Eleanor Nursing and Social Care Limited

Ealing Office

Inspection report

Eleanor Nursing and Social Care Limited
157 Uxbridge Road, Hanwell
London
W7 3SR

Tel: 02085793233
Website: www.eleanorcare.co.uk

Date of inspection visit:
22 February 2018
23 February 2018

Date of publication:
29 August 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 22 and 23 February 2018 and was announced. We gave the registered manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm the registered manager would be available when we inspected.

The last inspection took place in June 2016. The service was rated 'Requires Improvement' in the key question 'Is the service Well Led?' but 'Good' overall. We found a breach of Regulations relating to good governance because the service did not have a registered manager in post. Following the inspection, we asked the provider to complete an action plan to tell us what they would do, and by when they would make the necessary improvements to meet the regulations. At this inspection we found the Regulation had been met and a registered manager was in post.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, some living with the experience of dementia, people with learning disabilities and people with mental health needs. The majority of people had their care funded by the local authority or local clinical commissioning groups. At the time of our inspection sixty people were using the service. Ealing Office is a branch of Eleanor Nursing and Social Care Limited, a private organisation which has five domiciliary care agency locations and also manages two care homes.

The service had a registered manager. 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.

During the inspection we found that people had signed their care plan agreements, medicines administration forms and timesheets to indicate consent to the care provided to them. After the inspection, the provider sent us two capacity assessments for people who required support with decision making. However the assessments were generic and not decision specific and therefore did not fully follow the principles of the Mental Capacity Act (2005).

People using the service said they felt safe. The provider had appropriate procedures for keeping people safe including risk assessments and risk management plans to minimise risks.

Care workers we spoke with knew how to respond to safeguarding concerns. They had the relevant training, supervision and appraisals to develop the necessary skills to support people using the service. There were safe recruitment systems in place to ensure care workers were suitable to work with people using the service.

People using the service received their medicines in a safe way.

People were protected by the prevention and control of infections and care workers had access to personal protective equipment that helped to prevent cross infection.

People's needs and choices were recorded and included information about what was important to the person and how to best support them.

People's dietary requirements were met and we saw evidence that relevant health care professionals were involved to maintain people's health and wellbeing.

People using the service spoke positively about the care they received. They were supported to express their views and be involved in making decisions about their care. People told us they generally had the same care workers and this provided consistency of care.

People using the service told us they received personalised care that was responsive to their needs and reviews were completed annually or when required.

The care plans did not however contain any information around people's wishes, views and thoughts about end of life care but the registered manager said this would be addressed.

Where a concern or complaint was raised it was appropriately investigated and recorded. People had information on how to make a complaint and knew how to if they needed to.

The service had a number of systems in place to monitor, manage and improve service delivery. This included a complaints system, audits, care worker observations and satisfaction surveys.

Care workers we spoke with felt supported by the registered manager and the office based staff who they said were available and acknowledged their work.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider had systems to safeguard people from abuse. Safeguarding and whistle blowing policies were up to date and staff knew how to respond to safeguarding concerns.

People had risk assessments and management plans in place to minimise the risk of harm to people and others.

There were a sufficient number of care workers employed and safe recruitment procedures were followed to make sure they were suitable to work with people using the service.

The provider had the relevant training and audits in place for the safe management of medicines.

The provider had an infection control policy in place and the care workers understood the risks around the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Instead of a decision specific mental capacity assessment, the provider used a generic assessment which was not fully in line with the principles of the Mental Capacity Act 2005.

Care workers were supported to develop professionally through training, observations, supervision and yearly appraisals.

People's nutritional needs and dietary requirements were assessed and we saw evidence of involvement with relevant healthcare professionals to support people to maintain good health.

Is the service caring?

Good

The service was caring.

People using the service spoke positively about the care they received and said care workers treated them kindly and with

respect.

Care workers we spoke with understood people's right to choose and supported people to make day to day decisions about their care.

Is the service responsive?

Good

The service was responsive.

People and their families, where appropriate, were involved in planning people's care. Care plans included people's preferences and guidance on how they would like their care delivered. Reviews were held at least annually.

The care plans did not contain information around people's wishes, views and thoughts about end of life care and this was to be addressed.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

Is the service well-led?

Good

The service was well led.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided and make improvements.

The provider had a positive and open culture that promoted feedback from all stakeholders.

People using the service and care workers felt able to approach the registered manager and office staff and said they listened to any concerns.

Ealing Office

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 comprehensive inspection took place on 22 and 23 February 2018 and was announced. We gave the registered manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm the registered manager would be available when we inspected.

The inspection was conducted by one inspector.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding team and commissioning team to gather information about their views of the service.

During the inspection we spoke with the registered manager, the quality assurance manager, a care supervisor, the operations director and five care workers. We viewed the care records of eight people using the service, the employment files for seven care workers which included recruitment records, supervision and appraisals and we looked at training records for all staff members. We also viewed the service's checks and audits to monitor the quality of the service provided to people. After the inspection visit we spoke with nine people using the service.

Good

Is the service safe?

Our findings

People using the service told us they felt safe. The provider had whistleblowing and safeguarding policies and procedures that provided guidance to care workers about how to protect people from abuse. The care workers we spoke with were able to identify the types of abuse and knew how to respond to concerns. They said, "If I found bruising [on a person using the service] we would report it to the office immediately. Could contact social services or the GP", "I have to straight away phone my managers and write on the daily log book on the pages of concern", "I would inform the office. I'd go to social services" and "Tell line manager and if nothing happens, cascade up to CQC level."

There had been no incidents or accidents reported by care workers. Where an incident or complaint was raised by the local authority's contract team, it was recorded electronically, investigated, and where risks were identified, the action taken to mitigate these was recorded and followed up with spot checks. The registered manager also understood their responsibility to raise, record and report safeguarding adult alerts or incidents to the relevant agencies including the local authority and the Care Quality Commission.

During the inspection we viewed the recruitment files of seven care workers. There were systems in place to ensure suitable care workers were recruited to work with people using the service. The files contained checks and records including a recruitment check list, application form, interview questions, at least two references, identification documents with proof of permission to work in the UK if required and criminal record checks. Where appropriate we also saw maternity risk assessments. This meant the provider employed care workers who were suitable to provide safe and appropriate care to people.

Each person using the service had a risk assessment and risk management plan to support them to stay safe. Risks assessed included, the environment, food preparation, use of chemicals, medicines, cross infection, falls, first aid, fire, smoking, equipment such as hoists and moving and handling. The assessments were regularly reviewed and updated. Where relevant, people had financial forms that recorded money related activities, for example shopping, and the financial transactions. This was signed by the person using the service and the care worker.

The provider could demonstrate they had planned for different emergency situations and had a business continuity plan dated May 2017.

There were enough staff to meet people's needs and keep them safe. People we spoke with told us they had the same care workers and they were generally on time, which was confirmed by the rotas we saw. People's comments included, "We have been incredibly lucky. One of the carers has been with us the whole time", "It's nice to have the continuity of the same someone coming over a period of time", "On occasion with bad weather they have been late", "If she has a problem with the bus, she lets me know", "They come on time always" and "I give them a few minutes now and then and they let me know if they're running late." Care workers told us, "Yes I do have enough time [between calls] and if I don't, I call the office and they call the client" and "If I see I might be late, I call the office to inform the service. I might be stuck in traffic."

The service had an electronic rostering system and as soon as a new person was identified, their call times were input onto the system. The registered manager said they tried to match people and care workers by locality and preferences based on need and the initial assessment. For example we saw people had care workers who spoke the same language as they did. Once a person was in the electronic system, it automatically allocated the person's regular care worker to them each week, and identified other care workers who were able to support the person, if the first choice care worker was not available. This helped to provide continuity of care.

At the time of the inspection, the service was using paper time sheets signed by the person using the service and monitoring was carried out by phone. However the provider was moving to a new electronic system that would allow care workers to scan with their phones when they arrived and left a person's house. This would then automatically be recorded at the office and improve the monitoring of service delivery.

People using the service received their medicines in a safe way. The service had a medicines policy in place to provide guidance about the management of medicines to care workers and the service user handbook at the front of people's care plans outlined the service's medicines policy. Each person had a medicines authorisation form, confirming what type of assistance they needed with medicines and identified the care worker's role in assisting or administering medicines. This was signed by the person using the service. Medicines administration records (MAR) were all signed correctly except one MAR where the person was signing using only one initial instead of two. The registered manager asked the care supervisor to speak to the care worker to resolve the issue. We also saw medicines risk assessments for each person and MAR audits were used to identify any discrepancies so they could be investigated.

Medicines competency testing was undertaken as part of the spot check observations of care workers. It was not always clear from the records if medicines administration had been observed during the spot checks. The registered manager agreed to make the records clearer in the future. We also saw that one care worker had not been observed in the last year. The registered manager investigated this and found there had been an input error in the electronic system which generated spot check dates and for that reason the care worker's observation dates had not been flagged up by the system. This was resolved during the inspection.

People were protected by the prevention and control of infections. Care workers we spoke with said, "They always give us training around washing our hands, wearing gloves, aprons, shoe covers and arm covers. It's very important and they are very strict on that", "Always wear gloves and aprons" and "We use separate gloves for personal care and make sure everything is separate."

Requires Improvement

Is the service effective?

Our findings

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 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. We checked whether the service was working within the principles of the MCA.

We saw evidence that people had signed their care plan agreements, medicines administration forms and timesheets as evidence that they had consented to the care they were receiving. During the inspection we asked the registered manager to bring us any file with an example of a mental capacity assessment but we were not shown one. The quality assurance manager showed us a capacity assessment template but said they were not using it because they were changing to a new electronic system. The new system would record who could give consent to care and if it was not the person using the service, there would be a record of who had lasting power of attorney if relevant, or who had acted as the person's representative for a best interests decision meeting.

As we were not provided with an example of a completed mental capacity assessment or with a reason as to why one was not forthcoming at the time of the inspection, we considered the service may have be in breach of regulation 11. However, after the inspection, the provider told us that at the time of the inspection no one using the service had lacked capacity. They also provided capacity assessments completed in March and April 2018 for two people who were using the service at the time of the inspection and had since required mental capacity assessments to be undertaken. Whilst we did not have evidence about capacity status at the time of the inspection, our view of the assessments sent to us was that they were not always robust or consistent. For example, one person's assessment recorded on the first page of the assessment that the person was unable to understand, retain or weigh up information provided. However, the second page indicated the person was able to communicate and make every day decisions. This contradicted the first page. The second page went on to say the person was at high risk in areas such as self neglect, medicines, nutrition, falls and isolation but it was not clear, for example, if the person was in danger of falls because of their physical ability or because of their diminished mental capacity in this area. Additionally, the assessments were generic and not decision specific which meant the principles of the Mental Capacity Act (2005) were not always being fully followed.

New referrals were received from the local authority's brokerage team by email. The care supervisor arranged to meet with people and their families, if appropriate, to undertake an assessment of the person's needs within 48 hours. This formed the basis of a personalised care plan for each person which was updated at least annually. If there was a change in people's needs we saw this was communicated to the local authority to be reviewed and addressed.

People's needs and choices were recorded. Care records contained a profile that included information

about what was important to the person and how best to support them. Much of the information was also recorded electronically and we saw summary print outs that were kept in people's home files to provide a quick reference for care workers. It included medical information, background information regarding people's family and past history, contacts and comments for the care workers. It also provided details of what tasks care workers needed to complete with days and times.

We saw care workers had the skills, knowledge and experience to deliver effective care and support. People we spoke with told us, "They seem well trained to me. I've got really good carers. I don't feel they are just looking at the clock", "They're trained well. The one I have now is the best. She has a lot to do but she does it" and "They come and know what to do."

Care workers received an induction when they started work with the service which included shadowing another care worker for a week and training sessions. We saw a training data base that had a colour coded alert system for when care workers were due training which indicated most care workers' training was fully up to date. Medicines training, safeguarding adults, manual handling and infection control were completed annually. Care workers said, "They do encourage the carers to do courses", "We have training from time to time. Just recently we had medicines and manual handling", "I have done NVQ level 2 and been on practical manual handling two weeks ago. I have done dementia, Alzheimer's, health and safety [training]" and "I have done the level 3 diploma with the company." The in house trainer had recently left the service and the provider was planning to employ a new trainer. Care workers had completed Qualifications and Credit Framework (QCF) level 2 and the provider was planning for all new care workers to complete the Care Certificate, which is nationally recognised training based on a set of standards that gives staff new to care an introduction to their roles and responsibilities within a care setting.

Supervision and appraisal dates were generated electronically by the office computer system. Care workers said, "[Supervisions are] useful" and "My manager is firm and fair. When they call us for one to one, we come in and they explain. We sit with them and both sides are happy."

The provider also undertook unannounced observations of care workers in people's homes and made telephone monitoring calls to people to assess the care workers' competency. People using the service told us, "The office do keep in touch with me and ring me to see how the girls are doing. It's really good teamwork. The girls are ever so good" and "Every four to six months they visit and they sometimes call me." Staff who carried out on site supervision and observations recorded the key tasks being observed which included the use of equipment, care related tasks, medicines and recording, timekeeping, identified training needs and any areas to be addressed.

People's care plans contained information about their dietary and nutritional needs and what support they required. People who were supported with meal preparation told us care workers offered them choices. People's health needs were recorded in their care plan and they were supported to have access to healthcare. We saw evidence that care workers raised concerns about people's health needs with the office staff who referred the information onto the appropriate agency to action. Care worker's we spoke with said, "I meet with the district nurses for two clients because I have to tell them what I see. Sometimes I meet the doctor or physiotherapist" and "If people are unwell I check if they take their medication and call the office to see if I should call the doctor or next of kin and don't leave until someone comes."

The service worked with other teams and services to provide care including the local authority, district nurses, doctors, dentists and ambulance crews. For example an occupational therapist recently contacted the care supervisor to advise they were putting new equipment into a person's home. The care supervisor arranged for all the care workers supporting this person, to be present when the occupational therapist was

there, so they could show the care workers how to use the new equipment. In another example the care supervisor did a spot check visit and found a person required a hoist. They made a referral to social services and the person was assessed by the occupational therapist.

Good

Is the service caring?

Our findings

People using the service spoke positively about the care they received. Comments included, "They all seem very nice. They know my routines and they do more [than is in the care plan]", "Now I find it is very, very good. They're really good", "[Care worker] is like a daughter to me. She can't do any more for me", "It's a team work effort. They're really, really good", "They come in and they will ask me how I am" and "They're very helpful. I'm quite happy with what they do for me. It's a good service." People also told us there was consistency with having the same care workers.

People's care records indicated any cultural and religious needs and preferences they had, for example receiving support from a male or female care worker. One person's profile stated, 'Female carer only. Buy them a paper before each visit in the a.m.' Another person said, "It's a normal routine and I can always ask for what I want. The girls I have are very, very good. They don't mind if I ask something extra." Care workers we spoke with were respectful of people's preferences and said, "I have all different clients and I respect their wishes. Like some don't want shoes on so I respect that. Everyone eats different food and dresses differently. I respect that."

People were supported to express their views and be involved in making decisions about their care. People told us care workers offered them choices about their care and said, "I ask for what I want. I have had one carer for a year and she knows what I like" and "I tell them what I want and they do that for me." Care workers told us, "Although you read it in the care plan, you have to ask them so they have choice because they might be in the mood for something else", "You have to tell them every single thing before you do it and get acknowledgement. Some service users forget, so you have to talk to them before you start and tell them what you're doing", "I ask them how can I help you and they can say what they want. I ask them for permission. Everyone has a personality and we cannot ignore what they want." and "Anything you are doing, you need to get consent for first of all. You need to engage and involve people and if they agree you do [the task] and if they don't, it is their choice."

Care workers told us they respected people's privacy and dignity. Their comments included, "You have to think of dignity. Close the curtains. The way I want my dignity to be kept, is how I have to look after them" and "Privacy is important. If people don't talk, we can see from their reaction. We ask them and explain to them and say it's okay." One person using the service told us, "[Care workers] are very, very respectful" with personal care.

Care workers tried to promote independence and one care worker said, "The book might say they can do some things and people might not always want to. For example if someone can shower but always wants a strip wash, try to encourage them to shower. Get people to do their own buttons and dress as far as they can but make sure they're safe."

People using the service had a service user guide in the front of their care plan that provided information on what they should expect from the service and who to contact in the service and externally, for example social services, if they needed to.

Good

Is the service responsive?

Our findings

People using the service told us they received personalised care that was responsive to their needs. One person said, "[Care worker] has got very used to us and us to her. We can tell her what needs to be done and she goes above and beyond." Care plans were based on the needs recorded at the initial assessment and reflected individual preferences and interests. Care plans had an 'about me' section that included the person's gender, marital status, first language, if an interpreter was required, religion, ethnic background, next of kin and other people involved in the person's care. The outcome based care and support plan provided guidelines for care workers on how to complete tasks as required by the person using the service and the person signed their care plan to indicate they were in agreement with the content.

Reviews were completed annually or as and when required. Care workers told us, "I keep eyes on everyone and follow the care plan. We report to the office anything we see or that makes them uncomfortable", "If we report changes to the office, they come and assess and report to social services" and "When we have concerns regarding the client, we talk and we have an outcome. We have to talk to the client and next of kin." People using the service were generally aware of their care plan and said, "I think I have a care plan. Someone comes here and they ask me questions. They check the book", "They have spoken to me about the care plan and what's in it", "I have a care plan in my home but I've never looked at it but they are available" and "Eleanor goes through the care plan every six months."

The care plans did not however contain any information around people's wishes, views and thoughts about end of life care and had not been considered as part of the care planning process. We discussed this with the registered manager who said they would incorporate this into the new electronic care plans.

People we spoke with knew how to make a complaint if they needed to and told us, "I'm quite happy. I have a phone number for the office. I don't need to complain. On occasion we ring up", "I call them if there is a problem", "I wouldn't make a complaint but I have the office number if I need to" and "The office phone me. I know [staff member] is very good. I would ask them if I had a complaint." In the service user hand book at front of the care plan there was information about the complaints policy, how to make a complaint and contact numbers, so people had the information easily to hand.

The care coordinators managed the complaints, reported them to the registered manager and undertook call monitoring. Complaints were recorded electronically and included safeguarding alerts where allegations of abuse or neglect were part of the complaint. Complaints were investigated, and recorded with an outcome and supporting documents. The provider had five locations and we saw an annual complaints review for all five locations with analysis, themes, service failures, aspects of care, lessons learned and an action plan. From 2018 the provider planned to have location specific reviews.

Good

Is the service well-led?

Our findings

During the inspection we saw the provider had a quality assurance manager and systems in place to monitor service delivery. The provider carried out a number of quality assurance checks including home visits and telephone calls to ask for feedback on service delivery. Financial transaction sheets, daily logs and MAR charts were returned to the office when the log book was completed, where they were audited and signed by the care supervisor. Safeguarding alerts and complaints were reviewed and there was an annual service audit with an action plan. Ongoing requirements for care workers such as supervisions, criminal record checks and observations were recorded electronically which generated new dates and reminders. However we saw this system was not always one hundred percent accurate as one care worker had not had observations in the last year due to an inputting error.

The registered manager told us any new care files for people using the service would be checked by them and ongoing information such as review dates would be flagged by the system. However these checks were not always effective as we identified the mental capacity assessments we were shown were not always fully in line with the principles of the MCA.

People who used the service told us they received a good level of care and support from the care workers. Their comments included, "Eleanor is very, very good and that's why I am still with them. I feel a part of the agency", "I think the service is quite good. They have a job to do and they do it" and "They're efficient. In my opinion the carers I work with are very satisfactory."

Care workers we spoke with felt supported by the registered manager and the office based staff who they said were available and acknowledged their work. Comments from care workers included, "[Name] is the office manager and will send a text at the end of the day saying thank you for your work today", "They let us know if the client tells them they are happy. We get a lot of praise", "There are always people in the office to talk to and they do listen which is important. Even though they are busy, they give us time", "If I have issues I will come in and speak with the management. The support is always there. They send out texts to say we can always come in", "It's nice to get carer of the month. It gives you a little boost" and "The office staff are very good. They are grateful if you do an extra shift. We always know they are there to support us."

The provider had a positive and open culture that promoted feedback from all stakeholders. People who used the service said they engaged with it. They told us, "I have a very good relationship with them and speak to them on the phone. I let them know if there is a problem", "They do the odd phone survey and someone came around to visit us" and "I have good communication with the agency and I'm pleased with them." We also saw the provider sent out a newsletter to people to keep them informed of what was happening within the organisation.

We saw evidence of team meetings and care workers told us they could contribute and give feedback at the meetings. They said, "Carers put their views across if they are not happy. Or office staff [give feedback]. We all talk", "We all discuss what we are working [on] and doing" and "I am very happy with the teamwork. They do support us from A to Z and support us in any way we need."

The provider employed an external organisation to complete staff and service user satisfaction surveys and these included an analysis and action plan. From April 2018 the provider planned to use an online survey, with the option of a hard copy, for people using the service, their families and staff.

The registered manager had been with the organisation since 2014 and was already a registered manager at another location before becoming the registered manager at this location in February 2018. They networked with other professionals through the local authority's provider forum and registered manager forum. They received emails from CQC, the United Kingdom Homecare Association (UKHCA) and a human resources company to keep up to date with current practice. They also attended internal managers meetings with other branches to share good practice and continuous learning.

The managers we spoke with said it was a conscious decision to keep the service small and be confident in their service delivery. They worked closely with the local authority "to find solutions and to tailor the service as much as possible to individual needs". The registered manager said they looked at all the active systems daily so that they had a good overview of the service and people's needs.

The provider was making service improvements that were recorded in action plans at location level and organisational improvements such as a new electronic system that was being piloted from March 2018. The new system would include care workers provided with phones to access all service users' records remotely including assessments, reviews and daily log books on line. The new system would provide live monitoring and raise an alert if tasks have not been completed. People using the service and relatives who have permission would also be able to log in to the electronic records system and see their records.