English Rose Care Limited

English Rose Care- Wellingborough

Inspection report

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Date of inspection visit:
20 April 2018
26 April 2018
03 May 2018

Date of publication:
31 July 2018

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was the first comprehensive inspection of English Rose at their Wellingborough location since the regulated activity of 'personal care' was registered with the Care Quality Commission (CQC).

English Rose provides a domiciliary care support service providing the regulated activity of 'personal care' to people living within their own homes in the community. When we inspected the service predominantly covered the Wellingborough and Kettering areas of Northamptonshire, although several people living in the Bedford area received a service. The service provided included support for people with end of life personal care support needs. There were 19 people receiving support at home when we inspected.

A registered manager was in post. 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 registered manager had not always maintained adequate oversight of the reliability of the service. Some people had experienced late or missed calls or had not always been informed if their care worker was going to be late. Although lessons had been learned and people felt they could now rely on the service the improvements were relatively recent and need to be seen to be sustained.

Some records relating to staff recruitment and the day-to-day running of the service had not always been consistently completed with the necessary details, with dates sometimes left unrecorded and the person completing the record left unidentified. Again, and following a recent internal audit carried out a senior staff member, these shortfalls had already been identified. The improvements made need to be seen to be sustained.

Although staff had received the basic training they needed to do their job training for staff with little or no experience could be further enhanced. It is acknowledged that further training opportunities were being organised when we inspected.

People's consent was sought before any care was provided and the requirements of the Mental Capacity Act 2005 were met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in place at the service supported this practice.

Staffing levels were sufficient to meet people's current needs, although recruiting sufficient staff able to work in the Bedford area had initially proved difficult. There had been previous occasions when providing 'back-up' staff to cover for sickness or holidays had compromised the reliability of service, with staff arriving late or relatives having to be contacted to establish if they were able to provide cover because of staff being unavailable. This had been recently resolved when we inspected but the availability of 'back up' staff needs

to be seen to be sustained in conjunction with the other recent improvements to the service.

The staff recruitment procedures ensured that appropriate pre-employment checks were completed to ensure only suitable staff worked at the service.

People's needs had been assessed prior their service being agreed. There were plans of care in place that been developed to guide staff in providing care in partnership with people who used the service. Their care records contained risk assessments and risk management plans to mitigate the risks to people. These plans provided staff with guidance and information they needed on how to minimise the identified risks.

Staff treated people with kindness, dignity and respect. People were happy with the way that staff provided their care and support and they said they were encouraged to make decisions about how they wanted their care to be provided.

Staff had a good understanding of what safeguarding meant and the procedures for reporting abuse. The staff we spoke with were confident that any concerns they raised would be followed up appropriately by the registered manager or other senior staff.

Arrangements were in place for the service to reflect and learn from complaints and incidents to improve safety across the service.

The provider worked in partnership with other agencies and commissioners to ensure that where improvements were needed action was taken. Communication was open and honest, and any improvements identified were worked upon as required.

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.

Although the necessary improvements to the reliability of the service had been made prior to our inspection they needed to be seen to be sustained and embedded in practice.

People were assured that appropriate action would be taken to protect them from harm. Staff were aware of the different types of abuse and how to report any they witnessed or suspected.

There were individual risk managements plans in place to protect and promote people's safety.

People were assured that they would receive their scheduled support on time and that carers would complete the agreed tasks.

People received the support they needed to manage their medicines.

Is the service effective?

Good

The service was effective

People were looked after by staff who were trained to carry out their roles and responsibilities.

People's consent to care and support was sought in line with the principles of Mental Capacity Act 2005.

Staff supported people to eat and drink and to maintain a balanced diet.

People were supported to access healthcare services if needed.

Is the service caring?

Good

The service was caring

Staff had developed caring and positive relationships with the people they supported at home.

Staff enabled people to express their views and to be involved in decisions about their day-to-day care and support.

Staff ensured people's privacy and dignity was promoted when assisting them with their personal care.

Is the service responsive?

Good

The service was responsive

People's needs were assessed prior to them receiving a service.

People had a choice about the way they received their care so they had control over their lives.

There was a complaints policy in place so people could raise any concerns they might have.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found there had been a lack of management oversight regarding the reliability of the service. Although the necessary improvements to the quality assurance of the service had been made prior to our inspection and the service was now reliable this managerial oversight needed to be seen to be sustained and embedded in practice.

People, their relatives and staff were positive about the way the service was managed.

Staff felt supported by the management team and said they had the managerial guidance and support they needed.

English Rose Care- Wellingborough

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 first comprehensive inspection of the service, carried out by one inspector, was announced and took place over three days, 20 April, 26 April and 3 May 2018. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to arrange calls to people using the service and staff.

We reviewed the information we held about the service and notifications we had been sent. Notifications are changes, events or incidents that providers must tell us about. We also received feedback from the commissioners of the service and a member of their quality monitoring team.

We initially visited the agency office in Wellingborough on the 20 April 2018 to look at care and management records. With their prior agreement we visited three people at home to find out about their experience of using the service. We also spoke with five people who had agreed to be contacted by telephone. During the inspection we met and spoke with the registered manager, the 'branch manager' who acts as their deputy, six care staff including a team leader, and two office based business support staff.

We looked at the care records belonging to six people who used the service. We also looked at other information relation to the day-to-day management of the service. This included four staff recruitment and training records. We also looked at policies and procedures, records relating to safeguarding, complaints and quality assurance monitoring records.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe, although some people said that until the service had recently improved they had sometimes felt anxious about their service not always being reliable. This was no longer the case. Although the service was now reliable and people felt safe we needed to see that positive changes made to the way the service was provided will be sustained and embedded into practice.

People had previously experienced late calls and had not always been informed in a timely way about the reason for the delay. One person said, "I know there's lots of genuine reasons why they [carer] will be late. They call me now, so that's good, but they didn't always, so I worried they had forgotten me." They said that their care workers were no longer arriving late unless there had been an unavoidable delay, such as traffic problems.

Agreed visits had been missed by staff in the past because of mistakes in scheduling or because staff had not informed care co-ordinators that they were unable to work. Although people had received their service when the error was realised the delay had sometimes left people feeling unsafe.

Improvements had been made to the reliability of the service when we inspected so, for example, people were now promptly advised if there was a delay in their carer arriving. One person said, "Just knowing they [care workers] will be coming a bit later makes me feel I'm safe." A relative said, "As long as I know they [the agency] are having a problem getting to [relative] I can do something about that. After all it is [relative's] safety that matters here. Things are much better now, I have to say, and I don't worry that [relative] will be left unsafe if there's a delay. They've really improved."

Contingency arrangements had been put in place for ensuring people received their service even when at short notice the original staff member was unable to attend their scheduled visit. The registered manager ensured there was sufficient numbers of suitable staff to support people to stay safe and meet their needs. This had been achieved by recently recruiting more staff and by ensuring that staff consistently contacted the agency office if they had been delayed or were unable to work. This enabled the care co-ordinator on duty to make timely arrangements for another care worker to pick up the scheduled visit and minimise disruption to the service.

Thorough employment checks to ensure that all staff were suitable to be working at the service were carried out. We looked at staff files that showed all staff had a disclosure and barring service (DBS) security check, and had provided references and identification before starting any work.

Staff confirmed they had received training in the safe handling and administration of medicines; and their competencies were assessed if staff were required to prompt and support people to manage their medicines.

People were protected by the prevention and control of infection. Staff received training in relation to, for example, infection control and food hygiene. Staff confirmed they were supplied with 'personal protective

equipment' (PPE), such as gloves and aprons, to protect people from the spread of infection or illness. Precautions taken by staff were observed during unannounced 'spot check' visits by their supervisor. 'Spot checks' also included ensuring that staff carried their agency identification with them and showed it to people. One person said, "I don't let anyone in if I haven't met them before and they don't have a 'badge' [identification] with them. They [staff] always remind me to keep safe if I get another carer coming I haven't had before. They've got my best interests at heart."

Lessons had been learned and improvements were made when things went wrong. Staff understood their responsibilities to report accidents and incidents and raise any concerns in relation to people health and well-being.

Good

Is the service effective?

Our findings

People's needs and choices were assessed and their care, treatment and support was delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in community services come under the Court of Protection. We saw people's capacity to make decisions was assessed, and people assessed as not having capacity had 'best interests' decisions made on their behalf by family members or their representatives.We checked whether the service was working within the principles of the MCA and saw that this was the case.

Records we looked at showed that people's care was assessed prior to taking up the service to ensure their needs could be fully met. The assessment covered people's physical, mental health and social care preferences to enable the service to meet their diverse needs.

Staff we spoke with understood the importance to always respect people's wishes for how they preferred to receive their care and seek their consent when providing them with support.

Staff had the basic practical skills and knowledge they needed to carry out their job in line with people's expectations and needs. Additional training opportunities were being organised when we inspected, for example in providing care workers with more insight into ways of managing people's natural anxieties when they had end of life support needs. A staff member said, "We know what we have to do to support people but you can never have enough training when you go into their [people's] homes; not just the basic 'nuts and bolts' practicalities of the job. It's not always an easy job so the more training we get, the better, and we will be getting that."

Staff told us they felt supported by the senior staff and had the guidance they needed if they were ever in any doubt as to what was needed. Records showed that staff received regular supervision and an annual appraisal of their standard of work.

People's care plans had information on people's medical history and their current health needs. A staff member said, "We have to 'keep an eye' on them [people]. We might be the only ones to see someone's condition [health] 'go downhill' if they have no relatives to look out for them, so it's a big responsibility that we take seriously." Another staff member said, "If someone was really unwell I'd call an ambulance but if I'd noticed that they were gradually deteriorating and becoming less able I'd raise it with my manager so they

could review their care and if the person was happy for us to do that we could call their doctor."

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. One person said, "They [staff] are all lovely, even the ones that cover for my usual carer when [carer] is away." Another person said, "I've no complaints at all about the way they [carers] help [relative]. They've all got a 'good way' with them, pleasant and good mannered. I can't fault their attitude at all. Even when they are really busy they never leave you with the feeling that you're being 'hurried along' so they can get to their next call."

The ethos of the service was to provide person centred care. People's care plans were individualised and reviewed and updated as and when people's needs changed. People were encouraged to be involved as much as they wanted to be, and were capable of, in making day-to-day and longer term decisions about how they received their care. One person said, "They [carers] don't just assume that what I liked yesterday I might still like today. They know I have a tongue in my head and they ask me just to make sure."

People's choices and preferences were recorded in their care plans and staff were introduced to the people they would support. A new care worker would be scheduled to provided support for a person they had already got to know when they initially 'shadowed' a more experience colleague as part of their induction into providing the person's care. One person said, "It's always nice to get the same carers and they [care co-ordinators] do their best to make sure that happens."

People's privacy, dignity, and respect for their individuality and desire to retain as much independence as their capabilities allowed was promoted. One person said, "If they [staff] need to help me clean myself they do their upmost to keep me from feeling embarrassed. They are all very thoughtful and considerate." The staff we spoke with knew the people they supported well and could describe their daily routines and preferences. The examples they gave about people's needs and the care they provided was were consistent with the information in people's care plans.

Staff had an induction that included being sensitive to issues of equality, diversity, and upholding people's human rights. Staff were aware of their responsibilities related to maintain confidentiality and of their duty to protect personal information. Information held electronically was password protected and written documentation was stored securely. One person said, "I've never heard any of them [staff] speak 'out of turn' about anyone else they have to visit. They keep that to themselves and quite right too. I wouldn't like to think they were gossiping about me."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their initially assessed needs and subsequently to any needs that changed over time. They were involved in agreeing to their care plan being set up and in later reviews of their care.

During this inspection we found that people had appropriate plans of care in place that were reflective of their care and support needs. People had been supported to review their plans of care with senior staff and new plans of care had been developed to direct staff in providing personalised care and support.

People's care plans covered all aspects of a person's individual needs, circumstances and requirements. This included details of the personal care required, duties and tasks to be undertaken by care staff, risk assessments, and how many calls and at what times were needed. People were asked to share information that was relevant to how they preferred their care to be provided. This information was used to create a working care plan that contained, for example, religious beliefs, cultural issues, and if there was any family support to supplement the care provided by the agency. One person said, "They [the staff member assessing] asked [relative] and me a lot about [relative] so they had a good picture of what [relative] liked and needed in the way of support."

The registered manager looked at ways to make sure people had access to the information about the service they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

A complaints policy was in place and records showed the service responded appropriately to complaints, following the policy. People's concerns and complaints were responded to, listened to and used to improve the quality of care. For example, according to the complaints record, one person had been mistakenly asked to pay a bill that had already been settled previously. When the mistake was realised the person received a letter of apology and a refund of the monies charged.

People who required support at home with end of life care had their service provided in a sensitive way so that in the time they had remaining they were as comfortable as they could be. One person said, "They [staff] make sure [relative] is treated gently and thoughtfully."

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not always consistently maintained an oversight of the reliability of the service with the result that improvements had only relatively recently been made. Prior to our inspection some people had experienced late or missed calls or had not always been informed if their care worker was going to be late.

During this inspection we found that the systems adopted by the registered manager and provider to monitor the quality of care that people received had improved. As a result the reliability of the service had been improved before we inspected. Although lessons had been learned and people felt they could now rely on the service the improvements were relatively recent and we needed to be assured that over time the reliability of service was sustainable. As the gap between when the improvements were made and the time of our inspection was only a matter of months sustainability had yet to be confirmed as embedded in practice.

There was an open culture within the service that encouraged communication between staff and senior staff, including the registered manager. The people we spoke with were, overall, pleased and satisfied with their service. They felt that the day-to-day organisation of their service was now better managed with regard to reliability and that communication between them and the agency office was much better. One person said, "If I have to call them [at the office] they are polite and helpful. They don't keep me hanging on the phone before they answer."

Staff that we spoke with said they felt the senior staff were approachable and never dismissive if they were unsure about anything. Some staff were a bit unclear about the difference between the day-to-day deputising role of the senior member of staff referred to as the 'branch manager' and the responsibilities of the registered manager. They all confirmed, however, that they had the managerial guidance and support them needed to do their job.

Staff understood their responsibilities and they received support through day-to-day contact with senior staff and administrative support staff based in the agency office. The staff we spoke with felt able to voice any concerns or issues and felt their opinions and ideas for improvement were listened to and valued.

The records maintained at the service were up to date and were reflective of the care provided to people living at home. However some records had not been dated and the author of the record had in some cases not been identified. Some records relating to staff recruitment self-assessments had not always been appropriately completed by staff, for example where a candidate had been asked to assess their own ability to carry out a task by entering a score some people had not followed the instructions and simply put a tick against each task. The ambiguity of this did not appear to have been commented upon in the interview record. These shortfalls had already been identified in an audit of records that had been carried out prior to our inspection. Refresher training for staff on ensuring accurate record keeping had been organised.

It is a legal requirement that a provider's latest Care Quality Commission (CQC) inspection report rating is

displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. As this was the first comprehensive inspection of this service there was no previous rating to display. The provider was aware that their rating for this the service would be displayed on their website.