Empathy Care24 Limited

Empathy Care24 Northampton

Inspection report

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Date of inspection visit:
24 October 2022
25 October 2022
03 November 2022
08 November 2022

Date of publication:
01 February 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Empathy Care24 Northampton is a domiciliary care agency providing personal care to people in their own homes. At the time of our inspection there were 86 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Care:
Risks to people were not always identified or managed safely. People's care plans and risk assessments did not always reflect people's current needs. We found missing information in people's care records in relation to equipment, pressure care and medicine administration.

Staff did not always report incidents to the registered manager or relevant office staff. Trends and patterns were not always identified by the registered manager to improve safety across the service.

People were not always protected from the risks of infection. People and their relatives told us staff wore personal protective equipment (PPE) when being cared for however, we observed staff not to be wearing face masks when supporting a person in their home.

Staff had received training in how to report allegations of abuse. People and their relatives told us they felt safe. Staff were recruited safely.

Right Support:
Mental capacity assessments were not always completed for decisions relating to people's care or treatment. We received mixed feedback from people and relatives if staff gained people's consent before supporting them with their care needs. Staff demonstrated an awareness of the importance of choice and consent.

Staff had access to people's care plans and risk assessments before providing care to people. Not all people's care plan's and risk assessments provided information on people's current care needs and risks. Where other professionals were involved in aspects of people's health and care, this was not always recorded in people's care plans.

Staff had received training in moving and handling, first aid, food hygiene and mental capacity. Staff had also received training on supporting people with a learning disability and autistic people.

People were provided with enough to eat and drink. Staff kept records on when people were provided with food and drink. Staff had received training in providing nutritional support to people.

Right Culture:
Systems in place to assess, monitor and improve the service were ineffective. The shortfalls found during the inspection had not been identified by the provider through quality monitoring processes.

We received mixed feedback from people and relatives in relation to communication with the registered manager and office staff. People's feedback was gathered through care review meetings and spot check visits. People and their relatives also had the opportunity to provide written feedback via a questionnaire.

Staff meetings gave staff the opportunity to raise concerns and discuss improvements to people's care.

The registered manager and nominated individual were guided to review the Right Support, Right Care, Right Culture guidance to ensure they fully understand the requirements should they support people with a learning disability or autism in the near future.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 February 2022) and there were breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

At our last inspection we recommended that where people have the capacity to consent, their consent and agreement is clearly recorded. Improvements had not been made or sustained.

Why we inspected
We received concerns in relation to personal care support, catheter care and short care calls. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Empathy Care24 Northampton on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk management, consent to care and management oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

At the time of inspection, it appeared that we had not received statutory notifications for notifiable incidents. We are currently looking into this matter.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.
Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always Effective.
Details are in our Effective findings below.

Is the service well-led?

Requires Improvement

The service was not always Well Led.
Details are in our Well Led findings below.

Empathy Care24 Northampton

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 2 inspectors and 2 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 24th October 2022 and ended on 8th November 2022. We visited the location's

office/service on 24th October 2022 and 3rd November 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 11 people and 10 relatives on the telephone about their experience of the care provided. We also spoke with another 3 people and their relatives whilst visiting people in their own homes.

We spoke with 9 members of staff including care staff, care co coordinators, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 7 people's care records including care plans, risk assessments and medicines records. We looked at 4 staff files in relation to recruitment. A variety of records relating to the management of the service were also reviewed including safeguarding and incident monitoring, auditing processes and staff training.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely;

At our last inspection, people were at risk of not receiving their calls at the planned times. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation

● Risks to people were not always assessed. People's care plans and risk assessments did not always reflect people's current needs or provide information to staff to manage and mitigate risks to provide safe care. For example, one person's care plan did not contain detailed information to support staff to understand their diabetes. This placed people at risk not receiving the correct care and treatment in the event of poor health from diabetes.
● Risks to people using wheelchairs had not been assessed. Risks assessments were not in place for two people who were at potential risk of falling from their wheelchairs. This meant staff did not have the information they needed to provide safe care and to mitigate and manage the risk.
● Staff did not always have the guidance and information available to prepare and administer medicines safely. There was no guidance or protocol in place for staff to follow on administering transdermal patch medicine as per best practice. Staff had not recorded where on the body the patch had been administered to. This is important so staff can check that the patch is still in place and to reduce the risk of overdose.

The provider had failed to assess the risks to the health and safety of people using the service, manage medicines safely and ensure staff had the skills and competence to support people safely. This is a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Moving and handling risks were assessed and documented to ensure staff had clear guidance on how to support people safely. People were supported by staff who had received moving and handling training.

Staffing and recruitment
● We continued to receive mixed feedback from people and relatives about the length of care calls. Some people told us staff completed the tasks required and left once finished. One person said "They [staff] stay

until they are done and then go off to the next call. They don't want to be hanging around." One staff member said, "It depends what things we have to do there. As soon as we are done, we leave."

● People and their relatives told us that call timings had improved since the last inspection and they received a phone call from the office staff or the carer themselves if the care call was going to be late.

● Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Staff had received training in how to report allegations of abuse. They told us they were confident in reporting concerns to their management team. However, staff did not always report incidents to the registered manager or relevant office staff. When this was identified, the registered manager held team meetings and supervisions with the staff involved to improve practice.

● The management team reviewed accidents and incidents to improve safety across the service. However, trends and patterns were not always identified to improve safety across the service. There had been a number of incidents involving people's catheter care and staff's skills and knowledge in this area had not been recognised as a possible factor.

● People and their relatives told us they felt safe. One relative told us, "[Person] is safe as she has continuity in her carers who have got to know her well." One person told us, "I am safe with my carers. They are friendly and ask me if there is anything I want them to do."

Preventing and controlling infection

● The team leaders and management team conducted regular spot checks on staff which included checking for appropriate use of Personal Protective Equipment (PPE). However, we could not be assured that all staff followed current COVID-19 Government guidance. We observed staff supporting a person in their home without wearing a face mask.

● People and their relatives told us that staff wore PPE including masks, gloves and aprons.

● Staff had received training in infection prevention and control and the provider had an up to date infection prevention and control policy.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

At our last inspection we recommended that where people have the capacity to consent, their consent and agreement is clearly recorded. Improvements had not been made or sustained.
- Mental capacity assessments were not always completed for decisions relating to people's care or treatment. This meant decisions on how people should be supported with tasks such as personal care and medication administration had been made without confirming the person's understanding of information relating to these decisions, ensuring they were least restrictive and in their best interests.
- One person's relative told us that their loved one was at risk of refusing personal care support from care staff and at times, hidden their medicines. The provider had not assessed this person's capacity to consent and the risks of refusing care had not been documented in the person's care plan.
- People with communication difficulties did not have information within their care plan to provide guidance to staff on how to effectively communicate with the person. This meant staff did not have the information available to ensure they supported people to make their own decisions.

The provider had failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received mixed feedback from people and relatives if staff gained people's consent before supporting them with their care needs. One person said, "They [staff] just get on with it." Another person told us, "The carers are polite and ask for my consent."

● Staff had received training in MCA and deprivation of liberty safeguards. Staff demonstrated an awareness of the importance of choice and consent. One staff member said "They've [people] got the right to choose what they want. Sometimes I'll support to choose."

Staff support: induction, training, skills and experience
● Staff completed mandatory training across three days including moving and handling, food hygiene, basic life support, first aid awareness and equality, diversity and human rights. This training was provided by an external training company.
● Staff received an induction and were enrolled onto the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People and their relatives told us that the provider carried out initial assessments before the care package commenced. One person told us, "The manager assessed my needs and talked to me before I started properly with the company. I told them what I needed."
● Staff had access to people's care plans and risk assessments before providing care to people so they could understand how to meet people's needs. Staff accessed these records on their phones. During the inspection, we found not all people's care plans and risk assessments provided information on people's current care needs and risks. Staff did not always have the information to provide effective and consistent care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Copies of people's care plans were in people's homes with an overview of people's needs to support transition into emergency care if needed. We found some people's care plans required updating to ensure they were reflective of people's current needs.
● Where other professionals were involved in aspects of people's health and care, this was not always recorded in people's care plans. Two people were supported by the district nurse team for pressure area care. This was not reflected in people's care records to ensure staff had the knowledge and understanding of people's healthcare needs or to follow any instructions from healthcare professionals.
● People and relatives told us staff helped them access healthcare services and support when needed.

Supporting people to eat and drink enough to maintain a balanced diet
● People were provided with enough to eat and drink. Staff kept records on when people were provided with food and drink. One person said, "They [staff] do my lunch for me, they heat up a meal and they make sandwiches later in the day."
● Staff had been trained to provide nutritional care to people. This included training on food hygiene and specialist feeding techniques. Care staff supported people who received their nutrition through a percutaneous endoscopic gastrostomy (PEG). A PEG is a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. This allows nutrition, fluids and/or medications to be put directly into the stomach.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection, systems were either not in place or robust enough to demonstrate the safety and quality of the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation

- There were ineffective governance systems to assess, monitor and mitigate the risks to people. During the inspection we identified missing or incomplete risk assessments for risks relating to choking and pressure sores. This had not been identified through the providers quality assurance systems and placed people at potential risk of harm.
- Systems to review and update care plans were ineffective. During the inspection we identified missing information in people's care and support plans. This included information on mental capacity and pressure care support. This meant staff did not always have clear and current guidance on how to support people in a way that meets their needs and keeps them safe.
- Systems to review medication administration were in place however, these were not always effective in identifying shortfalls and missing information within people's care records. For example, one person's medication administration record (MAR) for August 2022 showed a potential missed medication. The medication audit had not identified or addressed this.
- Systems to monitor people's care calls remained ineffective. There was no audit in place to review staff compliance with care call duration. During the inspection, we continued to receive mixed feedback from people and their relatives about staff leaving calls early. Records showed that staff did not always stay for the duration of people's care calls.
- The provider regularly attended the service but did not complete any audits or checks to ensure governance, systems and processes were in place and effective in identifying shortfalls.
- At the time of inspection, a review of records indicated we had not received statutory notifications for notifiable incidents. We are currently looking into this matter.

Systems were either not in place or robust enough to demonstrate the safety and quality of the service was

effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We received mixed feedback from people and relatives in relation to communication with the registered manager and office staff. One relative told us, "I've had several phone calls asking if [person] is happy with everything." One person told us, "I did phone up and [staff] snapped my head off so I hung up. I avoid ringing them." Another relative said, "The manager and the office staff are easy to contact. They are friendly and supportive." Another person said, "I have spoken to the manager on numerous occasions. She is helpful and supportive."

● The management team conducted supervisions and spot checks on care staff to monitor their performance and to ensure areas for improvement were identified and addressed.

● Regular staff meetings took place with the registered manager. These meetings gave staff the opportunity to raise concerns and discuss improvements to people's care.

● People's feedback was gathered through care review meetings and spot check visits. People and their relatives also had the opportunity to provide written feedback via a questionnaire.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider and registered manager had a good understanding of the duty of candour including their responsibilities to be honest with people, relatives and staff when things went wrong. We saw evidence of this being followed in practice.

Working in partnership with others

● The provider worked in partnership with other health care professionals, where needed, such as GPs, district nurses, and occupational therapists to help meet people's needs.

● The management team worked well with other partnership agencies including the local authority.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure they acted in accordance with the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people using the service, manage medicines safely and ensure staff had the skills and competence to support people safely.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate the safety and quality of the service was effectively managed.

The enforcement action we took:

Warning notice