European Nursing Agency Limited

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Inspection report

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07 June 2018
08 June 2018
12 June 2018

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection visit took place on 5 June 2018 and was unannounced due to concerns we received.

We made telephone calls to people who used the service, their relatives, staff and other professionals to obtain their views. These calls took place on the 6, 7, 8 and 12 June 2018.

European Nursing Agency, also known as ENA, provides 24-hour care by way of live in care workers who support and provide personal care for people in their own homes. At the time of our inspection there were 72 people using the service.

At the time of our inspection the provider had applied to add treatment of disease, disorder and injury to their registration but this application was still being assessed. The provider was registered to provide personal care to people.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider had completed an application to become the registered manager with CQC before the inspection took place.

At this inspection we found a breach of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. The provider had failed to operate effective quality assurance and auditing systems.

There was not enough staff in the office to ensure people and staff received the appropriate support.

Care plans we looked at lacked risk assessments and appropriate guidance around risks.

Staff helped and supported people to take their medicines safely. Staff received training in safe administration of medicines and knew how to make sure people received their medicines safely. However, we found that the providers monitoring systems were not adequate to ensure that medicine practices were safe.

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People felt safe using the service. However, although accidents and incidents were reported these were not always investigated and reported to CQC when required.

Staff received training to enable them to carry out their role effectively and safely. However, we noted that some staff training was overdue.

Staff sought people's consent to care. People received support to access healthcare appointments if

needed.

People and their relatives told us they were satisfied with the staff that provided their care. Staff members often took the time to have a chat and support people with their needs.

People were fully involved in making decisions about their own care. People felt staff treated them with dignity and respect.

People and their relatives told us they had been involved in developing people's care plans and felt that staff listened to them.

People and relatives knew how to raise concerns and felt they would be supported if they needed to complain.

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.

Accidents and incidents were not always investigated or reported to keep people safe.

Medicines were not audited appropriately to ensure people received medicines safely.

There were office staff shortages that impacted on daily tasks that were required.

Care plans we looked at lacked risk assessments and appropriate guidance for staff.

Safe and effective recruitment practices were followed to help ensure that all staff were fit, able and qualified to do their jobs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff supervision and training were not consistent. The provider was not able to demonstrate that supervisions were completed consistently for all staff.

People were provided with a healthy balanced diet which met their needs.

People had their capacity assessed and best interest decisions made following best interest processes in line with the MCA principles.

People's wishes and consent were obtained by staff before care and support was provided.

Is the service caring?

Good

The service was caring.

Care was provided in a way that promoted people's dignity and respected their privacy.

People were cared for by staff who knew them well and were familiar with their needs.

People and their relatives were involved in the planning, delivery and reviews of the care and support provided.

People's confidentiality of personal information had been maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not reviewed regularly and contained conflicting information.

People received personalised care that took account of their preferences and personal circumstances.

People and their relatives were confident to raise concerns which were dealt with promptly.

Is the service well-led?

Requires Improvement

Systems in place to quality assure the services provided, manage risks and drive improvement were not effective. Competency assessments were not in place at the time of the inspection

The provider failed to notify CQC of an incident when required.

The provider did not provide all the information requested by CQC and did not demonstrate they had an overview of the service.

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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 visit took place on 5th June 2018. and was unannounced. The inspection was completed by two inspectors and a registered general Nurse. Telephone calls were completed on 6, 7, 8 and 12 June 2018 by three inspectors and two experts by experience. An expert by experience is a person who has experience in this type of service. This was to help facilitate the inspection and make sure that people who used the service and staff members could tell us about their experience of the service. We also spoke with other professionals such as district nurses.

We spoke with 21 people who used the service and received feedback from 5 relatives. We received feedback from 20 staff, the deputy manager and the provider.

We looked at the care records for five people who used the service. We reviewed three staff recruitment files and training records. During the inspection visit the provider was not able to provide all the information we required. We did receive more information later, however, this did not include all information we requested.

Requires Improvement

Is the service safe?

Our findings

Although people told us that they felt safe we found that systems did not consistently ensure that people received safe care. People and relatives told us they felt the service they received was safe and met their needs. One person said, "I feel very safe with them. It helps to know who is coming around, that makes me feel safe." A relative said, I think [relative] is very safe with them. I am here so would know if there was a problem they are well trained carers including using the equipment."

We looked at accidents and incidents and we noted that although incidents were logged they were not always reviewed appropriately. We found no evidence of lessons learned to ensure that future risks were reduced. For example, on the 27 April 2018, we noted documented for one person, that while they were being hoisted they banged their legs on the hoist, and that their legs were discoloured so the staff member applied cream. An entry for the same person three days later noted: "yellow spots on both legs, I have no idea what this is or where it came from". The same care staff had recorded both these incidents. Although a body map had been completed to show the marks on the person's legs, there had been no follow up to review the staff member's competency using the hoisting to ensure that further risks of injury were avoided.

We saw a recorded incident for December 2017 where a staff member had strained their shoulder while supporting someone in a hoist. The follow up recorded the staff member was currently receiving physiotherapy for an old injury and they did not know they had to report the incident – There was no other follow up such as retraining or a competency checks for using the hoist to ensure that it was being used safely.

We found some of the risk assessments we viewed during our visit to the provider's office were not consistent. Care plans identified people's care needs but had no relevant risk assessment or risk management plans to mitigate risks identified. For example, people with catheters had no risk assessment regarding possible infection; people at risk of falls had no falls risk management, and people with bowel management had no risk assessment on the potential complications which could happen from staff performing bowel management procedures. Following our visit some of these risk assessments were produced and sent to us by the provider.

Staff members spoken with during our visit to the provider's office did not demonstrate an understanding of people's risk assessments involved. For example, in one of the care records we viewed the staff identified bowel and catheter risk assessment but were not able to explain how these would be managed.

Staff supported people with their medicines as the prescriber intended. One person said, "They give me my tablets at the same time each day and apply my creams. A relative said, "Yes they [staff] administer medicines and they record everything on the medicine chart." All staff we spoke with confirmed they had received training for the safe administration of medicines.

Staff gave mixed feedback about how medicines were audited by the care coordinators. One staff member said, "Care coordinators visited about two or three months ago and physically checked the medicines

against the medicine administration records (MAR)." Another staff member said, "As far as I am aware no one from the company comes to check the medicines.

On the day of the inspection we asked to see the medicine audits to ensure that, any issues were identified and actioned. We were shown examples of MAR sheets from January to March. However, we found no evidence to show that these were audited. The care coordinator explained that they make notes about the audit in each person's individual care plans. This meant it would be difficult for the provider to have an overview of any patterns or concerning trends that might be happening.
We noted two incidents concerning medicine errors that showed although the medicine errors had been investigated there was no evidence of follow up action with staff to ensure they were following best practice and understood their responsibilities.

We asked the care coordinator to send evidence of the medicine audits however this was not sent to us. The provider could not demonstrate that audits were completed. We asked the care coordinator how often they should complete medicine audits and they confirmed monthly. We found that there were no MAR charts received by the care coordinator for people supported with their medicines during April and May 2018 and one person we looked at did not have one for March 2018. This meant that staff may not identify errors and people could be at risk.

Staff we spoke with confirmed they had received training to ensure people were protected from abuse. Staff demonstrated they knew what abuse was and knew how to escalate and report any concerns. One staff member said, "I have been trained in safeguarding, I know about whistle blowing. We have a duty of care to report any concerns." However, the provider failed to inform the Care Quality Commission about a safeguarding that resulted in one-person sustaining a fracture. The provider has a requirement to inform CQC of such incidents.

Safe and effective recruitment practices were followed to make sure that all staff were of good character and suitable for the roles they performed. The provider conducted all the necessary pre-employment and identity checks before staff were offered employment. However, there were not enough suitably experienced care coordinators available to meet people's needs. This impacted on the care coordinators completing their required tasks. For example, care coordinators were required to complete monthly home visits and collect the MAR charts. However, they were not able to achieve this and had encouraged staff to send the charts electronically. We spoke with the provider who confirmed they were short staffed and only had three care coordinators, one of whom was still training and had started working at the service three weeks previously. The provider confirmed they needed five care coordinators and were recruiting. This impacted on the duties of the care coordinators and reflected in the audits not being completed.

There were systems in place to provide cover during an emergency such as a staff member having to go off sick. The care coordinator explained they have 'on call' care staff and retainers that provide details of their availability and as a last resort a care coordinator could cover although they commented, "This has not happened."

Requires Improvement

Is the service effective?

Our findings

We received a mixed response from staff we spoke with, some told us they received supervisions and felt they could get support by telephone 24 hours a day if needed. One staff member said, "Every month or so I have face to face contact supervision with the care co-ordinator. We have regular contact and I feel supported." However, another staff member explained that they had not received supervision or support on their first placement. A relative told us that the staff member had not had anyone come to check if the placement was ok and this was their second time back after the initial three-month placement. Another staff member commented, "supervisions are supposed to be once every eight weeks. This does depend on how busy the care co-ordinators are. They really do need more care coordinators but they know this and are making efforts to recruit." We requested evidence of supervisions at the inspection but have not received evidence from the provider to demonstrate that supervisions are completed on a regular basis for all staff members.

We spoke with one of the trainers about the training. They confirmed staff completed their training. However, there were some staff whose training was not up to date. The trainer evidenced that they sent emails to the care coordinators to highlight staff training needs but this had not resulted in all staff attending the required training.

Staff we spoke with told us they completed the providers induction that consisted of a week's training. Most staff told us it gave them the skills and confidence to do the job. One person who was new to working in care felt that there was limited practical training but the theory was good. One staff member commented, "Additional training modules were available for staff to attend when being placed with a person who had special support needs."

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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 in line with the principles of the MCA and found they were.

We saw in people's care records that consent to care had been documented and when reviews and assessments had been completed. People or their appropriate relative told us they had been involved with their care planning. One person said, "Yes they [staff] always listen to me, we discuss things regularly." Another commented, "We discuss all things and find ways around any problems between us." A relative said, "They [staff] do listen to [relative] and to me too. It is important as we; all have to get along under the same roof. We work as a team and it works well."

Staff understood the importance of choice and reporting changes about changing capacity. One staff member told us, "It is a case of constant observation. Everyone's needs and abilities are so different; there is not a one size approach that fits all. It depends on people's capacity, their needs and their lifestyle but I

would not be providing care that contravened a person's wishes." Another staff member said, "All care is provided only with people's consent. I am here to encourage the person to do as much as they can for themselves. I talk with them throughout ensuring that they are happy with how we are doing things."

Staff helped, supported and encouraged people to eat a healthy balanced diet that met their needs. All staff we spoke with confirmed they had received basic food hygiene training. Some people were supported with their shopping whilst other people who were more independent managed this themselves. One staff member said, "I do the cooking at this placement and yes, I have had basic food hygiene training. The person decides what they want to eat and I cook it for them, it is as easy as that". One person commented, "I decide what I am going to eat each day and the care staff will cook it." One relative said, "The cooking is a joint effort, my [relative] enjoys cooking so they help them. We all eat together."

People who required support from external health professionals received this when required. People's relatives and records confirmed that staff or their relative contacted a wide range of professionals when people's needs changed. We saw that other professionals such as, district nurses, nutritionists and GP's supported people health needs.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that staff provided support in a kind, compassionate and caring way. One person said," I would just like to say that since I've been using them [ENA], they have given me my independent life back which I sadly had been lacking, prior to them coming on board, so I've been extremely grateful to them for the help they have given me. "

People told us that staff stayed for three months or more and staff came back to support people on more than one occasion. This meant that staff and people had the opportunity to develop relationships and for staff the opportunity to learn people's likes and dislikes. One person said, "I have the same ones [staff] and they look after me very well" Another person commented, "My carer stays for three months and they have six weeks off. They are all brilliant. I've never had a problem with any of them"

People we spoke with confirmed that staff promoted their independence and supported them to live at home. People and their relatives told us that staff were kind and caring and confirmed they were treated with respect. People were positive about the staff and their experience. One staff member said, "The person I am supporting is able to tell me how they want their care provided and we work together to promote their privacy and dignity as much as humanly possible. One person commented, "They are all very respectful and become friends." When we asked a relative, if staff treated them with dignity and respect they said, "Very much so, to both of us. They always respect [relatives] privacy; make sure doors are closed"

People and where appropriate their relatives, were involved in the planning and reviews of the care and support they received. One person said," I am totally responsible for how my care is organised and I expect my carers to do things how I like them. I don't personally need or want my parents or relatives to be involved in decisions about my care." A relative commented, I am involved in meetings with [relatives] care coordinator but that is because they wish me to be. If at any point, they didn't want me to be involved then I'm sure they would tell me. However, all the decisions about how their carer is organised, are made only by them."

Records were stored securely and staff understood the importance of respecting confidential information. They only disclosed information to people such as health and social care professionals on a need to know basis.

Requires Improvement

Is the service responsive?

Our findings

We looked at care plans and found that people at high risk of developing pressure ulcer were identified. However, people at risk of developing pressure sores did not have details of preventive measures such as repositioning charts, barrier cream application or regular skin checks evidenced in the care plans we viewed.

Although staff identified each person's care needs, we found that care plans we looked at were not reviewed regularly. One staff member told us that people's care needs were reviewed monthly for three months then every three months. However, all the care records we viewed did not show any evidence of being reviewed every month or every three months. However, one person we spoke with said, "I've been having carers from them [ENA] for well over 10 years now. I have a care coordinator who I know well, and they regularly check my Care Plan to ensure its kept up to date. It's entirely my choice if I want to add new things to my plan or change timings and how I organise my life."

Some care plans were not consistent and contained contradicting information. For example, in one of the care plans on eating and drinking the first sentence identified the person as not being at risk of choking but after few sentences on the same care plan it stated that the person was at risk of choking. This evidence was shown to the deputy manager who confirmed they would update the care plans appropriately. People received care and support from staff that lived at their home. The provider ensured that initial assessments of people's needs were completed. The care coordinator told us that they were responsible for completing the care plan. They told us that they speak to the client's and family members where appropriate to ensure the care plan meets the person's expectations including their preferences.

Staff we spoke with knew people well. However, whilst we found care plans contained guidance for daily routines they lacked the detail for how these tasks should be completed and lacked the required risk assessments to ensure people were safe.

People confirmed they were involved with their care and felt listened to by staff. The care coordinator confirmed they managed the care packages for people. They also confirmed that they made regular calls to ensure that people were happy with the support and care provided.
Staff we spoke with told us they received a "care summary" prior to starting a placement that outlined the tasks expected of them. We received varying feedback about how accurate, detailed and up to date this had been. One staff member told us they found that the information provided for them prior to a placement was enough but when they got there, they found the care summary was out of date. For example, one staff member told us the information they received stated that the person was at their day centre each day but the person had not been to the day centre for a long time.

The care coordinator confirmed that people received profiles of staff to help them choose a suitable staff member and that people could ask for a change of staff if things were not working. The provider ensured a 24-hour or a 48-hour hand over depending on the persons complex needs. This enable staff to see and learn the person's care and support needs. One person commented, "I get different profiles on line. It is up to carers as to how long they stay. I have been very fortunate I have had my main carer for a few years." People

we spoke with were positive about the care and the staff.

People and staff felt able to raise concerns and confirmed they felt these were responded to appropriately. One staff member commented, "About a week ago I had an issue with my client which we couldn't resolve so I contacted the care coordinator. They were engaged on another call at the time but called me back half an hour later but we had already resolved the issue. I felt supported because they had called me back." One relative said, "We have only had one complaint and that was with a carer who was not a good match. They [staff] dealt with it very quickly and it was sorted out. People we spoke with were confident if they had any issues these would be resolved.

Requires Improvement

Is the service well-led?

Our findings

This was an unannounced inspection due to concerns raised. Some of the information we requested during the inspection was not readily available. We found ENA were understaffed in the office.

The provider told us that the previous manager, who had been in the process of registering with CQC, had left the service in May 2018 and that this had had an impact on the running of the service and the availability of documents. Shortage of staff and the absence of a manager had also impacted on the care coordinators ability to complete their daily tasks. The provider has made an application with CQC to be the registered manager.

We asked the provider to send the information we were not able to see at the inspection visit. The provider agreed to send this by 08 June 2018. However, we did not receive all the information we requested.

The provider did not demonstrate they had an over view of the service. For example, they required the care coordinator to show them where the medicine audits were kept on the online care records system. We asked the provider for training and competency assessments for tracheostomy care. The provider confirmed in an email that, "We do not currently have any clients where we are directly providing any tracheostomy care, cough assist or chest physio and so I am not able to provide you with any competency assessments." However, we spoke with one relative of a person who did have this support provided and the person's care plan also detailed this support was provided by ENA staff. This meant that the provider had not ensured that this was being done safely and in line with best practice.

We asked the provider to provide us with staff competency assessments for staff that supported people with digital stimulation to manage people's bowel control. We did receive these; however, the competency assessments we received were dated 15 June 2018. The provider told us that the previous assessments had been carried out by the manager who had left the service but the records for this were no longer available. Revised competency assessments were only put in to place following our request for this information.

We found that arrangements for the clinical oversight of people's bowel management was not sufficient to ensure that the procedures were being conducted safely and in line with nationally recognised best practice. We requested further assurances from the provider who then reviewed their policies and procedures in relation to this area of people's care.

We found systems in place to monitor the quality of the service were not adequate and had not led to sufficient action being taken. We saw that the provider had identified many issues after completing an audit of people's care plans in May 2018. These issues were given to the care coordinators to resolve. We noted that the care coordinators had scheduled to review progress in July. However, there were no action plans in place to plan how to make the required improvements. The provider did not demonstrate how they regularly monitored the quality and safety of the service. They were unable to show us how they conducted audits of medication; how they monitored safeguarding; how lessons were learnt from incidents and accidents and how staff training and competency was monitored. Although the provider told us that some

records had been lost when the previous manager left there were limited audits carried out by the provider prior to the manager leaving or since.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found that the provider had not reported an incident that they were required to report to CQC. One person had sustained a fracture and this had not been reported as required.

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 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that systems and processes were established and operated effectively to ensure compliance with the required regulations.