IQ Homecare Ltd

Kare Plus Oxford

Inspection report

Unit 2, Watlington House
Watlington Road, Cowley
Oxford
OX4 6NF

Tel: 01865922449
Website: www.kareplus.co.uk/oxford

Date of inspection visit:
12 July 2023

Date of publication:
14 August 2023

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

Kare Plus Oxford is a domiciliary care agency. They provide 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 the inspection 15 people were receiving personal care.

People's experience of using this service and what we found
Risks to people had not always been fully assessed or strategies recorded to reduce the risk of harm. Staff did not always have sufficient information or the skills and knowledge to support people safely. Training records did not evidence staff had received adequate training on people's specific needs.

When people sustained an injury, records were not always clear on how the injury occurred, the size, shape or colour of injury or when the injury had healed. Investigations for incidents or accidents were not consistently in place.

People did not always know which staff were supporting them for each visit, staff did not always turn up on time or stay the allocated amount of time. However, people stated staff were kind and caring. Staff recruitment required improvement to ensure all necessary checks had been completed before staff worked with people. Policies and procedures were in place but had not been consistently followed.

Medicine management required improvement. Although we found no risk of harm, records were not consistently completed to ensure medicines were given as prescribed.

Systems and processes to ensure good oversight of the service, to identify concerns and make improvements were not effective or embedded into practice. Issues found on inspection had not been identified previously by the provider's own audits or reviews.

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; the policies and systems in the service did not always support this practice.

Staff felt supported by the manager. However, regular meetings were not held to discuss concerns, make suggestions or share information. Not all staff had received a spot check to check if staff were working in a safe, person-centred way or if they were following policies and procedures.

Relatives were kept up to date on any changes in people's need, incidents or accident that occurred. Staff supported people to access healthcare support if needed.

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 8 June 2022)

Why we inspected
We received concerns in relation to management oversight and staffing. 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 changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kare Plus Oxford on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to risk management and oversight at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

Kare Plus Oxford

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.

Inspection team
The inspection was completed by 1 inspector and an 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 houses and flats.

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 not a registered manager in post.

Notice of inspection
We gave the service notice of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 12 July 2023 and ended on 20 July 2023. We visited the location's office on 12 July 2023.

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 who work with the service. We used the 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 this information to plan our inspection.

During the inspection
We reviewed a range of records. This included 3 people's care records and medicine records. We looked at 3 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.

We spoke with 4 people and 4 relatives of people who used the service about their experience of the care provided. We spoke with 7 members of staff including the manager and care workers.

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 the rating has changed 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong; Assessing risk, safety monitoring and management

- The provider did not have a clear oversight of safeguarding issues or concerns. A new system was implemented after the inspection.
- Records evidenced that one person had told staff of a potential safeguarding concern. Managers had not informed the local safeguarding team. However, the police and ambulance were involved.
- Records of injuries were not fully recorded. We found no information recorded regarding position, size, colour or shape of injury. Incidents and accidents recorded did not always have an investigation completed to identify any risks, trends or patterns to ensure mitigating strategies could be implemented to reduce the risk of reoccurrence.
- Risks had not always been assessed or mitigating strategies implemented. In all 3 people's care records we reviewed we found risks surrounding people's health conditions and medicines had not been fully assessed. Therefore, appropriate mitigating strategies were not in place to support staff to understand and reduce known risks to people.
- Staff did not always have the correct information to support people safely. We found conflicting information recorded regarding if a person wanted resuscitation in the event their breathing or heart stopped beating and incorrect information regarding the support and medicines a person required.
- Not all staff had the training to support people safely. The information provided evidenced staff did not have training on supporting people living with dementia or diabetes, and some staff had not completed their training before supporting people. One relative told us, "[Person] has dementia and their condition can change each day and I feel that the care staff don't always know what to do with [person]. I feel that the carers need special training do deal with the condition (dementia) and clearly, they don't."

The provider had failed to adequately assess or mitigate the risks to the health and safety of people. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received safeguarding training for both adults and children and understood the signs and symptoms of abuse. Staff were confident in raising any concerns either internally or externally to the service.

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).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

● We found the service was not always working within the principles of the MCA. The manager had not identified when a relative who did not have the legal power to do so was signing consent for people. The manager contacted people involved to ensure the correct person consented to any decisions required immediately after the inspection.

Staffing and recruitment
● The provider had not always followed their own policies or procedures regarding safe recruitment. We found no referenced had been sought for 1 staff member who was working with people. The providers policy stated they required written references for each staff member before they were able to start work. Another staff member had not had an updated disclosure and barring service (DBS) check. The provider and manager told the inspector staff should have an updated DBS every 3 years. The staff members DBS was last completed in 2019.
● We received mixed views on the consistency of staffing. Some people told us they did not always know which staff were next coming to support them or what time staff would arrive. However, other people stated they had a consistent staff team, who attended on time and knew them well.
● Not all staff felt people knew who were coming to support them or that staff turned up on time. One staff member said, "No they (people) don't appear to know who is coming. I tell them only if I am not coming to the next call." Another member of staff said, "Staff do not always turn up on time due to not having enough travel time between visits." However, we found no evidence of missed calls.

Using medicines safely
● Medicine management required improvement. When people had 'as required' (PRN) medicine prescribed, there were no PRN protocols in place to advise staff on when the medicine should be administered for what reasons and the maximum dose allowed in a 24-hour period. When staff recorded PRN medicines had been administered there was not always a reason recorded. However, we found no evidence of harm. The manager implemented PRN protocols after the inspection.
● People's medicine administration records (MAR) were not consistently signed to evidence staff supported people with creams as prescribed. Relatives told us they had some concerns with medicines management. One relative said, "Carers give medication, but it has been forgotten a couple of times, I think it was when a new carer came." The manager implemented a new system to ensure medicines were administered as prescribed and the medicine records were completed correctly.

Preventing and controlling infection
● Staff wore appropriate personal protective equipment (PPE) when supporting people with personal care to reduce the risk of cross infections.
● Staff received training in infection prevention and control (IPC). The provider had up to date policies and procedures in place regarding IPC.

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 good. At this inspection the rating has changed 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.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes were not effective at identifying risk and making improvements.
- Audits had not been completed regularly and had not identified the issues we found with missing or incorrect information in care planning documents and risks not being assessed.
- Medicine management audits completed had not always identified when MAR were not signed appropriately. The audit had not identified the lack of PRN protocols in place.
- Systems and processes to ensure oversight of accidents, incidents, safeguarding and complains had not been embedded into practice.
- Systems and processes were not effective in ensuring safe recruitment procedures had been followed. We found staff had started working with people prior to their references being received by the provider. This put people at potential risk of harm.
- The manager did not fully understand their responsibility under the duty of candour, to apologise to people, and those important to them, when things went wrong and to have a written record.

The provider had failed to ensure effective and robust quality monitoring systems were in place to ensure they had good oversight of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.
- The manager was aware of their role and responsibilities to meet the Care Quality Commission (CQC) registration requirements. Records showed statutory notifications of notifiable events were submitted to CQC as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff did not feel fully engaged with improvements in the service. Staff told us they did not get asked to feedback on the service.
- Staff told us, they felt able to raise concerns and suggestion. However, some staff stated regular meetings

were not in place. One staff member said, "The team never get to meet in a group. It would be beneficial if we got a monthly team meeting to share our experience, thoughts and concerns, and to be able to voice out to the management as a team."

● People and relatives told us the manager was responsive when any issues were raised. However, some felt information given to 'office staff' was not always passed on. One person said, "I feel there is a lack of organisation and communication between the office, manager, the care staff and me."

● People and relatives told us that staff were kind, lovely people and really caring."

Working in partnership with others

● The manager shared information with significant people. Relatives were kept up to date on any changes or concerns with people's needs. One relative said, "[Person] developed a sore and as soon as it was noticed I was informed and with the input from the district nursing service it has now healed."

● Staff liaised with healthcare professionals to coordinate better care for people.

● The manager was engaged and open to the inspection process and remained open and transparent throughout.

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 The provider had failed to adequately assess or mitigate the risks to the health and safety of people.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective and robust quality monitoring systems were in place to ensure they had good oversight of the service.