Nottingham Assured Home Care Ltd

Nottingham Assured Home Care Limited

Inspection report

181 Westdale Lane
Carlton
Nottingham
Nottinghamshire
NG4 4FL

Tel: 07974685094

Date of inspection visit:
06 May 2021
13 May 2021

Date of publication:
15 June 2021

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
Nottingham Assured Home Care Ltd is a domiciliary home care service providing personal care to adults with personal care needs. At the time of our inspection Nottingham Assured Home Care Ltd were supporting eight people.

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.

People's experience of using this service and what we found
The provider did not have systems for monitoring the safety and quality of the service in place. The provider did not identify shortfalls and areas for improvement. Audits were not carried out effectively to improve the service and learn from incidents.

We were not assured the provider was following infection and prevention control guidance in order to protect people from the transmission of COVID-19.

Medicines were not managed safely. Medications records did not demonstrate safe administration of medications, records did not contain sufficient information to inform staff what prescribed medications were required and at what time. Incidents involving medicines had not been learnt from and poor medication practice continued leaving people at risk.

The provider was not aware of their responsibility to notify CQC of certain events and we had not been notified of events which they are legally required to do.

People told us they felt well cared for and felt confident to raise concerns with the registered manager.

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 Good (published 27 March 2019).

Why we inspected
The inspection was prompted in part due to concerns received about medicine management. A decision was made for us to inspect and examine those risks.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nottingham Assured Home Care Ltd on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care, risk management, medicines management and governance.

Since the last inspection we recognised that the provider had failed to notify us of certain events. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Nottingham Assured Home Care Limited

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 Care Act 2014.

Inspection team
The inspection was conducted by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The Inspection was announced.

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the registered manager would be at the registered location to support the inspection.

Inspection activity started on 6 May 2021 with a visit to the registered location and ended on 14 May 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and one relative about their experience of the care provided. We spoke with three members of staff including the registered manager, senior care worker and a care worker.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always managed safely.
- Medicines records we reviewed did not contain the required information to ensure safe administration of medications. Medicine administration records did not direct staff in how to give medications and when they were required.
- Medication training had been completed; however, competency assessments had not been completed to ensure staff understood and administered medication safely. For example, we reviewed daily logs for one person, which documented a person was not able to consent to the administration of their medication but staff had still attempted to give this, medication administration was only stopped when the person shouted out no.
- The issues found during inspection leave people at risk of receiving their prescribed medications unsafely.

Assessing risk, safety monitoring and management

- People were not always protected from risks of avoidable harm.
- Records we reviewed did not contain the risks associated with people's health care needs. For example, people who lived with conditions such as diabetes and Alzheimer's did not have care plans or risk assessments in place to detail how staff could safely care for them. This placed people at risk of harm.
- Some of the records we reviewed had a brief risk assessment in place to reflect the risks relating to people's home environment, however one record we reviewed had no environmental risk assessment in place. There was an absence of personal evacuation plans (PEEP) in all the records we reviewed. This placed people at risk of harm if an emergency occurred.

Preventing and controlling infection

- We were not assured that the provider was following current national guidance for health and social care providers in order to protect people from transmission of COVID-19.
- The provider did not have a system in place to monitor and ensure staff and service users were accessing testing for COVID-19. This leaves people at a heightened risk of contracting COVID-19.

This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us that when staff cared for them, they wore personal protective equipment [PPE].

Staffing and recruitment

● Staff were not always recruited safely.

● Records reviewed did not demonstrate that a safe recruitment process was in place. For example, staff were not interviewed prior to commencing their employment. There was no formal induction process in place to ensure staff were suitably inducted into the service. This placed people at risk of receiving unsafe care from unsuitable staff.

● People we spoke with told us their care worker arrived when they asked them too.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Lesson were not always learnt when things went wrong.

● Following a safeguarding incident reported to the CQC by the local authority not enough action had been taken to ensure the incident was not repeated. This meant people were still at risk of receiving unsafe care.

● Staff had completed training in safeguarding but not all staff we spoke with knew how to raise concerns outside the organisation to relevant health and social care professionals. This meant there was a risk that not all concerns would be reported and investigated by appropriate professionals, placing people at risk of harm.

● People told us they felt safe when staff delivered care.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager was not always aware of their regulatory requirements.
- We were not assured that the registered manager was aware they were legally required to inform CQC of certain incidents. For example, we found three incidents where the registered manager should have notified us but failed to do so.
- Staff rotas did not detail what time staff were required to arrive and how long they were required to stay. This could place people at risk of receiving inconsistent care and support.
- The registered manager did not have an audit system in place in order to improve the quality of care, this meant errors and poor practice were not identified and acted on to reduce the risk to people's health and safety.
- The registered manager did inform us that they completed regular reviews on staff and acknowledged they needed to evidence this had taken place.
- All staff and people we spoke to told us the registered manager was approachable and supportive

Continuous learning and improving care

- The provider did not have quality assurance systems in place. This meant they did not identify issues to drive service improvement. For example, the provider had not carried out any recent care plan audits.
- There was not an effective audit process in place to identify any issues and learn from previous incidents and Improvements were not always made following incidents. For example, although people told us they received their calls on time, the provider did not have a system in place to monitor call times and prior to the inspection we received concerns relating to late and missed calls; which resulted in a person leaving the service. Improvements had not been made to how staff were allocated calls to reduce the risk of missed or late calls occurring. This placed people at risk of receiving inconsistent care.
- There was not an effective audit process in place to identify any issues and learn from previous incidents.

The provider failed to ensure that systems and processes were in place to improve the quality of care at the service. This was a breach of regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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; Promoting a positive culture that is person-centred,

open, inclusive and empowering, which achieves good outcomes for people

● We were not assured the provider fully understood their responsibility regarding the duty of candour.

● The registered manager advised us that following complaints they would meet with people to discuss issues and the people we spoke with confirmed this. However, we found following one safeguarding incident where a person had come to harm, the provider did not contact the person or their family to acknowledge where things had gone wrong and what they would do to improve the service.

● The registered manager was passionate about providing person centred care, however we found that some records we reviewed did not support this. For example, documentation we reviewed was generic and did not detail people's specific needs.

● Care plans did not always detail how to achieve the best possible outcome for people. For example, vital information relating to catheter care and best interest decisions was missing entirely. This leaves people at risk of receiving unsafe care.

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

● People and their loved ones told us they had been involved in planning the care they received. One person told us, "They do everything I ask of them; they couldn't do more for me.".

● The registered manager informed us they had purposively ensured the service remained small so they could fully involve people in their care.

Working in partnership with others

● The service had recently worked with the local authority following an incident and had worked with a social care professional in order to conclude their investigation, they fed back the registered manager had provided all the information requested.