Essex Cares Limited

Essex Cares Mid

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection by visiting the registered office for Essex Cares Mid region on the 11th and 12th of October 2016. We visited and telephoned people who used the service to get feedback about the service.

The inspection was carried out six months following a comprehensive rating inspection in March 2016, which found the service to be inadequate and it was consequently placed in special measures. We found during this inspection that the service had made significant improvements in all areas of concern and had plans in place to continue with improvements.

The service no longer provided re-enablement care. Consequently the number of people they offered care and support to had significantly decreased, and they now provided 21 care packages for those who urgent support which cannot be immediately found from other services.

The service did not have a registered manager in place, but had recruited someone who was experienced and was waiting for the necessary checks to be carried out by the commission in order to be classified as the registered manager for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection in March 2016, we found that many people had experienced both late and missed visits which had led to some people missing their prescribed medication and had impacted on their health and wellbeing. After our inspection we asked the provider to submit weekly reports detailing what missed visits had occurred. We found the service had significantly improved this area and systems were in place to reduce the risk of this happening again.

Safeguarding practices had improved and concerns were raised in a timely manner. Staff received regular support and we saw that supervision from their managers had significantly improved. They told us that the new management team were supportive and listened to their concerns. Regular meetings took place at all levels and the information as shared appropriately across the staff groups.

During the inspection in March, staff had not always received the correct training. However, this had also significantly improved. The training team were seeking out new and innovative ways to make sure that staff had the correct training.

We checked how the service followed the principles of the Mental Capacity Act 2005 (MCA). The MCA governs decision-making on behalf of adults who may not be able to make particular decisions. The requirements of the MCA were being followed, and the provider had implemented systems since our last inspection to ensure that people were protected and supported safely.

People told us that carers were respectful and kind and often went that extra mile to support them.

When the service had been given detailed information from other professionals, care records lacked detail and were not person centred.

At the time of this inspection support plans and risk assessments did not always document identified risks or people's individual needs, level of independence, preferences, and choices. They were not reviewed in a timely way. However, new internal quality monitoring by the service had also identified these issues and plans were in place to improve this area. We also saw that whilst support plans and risk assessments were poor, that communication records demonstrated that staff were safely meeting people's needs, often going the extra mile to do so. The service had improved its continuity of care, ensuring that people received a regular core team of staff to support them. Consequently, they had been able to develop relationships with people, and understood their personal preferences.

The provider had significantly improved the procedure for handling complaints, comments, and concerns and had introduced systems to investigate these effectively. We saw that the service went that extra mile to apologise.
Improvements to the management and quality monitoring systems meant that the provider could now identify when missed calls had not taken place and took action to make sure that people were placed at harm.

We did not identify any breaches in regulation within this visit and consequently the service is no longer 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?

Requires Improvement

The service was not always safe

Risks were not always documented appropriately in care plans to inform staff how to manage potential risks in a person centred way.

The service had systems in place to mitigate the risk of missed calls that might place vulnerable people at risk, although people did not know when staff would arrive within a two hour time frame.

Staff were effectively deployed to provide the care and people were supported to ensure their needs were met safely.

Is the service effective?

Good

The service was effective.

Staff had training relevant to their roles and regular competency assessments were carried out

People were supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet.

People were supported to make choices about their care and their preferences were respected.

Is the service caring?

Good

The service was caring

Staff were respectful of people's privacy and dignity.

People were encouraged to make decisions about their care and support.

People were encouraged to express their views about the service that was provided to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people's needs were met, support plans and risk assessments did not always reflect enough person centred and current information.

People at the service continued to express concerns around not knowing when staff would visit.

Complaints were adequately recorded and investigated, and the provider learnt from these, responding to individuals with care and attention.

Is the service well-led?

Good

The service was well led.

Communication systems where in place across all levels of staff so everyone working at the service worked to the same common goals.

The service had worked hard to improve all their systems, and processes in the last six months and had clear quality monitoring systems in place.

There were clear plans for continued improvements across the organisation and the registered manager received excellent support for all levels of staff.

Essex Cares Mid

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 service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

In March 2016, the service was inspected and placed in special measures by the Care Quality Commission (CQC) because of concerns that the service was failing to safely provide care for people due to significant missed visits. In the last six months the service have provided CQC with weekly quality monitoring reports detailing missed visits, potential safeguarding concerns and service risks. They also no longer provide re-enablement care, focusing on being a provider of last resort, a service who supports people who are unable to access other services. For example, to support people leaving hospital or where care packages have broken down.
This inspection, carried out on the 11th and 12th of October was a revisit to the service to ensure that that improvements had been made and that people using the service were safe.

The service was given 48 hours' notice to ensure appropriate senior staff would be there to support us with the inspection. One inspector visited the service and an expert by experience undertook calls to the service. Before our inspection, we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events, which the service is required to send us.

As part of the inspection, we spoke with nine people who used the service, four relatives, 14 members of staff, one manager, one director, the head of quality and corporate governance, and two training and development managers.

We viewed seven people's support plans, looked at five staff recruitment records and we reviewed safeguarding records, comments and complaints records collected in the last six months. We looked at quality monitoring records including staff support documents including individual training and supervision records, and reviewed other records relating to the management of the service, including a service improvement internal report and internal quality monitoring findings.

As part of the inspection, we spoke with nine people who used the service, four relatives, 14 members of staff, one manager, one director, the head of quality and corporate governance, and two training and development managers.

Requires Improvement

Is the service safe?

Our findings

In March 2016, we carried out a comprehensive inspection of Essex Cares Mid and found they were not providing safe and effective care to people. Concerns were raised at high levels of missed calls, and consequently the service was placed in special measures and was required to submit weekly reports to the Care Quality Commission.

During this inspection, we found that there had been improvements within the service which is now rated as being requires improvement.

Risks were not always documented appropriately within the risk plans when identified, and did not inform staff how to manage risks. In spite of this lack of documentation, we did see some good daily care records in people's folders, and communication logs kept by the management team of all the calls received from staff. This demonstrated that people had received safe and appropriate care that met their individual needs, for example when reporting concerns and acting on these by advocating for additional input from health and social care professionals. One person commented that, "I have to say that I always feel safe when they are here helping me. I didn't think I'd ever feel that way, but if they were to stop coming tomorrow, I don't know how I would manage anymore." However, the lack of informed risk assessments and associated care plan interventions could result in staff not knowing how to respond to people's needs appropriately.

People still told us that they sometimes had late calls, or they did not know when carers would be coming. One person said, "I got so fed up with constantly having to ring the office when carers were running very late that I have at last got recognition from the office that they should phone me and they now are doing so if my carers are anything more than 30 minutes late." Whilst another said, "Well, I can't actually remember now what time they should arrive as it can be anytime between 7am - 10am. I know it's not really a problem for me, because I'm not doing anything during the day, but it does get frustrating when you don't know whether you're going to be getting dressed at 7am or 10am and when nobody calls from the office, you just end up sitting around, waiting."

Staff received safeguarding training yearly and as part of their induction. Those we spoke to had a good understanding of how to safeguard people and told us that they were not afraid to raise concerns when people were at risk of harm. They told us who they would do this and some were able to give examples when they had reported concerns to managers. All safeguarding concerns were investigated appropriately and in conjunction with all concerned.

We also saw that staff received good manual handling training, training provided to ensure that staff could move people safely. People we spoke with who required this support told us that staff had the skills and knowledge to keep them safe. One person said, "I have to use one of those turning things to help me move about, but the carers really make sure they support me well and keep me safe." Whilst a relative told us, "My [relative] has to use one of those standing aids, they are very good with him and I hear them talking through with him how they are going to support him."

Recruitment procedure's had improved, and the manager tried to attend as many new interviews as possible, and where they were unable to attend senior co-ordinators carried out the interview and discussed applicants with the manger afterwards. Staff were employed to the service through values based interviews that looked at the need service the people using the service. Staff would have to undertake a week of mandatory training and shadow an experienced member of staff for three days after training. The service did ensure that people employed had appropriate criminal records checks (DBS), and two satisfactory references before working independently. There were sufficient staff to carry out care and the service continued to recruit more staff to ensure that the service could continue to be run safely.

Managers and planners now had a clear oversight of rotas and visits to people, the service very rarely experienced missed visits to people, where perhaps people would forgo important medicines or meals. Visits where a member of care staff had arrived very late were also regarded as a missed visit. We saw that in those recorded that no one had been placed at risk of harm.

Those with complex health and physical care needs were prioritised for visit times appropriately. One person said, "Because of my Parkinson's, I have two carers at a time. They do always manage to arrive together, although it will be different combinations of carers each time," another person told us, "I have two carers and I think they must work together throughout their shift because they always arrive and leave together." When people had complained about times of visits due to health concerns the service had acted upon these. One person said, "I have to have my diabetes medicine at a regular time. It has been difficult because of never knowing quite when they are going to get to me. Recently, it has got better and I think they now appreciate why I was being so persistent over the timings."

People received a core group of care staff whenever possible so that they had the opportunity to get to know them. People told us this was important to them, although the core teams were still larger than some people liked. One person said, "It's not particularly easy having lots of different carers, even when I know all of them, because I never know who I'm going to be opening the door to next. It can be a struggle for me to remember everyone at my age."

There had previously been issues of poor communication between the service's business centre, where staff called if there were concerns and staff and managers. This had, had a negative impact on the service being able to identify risks and missed calls. However, following the inspection in March, managers and planners now had full oversight of care rota allocation and carers concerns. If needed people could contact office staff directly and rearrange times so that they could attend appointments or go to work. One person said, "I had to phone a few weeks ago because I had a hospital appointment which meant that I really did need them to come at the time they are supposed to come in the morning. To be fair, the office staff did sort it out for me and I was able to get to my hospital appointment on time." Staff told us that they had seen a significant improvement. All those we spoke to who had been employed by the service prior to the inspection in March told us that this had, had the biggest impact on their working lives and quality of care they were able to provide.

If an emergency occurred staff could get assistance quickly senior care coordinators from other teams worked together to provide additional support out of hours. Staff told us, "It's so much better now, before the business centre was so busy, if you had an emergency and were going to be late you might not get through," "The office staff are all trained so often in an emergency they will come and take over for me and wait for the doctor or ambulance so that I can go on and support the next person."

During the previous inspection we had found significant failings in the recording of medicines. During this visit we looked at the Medicine Administration Record (MAR) for five people and all medicines had been

audited in the last three months, on occasions there were a few gaps in administration for creams, but that these had improved. The service had worked hard to reduce errors where staff had forgotten to record if they had supported someone with medication. We found that in all cases of missed signatures were for creams to be applied or eye drops to be administered. We saw one example of where someone had been given eye drops twice in a short space of time.

When this occurred the manager sought advice from the GP, and wrote to apologise to the person, detailing the error, how it had come to light during an audit of the medicine sheets and that they were not at risk of any ill health effects. When staff had made errors they were given additional training. The service was also reviewing the medicine sheets to ensure that they were easy for staff to understand. Staff were being held accountable for any errors.

Good

Is the service effective?

Our findings

The service had made significant improvements and we found it to be effective.

Staff had a good induction to the service and mandatory training was completed prior to working in the community. Staff shadowed experienced staff and would be signed off by senior care co-ordinators prior to being able to work alone. Regular spot checks took place on staff working in the community to check that they were adhering to people's care plans. These were comprehensive checks and we saw that managers followed up issues identified.

Supervision took place regularly and we saw that prior to supervision line manager's contacted people using the service to get feedback on the staff member. Information received was confidential and potential issues were fed back to staff and discussions about how they could be supported to make improvements. During the previous inspection, staff told us that they did not always feel listened to and this was documented in supervision records. However, during this inspection staff told us that they felt management responded to their concerns quickly and that the supervision process was supportive and helped them to reflect on their roles and responsibilities.

Staff had effective yearly appraisals to support their learning and development. The registered manager was developing a system for staff who demonstrated good skills to take on particular lead roles in which they would receive additional training, which they could then pass down to other members of staff.

At our last inspection, we found that not all staff had received regular mandatory training updates. This had significantly improved and the training department in conjunction with the management team and staff had worked creatively to ensure that all staff received appropriate training. This had included discussing with staff "best times" for them to have face-to-face training. On one occasion the training staff organised a session during late afternoon / early evening and provided staff with a meal so that they could take part. We spoke to two training personnel and they told of training ideas moving forward, and how they were planning to introduce bite sized learning sessions for staff throughout the day. People told us that staff had the skills to care for them. For example, one person told us, "I don't have any problems with their knowledge of basic caring skills," and, "They've always seemed very adequate for looking after me. I've got no complaints."

On both days of inspection training was taking place for care staff. Including Equality and diversity training and medicines management training with an external pharmacist. . . We spoke to staff after these sessions and they told us that these had been helpful and how they would implement training.
Staff were held accountable for their actions. We saw evidence where staff had, had to undergo additional training when issues had been identified. The manager worked closely with the training department who supported additional training. In some cases staff had to undertake a module of the Care Certificate and have additional supervision's and observations. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence that these workers have the same introductory skills, knowledge, and behaviours to provide compassionate, safe, and high quality care and

support.

We found evidence in talking with people, observations of people and within people's care records that staff were seeking consent before carrying at tasks. Staff we spoke to had a good understanding of the Mental Capacity Act, 2008. 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.

During the inspection in March, the service had breached the Health Social Care Act 2008 for the need to consent, however we found no evidence of a breach in this area during the inspection. One relative told us, "I am quite fussy so I do like the carers to help me with things in the way I like them to be done. They never complain, at least not to me." Other person said, "I think, that as we all get older, we do get set in our ways. I actually think the carers do very well putting up with me and my eccentricities!"

The previous inspection had identified serious concerns about people's nutritional needs not being met because of late and missed calls. The service had worked hard to reduce these risks and identify people who would be higher risk of neglect so that they took priority with meal visits. People told us staff supported them well to help them eat and drink. One person said, "I do find the kettle quite a struggle these days so I always make sure that I have a hot drink each time one of the carers visit's me. That way, I know I'm getting at least four hot drinks a day. They always leave me a jug of water for later as well which means that I can just pour a drink any time I fancy it." Another said, "I have my meals from [provider of meals] but the carers will still let me know what I have got by way of choice and then I'll decide what I fancy and they will heat it up for me."

Communication logs demonstrated that staff and managers had regular contact with other health and social care professionals to meet people's on-going health needs. We also saw that staff recorded these contacts and visits within people's communication files and would read these entries before carrying out care. Because people had a regular carers visiting, this meant that they knew people's needs well and could support them in their day-to-day activities.

Staff told us that they sometimes met with other professionals at people's homes, such as district nurses to health concerns such as wound care. They had been given support by district nurses to administer eye drops. If staff felt that people's mobility had worsened or they needed additional equipment to remain independent, and where people had requested additional support, we saw that they would contact the senior co-ordinators and request a reassessment of that person's needs. Co-ordinators had met with occupational therapists in people's homes to look at equipment needs and could access equipment quickly.

Good

Is the service caring?

Our findings

During the previous inspection we found that the service not always caring and considerate towards people. This follow up inspection found that the concerns raised in March had been rectified and the service is now rated good in this area.

All the people we spoke to told us care staff were very kind and helpful. One person told us, "Yes, they are very kind; we can have a bit of a laugh which I like." For a number of people the only contact they might have would be the carers during the course of the day and that carers often did extra jobs for them if they struggled to do these themselves. One person commented, "I hardly see anyone else all day, so my carers are a bit of a lifeline. My regular carers are all very kind and they never mind doing any extra jobs that I need help with."

People told us that staff protected their confidentiality and that this was important to them. One person told us, "No, they never talk about anyone else which is good." During the inspection in March people had commented that staff often spoke about others they were about to visit due to feeling stressed. However, we saw that the management team had addressed this effectively. The manager asked people if staff spoke about other people during care reviews and quality checks and if there were concerns these were addressed with the staff teams and with individual members of staff, however we did not see any evidence that staff were potential breaching people's confidentiality during this visit.

We were told by people that staff maintained their dignity when they provided support by ensuring they felt comfortable when providing personal care. One person said, ""They wouldn't dream of letting me wear dirty clothes, they spot dirty marks much easier than I do these days!" and another said, "My carers certainly wouldn't think of starting to undress me until the curtains are shut in my bedroom. I definitely don't ever have to ask them to do that, it's just something they automatically do."

Care plans documented whether they had any preferences of who provided their care, for example if they wanted a male or female carer. We saw that the service included this information when planning care visits. The management team had worked hard to improve the continuity of care to people, as this was something that had previously been highlighted causing distress.

Staff always announced themselves when they entered into people's homes if they were unable to answer the door themselves. People' told us this was respectful. One person commented, "My carers always make sure that they call up the stairs to me when they've let themselves in with the key safe so I'm not worrying about who is coming in." We found staff to be caring for example during our visits with care staff, they were kind, and caring to those they supported, sometimes in difficult situations.

Requires Improvement

Is the service responsive?

Our findings

Initial assessments of people's needs always took place before the care package commenced. This also included detailed information from people's social workers Assessments were thorough and highlighted things that people found important to them, such as preference's and wishes. However, the information was not clearly recorded into people's support plans or risk assessments in a person centred way. The support plan is the plan that carers read prior to providing care to people.

Support plans did not contain information about how best to support the person, and what level of support they needed. They would just identify the task at hand, for example support [person] to make breakfast. They did not continue information about the level of support or what a person liked. We visited one person with very particular preferences about how they liked their morning routine. Whilst staff knew the person and routine well, this was not recorded within the support plan. This meant a new member of staff would not necessary know how to support the person, who due to their health needs, found it tiring to keep explaining.

The service had tried to ensure that whenever possible people received care from a core care team of staff to help with continuity of care. Previously staff had told us, "You never know what you will be walking into." However, all 14 staff we spoke to told us that this had significantly improved through continuity of rotas that allowed them to develop relationships for people the cared for. We did however, still identify that information on the CACI (CACI is an electronic hand held rota system for staff) did not always give staff information about changes in needs of people.

However, whilst this area still required some improvement, we saw evidence that the service had identified this themselves through their own quality assurance inspections. The service had been working on a more person centred format for support plans that they planned to roll out across the organisation following agreement with the registered managers in the service at a meeting later in the week. The manager also had discussed plans to introduce care records training using case study scenarios to train senior staff in preparing support plans. Whilst this was not yet in place, we saw that these plans had been developed. We spoke to staff and find that their knowledge of people's individual needs was excellent and daily care entries and records of communication demonstrated this.

Care provided was supposed to be short term however; people often required longer periods of support due to difficulties of finding alternative care. Consequently, the management time had been working on a new process for review and assessing people's care, discussing time framed for review goals. We observed that when people's care was reviewed support plans were updated to reflect any changes.

The service was responsive to people's complaints. We saw that the manager and staff time had good integrity and where open and honest. Some mistakes had been picked up by the service's own internal auditing procedures and we saw that staff notified people if there had been any error, such as a medication missed. When the service had investigated a complaint people were notified about the outcome. They had introduced a system which meant the chief executive would be informed of complaints and errors and that

they would send a letter of apology along with some flowers or pot plant and explain what they had done since the investigation to improve things or mitigate the incident happening again.

However, a common theme of complaint continued to immerge regarding calls times and people not always knowing when people would come within a two hour time frame. One person said, "The only issue I tend to complain about most of the time to be honest is about trying to be more precise in the time of the visit. It really does seem like it is organised around the convenience of the carers, rather than when I would like the call."

When people had raised an issue about a member of staff we saw that the manager dealt with this sensitively. One person said, "I have experienced one carer who really wasn't very suitable at all. She seemed to enjoy 'mothering' me and calling me 'darling' all the time. I did speak to the agency and they did make sure that she didn't come back to me anymore." If staff required additional training, for example in communication, the registered manager worked with the training team to find something suitable.

Good

Is the service well-led?

Our findings

The service had worked hard to improve areas of concern following on from being placed in special measures in March, 2016. They had redeveloped their systems to monitor and assess the quality of care and protect people and we found that in this area they were good.

Previously, the traditional manager's responsibilities for overseeing rotas, staff supervision, and monitoring the quality of staff performance, were carried out by the service's business support staff. These responsibilities had been firmly placed back with the manager of the service who had a good oversight of staff and care provided. Staff had received regular supervisions, where previously this had been lacking, and managers listened to staff concerns about rotas, timing' and distance. Consequently, systems in place to support staff to carry out their role were much more robust. Staff told us that this change had had the biggest impact on the quality of care they were able to provide and the reduction of stress and anxiety they felt within their role.

The checks in place to ensure that staff were supporting people correctly with their medicines had improved, and continued to be an area of on-going improvement. Staff told us that training was good, and managers showed us systems introduced to improve the oversight of medicines managed. We saw there had continued to be missed signatures for medicines such as creams and eye drops; however, these had significantly reduced in the previous two-month period and effective auditing identified errors. When errors occurred, the manager investigated these appropriately and sent letters to people to explain the error, potential risks, and support available. Senior managers within the organisation were notified and apology letters were sent.

Systems in place to manage missed or late calls had significantly improved and these had significantly reduced.. By identifying what is considered a missed call and a late call the service had been able to evidence that they were meeting people's needs appropriately. When a missed call was documented, (either a call that did not take place or a call after a two-hour period) we found that the manager had carried out a proper investigation, that actions had been developed, and that risks had been mitigated. They communicated with people effectively and sent letters of apology. The manager had also visited people to apologise in person and taken a small gift.

Appropriate safeguarding's were raised if people had been placed at risk by a missed or late call, although incidents of these were very few and risks were mitigated by immediate follow up checks on people after a two hour missed period had been identified.

Staff felt supported and told us that the manager and wider management team listened to them. We saw evidence in care logs that staff regularly phoned in to report concerns and that care teams communicated well with each other so that they could ensure people's needs and preferences were met.

Regular staff meetings at all levels of the organisation took place to share lessons learnt from incidents and errors and organisational updates. If staff were unable to attend the meetings they would receive feedback

during supervision or a call with any significant changes. Meeting minutes reflected that managers and care staff views were important and that the whole organisation took responsibility for making improvements to the service. New initiatives were discussed with managers and staff in consultation. Previously managers and staff had reported feeling disconnected from the organisation and there had been significant work to attempt to engage and encourage a collaborative journey of improvement within the service.

Managers were honest and open about the service and where they felt they still needed to improve, including care planning, and to ensure that these were individualised and risk assessments. They had identified this need within their own quality audits. The Quality manager had worked with registered managers to devise a person centred approach to people in their care. This work was due to be presented to registered managers at the time of inspection to gather views, assess the quality and decide about whether new style care plans would be effective in meeting people's individual needs.

The organisation obtained the views of the people who used the service and had utilised the previous CQC report to adapt questions they asked people to concerns raised at the previous inspection. For example, asking whether staff spoke about other people in their care during care visits. We saw that people had given positive responses to questions and when concerns had been raised the manager had investigated these properly, sharing information with staff to support on-going improvement.

We saw that the service had been seeking feedback from people since the previous inspection and the responses that they had received for people. One particular area of concern had been continuity of staff, and the service had worked hard to improve this.