

Ebenezer (Stone of Help) Ltd

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Ebenezer (Stone of Help) Ltd is a domiciliary care agency. It provides care for people living in their own houses and flats. People are supported in their own homes so that they can live as independently as possible. CQC regulates the personal care and support. There were four people using this service at the time of our visit.

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

Risk to people were not always assessed and actions taken to mitigate the impact. Medication was not always managed safely and where mistakes had been made, management did not have oversight to make improvements.

Staff recruitment was safe, however, staff training was not always delivered in a timely manner. Staff had not received essential training which was specific to the care needs of the person they were supporting.

Staff supervision was not carried out regularly and varied in the quality of the content. Staff competency was not checked adequately.

The service lacked management oversight, managers did not carry out audits and checks on all aspects of the service. This meant that they were not monitoring the service effectively.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. We could not see evidence of where people were supported to have maximum choice and control as staff were not trained effectively to deliver effective, person centred support to meet the needs of people using the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The last rating for this service was good (published 19 February 2019).

Why we inspected

We received concerns in relation to staff training and the management of complex needs and behaviours which challenge. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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, Effective 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 Ebenezer (Stone of Help) 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 monitor the service and 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 two breaches in relation to safe care and treatment and governance 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 for 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 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?

The service was not always Safe.

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always Effective.

Details are in our Effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always Well-Led.

Details are in our Well-Led findings below

Requires Improvement ●

Ebenezer (Stone of Help)

Ltd

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 carried out by one inspector, a specialist nurse advisor 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.

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

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 the service 24 hours' notice of the inspection. This was because the service is small and we wanted to ensure that there would be staff in the office to speak with us.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included checking incidents the provider must notify us about, such as serious injuries and abuse. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well,

and improvements they plan to make. This information helps support our inspections. We used this information to plan our inspection.

During the inspection

We reviewed a range of records. This included all or parts of records relating to the care of four people as well a range of staff files. We also viewed training and supervision records and records relating to the safety and management of the service.

The Expert by Experience spoke with four relatives and asked them about the quality of the care provided to their family members. They also spoke with six care staff on the day of the inspection.

After the inspection

We spoke with the registered manager and asked them to provide us with a variety of additional information. All information was sent within the required timeframe. We used all this information to help form our judgements detailed within this report.

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.

Assessing risk, safety monitoring and management, Learning lessons when things go wrong

- Risks were not managed. Not all risks had been assessed and actions had not been taken to mitigate risk. One person had two topical creams, and both were inflammable. There was no risk assessment in place to warn staff that this posed a serious risk if the person was exposed to a naked flame. The registered manager sent a risk assessment through after the inspection.
- People who presented with distressed behaviours had not always been supported to manage these well. This placed the person and staff at risk. We saw an assessment document for one person from a healthcare professional. This stated that the person could lash out if someone became too close. This was not translated into the care plan, risk assessed or brought to the attention of the staff. This had resulted in a staff member being hit by the person because they were too close.
- Health rated risks were not managed safely. An epilepsy recording chart was in place for one person but gave minimal information on actions before, during and following a seizure.
- Opportunities to learn from adverse incidents had been missed. We looked at accident and incident records. They did not contain adequately detailed information and management did not audit the documents to ensure that lessons could be learned and they could reduce future risk.
- Staff had not received accredited training in supporting people with complex behaviours and this posed a risk to people with staff being unable to keep them safe from avoidable harm. Staff did not have the skills to de-escalate a situation and keep people safe.
- We could not find evidence that staff had received training in practical moving and handling or resuscitation. The lack of effective training put people at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely. Not all staff had received competency assessments had recently been introduced but had only been carried out on two staff. We were told that these would be embedded, and all staff trained in medication would have their competency assessed.
- Medication administration records (MAR) were not completed correctly. Signatures had been crossed out and in some cases medication had been crossed out without any explanation and no code was used which would have identified the reason on the record. When medicated is altered or discontinued it should be signed by two staff members and a reason given.

The failure to mitigate risk and keep people safe is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Referrals had been made to safeguarding and there were several safeguarding investigations ongoing at the time of our inspection.
- Not all staff had been trained in safeguarding adults, however, staff told us that they would be confident to report any safeguarding concerns and knew how to spot the signs of abuse.

Preventing and controlling infection

- Staff had received training in infection control and how to prevent the spread of infection such as effective hand washing. However, there was no evidence that staff had received training in COVID-19 and preventing the spread of infection.
- Staff were supplied with personal protective equipment this was provided to each member of care staff and replenished regularly.

Staffing and recruitment

- There were enough staff available to meet the needs of the people using the service. Most staff who we spoke with told us that they felt that there was enough staff to provide support to people. The manager told us that staff were calculated to the needs of people using the service.
- The provider had ensured that new staff undergone safety checks for working with vulnerable people. These included criminal records checks, references and proof of identity.
- Staff were not asked service specific questions at interview. This posed a risk that people recruited had no knowledge of what the position entailed.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Important information on people's health needs were not always translated to documents shared by other professionals. We saw that people's needs had been assessed but this had not been translated into the hospital grab sheet. This meant that if a person was admitted to hospital, healthcare professionals did not have full details. For example, one person was diagnosed with dysphasia and was at risk of choking. This information was in the care plan but not in the information for hospital admittance.
- People's health needs were assessed and monitored, professionals were involved in people's care and treatment and their care plans and risk assessments did not always reflect this.

The failure to ensure information on health needs is contained in documents shared with other professionals is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Assessment of people's needs, included protected characteristics under the Equality Act 2010, had been completed. For example, people's marital status, religion and ethnicity was recorded. This is important information to ensure people do not experience any discrimination.

Staff support: induction, training, skills and experience

- Staff had not received the required training or support for their roles.
- One staff member said "I get worried but there is no support, there is no support for new staff, new staff come and they haven't read the care plan."
- Staff training was being carried out but there were several training courses which very few staff had completed. Only five staff had received practical training in moving and handling which posed a risk to people using the service who required specialist equipment to transfer.
- Staff training in specific health conditions was not always offered. Staff training in dysphasia (choking risk) had not been delivered until after the inspection had taken place. This posed a risk of staff having poor knowledge of how to effectively support a person who used the service who was at risk of choking.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not always supported to eat healthily. We could see that care plans contained information on healthy eating. However, one family member told us ready meals were "heavily relied upon because of the lack of cookery skills of some staff". The frequent use of ready meals did not support healthy eating. One staff member told us "We do support healthy eating, but ready meals are used a great deal."

- One relative told us, "One staff member cooks everything fresh, we like it when they are on duty." Another told us that they cooked and delivered the food as family and food was important to their culture.

Staff providing consistent, effective, timely care

- Relatives told us that their family member received support that met their needs from a consistent team of staff.
- One relative said "the staff are ones that do care, they are not just in a job. Each staff member brings something different to the table, I am very lucky with the care for [name], it is a nice balance and they all get on".
- Staff told us that they felt they worked effectively in small teams to support a person effectively. Staff who we spoke to told us that they felt supported and would ask for help if they needed to.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of those who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

- We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that one person had been authorised with no conditions.

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

- Systems to improve the quality and safety of the service were not effective. We saw that medicines management was not effectively audited and also incidents and accidents records lacked detail including body maps and information on behaviour prior to the incident. The lack of oversight meant that they would be unable to identify themes which may prevent the same incident occurring again.
- At the time of our inspection the registered manager was not available. We spoke with the registered manager after the inspection and they told us how they were making improvements and developing their management oversight. This was not fully evident at the time of our inspection and would need time to embed.
- The provider and registered manager had not assured themselves that staff had the required competencies to care for people safely. They had not conducted regular observations of staff, even when some training had been delayed due to COVID-19. This meant that people were at risk of receiving poor care and treatment.

The lack of management oversight and effective systems in place to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were confident to raise issues when they needed to. One relative we spoke with told us that they would speak to managers if they felt that anything was wrong.
- People told us that the staff were helpful and responded to any concern

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 manager was aware of compliance with duty of candour and we found that they were open and honest when we requested information.
- We saw that complaints had been addressed and responded to in a sympathetic manner and the registered manager had apologised when the service had been responsible.
- The provider accepted the feedback from the inspection and was improving ways of working, information

was sent after the inspection to evidence improvements.

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

- We saw that one person had no verbal communication and picture cards and objects of reference were used to communicate.
- Relatives told us that they received a telephone call weekly from the registered manager to update them.
- The provider did not obtain feedback from people using the service or their relatives to understand how well the service was being provided and whether they could improve it. One relative told us that they received updates by phone but were not asked for an opinion.

Working in partnership with others

- We saw in care planning where professionals had been referred to. This included the GP, district nurses and speech and language specialist.
- We reviewed meeting minutes which the provider had with the local authority and safeguarding, supporting the service to improve. At the time of our inspection the suggested improvement had not all been made.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider failed to have sufficient systems in place to manage and mitigate risk including staff not being trained in healthcare needs that they were required to support.</p>

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed to have effective management oversight including ensuring staff were trained and managed and that systems were in place to audit quality of the service delivered.</p>

The enforcement action we took:

Warning notice