

EMH Care and Support Limited

Wright's Court

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	Inspected but not rated
Is the service well-led?	Inspected but not rated

Summary of findings

Overall summary

About the service

Wright's Court is a domiciliary care agency. It provides personal care to people living in their own homes within a supported living service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care which includes help with tasks related to personal hygiene and eating. Where people do receive personal care we also consider any wider social care provided. At the time of the inspection eight people were receiving personal care.

People's experience of using this service and what we found

Systems and processes to ensure oversight of the service, did not always effectively identify issues; audits had not identified the concerns we found on the day of inspection. However, the provider had created an action plan due to shortfalls highlighted through their internal governance arrangements. At the time of this inspection the action was in the process of being implemented.

People and staff told us there was not always enough staff on duty. Staff were often late to calls and people did not know which staff were due to support them. Staff were not clear on their roles and responsibilities and staff required additional training to ensure they could meet people's needs.

The provider did not have all the necessary risk assessments in place for people's known risks. Care plans were not sufficiently updated and didn't always contain information staff would need to meet all of people's current care needs.

Systems in place to record safeguarding incidents and to identify areas of improvement were not effective. Staff did not always follow the providers procedures. Therefore, some incidents had not been escalated appropriately.

Medicine management systems were not effective. People had not always received their medicines as prescribed. The provider was in the process of changing medicine systems.

People told us they knew how to make a complaint. There were procedures in place for making compliments and complaints about the service. However, the provider had not consistently responded to or investigated all of the complaints that had been made.

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 3 December 2019 and this is the first inspection.

Why we inspected

We received concerns in relation to the management of support hours, training and medicines. As a result,

we undertook a focused inspection to review the Key Questions of Safe 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.

We have found evidence that the provider needs to make improvements.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We have identified breaches in relation to safe care and management oversight.

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.

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

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.

Inspected but not rated

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Inspected but not rated

Wright's Court

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. An Expert by Experience phoned people and their relatives the day after the site visit. 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. This service provides care and support to people living in two 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

There was not a registered manager in post at the time of inspection. A manager was being recruited but had not yet registered. This means only the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced; however, we phoned the service before entering. This supported the service and us to manage any potential risks associated with Covid-19.

Inspection activity started on 6 August 2020 and ended on 17 August 2020. We visited the office location on 6 August 2020. People and relatives were contacted on 7 August 2020. We spoke with staff to on the 7 and 17 August 2020.

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. We used all of this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the head of supported housing, team leader, and care workers.

We reviewed a range of records. This included four people's care records and multiple medicine records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 time we have inspected the service and we have not been able to give a rating as there was insufficient information to enable us to make a judgement.

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

- Staff did not always follow the provider's procedures when safeguarding incidents or complaints were identified. Not all incidents and complaints had been investigated as the information had not been escalated in line with the provider's and safeguarding procedures.
- People who were at risk in specific areas did not have risk assessments in place. For example, risk of harm from dropping a cigarette or certain manual handling situations. This meant that staff may not be aware of the risks or know what strategies were needed to keep people safe.
- People who had an identified risk of scalding did not have their water temperature checked consistently before being supported to bath or shower. This put people at risk of scalding.
- People were at risk of unsafe medicine administration. Staff did not record clearly when people's medicines were required. For example, one person's medicines chart was unclear if a medicine was 'as required' or if the medicine was to be given four times daily.
- When staff had transcribed medicines onto people's medicines charts, there was not always enough information recorded and best practice guidance was not always followed. For example, two staff had not signed when they transcribed medicines. Another person's chart did not contain the person's name, date of birth or their allergies. This put people at risk of receiving the incorrect medicines.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. The provider had failed to ensure people were protected from the risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had completed an action plan that identified areas of concern we found during inspection. The action plan was in the process of being implemented, however not all actions had been completed at the time of inspection.

- People told us they felt safe at Wrights Court, and that staff supported them with ordering and collecting their medicines. One person said, "Staff take care of my prescriptions in time; they have an ongoing delivery. Never had to wait or worry about that."

Staffing and recruitment

- People did not receive their care at the planned times. People and relatives told us that staff regularly turned up at the wrong time. One person said, "Staff don't always come every day. I have to go and find someone sometimes." Another person told us, "[Due to health reasons] I need a routine, it is essential. I am

down for a call at [time], but now it is more like an hour and quarter late, so by the time I get to eat it's not good [for health reason]."

- The provider did not ensure there was a regular rota, or ensure people received care from staff they knew. People told us that they rarely knew which staff would be coming to support them. One person told us, "I never know who is coming."
- The provider had an action plan in place to improve the times of care calls and to support people to know which staff would be attending. However, these actions had not been started during the inspection.
- People and relatives thought that staff required more training. One person told us, "I think staff need training in mental health, they don't have it." A relative told us, "I feel the staff they have, which is agency a lot of the time, just do not have the skills or training."
- Safe recruitment and selection processes were followed. Staff files contained all the necessary pre-employment checks, including references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Preventing and controlling infection

- Staff were seen wearing the appropriate personal protective equipment (PPE).
- People told us that staff followed infection control procedures. One person said, "Staff always wear gloves and aprons and masks."

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 time we have inspected the service and we have not been able to give a rating as there was insufficient information to enable us to make a judgement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service did not have a registered manager in post. Staff told us, the communication was poor and there were too many 'managers'.
- The provider had failed to implement effective governance systems or processes to effectively assess, monitor or drive improvement in the quality and safety of the care being provided. Systems to monitor quality assurance and audits were not robust. The manager had not identified the issues such as staffing, staff training, medicines management and reporting incidents found during inspection.
- The provider had not carried out audits for medicines, incidents and call logs. This meant they did not have systems in place to identify or rectify issues.
- The systems in place to review and monitor people's care plans and risk assessments were ineffective. People's risk assessments and care plans contained conflicting information about areas of risk in their lives. Risk assessments were not fully completed.
- People did not receive their planned care as staff were unclear on who they should be supporting, the rota and allocation of staffing was disorganised and not clear. Staff did not receive regular supervisions.
- People were at risk of receiving care from staff who did not have the training to meet their needs. Staff had not received appropriate training to support specific needs. For example, not all staff had training in mental health, self harm or communication, but were expected to support people with these needs.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate monitoring and oversight of the service. The provider did not have effective arrangements to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance.

The provider had completed an action plan that identified areas of concern we found during inspection. The action plan was in the process of being implemented, however not all actions had been completed at the time of inspection.

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

- We saw no evidence that complaints had been responded to in line with the providers policies.

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

characteristics

- People and relatives told us they were not asked to feedback on the service delivery. One person said, "They don't talk about me and what I think about my support." A relative told us, "Apparently a new manger is to be in place from September. But we are not fully advised of these things. We are definitely not contacted regularly by the service."

Continuous learning and improving care. Working in partnership with others

- The provider was implementing a keyworker system to support learning and improvement of care.
- The provider was working with partner agencies to improve care.

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 Systems were not in place to ensure the safety and welfare of the people in the service.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance systems were either not in place or robust enough to assess, monitor and improve the quality of the service.