Elmar Home Care Limited

Rectory Gardens

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rectory Gardens (known to people as Elmar Home Care) is a domiciliary care agency and provides personal care and support to people who require assistance in their own home. At the time of our inspection there were 113 people being supported by the service.

People's experience of using this service and what we found
Staffing levels and rota systems were unsafe. People's calls were significantly late, early, short or missed. People and their relatives told us staff were often late or missed calls completely. Pre-employment checks had not been carried out to ensure staff were suitable to support people.

Risks to people were not adequately assessed to keep them safe. Medicines were not safely managed. Medication administration charts were not audited correctly, and action was not taken to address errors promptly.

There was a lack of oversight, scrutiny and governance by the manager and nominated individual. Checks and audits were not effective and / or not completed to monitor the quality and safety of the service. People and staff had provided feedback to the registered manager; however, no action had been taken to analyse this or take any action.

People's care was not planned to ensure staff received guidance on how to provide people with caring, dignified support. Care plans failed to identified people's individual preferences and were generic in nature.

People's needs and choices were not recorded to give staff appropriate guidance to care for them. Staff did not always receive sufficient training to help them carry out their roles. Multiple training topics were covered in one day induction, meaning staff were not provided with enough time to develop their learning.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection
This service was registered with us on 21 July 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about a closed culture, allegations of abuse and neglect and poor managerial oversight. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe, effective,

caring, responsive and well led sections of this full report.

Enforcement
We have identified breaches in relation to person centred care, need for consent, safe care and treatment, good governance and staffing at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rectory Gardens

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 carried out by two inspectors, a medicines 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 a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 9 February 2023 and ended on 17 February 2023. We visited the providers offices on 9 February 2023.

What we did before the inspection
We reviewed information we had received about the service since registration. We sought feedback from the local authority and safeguarding 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 spoke with 4 people who used the service and 17 relatives about their experience of the care provided. We spoke with 15 members of staff including the provider, managing director and registered manager. We looked at 8 people's care records and multiple medication records. We looked at multiple staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including training data and medicines audits were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● Staffing levels and rota systems were unsafe. The provider's electronic call data demonstrated clear and widespread evidence of significantly late, early, short and missed calls.

● There was systemic and widespread evidence of unsafe practice. Staff were scheduled to be at multiple calls at the same time or back-to-back calls without any time for travel. We found 50% of calls were either scheduled with no travel time or at the same time as other calls. This meant it was inevitable people's calls would be late or missed and staff stayed for less time than scheduled. Across the service, more than half of people's planned care time was not delivered.

● We saw multiple examples of rotas which were impossible for staff to follow which severely impacted on people's planned care. For example, one care worker was scheduled 24 calls in a day from 7am to 9.30pm, no travel time was provided. We found this staff member was scheduled to care for multiple people at the same designated times.

● People and their relatives told us staff were often late or would rush calls. People commented, "They [care workers] don't stay for the full hour that they're supposed to, they are basically in and out" and "I would say it's a middle kind of service. Some of the carers seem very rushed, they don't always stay for the full amount of time."

● People's relatives were also critical about the times and duration of calls. Comments included, "Sometimes they don't turn up at all, usually on a Friday when it's not the regular carer. I phone the office and they will say 'I don't know what's happened- we'll knock it off your bill" and "A few times recently they haven't turned up at night."

The provider had failed to deploy sufficient numbers of staff to make sure they could meet people's needs. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A framework was in place to support safe recruitment practices. However, the administration of pre-employment checks was not consistent. For example, professional references were not always obtained when a candidate had previously worked in care, and gaps in employment history were not explored.

Safe recruitment of staff was not followed. This placed people at risk of harm. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not managed safely. A medicines policy was in place at the service, although this was not being followed.

● Staff completed training and had their competency assessed for the safe administration of medicines. Although training had not been completed for more complex medicines administration which required medicines to be administered via the PEG (percutaneous endoscopic gastrostomy) feeding tube. Following our inspection, training was arranged for staff to attend.
● Medicines care plans were completed when a person was accepted into the service, although these were not kept up to date. Some care plans contained conflicting information on how and when to administer medicines and if people required a thickening agent in their drinks to reduce the risk of choking.
● Medicines administration records (MARs) did not always include important information. For example, the name of the person the MAR belonged too. People's allergies were not recorded on the MARs we reviewed. Medicine names where spelt incorrectly, and wrong doses were handwritten. There was no additional information on the MAR's to assist staff to administer the medicines correctly, for example if they needed to be taken with food.
● Prescribed creams were not on the MAR's and there was no evidence seen in the daily notes to say that creams had been applied as prescribed. Therefore, we could not be assured that they were being applied.

The provider had failed to ensure the safe and proper management of medicines. This is a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management.
● People's individual risks had not been assessed in any great detail at times.
● During the inspection we spoke with one person who was distressed on the telephone because a staff member had not fully supported them to get dressed. Supporting this person with getting dressed was a key aspect of their care they struggled to manage themselves. We found the care worker had completed the scheduled 45-minute call in just 12 minutes. We shared this concern with the provider.
● We identified limited detail within care plans and risk assessments for people with diabetes, pressure sores, continence support and people living with dementia. This meant staff may not identity or know how to respond to symptoms associated with these healthcare conditions to keep people safe. This placed people at increased risk of harm.

There was a failure to provide safe care and treatment by not managing known risks to people which put them at an increased level of risk. This 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
● Systems in place did not effectively safeguard people from the risk of abuse.
● People were not safeguarded from the risk of abuse, particularly neglect due to late, early, short and missed calls.
● We made a safeguarding referral to the local authority regarding a concern for a person's safety during the inspection.

Learning lessons when things go wrong
● Systems were not in place to ensure lessons were learned when things went wrong, for example with medicines and call times.
● The provider did not learn from complaints raised about the service. We found similar themes of complaints reoccurred.
● Despite this, people told us they felt safe when receiving care from staff. One person said, "No they [care workers] don't always stay for the full amount of time. However, I do feel safe with all the carers, I have never had reason to feel that they put me at risk."

● Staff we spoke with understood their responsibilities to report any concerns for people's wellbeing and safety.

Preventing and controlling infection

● People and relatives raised no concerns around staff practice in relation to infection control. They confirmed staff wore personal protective equipment (PPE). Office staff ensured staff had all the correct equipment they needed to support people.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
- Staff were not always sufficiently competent or skilled to carry out their roles.
- Staff were not trained in all topics required to safely meet people's individual needs. It was not evident that not all staff had received PEG training, food hygiene, dementia awareness or diabetes training.
- New staff received a 1-day induction prior to starting work at the service. We questioned the quality of this induction as there were a number of topics and training courses needed to be undertaken. This meant staff were not provided with enough time to develop their learning.
- People and their relatives were also critical of some of the staff team's skills. Comments from relatives included, "I'm not sure how much training they [care workers] have about dementia, they seem inexperienced."

The provider had failed to ensure that staff were suitably competent, skilled and experienced to support people effectively. This was a breach of Regulation 18(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was system in place for regular supervision. We received positive feedback from the staff team in respect to the support they received. Comments included, "The support from the office managers is great. Always very helpful" and "I feel well supported, I like my job."

Ensuring consent to care and treatment in line with law and guidance
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 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 checked whether the service was working within the principles of the MCA.

●The provider was not working in line with the principles of the MCA. They were unable to evidence that people's rights under the MCA were being protected. Assessment and care planning processes did not always consider people's capacity to consent to care and treatment.
● Where people's capacity was in doubt, the provider had failed to ensure decision specific capacity assessments were carried out.
● We asked staff about their understanding of the MCA and they did not have appropriate knowledge and understanding around capacity and consent and there was no evidence they had received training.

The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with. This is a breach of Regulation 11(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care
● Staff did not always have sufficient guidance in place to ensure people's health needs were met in a consistent and safe way. For example, people's health conditions were listed within their records, however the provider had failed to include any further guidance on how to support people with these conditions. This placed people at risk of not receiving care in line with these needs.
● People's care and support was planned, however, support plans required further work to make them relevant and person centred.

Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet
● People and relatives provided us with a mixed view about the support people received with their eating and drinking needs.
● We received negative feedback about the cooking skills of some staff from people and their relatives. One person told us, "I don't get the carers to prepare my food. I am not very confident about the staff's ability to prepare food."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● People were not supported to be involved in decisions about their care. Care records did not contain any detail about people's cultural or religious needs.
● People and their relatives told us that they had not received regular reviews to discuss their care and express their views. A relative told us, "We have never been asked for any feedback on the service. Some feedback opportunity or other involvement with how things are going would be good." Another relative said, "They haven't looked at doing a care plan review no."

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
● We found the care staff team to be well intentioned towards people. People gave us numerous examples of where the staff team demonstrated a caring nature towards them. One commented, "The regular carer is kind and always asks how I am too. [Care workers name] also asks if there is anything else she can do."
● However, the approach to care delivery was not always dignified. We found instances where care had not been provided at the correct allocated times, which at times impacted people's dignity. For example, one relative told us that due to late visits their family member had been incontinent, which impacted on their dignity.
● People's care plans did not contain information about how staff should promote people's independence or maintain their dignity. Where people required support with their mobility information about how this should be done safety had not always been considered, which placed people at risk of receiving care that was undignified or unsafe.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant services were not planned or delivered in ways that met people's needs.

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

- People's care plans were not person-centred and lacked detail to direct staff on how to support them with their individual needs.
- There was little or no background information about people or their choices, likes and dislikes. Information to support staff to understand people's individual health conditions was not detailed within the care plan records.
- A small number of people's relatives explained gender specific care was not always provided. In one case an untoward incident occurred. This person's relative was upset as their preference for a male care worker was not adhered to and exposed the person to a situation that could have been avoided.
- Care plans contained contradictory and inaccurate information and lacked enough detail for staff to provide person-centred, safe and effective care. For example, 1 person's care plan stated they received 4 calls a day, however after further feedback from the provider we identified this was changed to 2 calls, however the care plan had not been updated.

The provider had failed to ensure people were provided with individualised care and choice. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008/ (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs had been considered as part of the initial assessment. This was documented, however there were no individual plans in place for people stating how they may choose to communicate and the level of support they may need with this. For example, we were aware 1 person was unable to verbally communicate, their care plan did not consider other ways the person may communicate.

Improving care quality in response to complaints or concerns

- People and their relatives had access to a complaints policy should they wish to raise any concerns. The complaints policy detailed who to contact if people or their relatives were not happy with the service.
- Within the last 6 months we noted there had been a high volume of complaints. The management team said they took complaints and concerns seriously and identified some themes. However, there was no

further analysis of complaints or satisfaction with responses about the service that could be used as a means of continuously reviewing performance, quality and safety.

End of life care and support

- The service was not supporting anyone with end-of-life care at the time of our inspection.
- People's care plans lacked information regarding their end-of-life wishes and preferences. We discussed the need for consideration of advance care planning with the management team. They told us end of life care was an area they were looking to develop at the service going forward, this had also been identified in their action plan.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There were widespread shortfalls in the day to day running of the service, leading to multiple breaches of regulation. There was a lack of oversight and scrutiny of the service by the senior management team.
- We found the registered manager had little oversight of the day to day running of the service and worked at the providers other location based in Yorkshire and stated they just visited the service twice a month. There was an over-reliance on senior staff members to run the service.
- Quality assurance processes and audits were limited and checks on the quality of the service tended to be completed by coordinators. There were multiple unexplained gaps in medicines records, and some people's daily notes did not record the times calls took place so there was no audit trail.
- The provider's approach towards staff rotas and call scheduling meant it was inevitable people's care needs would not be safely and effectively met or not met at all. A poor culture had developed at the service, and it became accepted practice to shorten people's calls in order to fit everyone in.
- Record keeping in relation to people's daily care was at time illegible to read, lacked detail and completeness. Daily records were not reviewed by the management team in order to improve the quality of daily notes.

The provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17(1) 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

- Improvements were needed to ensure people consistently received empowering, high-quality care and good outcomes. The provider had failed to develop a positive, person centred culture.
- The organisation of the staff rotas demonstrated a disregard for people's needs and resulted in a culture of rushed calls, which impacted the quality of care provided.
- People and relatives provided us with a mixed view regarding how well-led the service was. For example, comments included, "I don't have much contact with the office staff and at weekends it can be hard to contact anybody as they don't open the office on Saturdays and Sundays. That can be difficult, and I feel they should be open. It's hard to get through" and "I'm not sure the managers know how to organise the carer's rotas and they can be sent all over the place, but they are too young and sweet to challenge the managers on this. I can't get my head round the management structure."

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 registered manager and nominated individual lacked awareness of their statutory responsibilities in relation to safeguarding and statutory notifications to inform CQC of certain changes, such as applying to relocate the registered office. These matters will be followed up outside of the inspection process.

● Systems and processes were not in place, so we could not be sure they would identify when things had gone wrong and be able to respond accordingly.

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

● The service obtained feedback from staff and people about the service. However, feedback provided was minimal and the registered manager did not use this feedback in order to improve the service.

● There were systems to keep people and their relatives updated and informed. Staff meetings were held monthly to share information. The meetings kept staff updated with any changes in the service and allowed them to discuss any issues or areas for improvement as a team.

Continuous learning and improving care; Working in partnership with others

● The nominated individual was open to inspection feedback and recognised they needed additional support. They told us they would work to improve the quality of care people received.

● The nominated individual agreed to not accept any new packages of support until the service was in a better position. A new experienced manager was soon due to be appointed.

● Where people received support from external professionals, the service had worked with them where possible.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people were provided with individualised care and choice.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured safe recruitment practices were followed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of staff to make sure they could meet people's care and treatment needs. This placed people at risk of harm. And The provider had failed to ensure that staff were suitably competent, skilled and experienced to support people effectively.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe and proper management of medicines. And There was a failure to provide safe care and treatment by not managing known risks to people which put them at an increased level of risk.

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Warning notice.