Embrace Uk Community Support Centre

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Inspection report

Selby Centre
Selby Road
London
N17 8JL

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25 April 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Embrace UK Community Support Centre is a domiciliary care agency. It provides personal care to people living in their own flats and houses in the community. At the time of this inspection 40 people were receiving personal care and support.

This inspection took place on 23 and 25 April 2018 and was announced. This was the first inspection of this service since they became registered in 2012. The service has only been operational for nine months.

There was a registered manager for the service who was also the provider. 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.

Staff were knowledgeable about safeguarding and whistleblowing procedures. The provider had safe recruitment processes in place. There were enough staff to ensure visits to people were not missed. Risk assessments were carried out to mitigate the risks of harm people may face. There were systems to manage people's medicines. However, medicines taken as needed were not always fully recorded. People were on the whole protected from the risks associated with the spread of infection but occasionally staff did not have access to enough personal protection equipment.

People had an assessment of their needs to ensure the provider could meet their needs. New staff received induction training at the start of their employment and staff were offered refresher training to maintain their skills. Staff were supported with regular supervisions to ensure they could deliver care effectively. People were supported to eat a nutritionally balanced diet and to maintain their health. The provider and staff knew about their responsibility to obtain consent from people before delivering care.

Staff described how they developed caring relationships with people they supported. People and their relatives were included in the care planning process. Staff were knowledgeable about equality and diversity. People's privacy and dignity was promoted and their independence was maintained.

Care records were personalised and contained people's preferences. Staff understood how to deliver a personalised care service. The service had a complaints procedure. People and their relatives knew how to make a complaint if they were not happy with any aspect of the service.

People and their relatives spoke positively about the management of the service. The provider had a system to obtain feedback from people and their relatives about the quality of the service in order to make improvements where needed. Staff had regular meetings so they could contribute to the development of the service. The provider carried out spot checks and quality assurance checks of the work of staff to monitor the quality of the service being delivered. The provider worked with other agencies to share good practice and find ways to make improvements to their service.

We have made three recommendations regarding safe management medicines, controlling the risk of spread of infection and effective quality assurance.

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. Staff knew what actions to take if they suspected a person was at risk of harm. People had risk assessments in place to mitigate the risks they may face.

The provider had safe recruitment processes in place. People received their regular medicines as prescribed. However medicines taken as needed were not always fully recorded.

The provider had systems in place to protect people from the risk of the spread of infection. However there were occasions when staff were not provided with enough personal protective equipment.

The provider worked jointly with other agencies to reduce the occurrence of incidents.

Is the service effective?

Good

The service was effective. People had a robust care needs assessment before they began to use the service.

Staff were supported with training opportunities and supervisions in order to provide people with effective care.

People were supported with their healthcare needs and to meet their nutritional dietary needs.

Staff were knowledgeable about obtaining consent before delivering care.

Is the service caring?

Good

The service was caring. Staff described how they developed caring relationships.

People and their relatives were involved in care planning.

Staff demonstrated they knew about meeting people's equality and diversity needs.

People's privacy and dignity was promoted and their independence maintained.

Is the service responsive?

Good

The service was responsive. Staff knew how to provide personalised care.

Care plans were personalised and contained people's preferences.

People knew how to complain and the provider had a system to handle complaints.

Is the service well-led?

Good

The service was well-led. People and relatives spoke positively about the registered manager.

The provider had a system of obtaining feedback from people who used the service.

Staff had regular meetings with the provider to be updated on good care practices. The provider carried out regular unannounced visits to observe staff working.

The provider had systems to monitor the quality of the service provided. However the provider did not always record these checks when there were no issues identified.

The provider worked in partnership with other agencies to share good practice.

Embrace UK Community Support Centre

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 inspection took place on 23 and 25 April 2018 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure someone would be in. This was the first inspection of this service since they became registered in 2012. The service has only been operational for nine months. One inspector carried out this inspection.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority to obtain their view about the service.

During the inspection we spoke with the registered manager, reviewed four people's care records including risk assessments and care plans, and reviewed four staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation. After the inspection we spoke with three people who used the service, two relatives and three staff members.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. The provider had a safeguarding policy which gave clear guidance to staff on how to raise concerns if they suspected abuse. There had been no safeguarding incidents since the service became operational. The provider had a whistleblowing policy which gave guidance to staff on what whistleblowing was and the protection a whistleblower could expect to receive. However, we noted the policy omitted to mention that staff could potentially whistleblow to the local authority or the Care Quality Commission (CQC) if they did not feel confident of disclosing concerning information to the provider.

Staff were up to date with their safeguarding training and demonstrated they were knowledgeable about how to report abuse. One staff member told us, "You have to go to the office and let somebody know." Another staff member said, "I have had the safeguarding training. I would have to call the office and document what I saw." A third staff member told us, "I have zero tolerance to abuse. It's not acceptable. If you see something is not right you need to blow the whistle. I can discuss with my line manager or social services or CQC." This meant the provider had systems in place to safeguard people from abuse or harm.

People had risk assessments as part of their care plans regarding their care and support needs. Risk assessments included clear actions for staff to mitigate the risks. People's risk assessments included clear action for staff to mitigate the risks. People's risk assessments included skin integrity, mobility and falls, and the environment. Risk assessments for the environment included lone working for staff, street lighting, weather, electrical, fire and emergency evacuation.

One person's environment risk assessment included, "[Person] has a camera controlled entry system and can see whoever is coming. Is able to open door using remote control. No awkwardness in floor level and no trip hazards." We noted another person's risk assessment stated, "The shower is together with the bath. There are no grab rails for [person] to hold onto." We discussed this with the registered manager who told us they had arranged to have a conversation with the social worker to discuss this issue and to arrange for a referral to an occupational therapist. This meant the provider had taken steps to mitigate the risks that people and staff may face.

The registered manager told us they could support people with shopping but at this time there was nobody who needed this. The provider had a policy for handling people's money which gave clear guidance to staff about recording transactions on a record sheet and obtaining receipts for items purchased. This meant the provider had a system in place to protect people from financial abuse.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had been given written references. New staff had criminal record checks (DBS) to confirm they were suitable to work with people and the provider had a system to obtain regular updates. This meant a safe recruitment procedure was in place.

People and their relatives told us visits were never missed and only occasionally were staff late due to traffic incidents or delays during a previous visit. The registered manager told us customers signed staff timesheets to confirm attendance and since they became operational there had not been any missed calls. The provider had invested in new technology to make it easier to monitor staff attendance and timekeeping. The new system would introduce a bar code kept on each person's care file within their home and the care worker would scan the bar code to indicate the time they arrived and the time they left the visit. The registered manager told us the new system would run alongside the timesheet signing system and would show up any differences to the written timesheets which would be addressed in staff supervisions. This showed the provider had taken reasonable steps to ensure people received their planned visits.

Each person who needed support with their medicines had a medicine risk assessment which stated where the person's medicines were kept and who was responsible for collection from the pharmacy. For example, one person's medicine risk assessment stated, "[Family member] arranges and collects medicine from pharmacy. District nurses help with medicines so care workers do not need to do so."

Records showed medicines were given to people by appropriately trained and competent staff. The provider had a medicines policy which gave clear guidance to staff about their responsibilities regarding medicines management.

People had separate sheet in their medicine booklet listing each tablet in the blister pack and what each tablet was for. We reviewed medicine administration record (MAR) charts which had been returned to the office at the end of each month for auditing. These showed appropriate arrangements were in place for recording the administration of medicines. Staff had signed to indicate the medicines had been administered. There were no gaps in signatures indicating people had received their medicines correctly.

People who required 'pro re nata' (PRN) medicines had clear guidelines in place. PRN medicines are those used as and when needed for specific situations. However, we noted for one person's PRN medicine for constipation the GP had stated on the prescription that one or two tablets could be administered. However staff did not indicate on the MAR sheet how many they had administered. The registered manager explained that the person had capacity to decide how many they needed on each occasion. We recommend the provider seeks advice and guidance on effective medicines management.

The provider had an infection control policy which gave guidance to staff on how to prevent the spread of infection. Records showed that staff had received training in infection control. People told us staff cleaned up after themselves before they left the visit. However there was mixed feedback from staff about the availability of personal protective equipment (PPE) for staff. One staff member told us, "That is no problem. If you need aprons, gloves or shoe covers you just send a message to the managers." Another staff member said, "I went to the office last week and there was none (PPE) in stock and there was none in [person's] house until 8pm that day." We recommend the provider follows advice and guidance on controlling the risk of spread of infection.

There had been no accidents or incidents since the service became operational. The registered manager described how they had worked jointly with the local authority to avoid a situation with one person. This person had dementia and rarely wanted to leave their home. A staff member visiting the person for the first time had found this person outside in the street and the registered manager realised this was a risk so they raised their concerns with the local authority. The social worker acted quickly and introduced an alarm system attached to the person's front door which would alert social services when the door was opened. This required staff to phone social services each time they visited the person or took the person out for trips to the park. This showed the provider had a system to work jointly with other agencies to ensure people's

safety.

Good

Is the service effective?

Our findings

People and relatives told us staff had the skills to work with people. One person told us, "[Staff member] does a very good job."
People had a care needs assessment before they began to use the service to ensure the provider could meet their needs. Information gathered during the assessment included the person's history, interests, support needs, communication, health, religion and culture. For example, one person's assessment included, "Unable to speak but understands when spoken to in [their] language. Limited mobility, walks around house but uses wheelchair when outdoors. Attends day care five days a week. Care worker to speak in short sentences." This meant the provider ensured they could meet the person's needs before accepting them into the service.

The service had recruited a care manager because the service had grown in size and this staff member was due to start their employment soon. The plan was for the care manager to oversee training. Currently one of the board members who was a trainer provided induction training and refresher training for staff.

Staff confirmed they had opportunities for training. Training records showed the training staff received included dementia awareness, food hygiene, first aid, health and safety and moving and handling. Staff were also expected to complete the Care Certificate. The Care Certificate is training in an identified set of standards of care that staff are recommended to receive before they begin working with people unsupervised.

Staff received regular supervisions in line with the provider's policy. One staff member told us supervisions were useful and said, "They talk to you about your progress and you set different objectives." Supervision records showed staff had the opportunity to discuss topics including policies and procedures, working relationship with colleagues, punctuality, emergency procedures, communication and record keeping. This meant staff were supported through supervision and training.

One person told us their care staff supported them with their dietary requirements. Staff confirmed they supported people with their nutritional needs. Care plans included people's dietary requirements. One person's care plan stated, "No problems with swallowing or chewing. Needs help with meal preparation but independent with eating and drinking." Care plans documented food preferences which included cultural diets.

People were supported with their healthcare needs. Records showed staff liaised with the GP, the pharmacy and the hospital to ensure people had the medicines and the healthcare they needed. Information on specific health conditions such as diabetes, epilepsy, hypertension and strokes were included in care plans. This showed the provider worked jointly with health professionals to enable people to maintain their health.

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.

We checked whether the service was working within the principles of the MCA. One staff member told us, "We ask for consent all the time. I ask what they want to eat. Even for dressing I take three items and ask what they want to put on." Another staff member said, "I ask [person] what they want to wear. I ask if [person] wants a cup of tea and ask if they want the heating on. When I am leaving the visit I ask if [person] wants a blanket." A third staff member told us, "I always have to ask for consent." This showed staff were aware of their responsibilities under MCA and the need to obtain consent before delivering care.

Care records contained consent forms for care and medicines which people signed by way of agreement. Where the person was physically unable to sign this was indicated on the form and noted that the person had given verbal consent. This meant the provider was working within the requirements of the MCA.

Good

Is the service caring?

Our findings

People and their relatives told us they thought staff were caring. One person told us, "I'm very happy with [staff member]. I would not want another person. She's fantastic." Another person said, "They are very kind and very nice people. I'm happy with the care staff." One relative told us, "[Staff] are most definitely caring." Another relative said, "[Staff] are always friendly and sociable. They have built up trust with [family member]."

The registered manager gave an example of staff demonstrating they were caring when one person was unwell but did not wish to go to the hospital. The staff member informed the office they would not leave the person alone and waited until a family member arrived to stay with the person.

Staff described how they got to know people and their care needs. One staff member told us, "We visit [people] with more experienced carers. Introduce yourself. We do read the care plan and communicate with the [person]." Another staff member said, "By communicating [with the person], introducing yourself, asking questions. I ask them what they like and what they want." A third staff member told us, "I need to look in the care plan. I need to talk to the [person] so you can find a common ground." This staff member explained if the person told them they liked football or current affairs then that gave a subject to have a conversation about.

People and their relatives confirmed they were involved in the care planning process. The registered manager told us they aimed to provide a holistic service to meet all of people's needs. They told us people and their family were encouraged to get involved in other parts of the service to help prevent social isolation. Care records showed people and their relatives were involved in care planning and decision making.

Staff demonstrated awareness of equality and diversity. One staff member told us, "I treat everyone the same. I don't discriminate against anyone regardless of their culture, religion, colour of skin, gender, sexuality." Another staff member said, "Everyone has the right to diversity and equal treatment. We don't abuse people or discriminate against them."

The registered manager told us, "When we do induction and when we do training we incorporate equality and diversity. We encourage our staff to try to be patient and to try to listen and respond. What we do is attach carers of same religion, culture and nationality to families."

The registered manager told us how the service could support a person who identified as lesbian, gay, bisexual or transgender (LGBT). They said, "If they disclosed that they are LGBT, we would advise, we provide confidential advice. We give them reassurance. Another arm of the organisation works with sexual health including LGBT." The registered manager explained they offered people support with relationships and told us, "It is part of the ongoing training package." This meant staff were knowledgeable about equality and diversity.

The provider had a dignity in care policy which gave clear guidance to staff about respecting people's dignity and privacy when delivering care. Staff knew about promoting people's privacy and dignity. One staff member told us, "By confidentiality; you don't talk about people's private business to anyone else. Make sure the door is closed when [person] is taking a shower or bath. Ask [person] if they would like me to help them." Another staff member said, "Curtains are closed. Knock on the door before entering and don't leave the door open where others can see in." This meant people's privacy and dignity was promoted.

Staff were knowledgeable about maintaining people's independence. One staff member told us, "You allow [person] to do the things they can do themselves so they can get involved in their care. I will be there if they cannot do it so I can assist them. This is one of the crucial aspects of care." Another staff member said, "If [person] can do it themselves, I support them to be as independent as possible." A third staff member told us, "The care plan tells us what [person] can do and what they need help with. If they can do something themselves, I don't do it for them." This meant people's independence was maintained.

Good

Is the service responsive?

Our findings

People told us care was given in accordance with their preferences. One person told us, "I tell [staff] what I want and they do it."

Staff were knowledgeable about delivering personalised care. One staff member told us, "Everybody's different and everybody likes to do things differently." Another staff member said, "At the end of the day, we have to give care the way [person] wants it." A third staff member told us, "We need to empower [people who used the service] and involve them in their care."

Care records were personalised and contained people's support preferences. One person's care plan stated, "I want to feel tidy and clean as this is important to me. I like to look neat and smart." Another person's care plan stated, "I would like to feel safe at home whilst [family member] is not around. Care worker to arrive in time to receive me from the bus from the day centre."

Staff completed daily support record forms and the provider was in the process of introducing a new system of recording. The forms were to be replaced with a journal booklet which gave the staff more space to fill in the details of the visit. There were also sections for staff to indicate if support with medicines was given and if cash had been handled.

The provider had a system of matching staff to people using the service. The registered manager told us, "We have a diverse staff community with different languages spoken. This helps to match staff to clients with language, culture and identity." The above showed people received care in accordance with their preferences.

One person told us they had not needed to make a complaint and if they did need to complain stated, "I would phone up the office." Relatives told us they knew how to complain if they were not happy with the service.

The provider had a complaints policy which gave clear guidance to staff about how to handle complaints. The registered manager told us there had been no complaints since they became operational.

Staff explained what they would do if somebody was not happy with the service. One staff member told us, "If I cannot handle it myself I would inform the agency and document what the [complainant] said." Another staff member said, "If [person] is not happy with anything, we report it to the office. It's all about the way we communicate and the body language we use."

The provider kept a record of compliments. We noted there had been two compliments recorded. One relative had written a letter of thanks to the provider on 21 March 2018 which included, "You have been a massive support. The carers have been amazing. I cannot express how we feel with [family member's] improvements. The time and love all the carers put into this job is astonishing."

At the time of this inspection the provider did not provide end of life care. The registered manager told us a lot of referrals were for enablement support which was limited to working with a person for a six week period. We noted that where appropriate people had on their care files fully completed and signed DNACPR forms. A DNACPR form is a medical decision record which indicates that it is not in a person's best interests or the person does not wish to receive resuscitation if their heart or breathing stops. The doctor signs the form and also the person and their representative will sign if they agree to the decision. We found the DNACPR forms on people's care records had been correctly completed.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. People and relatives told us the service was well managed. One person told us the registered manager called them to check if they were happy with the service and the registered manager was easy to talk to. A relative told us they had raised concerns with the registered manager about the keysafe being left open on one occasion by a new member of staff. The registered manager had reassured the relative this would be addressed and since then the keysafe was never left open again. This relative told us, "[Registered manager] tries her best to advocate on behalf of [people who used the service]. She spoke to social services because she saw [family member] had nobody to help [them] with medication in the evenings and it got sorted."

People and their relatives told us the registered manager had phoned them to check their satisfaction with the service. Records showed the provider phoned up people and relatives to find out if they were happy with the service. We reviewed four telephone audit forms and saw that people were satisfied or very satisfied with the service. One form stated, "[Family member] said the carers are very professional." Another form stated, "[Person] is very happy with her regular care workers. She wishes them not to be changed." This showed people's feedback could be used to make improvements to the service.

Staff meetings were held every six to eight weeks. We reviewed the minutes of the most recent meeting held on 24 March 2018. Topics discussed included medicines, record keeping, time keeping, dealing with an emergency and the procedure for when a person seems to be not at home at the time of the visit.

The registered manager told us, "What we do when we have a meeting, we discuss and we talk. You see the carers are attached to the [people who used the service] more than we are so we have to listen to them. Their opinions and their views are very very important. We listen to them and they are heard." This showed staff were involved in the development of the service.

The provider carried out spot checks of staff at work. We reviewed the records of spot checks carried out on 6 February and 3 March 2018 for two staff and saw no issues were identified. Records showed these checks included whether the staff member arrived to the visit on time, stayed for the allocated time slot, had their identification badge, adhered to the dress code, and followed good practice with moving and handling, managing medicines and record keeping. The outcome of the spot checks was discussed with staff during their supervision.

Records showed that random quality assurance visits took place. During these visits the person's care records in their home were checked and the person was asked if they were happy with the service. We reviewed the records of two quality assurance visits that took place in January 2018. Both these visits noted the care folder was in place and records were complete, accurate and appropriate. Comments on both quality assurance visit forms included, "My carers are very professional and treat me with respect" and "My carers are very good to me and always encouraged me to do things." We noted the action identified in both cases was that people wanted to be informed if there was ever to be any changes in staff member or visit times. The above showed spot checks and quality assurance visits were used to make improvements to the

service.

The registered manager told us staff brought completed log books and medicine records in every month and these were checked in the staff member's presence so that any issues could be dealt with at that time. However, at the time of this inspection, these audits were not recorded. If any issues were identified with the record keeping an action checklist was completed and given to the staff member. We discussed with the registered manager the importance of recording all checks on care records. We recommend the provider seek best guidance and advice on effective quality assurance.

The registered manager explained the organisation is a registered charity and had several services it offered to benefit people who were disadvantaged. The other services included advice and guidance, physical exercise, sexual health promotion and a youth service.

The service had developed a strong link with schools, colleges and local voluntary services. The registered manager told us they were invited to speak to students at the local college about working in health and social care services and school children did work placements in the office to gain experience. The provider also ran a parenting course for parents of children with special needs. The registered manager told us they participated in the local provider's forum so that they could learn new ways to improve the service and could share their examples of good practice.