Eleanor Nursing and Social Care Limited

Eleanor Nursing and Social Care Ltd - Leegate Office

Inspection report

15 Leegate
Burnt Ash Road
Lewisham
London
SE12 8SS

Tel: 02086901911
Website: www.eleanorcare.co.uk

Date of inspection visit:
30 August 2017
31 August 2017
04 September 2017

Date of publication:
28 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an inspection of Eleanor Nursing and Social Care Ltd - Leegate Office on 30, 31 August and 4 September 2017. This was our first inspection of the service since it was registered in July 2017. The service provides care and support to people living in their own homes. There were 300 people using the service when we visited.

There was a registered manager at the 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.

Risk assessments and support plans contained some information for staff, but we saw many examples of incomplete record keeping that meant staff may not have always the information they required to support people safely and effectively.

People received their medicines safely. Care workers appropriately recorded which medicines they were prompting people to take within their daily records and were filling in medicines administration records (MARs) when they administered medicines to people.

Safeguarding adults from abuse procedures were robust and staff understood how to safeguard people they supported. Staff had received safeguarding adults training and were able to explain the possible signs of abuse as well as the correct procedure to follow if they had concerns.

Staff demonstrated knowledge of their responsibilities under the Mental Capacity Act 2005. However, records did not always contain accurate details of people's capacity to make decisions about their care. People using the service and their relatives were involved in decisions about their care and how their needs were met.

Staff demonstrated an understanding of people's life histories and current circumstances and supported people to meet their individual needs in a caring way. However, care records contained limited details about people's individual needs or preferences.

Recruitment procedures helped ensure that suitable staff worked within the service. There was an induction programme for new staff, which prepared them for their role.

Care workers were provided with appropriate training to help them carry out their duties. Care workers received regular supervision and appraisals of their performance. There were enough staff employed to meet people's needs.

People were supported to maintain a balanced, nutritious diet where this formed part of their package of

care. However, care records did not always contain enough information about the support people with diabetes required in relation to their diet.

People using the service and staff felt able to speak with the registered manager and provided feedback on the service. They knew how to make complaints and there was a complaints policy and procedure in place.

The organisation had systems in place to monitor the quality of the service, but these were not always effective. Various audits were conducted by an internal quality assurance officer, but these did not identify the issues found. Information on significant events was reported to the Care Quality Commission as required.

During this inspection we found a breach of regulations in relation to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not consistently safe. People's care plans and risk assessments were sometimes incomplete and did not incorporate all the known information about people's needs. Risk assessments were not always completed when required.

Procedures were in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective. The service was not always meeting the requirements of the Mental Capacity Act (MCA) 2005. Care records did not always contain correct details about people's capacity to make decisions. Care staff were aware of their responsibilities under the MCA.

Staff received an induction, training, regular supervision and appraisals of their performance.

People were supported to eat a healthy diet where this formed part of the package of care required. However, care records did not contain enough dietary advice to care workers for people with diabetes. People were supported to maintain good health and were supported to access healthcare services.

Is the service caring?

Good

The service was caring. People using the service and their relatives were satisfied with the level of care given by staff.

People and their relatives told us that care workers spoke with them and got to know them well. People and their relatives confirmed their privacy and dignity was respected and care workers gave us practical examples of how they did this.

Is the service responsive?

Good

The service was not consistently responsive. People were encouraged to be active and maintain their independence where this was part of the package of care required.

People's needs were assessed before they began using the service and care was planned in response to these needs. However, care records contained brief details about people's preferences in relation to how they wanted their care to be delivered.

People told us they knew who to complain to and felt they would be listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems did not identify the shortfalls we found in relation to risk assessments and care plans.

Notifications were submitted to the Care Quality Commission as required.

Eleanor Nursing and Social Care Ltd - Leegate Office

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.

The inspection took place on 30, 31 August and 4 September 2017 and was conducted by one inspector. The inspection was announced. We gave the provider 48 hours' notice of our inspection as we wanted to be sure that someone would be available.

Prior to the inspection we reviewed the information we held about the service and we contacted a representative from the local authority safeguarding team.

We spoke with 20 people using the service, six relatives of people using the service and senior staff at the service. We spoke with 15 care workers after our visit over the telephone. We also looked at a sample of 31 people's care records, 20 staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when using the service. Comments from people included "I feel very comfortable with the carers, very safe" and "I trust the carers." However, despite these positive comments, we found that the provider had not always done all that was possible to protect people from harm.

We looked at 31 people's support plans and risk assessments. The registered manager or another senior member of staff visited the person using the service and conducted a risk assessment on the safety of the person's home environment as well as conducting a needs assessment around various possible areas of support including the person's mental state, medical conditions and nutritional needs. This information was then used to produce a care plan detailing the person's health and support needs.

People's care plans and risk assessments contained examples of identified risks that had not been fully explored within a specific risk assessment. For example, we identified two people who smoked within their homes, but a specific assessment exploring this risk had not been conducted. We spoke with the registered manager about this who confirmed that safety measures had been put in place. These included providing these people with a pendant alarm in case of emergencies as well as issuing verbal advice to these people about how they should minimise the risk of injury to themselves. However, she agreed that no specific assessments had been conducted which had comprehensively explored the level of risk to ensure that people were protected from the risk of avoidable harm. The registered manager said she would address this immediately.

We also identified that risk assessments had not always been completed for people who were at risk of Urinary Tract Infections (UTIs). The care records identified that these risks were present but specific risk assessments had not been conducted to fully explore the level of risk and provide guidance to staff about the actions that were required to mitigate this. The registered manager explained that whilst written records did not fully explore the level of risk involved, care workers were given instructions about what signs to look out for and what actions to take to minimise the risk of UTIs developing in people. Care staff we spoke with demonstrated a good level of knowledge about how to manage the risks associated with UTIs.

We also found that some identified risks were not incorporated into people's care plans to ensure that their individual needs were met. For example, on the first day of our inspection we found that people with an identified risk of pressure sores or falling did not have specific assessments in place. The registered manager explained that these people had assessments within their homes, but these were not available in the office. On the final day of our inspection we were shown these assessments for all people whose records we had viewed. However, we found the advice within these was not incorporated into their care plan. This meant that care plans did not always contain specific information for staff about how to meet people's individual needs to ensure that they were protected from avoidable harm.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding adults policy and procedure in place. Staff told us they received training in safeguarding adults as part of their initial induction and demonstrated a good understanding of how to recognise abuse, and what to do to protect people if they suspected abuse was taking place. This included measures to minimise the risk of financial abuse. There were clear procedures in place and care staff were required to record the details of any financial transactions that they had completed on people's behalf together with the receipts to evidence expenditure which were then reviewed by senior staff. A member of the safeguarding team at the local authority confirmed they did not have any concerns about the safety of people using the service.

Staff received emergency training as part of their initial induction and this covered what to do in the event of an accident, incident or medical emergency. Care workers told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. This included precautionary measures to avoid incidents from occurring and how to respond if an accident did occur. Care workers told us they would contact the emergency services in the event of an accident or incident or take other appropriate action, such as informing the person's GP and their manager.

People using the service and their relatives told us they were usually seen by the same care worker and this ensured they could develop a relationship and get to know one another well. Comments included "I have the same carers, they are very good" and "I see the same care worker. Things are going well." People and their relatives told us that care workers did not seemed rushed when supporting them and care workers confirmed they had enough time to meet people's needs.

We spoke with senior staff about how they assessed staffing levels. They explained that the initial needs assessment was used to consider the amount of support each person required. As a result senior staff determined how many care workers were required per person and for how long. Senior staff told us that if as a result of their assessment more care workers were needed than requested by the person, this would be negotiated with the person and/or the local authority that funded their care and we saw evidence of this in one of the care records we viewed. Care workers also confirmed that they kept the office informed about whether they needed more time to conduct their work. They told us the timings of their visits could be extended if this was required.

We looked at the recruitment records for 20 care workers and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms contained details of people's employment history.

Medicines were administered safely to people. Care workers were responsible for administering medicines to some people and filled in medicines administration record (MAR) charts. Care staff made a note in people's care records where they prompted them to take their medicines. Care staff sent MAR charts and daily records to the office on a monthly basis and they were reviewed by senior staff who queried any discrepancies.

Care staff we spoke with told us they had received medicines administration training and records confirmed this. Care staff were clear about the medicines that people should be taking and provided appropriate support that met people's individual needs.

Requires Improvement

Is the service effective?

Our findings

People's needs were not always met effectively as staff had not always taken appropriate action to ensure that people's rights were protected in relation to consenting to their care and support. 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. 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.

We checked whether the provider was working within the principles of the MCA, and found that the requirements of the MCA were not always met. We saw in two people's care records that their mental capacity assessments did not accurately conclude whether or not they had capacity to make specific decisions about their care. In one example the assessment had not been fully completed as it did not make a conclusion and another person's assessment stated that they did have capacity when the Registered Manager agreed that they did not have capacity to make decisions about their care and support needs. Therefore we could not be assured that people were being appropriately supported to make decisions about their care and support. We recommend that the provider takes advice from a reputable source about accurately recording whether peoples capacity to make decisions.

We spoke with care workers about their understanding of the issues surrounding consent and the MCA. Care workers explained what they would do if they suspected a person lacked the capacity to make a specific decision. They described possible signs people could demonstrate if they lacked capacity and told us they would report this to their manager.

People told us they were encouraged to eat a healthy and balanced diet where this was part of the package of care they received. People's care records contained some information about their dietary requirements and this included information on their likes and dislikes in relation to food. However, we found that care records did not always include details of people's dietary needs in relation to medical conditions they had such as diabetes. We spoke with the registered manager about this and they explained that whilst this information was not included in people's care records, knowledge about people's dietary needs was included in training sessions and in discussions with care workers. We spoke with care workers about this and found they had a good level of knowledge of people's dietary needs where they had diabetes despite this information not being included in their care records.

Care records contained information about people's health needs. This included a description of people's known health conditions as well as some information about how these affected people. Senior staff liaised with healthcare professionals where specialist advice was required for known health conditions. When we spoke with care workers they were aware of people's health needs and demonstrated a good knowledge of how they were expected to support people with these.

Staff told us they felt well supported and received regular supervision of their competence to carry out their work. Records showed that supervision sessions were used to discuss specific people and their needs, care worker's training and development needs and any other issues. Senior staff told us supervisions were supposed to take place every three months, and the records we saw confirmed this.

Senior staff also told us annual appraisals were supposed to be conducted of care workers' performance once they had worked at the service for one year. Care workers confirmed these were taking place and said they found them useful to their practise. Records also confirmed these were taking place.

People told us staff had the appropriate skills and knowledge to meet their needs. Their comments included "The carers know what they're doing" and "I have the same carer and she gets on with things. I don't need to tell her what to do." Senior staff told us and care workers confirmed that they completed training as part of their induction as well as some ongoing training. Records confirmed that most staff had completed mandatory training in various topics as part of their induction prior to starting work. These topics included moving and handling, first aid and safeguarding.

Good

Is the service caring?

Our findings

People and their relatives gave good feedback about the care workers. People told us, "I am happy with the carers. They are kind and caring", "They are very nice people" and "I am very satisfied. The carers are very nice." People told us they were treated with kindness and compassion by the care workers who supported them and said that positive relationships had developed.

Our discussions with the registered manager and care workers showed they had a good knowledge and understanding of the people they were supporting. Care workers told us they usually worked with the same people so they had got to know each other well. Care workers gave details about the personal preferences of people they were supporting as well as details of their personal histories. They were well acquainted with people's habits and daily routines and the relatives we spoke with confirmed this. For example, care workers knew details about people such as how people liked their hot drinks prepared and what television programmes they liked to watch.

Care workers explained how they promoted people's privacy and dignity and gave many practical examples of how they did this. Comments included, "I'm very careful when I'm giving personal care. Some people can get embarrassed so I try to put them at ease" and "I treat people the way I would want to be treated, the way I would want my mother treated. I always explain what I'm doing and ask if it's okay first." People we spoke with also confirmed their privacy was respected. One person told us their care worker "respects my privacy" and another person told us "they show respect."

Care records included details about whether people required a male or female care worker and people told us their preferences were met in this area.

Care records gave some details about people's cultural and religious requirements, and the registered manager confirmed that these were identified when people first started using the service. When we spoke with care staff they had a good level of knowledge about people's culture and spiritual beliefs and how this influenced and contributed to the support they provided. For example, one care worker explained how one person's faith affected their personal care needs as well as what they could eat. Another care worker told us they supported one person to attend their local place of worship and they understood how important this was to them.

Good

Is the service responsive?

Our findings

People using the service and relatives we spoke with told us they were involved in decisions about their care and said staff supported them when required. One relative told us, "We are very involved in the care. We work together with the carers."

Care workers told us they offered people choices as a means of promoting their independence. One care worker told us "I always offer choices with their care. That could be what they'd like to eat or wear. I don't make decisions for people." Another care worker told us "We work hard to promote people's independence." The registered manager also confirmed that they were beginning a pilot with the London borough of Lewisham which centred on promoting people's independence with the goal of minimising the care given to people. We reviewed the care plans belonging to people involved in the pilot and saw these focused on working towards goals that enhanced people's independence in completing daily living skills so that they only needed minimal support with these.

People's needs were assessed before they began using the service and care was planned in response to these. Assessments covered areas such as physical health, dietary requirements and mobilising.

People who used the service and/or their relatives where appropriate had been involved in developing care plans to ensure that their views were taken into account. They provided information about how the person's needs should be met, however, some information was unclear and lacking in detail. For example, most care records contained either very limited or no information about people's life history or preferences in relation to how they wanted their care to be delivered. This created a risk that new or care workers who were unfamiliar with the person's needs would not have the information to provide the type of care people wanted. We recommend that the provider seek advice from a reputable source about developing person centred care plans.

We saw evidence that people's care records were reviewed within 12 months. Risk assessments and care records were updated after a 12 month period and these included updated details about people's needs. People's daily notes were also reviewed on a monthly basis and the registered manager queried any discrepancies with the care worker if needed.

People using the service and relatives we spoke with confirmed they had been involved in the assessment process and had regular discussions with staff about their needs. Relatives also confirmed care staff kept daily records of the care provided and these were available for them to see.

Care records showed some information about people's involvement in activities where this was relevant to the package of care being provided. As part of the initial needs assessment, the registered manager or other senior staff spoke with people and their relatives about activities they already participated in so they could continue to encourage these where they were able to do so within the authorised time limits. Senior staff told us they worked with family members to keep people active by encouraging them to participate in activities they enjoyed. Care records contained a section on people's activities and hobbies and this

included some advice for care workers in promoting these. For example, most care records included details about what indoor activities people enjoyed, for example, watching television or reading and care workers were aware of this when questioned.

The service had a complaints policy which outlined how formal complaints were to be dealt with. People who used the service and relatives confirmed they knew who to complain to where needed and told us they felt confident they would be listened to. Senior staff told us how they handled complaints and we saw records to demonstrate this. The service had received very few formal complaints, but we saw correspondence to demonstrate that these were responded to within the stipulated timeframe and changes were made in accordance with people's requests.

Requires Improvement

Is the service well-led?

Our findings

The provider's systems for monitoring the quality of the service were not always effective. Although internal audits were taking place these had not identified the issues we found in relation to risk assessments and care plans. A senior member of staff within the organisation known as the Compliance & Quality Assurance Officer undertook a self-inspection and produced a report that covered numerous areas including recruitment checks, training needs checks and policies and procedures. The report also covered an assessment of care plans and risk assessments. After the production of the report, the provider produced an action plan which stipulated targets for improvement that were identified by the report, with timeframes for completion and the person responsible. However the internal monitoring did not identify the issues we found with the quality of risk assessments and care plans.

Providers are required to notify the Care Quality Commission (CQC) about significant incidents including safeguarding concerns. We found the provider was submitting notifications to the CQC as required.

We saw evidence that feedback was obtained from people using the service, their relatives and staff. Feedback was sought during monitoring visits and monitoring telephone calls which took place approximately every three months. The registered manager told us that if issues were identified, these would be dealt with individually. We saw recorded details of this monitoring within the records we viewed and found feedback to be positive. For example, one person complained about the timeliness of their visits and we saw that actions were taken to ensure these were on time and the subsequent review indicated that this was no longer an issue. Annual surveys were also conducted with staff and service users. The results of both surveys were positive with 100% of service users stating they were happy or usually happy with the care and support they received and 82% of respondents to the staff survey stating they were happy with their jobs. We saw action plans were devised to ensure improvements were made as a result of the feedback received.

Care workers confirmed they maintained a good relationship with the registered manager and felt comfortable raising concerns with her. They stated that she had 'an open door policy' and we saw care workers speaking with the registered manager throughout our inspection. Team meetings were conducted on a monthly basis and care workers told us they found these useful.

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with detailed explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of people's job descriptions and saw that the explanations provided tallied with these.

The provider worked with members of the multidisciplinary team in providing care to people. This included the local pharmacist and the GP. There was also evidence of close working with the local authority who conducted regular monitoring visits to the service which took place every two months. We saw the results of these were positive.

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 The provider did not assess all risks and do all that was reasonably practicable to mitigate against such risks in the delivery of care. 12(2)(a) and (b).