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Kells Domiciliary Care and Nursing Agency

Inspection report

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Date of inspection visit:
10 October 2016

Date of publication:
22 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 October 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service. Kells Domiciliary Care and Nursing Agency provides domiciliary care and support for nine people in their own home. The service works primarily with older people living with dementia and people with sensory and physical impairment. The agency provides nursing and care workers.

The service had recently moved location. This was the first inspection at the current address. The service was last inspected 17 September 2013 at the previous location and was meeting all the regulations inspected. 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. The registered manager was present during the inspection.

Risk assessments did not give staff guidance on how to mitigate risks. Risk assessments failed to provide staff with appropriate information with regards to the people they were taking care of.

Care plans were not person centred and did not state people's likes, dislikes or how they wanted their care to be provided. Care plans were brief, often several sentences and did not provide staff with an appropriate level of knowledge to be able to work with people.

Staff received regular supervision. However, this was not adequately documented. Staff did not receive yearly appraisals.

Medicines audits were not completed. Staff had received training on medicines administration and people were supported to take their medicines safely.

People were involved in decisions about their care. Where people were unable to have input, people's families were consulted.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions outlined in the Mental Capacity Act 2005. However, the service worked with people living with dementia and there were no records of mental capacity assessments around decision making.

People received a continuity of care. The provider always tried to ensure that the same care workers looked after people. This promoted good working relationships with people who used the service.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

We found that there was an open culture that encouraged staff and people to discuss issues and ideas, through team meetings and informal discussion.

There was a complaints procedure that people and relatives knew how to use.

The service operated an on-call system for any issues that arose out of hours. People and relatives told us that there was always someone available to help.

Overall, we found breaches in regulations 9, 12, 17 and 18. Where there were breaches of regulations, 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?

Requires Improvement

The service was not always safe. Risk assessments did not always provide staff with guidance on how to mitigate risks.

Where people had medicines, they received these on time. Staff had received medicines training.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not received an appraisal. Staff felt supported and received regular supervision.

Staff had on-going training to effectively carry out their role.

Staff understood their responsibilities in relation to meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS). However, staff had not received training on the MCA.

People's healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Good

The service was caring. People were supported and staff understood people's needs.

People were treated with respect and staff maintained privacy and dignity.

Staff understood, and were positive about equality and diversity.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care was not person centred and care plans were not detailed. People's likes and dislikes were not noted.

People received reviews of their care. People and relatives were involved in planning their care.

People receive a continuity of care and often had the same staff visiting them.

Staff were knowledgeable about individual support needs, their interests and preferences.

Complaints were responded to in an effective and timely manner. People and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led. There were no systems in place to assure quality of care provided. Audits were not carried out for any aspect of the service, including medicines, care plans and risk assessments.

Staff felt that there was an open culture within the service and felt supported by the registered manager.

People were positive about the support they received from the manager.

Kells Domiciliary Care and Nursing Agency

Detailed findings

Background to this inspection

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

This inspection took place on 10 October 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at five care records and risk assessments, 11 staff files, medicines records and other paperwork related to the management of the service. We spoke with one person that used the service, one relative, five staff and one supported living scheme manager where care was provided to a person.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe. One person told us, "They're very good to me. I'm being very well looked after." A relative said, "[Relative] is safe. Absolutely, always."

Risk assessments were not always consistent. Some risk assessments gave staff appropriate guidance on how to mitigate known risks. However, other risk assessments noted a known risk and did not adequately assess the risk to the person.

One person was noted to have a medical history of fluid on the lungs causing breathlessness and could be unsteady and confused. There was no information available on the person's health conditions and whether the conditions carried any risks or how staff could mitigate the risks. The person's risk assessment noted that they were 'at moderate risk of falls'. We asked the registered manager how they had assessed the person's risk as moderate. The registered manager told us, "It's my opinion and the reason they [the person] needs someone with him is because of his risk of falling at night." There was no system in place to adequately assess the risk of falling. The risk assessment informed staff that the person, 'needed help when up and about' but failed to provide guidance to staff on how to do this. Another person's risk assessment noted that the person 'needs observing and help them when weak or wobbly.' There was no further guidance for staff on how to mitigate the risk or why the person experienced periods of weakness. The person's care plan contained a risk tool that graded on a scale of one to ten the severity of a known risk. We asked the registered manager what the guidance was around grading people's risks. However, there was no structured guidance and the grading was completed on what the registered manager felt the risk was personally. For another person the care plan noted that there were no risks identified. However, the person had been diagnosed with Alzheimer's, had a degree of memory loss, sometimes did not eat or drink and needed reminding. There was no risk assessment to address the known risks to this person.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, other risk assessments were detailed. One risk assessment noted that the person was at risk of falls and provided guidance for staff on how to mitigate the risk. The risk assessment included information for staff on how to support the person whilst maintaining their independence and encouraging them to be as mobile as possible. This included how to emotionally support the person if they became upset or anxious. One person also had a detailed medicines risk assessment that gave staff clear guidance on how to administer medicines safely and mitigate any risks.

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member told us, "It's [safeguarding] about making sure people are safe. I would report it." Another staff member said, "If someone is in danger of abuse in any way we report it to the local authority safeguarding team and manager. It must be investigated." Staff told us and records confirmed that they were trained in safeguarding during their induction.

Staff understood what whistleblowing was and knew how to report concerns if necessary.

Three people using the service had their medicines administered by staff. Where people were able to take their medicines themselves or required prompting by staff, this was documented in their care plan. One person had used a medicated patch prescribed for the treatment of a dementia related illness. The person's care plan clearly stated when the patch should be changed and the placement of the patch on the person's body. However, the procedure for administering medicines for people was not documented in some people's care plans. For one person, that we visited in their own home, the Medicine Administration Record (MAR) chart showed 12 omissions in signing to say that medicines had been administered for the morning. We discussed this with the registered manager who told us, "In the mornings it's [the medicine] left out for her but not signed as they have not seen her take it. The night carer will leave it out for her and she does take it." The person confirmed that their medicine was left for her by staff and she took it in the morning. We discussed with the registered manager the difference between prompting for medicines and administering. The registered manager said that they would look into this.

Records showed and staff confirmed that where they were administering medicines, they had received training in the last year.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

The service had a 'lone working policy'. The registered manager told us that lone working and staff safety was covered in staff induction. Staff had access to this policy and confirmed that they understood how to keep themselves safe when working alone.

Requires Improvement

Is the service effective?

Our findings

There were no documented appraisals. Staff that we spoke with told us that they had not received an appraisal. The registered manager confirmed that appraisals had not been completed for any staff member employed and told us, "I don't do appraisals. I don't see the point because they're [staff] in here all the time doing supervision. They're [staff] happy to work and they're [staff] still here."

The registered manager did not ensure that staff were supported through annual appraisals. Staff development and progress was not adequately monitored.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt supported and received regular supervision. Records showed that staff received supervision every three to four months, although supervision records lacked detail of supervision discussions.

Both the registered manager and deputy manager delivered training. The registered manager was also a registered nurse and the deputy manager held a teaching qualification. All training was delivered by the service. Staff received a three day induction when they started work. This was a class room based induction that covered the mandatory training. Mandatory training is training that is essential and required for staff to carry out their role effectively and safely. Induction was delivered by the registered manager and included, safeguarding, medicines, manual handling, working with dementia, food hygiene, fire safety and health and safety.

Further training was provided by the deputy manager. We were unable to view any training records prior to 2016 during the inspection. The registered manager told us that these had been archived and the person that had access to them was on holiday. Staff that we spoke with confirmed that they received regular training and told us that training was, "Very good" and "We can request training if we need it."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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 when this is in their best interests and legally authorised under the MCA.

The service had a policy on, 'Working with service users who might lack mental capacity.' The policy outlined how the service worked with people who may lack capacity and stated that any decisions where the person may need help should be detailed in their care plans. However, there were no records of people's

capacity in any of the care plans that we looked at during the inspection. We discussed this with the registered manager who told us, "I know who has capacity and who does not." We asked the registered manager how new staff would know if a person had capacity if it was not documented. The registered manager told us that he talked all new staff through the people they would be working with including their capacity.

The registered manager told us that no staff had received training in the Mental Capacity Act (MCA). A training course was being prepared and we were shown hand-outs that had been designed to support the training. However, all staff that we spoke with were able to explain what the MCA was and the impact it had on the care that they provided to people. Staff told us that the MCA meant, "That they [people] are able to do things for themselves and make decisions. That they have capacity until deemed otherwise" and "People who can't decide for themselves and may need help. An assessment would be needed." Staff were also able to tell us about the specific individuals that they worked with and their ability to make decisions.

Care plans showed if people required help with meal preparation when care staff visited. Some people were supported to cook meals and others required prompting to eat regularly. One care plan gave staff explicit guidance on how to support the person during meal times noting, 'Ensure [person] is sitting comfortably at the table, cut [person's] food up if unable to do so, allow sufficient time to eat and enjoy meals, serve foods at the right temperature.' Staff said that when they offered food, they knew what people's likes and dislikes were as they had worked with them for a long time and always offered choice. One person had meals delivered and staff prepared snacks in between, if requested.

People and staff told us that the service did not generally attend healthcare appointments with people and that this was managed by the family. However, staff told us that if a person required support they would ensure that this was provided. There were no records of people's healthcare visits and the registered manager told us that this was recorded in people's daily logs.

There were records where the service had referred people to other health care professional such as a tissue viability nurse, dentists and GP's. We spoke with one of the nurses [employed by Kells] who gave an example of a person that the service worked with who had recurring pressure ulcers. The nurse visited daily but said that when there was a change in the person's condition they were referred to the district nurses. The nurse also said that where necessary she had ensured that appropriate pressure relieving equipment was ordered and in place to help mitigate the risk and updated the persons care plan accordingly.

Good

Is the service caring?

Our findings

People and relatives thought the service was caring. One person said, "I'm satisfied with everybody. Everybody is kind to me." A relative told us, "We are blessed to have them [staff]. They are like a family." Comments that the service had received on monitoring forms included, 'Without the care and support [my relative] receives, I doubt she would still be here today. Wonderful care,' 'Staff are willing to stay a bit later if [my relative] is in need of care' and a person fed back, '[Staff member] comes in and looks after me very well. I have no worries. I am 100 years old now.'

Care workers told us about the importance of treating people with dignity and respect and making sure people were seen as individuals and had their needs met in a person centred way. One staff member said, "I treat my clients as I would myself. [The registered manager] is always promoting that we treat our clients with dignity and respect." Another staff member said, "It's [dignity and respect] things like going to the toilet, that they have alone time once they are securely seated. Asking if it's okay to come in. I make sure I get their permission before I carry out any care." A relative said that staff, "Absolutely treat [relative] with dignity and respect." Some of the people being supported by the service lived with relatives. Staff understood how to ensure privacy and dignity if they were caring for someone in their home where there were other people present.

The manager of a supported living scheme where Kells provided care to a person in their own home was positive about staff members caring attitude and told us, "The carers are marvellous with her. When it's her birthday they [staff] went out and got cakes and on her 100th birthday they contacted the family and wrote to the queen." She also told us that care workers tried to encourage the person to go out daily and would take [the person] for walks to help maintain her mobility. Care workers knew that the person liked fresh fruit and would regularly bring in fresh fruit for her and ensure it was cut into manageable pieces where necessary.

Staff told us that they always tried to ensure that people were supported to do as much for themselves as possible. This was to ensure that people did not become de-skilled. One staff member said, "It is important to ask if they can do something themselves, before I ask if I can help. It's about empowerment."

Staff members knew people well and were able to tell us what people liked and did not like. One staff member told us about a person that could present with behaviour that challenged. The staff member had been working with the person for two years and said, "It's about knowing your patients and understanding them."

The service had an equality opportunities policy that staff had access to. The registered manager told us that equality and diversity was part of staff induction. The policy stated that staff were, 'Required to attend on-going equality training to ensure that equal opportunities is always part of their work.' We asked staff what they understood about equality and diversity. One staff member said, "People should be treated the same, regardless of their gender or who they are in a relationship with. I am there to give care." Another care staff member said, "It's about treating everyone equally and making sure that we provide care and not

judgement."

Requires Improvement

Is the service responsive?

Our findings

Care plans were task focused and not person centred. Care files did not contain any information around people's histories, their likes and dislikes or activities that they enjoyed doing. Many of the people that the service supported received a lot of care, in one case 24 hours. Staff that we spoke with knew people well and had worked with them, often for several years. One person was noted to be Jewish and ate only kosher foods. The care plan did not explain what kosher was or how the person observed their faith. We discussed this with the registered manager who said, "Well, I tell them [staff]." Several of the people that the service supported were noted to be living with dementia. However, there was no information on how these individuals experienced their dementia and how staff could work effectively with them. The registered manager verbally explained how the dementia affected people that were being supported but confirmed that this was not written down.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a referral policy. We asked the registered manager about this who told us, "Nothing is written down, they [referrers] ring me up and I go out and assess." There was no documentation that could be given to potential referrals around how the service managed and processed new referrals. The service was not transparent on what people could expect when they made a referral. Assessments of new referrals were completed by the registered manager and the initial assessment formed the care plan.

The registered manager told us and records we viewed confirmed that the service completed reviews of care every six months. The registered manager said, "It's [reviews] not necessarily every six months. I pop in to see them if I am in the area." If there were any changes to the care plan these were noted on the review forms. The registered manager told us, "I don't rewrite the care plan unless it is a major change." A relative told us that they were fully involved in any reviews and had input into planning their relatives care, "Yes, they do reviews yearly. I am the person and I have full input."

For a person that received 24-hour care, the relative told us that staff ensured that the person took part in activities that they enjoyed and staff were always willing to accompany the person out. The relative told us, "They take [them] to the cinema, shopping, for walks. They [the staff] are more than willing to facilitate."

The registered manager said that continuity of care was important for the people that used the service and that the service always ensured that people had regular carers that they got to know.

Staff and people told us, and rotas confirmed, that people often had the same care workers visiting them, which enabled people to experience continuity of care. One person told us, "I always have the same girls, I remember them." A relative told us, "We have 24 hour care. Four or five people, it's a team. They put the rotas up so we always know who's coming. They are always on time. They call if they are running late but it's rare."

The registered manager told us that generally the service did not take on care calls under four hours. Staff were clear on their rotas and said that they had enough time to travel to visits. The registered manager said that he did not monitor late calls or missed visits and told us, "I don't have any [missed calls] because we don't do short visits. We don't monitor late calls because if they [staff] don't turn up the clients would let me know. If I can't find anyone to cover, I go."

The registered manager completed monitoring visits and phone calls to people and relatives to assess the quality of care. Monitoring forms were sent out to people and relatives every six months. These asked questions about the staff attitude, caring, reliability, communication, knowledge and appearance when completing care visits. We looked at 20 responses form the last year and found that they were overall positive. The manager said that if there was an issue that came up from the monitoring he would address it immediately.

The service had a complaints policy. The complaints policy was given to people when they began using the service. People and relatives told us that they knew how to complain. A relative told us, "I just phone up and talk to them. I know there is an official way of doing things but I just call the office." One person said, "I've no complaints whatsoever." There were two complaints recorded. However, there was no information documented on the outcome of the complaints recorded, how the complaints had been resolved or evidence of learning from the complaints. The registered manager verbally told us how these two issues had been resolved and what action had been taken.

There were records of compliments from relatives. One relative had written, "I thank you for providing such excellent care for my mother over the last two months of her life. Both you and your staff were superb and provided the reassurance and help we needed at this difficult time."

Requires Improvement

Is the service well-led?

Our findings

Staff told us that they felt supported by the registered manager and feedback that we received from people and relatives was positive about the care that they and their relatives received. However, many of the systems and processes within the service were informal and not documented.

There was no documentation or audits that looked at medicines management. The registered manager told us that they checked people's medicines informally when they visited them but did not document this. There were no audits documented for any other aspect of the service. We spoke with the registered manager about this who said, "I don't do any audits. It's a small agency and I am always checking informally but I don't write it." We discussed the importance of completing audits to ensure issues identified were documented and followed up.

Supervisions were very brief often consisting of two or three lines on a blank form. For example, one staff member's supervision documented, 'Happy working', 'Aware of policy' and 'Needs training'. The supervision failed to record what policies they were aware of, what training had been identified and when it would be provided or if the staff member had any concerns. One staff member told us, "I'm always talking with him [the registered manager]. I feel very supported but nothing is written down."

Assessments of new clients and background histories had not been documented.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said that the registered manager promoted an open and inclusive environment. One staff member said, "I think [the registered manager] is brilliant. [They're] always really supportive. If I bring anything up that needs action [they] always follow it up and communicate with me." A relative said, "[The registered manager is] very good. If I've been upset [they're] always understanding and lovely." During the inspection, we observed staff coming into the office. The registered manager was always welcoming and interactions between the management and staff were warm and genuine.

There was a system in place for reporting accidents and incidents. Staff were aware of how to report accidents and incidents. There were no records of any accidents in the past year.

The provider operated an on-call system for out of hour's issues that arose. This operated seven days a week between 16:00 and 08:00 and at weekends. Relatives told us that they could always contact staff in the office and someone was available when the office was closed.

The service completed six monthly monitoring checks. The registered manager told us that these were "In effect mini surveys." Feedback viewed was positive. However, the outcomes of these monitoring forms were not collated and reviewed to improve practice.

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
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that care plans were person centred, met people's needs and reflected their preferences. Regulation 9(3)(b)(c)

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not adequately assess the risks of service users receiving care and treatment. 12(1)(2)(a)(b)

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was failing to assess, monitor and improve the quality of the service. The provider was failing to ensure good governance of the service. 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Nursing care	Regulation 18 HSCA RA Regulations 2014 Staffing

Personal care Treatment of disease, disorder or injury	The provider was failing to ensure that staff were supported through annual appraisals. 18(2)(a)