Cera Care Operations Limited

Cera - Wiltshire

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Cera – Wiltshire is a large domiciliary care agency that provides personal care to people in their own homes.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. Personal care 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
People's medicines were not being safely managed. Audits had identified on-going errors, but more were identified at this inspection. Time specific medicines were not consistently given at the same time each day, and staff were giving one person their pain relief within the recommended time frame of four hours. This placed the person at risk of overdosing. Medicine administration records had not been accurately completed, and supporting documentation was not always available to ensure medicines were given as prescribed. Staff had received training in the safe administration of medicines, but not all had had their competency assessed.

Not all risks to people's physical and mental health, had been identified and sufficiently addressed. This included one person's risk of blood clots, and another person of very low mood, with the risk of suicide. Other risks associated with falling and the environment had been considered. Accidents and incidents had been appropriately documented and reported, with immediate actions taken where required.

Infection prevention and control measures were in place. This included staff training, large stocks of personal protective clothing (PPE) and a contingency plan in the event of high levels of staff contracting COVID-19. However, the staff testing programme was not mandatory, and staff were not expected to inform the registered manager if they had completed a test, or its outcome.

There were not always enough staff to ensure the reliability and efficiency of the service. This was particularly so at weekends or at times of staff sickness. Feedback from some people and staff, confirmed visits could often be late or not consistently at the same time each day. Staff recruitment was on-going and new staff were regularly starting employment at the service. Safe systems were in place to ensure those staff appointed, were safe to work with vulnerable people.

Systems were in place to help protect people from the risk of harm. Staff had received training in safeguarding and were aware of their responsibility to report any concerns. People felt safe with staff supporting them, and relatives had no concerns about safety.

People did not always receive a personalised service, which met their individual needs. Some timings of visits were inconsistent, and not always at a time to suit the person. Staff told us they had no, or sometimes very little travel time, which meant they were often late arriving to support a person. Some staff felt

pressurised and found travelling between people's visits stressful.

The content of people's care plans was variable in detail and accuracy. One plan stated a person had a catheter but there was no information for staff about how to manage it. Another plan gave discrepancy, regarding the application of a person's pain patch. Much of the information staff had recorded within the communication logs, was task orientated rather than person centred. A new electronic care planning system was being introduced to help these areas.

Management told us promoting social activity to avoid social isolation was an important part of the agency's vision. However, not all staff took the opportunity to spend time with people, once all required tasks had been completed. Records showed some staff had left earlier, rather than use the time to reduce social isolation. The registered manager confirmed promoting social activity would be further addressed, once the restrictions of the pandemic eased.

People and their relatives were given a copy of the complaints procedure when they first started using the service. They knew how to raise a concern or a formal complaint if needed. Improvements had been made to the complaints process following a complaint which had been made before our inspection and not been handled well. This included a department within the organisation, reviewing any documentation before it was sent to the complainant.

Auditing systems were in place to assess and monitor the service. However, not all were effective as the shortfalls identified at this inspection had not been identified. Investigations into the root cause of medicine errors, or measures taken to minimise them, had not been adequate to ensure improvement.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Cera - Wiltshire

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
This inspection was undertaken by three inspectors and two Experts 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.

This service also provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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
We gave a short period notice of the inspection, as we needed to be sure that the provider or registered manager would be in the office to support the inspection.

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.

During the inspection
We spoke with 11 people who used the service and eight relatives about their experience of the care provided. We spoke with eleven members of staff including the registered manager, operations director, regional manager, and care workers.

We reviewed a range of records. This included 12 people's care records and multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a further five people's care records and medication records. We looked at a variety of records relating to the management of the service, including quality auditing, policies and procedures. We spoke with two professionals who have contact with the service and received written feedback from one other.

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

- People's medicines were not safely managed.
- Due to the timing of their visits, one person had regularly been given paracetamol more often than the recommended four hourly timeframe. This meant they were being overdosed and at risk of significant harm. The service had not identified this, but took immediate action once we alerted them.
- Time critical medicines were not always being given consistently as recommended. For example, one person who received a medicine associated with Parkinson's disease was given it on different days at 13.45, 11.50, 12.10 and 13.15. This meant people were at risk of existing conditions being poorly managed.
- The medicine administration records (MAR) were not always clear and did not always detail all medicines, and their prescribing instructions. The MARs had not always been fully completed by staff when administering the medicines. This increased the risk of error and did not demonstrate whether people had received their medicines or not.
- Guidance for staff to support the safe administration of medicines was not always available. For example, some "as required" medicines did not have additional guidance for staff reference. This did not ensure the medicines were administered as prescribed, or for maximum effectiveness.
- The service had identified staff were making errors with people's medicines. There had been errors each month from January 2021 onwards. This had included giving a person the wrong medicine, not completing the medicine administration record properly and not applying topical creams as prescribed.
- The service had identified not all staff had completed an assessment to demonstrate their competency when managing people's medicines. This did not ensure all staff were competent when managing people's medicines. A recent action plan showed this was in the process of being addressed and would be completed by 9 July 2021. The registered manager told us they were on target to meet this deadline. After the inspection, a senior manager told us the pandemic had impacted on completing the medicine competency assessments.

We found no evidence that people had been harmed, however robust systems were not in place to ensure people received their medicines on time, as prescribed and without error. This was a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people's safety had not always been identified and sufficiently addressed. This placed people at risk of potential harm.
- Records showed some people faced significant risks associated with their physical or mental health. Guidance to help staff recognise any early warning signs, or the need for additional support, was limited.

● Other risks people faced such as those associated with allergies, skin integrity, falling and the environment, had been identified.
● Accidents and incidents were documented and formed part of the auditing process. Records showed such events included falls, medicine errors and injuries to staff from slips and moving people. Immediate action had been taken to address the incidents identified.

Preventing and controlling infection
● Not all systems in place were fully effective to prevent and minimise the risk of infection.
● Staff were encouraged to complete regular testing for COVID-19 in line with current government guidance. However, the testing was not mandatory, and staff were not required to inform the registered manager of the test's completion or the results. The registered manager told us staff were committed to people's safety and they trusted them to complete the tests correctly. Without formal notification however, an outbreak and transmission of the virus would not be easily identified.
● The agency had a large stock of personal protective equipment (PPE) for staff's use. Points had been set up within the county, to make it easier for staff to collect their PPE. Staff had received training on how to use the PPE correctly and watched a video, which showed how to put it on and take it off safely.
● Those people and staff who were at higher risk of contracting the virus had been identified. Measures were in place to enhance their safety.
● The service had an appropriate contingency plan in place, in the event of high levels of Covid-19 amongst the staff team. Staff were reminded about testing and other precautions such as social distancing and the use of face masks, at the most recent staff meeting.
● People and their relatives told us staff took additional precautions to minimise the risk of infection. One person told us, "When the carers come in, they are wearing all the gear, gloves, masks and tunics." Another person said, "They wear all the gloves, masks and do what is needed to keep us safe."

Learning lessons when things go wrong
● There was not always evidence of lessons learnt when things went wrong. This meant existing systems were not always developed and improved upon.
● There had been regular errors with people's medicines and as a result, the staff involved had received additional training. However, there was no investigation as to why the errors were occurring. Similarly, when investigating a person's pain relief being given within the recommended period of four hours, the actual scheduling of their visits was not considered.

Systems and processes to safeguard people from the risk of abuse
● The service had systems in place to help protect people from the risk of harm.
● Information about abuse was available to staff and safeguarding formed part of the mandatory staff training plan.
● Staff told us they would inform the registered manager if they were concerned about a person's safety.
● People told us they felt safe with the staff supporting them. Relatives had no concerns about safety. Specific comments were, "I feel very safe with them" and, "[Family member] is very safe with the carers. She trusts them and the carers are very reassuring and caring with her." One person told us they felt safe when staff assisted them with using their hoist.

Staffing and recruitment
● There were not always enough staff to ensure the reliability and efficiency of the service.
● Last minute staff sickness was not always easily covered. Staff told us additional visits were often put into their existing schedule, so they had more visits to fit in. They said this could impact on their arrival times for people's support. One staff member told us, "Sometimes your morning calls run into your lunch time calls,

so you just keep going until you're finished." Other staff did not seem affected by any shortages and continued with their usual schedule of visits. They said they supported the same people each week, which worked very well.

● Staff told us they could not always support people on time. They said this was particularly apparent at weekends, as there were less staff on duty to cover people's support. One staff member said, "Everyone pulls together to get all the calls done so we might do extra. You have to be prepared to move around." However, this meant people could be supported later than their agreed time, or by staff who did not know them well.

●Staff told us they had no, or sometimes very little travel time, between people's visits. They said they were often running late, or spending less time with a person, to make up time. After the inspection, senior management told us the service was always looking to improve travel time due to the rural and urban challenges they faced.

●People confirmed lateness was often a problem, and there had been a recent complaint about shortened staff visits. Specific comments were, "Staff are often late, but I understand that some people need extra help who are before me" and, "Sometimes staff do turn up late, but it's always for a good reason and they do apologise for being late. They do ring to say they will be late."Another person said, "I would say the provider is managing with the staffing issues they currently have. Sickness and COVID problems sometimes mean they have different staff or are going to be late."

● Timings of visits were inconsistent, and not always at a time to suit the person. For example, one person repeatedly had a late lunch time visit, despite raising this with the service.

● Records confirmed some late visits. This included one person who needed their teatime visit at 18.00, due to dietary needs, but some of their visits were documented as 19.00, 18.55, 20.15 and 19.20.

● At the time of our inspection, we received a concern about the pressure staff were under to ensure people's support was delivered on time. They said people regularly experienced late visits and often cancelled them, due to being too late.

● We asked the registered manager for an overview of late and missed visits. We received information in percentages regarding the timing of calls but no details of missed visits. After the inspection, the registered manager told us they acknowledged this part of staff's role could be stressful. They said lateness often arose because the allocated time of a person's support was insufficient. This was being addressed with the funding authority who commissioned service from the provider.

● The registered manager told us whilst there had been staff sickness, the service did have enough staff to manage the current care packages they had. They said sickness absence was being managed and had improved as a result. The registered manager said there was on-going recruitment, and there were new staff starting week after week. Work had also been done on scheduling consistent teams, to support regular people. After the inspection, the registered manager told us they had reviewed the timings of people's support over the last three weeks. They said 91% of the 13,031 visits were attended within a + or – 60-minute window of the scheduled call time. 55% of calls took place within 15 mins of the scheduled call time.

● The service benefitted from a department, which specialised in the recruitment of staff. The recruitment process used, showed appropriate checks were undertaken to ensure suitable staff were appointed.

We found no evidence that people had been harmed. However, the scheduling of visits negatively impacted on some people's wellbeing and did not provide them with a personalised service. This was a breach of Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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 people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive a personalised service, which met their individual needs.
- The content of people's care plans was variable in detail and accuracy. For example, one care plan stated a person had a catheter, but there was nothing about the management of the catheter in the continence section of the plan or communication log. Another plan stated staff should change the person's pain patch every Sunday, but on the medicine, administration record it was to be done on Friday. This increased the risk of errors. One care plan stated staff should stay with the person until they started eating. There was no evidence of that this was happening within the communication logs.
- The registered manager told us a new electronic care planning system was being introduced, which they expected would improve care planning. Greater focus was also being given to regularly checking all documentation in place.
- Much of the information about people's support, which staff documented in the communication logs, was task orientated and not person-centred. This included, "Washed and dressed [person]. Placed her in lounge", "Strip wash, dried, dressed, new pad on" and, "put him to bed." One record stated "Put Medihoney on". Medihoney is a dressing applied to help wounds heal. There was no detail of the condition of the person's skin.
- People gave us variable feedback about their support. One person told us, "I have found the service to be very good and responsive." Another said, "I can't speak more highly of this company. They are kind, caring and thoughtful and are absolutely wonderful." Other comments were less positive and said, "Carers often arrive too late in the morning and too early in the evening" and, "My calls are often late, and I don't like lying in bed until 11am. They just seem to come when they can. My normal time should be 8.30. Nobody rings me to say they are going to be late. I ring the office and they tell me about sickness or traffic etc."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service met the AIS standard. A recent audit completed by the provider confirmed this.
- People's communication needs were detailed in their care plan. This included whether they were reliant on glasses, had a hearing aid or needed staff to talk at a slower pace.
- Documentation was available in large print or could be translated to another language if required. The operations manager told us they were currently working on enabling the recruitment process to be completed in languages other than English.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Promoting social activity to avoid social isolation, was an important part of the agency's vision. However, the covid 19 pandemic had impacted on this significantly.

● The agency's most recent audit had identified social inclusion was an area which needed greater focus, once the pandemic had eased. The registered manager confirmed they had many plans for this.

● Whilst it was recognised the pandemic had impacted on relationships, not all staff took the opportunity to spend time with people, once all tasks had been completed. For example, records showed one person had been allocated 30 minutes for their lunch time visit, but there were times when staff did not stay this long. Some of the visit's durations included, 11.49 – 12.08 and 11.31 – 11.48.

● Some people had the same staff supporting them, which enhanced relationships, overall wellbeing and social inclusion. One person told us, "It is usually the same carers who come here. I know most of them quite well". Another person said "Yes, I get the same group of staff who come to look after me mostly. The carers have been wonderful and know me really well."

Improving care quality in response to complaints or concerns

● People were given a copy of the agency's complaint procedure when they first started using the service.

● People knew how to raise a concern if they were not happy with the service they received. One person told us, "I'd ring the office if I had a problem. I had to complain once, and it was sorted out." Another person said, "I know how to contact the office when I've had problems. They are very approachable, and they've sorted out problems very quickly."

● Staff told us they were encouraged to say if they were not happy with any aspect of their work.

● Records showed complaints were coordinated to give an overview of the key areas raised. This enabled trends to be identified and addressed.

● Changes had been recently been made, to enable the management of complaints to be more effective. This included a central team to review the outcome of any investigation, before the concluding letter was sent out to the complainant.

End of life care and support

● The agency supported people at the end of their life if needed. This included those who were discharged from hospital to spend their last days at home, with their family.

● There was not a specific care plan format for end of life care. This had been identified within an audit and was being addressed by the organisation's quality team.

● Some people's end of life wishes had been recorded and were discussed as part of their care plan review.

● Staff worked alongside associated health care professionals, to ensure people's end of life care met their needs. This included the local hospice, MacMillan cancer support and community nurses.

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; Continuous learning and improving care

- There were systems in place to assess and monitor the service. This included a full audit undertaken in May 2021. Not all audits were effective, as shortfalls were not being consistently identified or sufficiently addressed. For example, as identified at this inspection, care plans and risk assessments were not being adequately checked to ensure they were complete and accurate. It had also not been identified staff were not staying the full allocation of the visits or the timings of some, were not conducive to people's care or medication needs.
- Audits had identified there had been ongoing errors with the management of people's medicines. However, the errors found during this inspection had not been identified. This meant the investigations into the root cause of the errors, or measures taken to minimise them, had not been adequate to ensure improvement.
- The registered manager was not fulfilling their responsibility of ensuring staff were adequately protecting people from the risk of Covid-19. This was because there was not an accurate account of those staff who were not regularly taking part in the Covid-19 testing programme. Whilst reliant on trust, the absence of this information did not enable the registered manager to take appropriate action to prevent the risk of transmission.

We found no evidence that people had been harmed, however the auditing systems in place were not sufficiently robust in identifying and addressing shortfalls in the service. This was a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A new electronic care planning system was in the process of being introduced. The registered manager said this would ensure the care plans would be better audited, and always accessible to staff through an app. The app also enabled people to contact the office and see details of their support and who would be providing it.
- Audits had shown 96.6% of the staff team had completed their refresher training. This enabled their knowledge and skills to be kept up to date. Staff confirmed they were happy with the training they received.

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

● The service had a clear vision to empower people to live their best lives in their own home.
● Staff told us they believed in and adopted the vision of the service. They said they enjoyed their jobs and liked to make a difference to people's lives. One staff member said enabling people to stay at home, rather than having to consider long term care, was very rewarding.
● All staff had a supervisor, which they had regular contact with. This included one-to-one meetings, performance reviews and informal conversations. Staff told us they could ring their supervisor at any time, which made them feel very supported.
● People and their relatives were complimentary about the staff. One person said, "They are kind, caring and thoughtful and are absolutely wonderful." Other comments were, "They talk from experience and are well trained" and, "I feel the carers are very thorough, they know what they are doing usually. They are knowledgeable and experienced on the whole."
● A health/social care professional also gave positive feedback about the staff. They told us, "My client really looked forward to the carers visiting. They chatted to her and provided a sense of company and emotional support. They seemed quite person centred in their approach and did not rush my client during the visits."
● The registered manager understood their duty of candour. This had been assessed within a recent audit undertaken by senior managers.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There were systems in place to enable people to give their views about the service they received.
● Some people told us they were involved in developing and reviewing their care plan. Others said they had given feedback about the service they received via questionnaires or by a telephone review. Some people however, said they had not been asked for their views.
● A summary of people's feedback, gained through telephone conversations, had been coordinated in a document titled "Client satisfaction survey Feb 2021 – Building a Better future for care." Most of people's feedback was positive, such as the "Carers are very good." Other more negative comments involved the timing of visits and better communication about any changes.
● The service worked closely with various health and social care professionals. This included commissioning, care managers, hospital discharge teams, other care agencies and housing associations.
● The registered manager confirmed they worked in collaboration with a multidisciplinary team, within the organisation. This included the regional and peripatetic manager, quality and compliance manager, learning and development team and the organisation's nominated individual.

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 Robust systems were not in place to ensure people received their medicines on time, as prescribed and without error. This is a breach of regulation 12, (1)(2)(f) Safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The auditing systems in place were not sufficiently robust in identifying and addressing shortfalls in the service. This is a breach of regulation 17, (1)(2)(a)(b), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The staff availability and the scheduling of people's visits negatively impacted on some people's wellbeing and did not provide them with a personalised service. This is a breach of regulation 18 (1), Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.