New Hope Specialist Care Ltd

New Hope Care Rutland

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
New Hope Care Rutland is a domiciliary care service providing personal care to people living in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection there were 20 people receiving personal care.

People's experience of using this service and what we found
Risks for people were not consistently assessed and planned for. There was a lack of information about how risks associated with people's needs might impact on the care being provided. Staff did not always respond to new risks or changes in people's needs in a timely manner.

The registered manager did not consistently have good oversight of the service. Quality checks took place, but these did not always identify where improvements were needed. The provider's own checks had not identified the shortfalls we found in risk management, medicine administration records and staff training.

Staff were recruited in line with the provider's policy, but improvement was needed to ensure they were sufficiently skilled and knowledgeable to meet people's individual needs. Staff turnover was high and some people felt this had an impact on the consistency of their care. People and relatives told us they received their medicines safely but staff did not always complete medicine administration records accurately. Staff used personal protective equipment effectively and safely. Staff understood how to protect people from abuse.

The registered manager had not always ensured we (CQC) were always informed about incidents we should be legally told about, although they had escalated incidents of concern to other safeguarding authorities.

People were not formally consulted or engaged in the development of the service. However, people and relatives felt the deputy manager was approachable and was committed to meeting people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; overall the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was requires improvement (published 6 July 2022).

Why we inspected

We received concerns in relation to staff response to changes in people's care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for New Hope Care Rutland on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment and good governance at this inspection. You can see what action we have asked the provider to take at the end of this full report.

We have made a recommendation that the provider considers the current MCA legal framework where people experience fluctuating mental capacity.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

New Hope Care Rutland

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was announced. We gave short notice on 3 April 2023 to the registered manager. This was so they would be available to support the inspection process. Inspection activity started on 4 April 2023 and ended on 19 April 2023. We visited the registered office on 4 and 19 April 2023.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all the information service to plan our inspection.

During the inspection
We visited the registered office where we met with the manager and an administration assistant. The registered manager was not available to speak with us during this inspection. We spoke with 10 people and another 2 people's relatives about their experience of the care provided. We also received feedback from 3 care staff. We reviewed a range of records including 3 people's care plans and records, 3 staff recruitment files, staff training records and other records relating to the day to day management of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection this has key question has changed to requires improvement. This meant people were not consistently safe or protected from avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks were not consistently assessed and planned for. There was a lack of information about how risks associated with people's needs might impact on the care being provided.
- For example, one person was assessed as requiring support to maintain their mental health well being. Their care plan failed to identify the nature of their mental health needs and the support they needed to stay well. The person's care records showed staff had failed to identify and act on a decline in the person's mental health and had only intervened when the person reached a crisis in their mental well being. This lack of timely, responsive care placed the person at risk of harm from self-neglect.
- Staff did not consistently maintain a clear record to provide assurances that new and emerging risks had been escalated to relevant healthcare professionals. For example, one person had experienced a period of ill health. Care records completed by staff recorded the change in needs but failed to show what, if any, actions had been taken in response to this. This placed the person at risk of harm through not receiving the timely care and support they needed in response to their changed needs.
- A relative told us, "Staff seem to chose the path of least resistance. They don't seem to see new potential or emerging risks through changes in people's behaviour or responses. They don't seem to realise this could mean someone is becoming ill. This was the case for my family member and I had to intervene to see a GP."
- Staff completed incidents records. There was no evidence these had been reviewed to ensure lessons were learnt and action taken to ensure any necessary remedial actions had been taken.

Risk management systems were not sufficiently robust and placed people at risk of unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We shared detailed feedback with the deputy manager regarding our specific concerns and they were taking action to ensure care plans and records are updated to include clear information about risks and about how these are to be mitigated, including new and emerging risks.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA. However, we have made a recommendation that the provider considers the current MCA legal framework where people experience fluctuating mental capacity due to their needs.

Using medicines safely

● Staff had received training in the safe administration of medicines and, overall, people were supported to take their medicines as needed. However, improvements were needed to ensure consistency in this. For example, we found gaps in signatures on medicines administration records. These are important records to evidence staff have administered or prompted people to take their medicines as prescribed. The manager told us they would address this with staff following our inspection.

● People and relatives told us staff supported them to take their medicines as prescribed. One person told us, "Staff support me with my medications and they give it to me via a blister pack."

● People's care plans included details of their medicines and the support they needed to manage these.

Systems and processes to safeguard people from the risk of abuse

● Overall, the registered manager understood their responsibilities to notify external agencies including the local authority and Care Quality Commission (CQC) of certain events, which included allegations of abuse and serious injury. However, during our inspection we identified two incidents that had not been reported to us as legally required. We requested the notifications be sent to us and this was done after our inspection.

● People and relatives felt safe with staff in their homes and protected from the risks of abuse when their care calls took place.

● The provider had a safeguarding people from abuse policy which informed staff what actions they should take if abuse was suspected. This required review to ensure contact details of local safeguarding agencies were included with the procedure.

● Staff had received training in protecting people from abuse. They told us they would report any concerns to their manager and felt these would be listened to and acted on.

Staffing and recruitment

● People and relatives felt some staff required further support to be sufficiently skilled in their roles. One person told us, "Overall, I am happy with the staff. There are some that are better than others. Some are not good at communicating and tend to leave early." One person described how staff struggled to understand how to cook their meals. This was supported by a relative who told us they had to ask the deputy manager to teach staff how to heat meals and make sandwiches. We raised these concerns with the deputy manager who told us, due to turnover of staff, they would undertake new training to ensure staff had these skills.

● The provider had a care call monitoring system. However, this was not always effective in providing oversight and monitoring of call visits. For example, we undertook an analysis of call visits and times for February and March 2023. These showed people received their visits but some staff left before the scheduled end time. Additionally, there were gaps in visits as staff had either forgotten to log in or were in a poor signal area. The deputy manager told us they would monitor and follow this up with people and staff.

● People and relatives told us they had not experienced missed calls and late calls were usually supported by a telephone call. People also said they usually received a rota telling them which staff were allocated to their calls for the week, but this frequently changed so they were uncertain who had been allocated.

● Staff were recruited in a safe way. We reviewed staff employment records and checks such as references had been obtained.

● Pre-employment checks had been undertaken, including overseas checks for sponsored staff. DBS (Disclosure and Barring Services) checks had been obtained. A DBS provides information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● Staff had undertaken training in infection control and were provided with updates to guidance and information on best practice.

● Staff had access to sufficient supplies of personal protective equipment (PPE) such as gloves and aprons to prevent infections.

● The deputy manager undertook regular spot checks of staff which were also used to ensure staff followed safe infection prevention and control procedures.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection this key question has remained requires improvement. This meant the service was not consistently managed and well-led. Leaders and the culture did not always promote high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Whilst there were some governance systems in place, we were not assured, these were being fully effective in identifying where improvements were needed and ensuring remedial action was taken.
- For example, the deputy manager carried out audits and checks on care and medicine records. However, care record audits had not identified the concerns we found around staff failing to respond to changes in people's well being in a timely manner, or that risk assessments were not sufficiently robust.
- Medicine audits undertaken prior to our inspection had identified missed signatures on people's administration records. However, we found continued errors which demonstrated remedial action had not been effective in making the required improvements to staff practices.
- Systems and processes were in place to escalate significant incidents and events affecting people and their care to all relevant agencies. These had not been used effectively as we found 2 incidents which had not been escalated to the CQC.
- The registered manager visited the service on a weekly basis to maintain oversight. There was little evidence that this oversight had been effective in ensuring people received safe, consistent care. There was minimum support for the deputy manager who attempted to balance front line care and management responsibilities. For example, the deputy manager was unable to take telephone calls from the office if they were providing direct care. This meant delays for people needing to communicate with the office. The provider had made no alternative arrangements to ensure people had consistent access to management.

Systems and processes were not sufficiently robust or operated effectively to ensure the provider assessed and monitored their service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Unannounced spot checks on staff's skills took place. This included ensuring they were using the required PPE to reduce risks of cross infection and followed safe working practices.
- Staff spoke positively about the deputy manager but had little contact with the registered manager. One staff member told us, "[deputy manager] handles most situations. They are very supportive, take time to listen and accommodate wherever they can. I rarely see the [registered manager]." A second staff member told us, "I don't really know the [registered manager]. The deputy manager does everything and helps us a lot. We can always contact them if we need help."
- People and relatives told us they did not know who the registered manager was but knew the deputy manager and felt they were approachable.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Improvements were needed to ensure people consistently received person centred care that achieved good outcomes. Whilst some people were happy with their care or described it as 'adequate', others felt improvements were needed.

● One person told us, "The service has been haphazard. I have had some very good carers, and some not so good. The amount of different carers results in a lack of consistency."

● A relative told us, "It does depend who visits. Some carers are good and others not so good; they cut corners and leave early. I think the biggest improvement needed is around staff consistency and training."

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

● People and relatives told us they had not been asked to complete any surveys or were consulted about their views on their care and support. One person told us they had been involved in a recent review of their care, whilst the majority of people told us there had not been a recent view of the care provided.

● People and relatives told us they tended to contact the deputy manager directly or during spot checks if they had any issues or needed to share information, and this was acted on.

● Staff attended occasional meetings but most consultation and information was through an electronic application. Staff told us this was effective for them and enabled them to be consulted, share and receive information as they needed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People and relatives told us the deputy manager was open and responsive if things had gone wrong and took action to make things right. A relative described how they had concerns regarding information for their family member. The deputy manager had taken immediate action and this was no longer a concern.

● Where a person had raised a formal complaint, we saw the provider had apologised and taken remedial action to make things right. The person had confirmed the service was 'much improved' as a result of this.

Working in partnership with others; continuous learning and development

● Staff worked in partnership with other healthcare professionals involved in people's care. For example, working with people's social worker to ensure special equipment was in place.

● The deputy manager was committed to learning and developing to be effective in their role, though this required more robust support from the provider and registered manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk management systems were not sufficiently robust and placed people at risk of unsafe care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not sufficiently robust or operated effectively to ensure the provider assessed and monitored their service.