Records we viewed also showed that staff were recording when they had supported people with food and drink provision.

People's healthcare needs were monitored and supported through the involvement of a range of relevant professionals such as General Practitioner (GP) and nurse specialists. We found that people received appropriate healthcare support to meet their diverse needs. People and their relatives were happy with the level of healthcare support provided and told us that they were kept informed about people's health and wellbeing. One relative informed of when they relatives medication had been changed the service communicated with them and also arranged for the new medication to be delivered.

Requires Improvement

Is the service caring?

Our findings

Comments from people and their relatives were varied about staff supporting them. One person told us, "The care staff are very good." Another said, "The care staff are kind hearted and do they best for me." Another relative told us, "My relative has become so fond of one of the staff and we have asked the office if the staff member can visit more often, but we know that's not possible as they need a day off." However relatives and people also added that some staff did not always give them time when they were assisting them and always appeared to be in a rush. One person informed us, "When the service first started supporting me the care staff used to come in and spend time with me supporting me with my care and then after we would have a cup of tea and chat before they went to their next call, but now staff are in and out so quickly." A relative informed us, "At the weekends when we have visited our relative we have noted that staff do not stay for the allocated time and hardly verbally communicate with our relative, at lunch time they[staff] will come in and make our relative lunch, prepare the tablets, write in the book and then leave."

People's care plans showed little evidence that they had been involved in their care. There were people's signatures in some, but not all, of the care plans we checked. There was no system in place for people to review their care with the service on a regular basis. Records were inconsistent regarding people's involvement in planning their care and treatment. Some support plans contained of details about people's preferences for support while others were task focussed.

People and their relatives told us that the service did not always contact them regularly for their feedback, with some people indicating they would like to be contacted more often.

People told us that they felt staff respected their dignity. Staff described how they maintained people's dignity by ensuring they remained covered during personal care and by closing bathroom doors when assisting people.

We found advocacy information displayed within the service. An advocate provides support and advice to people and is there to represent people's interests. However, when we spoke to people and relatives about who they would turn to should they need external support they had very little knowledge of who they would speak to.

Requires Improvement

Is the service responsive?

Our findings

People's care and support needs were well understood by the staff working for the service; however we found this information was not reflected in detailed support plans and individual risk assessments. We looked at nine people's support plans and found the service had not assessed people's needs when the service would have started instead they used the information either from the Local authority and hospital when the peoples care commenced. In one person's support plan we found the service had retained four different care plans from the hospital for every time the person had gone into hospital. From reviewing the person's folder it was not clear which care and support plan staff where working from as each support plan had different instructions. This placed the person at risk of receiving incorrect or outdated support from care staff.

Although the manager told us that a comprehensive assessment was carried out prior to the commencement of the service, there was no evidence available to show us that these had been completed. Files viewed contained minimal information on the needs of people using the service and the support they required from staff. For example, there was no evidence that assessment of needs had been undertaken by the service for people using it. Furthermore, the care plans viewed listed tasks to be completed during visits, but did not describe in detail how the care should be delivered. This meant staff had very basic information on the needs of the people using the service and how to deliver person centred care.

We discussed the findings with the management team who assured us that they would take action to introduce a robust assessment and develop care plans to ensure more detailed person-centred information was developed for staff to reference.

The service had policies and procedures in place for receiving and dealing with complaints and concerns received. The information described what action the service would take to investigate and respond to complaints and concerns raised. We reviewed one complaint that had been made in the last twelve months and found that the service had responded appropriately to the complainant and had also ensured that other organisation mentioned in the complaint had responded to the complainant in a timely manner and with acceptable response. Staff, people and relatives knew about the complaints procedure and that if anyone complained to them they would either try and deal with it or notify the manager.

Inadequate

Is the service well-led?

Our findings

Quality assurance systems and processes which assessed, monitored or improved the quality of the service were not effective or established. The service could not evidence any effective systems or processes which assessed, monitored or mitigated the risks relating to the health, safety and welfare of people using the service. The registered manager/provider were unable to demonstrate how they continually analysed, evaluated and sought to improve the governance and auditing processes and practices in line with their own quality assurance policy.

Although there were quality monitoring systems in place which had been purchased from an external company the manager informed us that they had not started using them. This meant they were not monitoring or able to provide numerical information relating to the incidence of complaints, accidents and incidents and pressure ulcers, or other arrangements in place to assess and monitor the quality of the service provided. The lack of quality monitoring meant that the service had not reviewed staffing levels to ensure that the deployment and recruitment of staff was suitable to meet service users' needs. We found some people to have experienced poor care outcomes because the service had not recognised the multiple failings within the service, including areas such as medication management, care planning and risk management.

There were no systems in place to monitor late or missed calls, meaning they were unable to evidence how they worked on making improvement were missed or late calls had occurred. Where people have had missed calls no communication had been made with them or their relatives leaving them vulnerable and without proper care. People and relatives we spoke to informed us there had been some missed calls however the office had not always communicated with them when this had happened. One person informed us, "Missed or late calls often happen at the weekends, bank holidays or when one of the care staff go off sick, and sometimes the office does not call me or my relative to let us this is what is happening." The manager also informed that an audit system to monitor missed or late calls would be put in place and this would also be used as a tool to drive improvement within the service.

The registered manager informed that due to the rapid growth of the service, they were looking at employing office staff to support in reviewing and monitoring the service's quality assurance systems.

All of the above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Whilst reviewing people's care visit daily report sheets and the registered manager informing us during the inspection, we found that on three separate occasions from February 2016 to April 2016 the service had contacted paramedics for three different people due to them either falling or having an inflamed blood vessel. All three people were taken to hospital. However the service had failed to notify the Commission of these incidents. In addition we were informed by the Local authority of a current open/unresolved safeguarding investigation which was opened in February 2016 raised against the service. When we spoke to the registered manager about sending in notifications which is a requirement of their registration, the

registered manager was not aware of the need to notify the commission of the above incidents, we advised the manager to review information relating to their registration which can be found on the CQC website.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Personal records were stored in a locked office when not in use. The manager had access to up-to-date guidance and information on the service's computer system which was password protected to help ensure that information was kept safe.