EOF Capital Ltd

Eagle Care

Inspection report

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02 May 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Eagle care is a domiciliary care agency that was providing personal care to older and younger adults living in their own houses at the time of the inspection.

People's experience of using this service:
Risks to people had not been fully assessed. We found missing information and errors in recording.

Medicines were not managed safely, and people could not be assured that they would receive their medicines in line with their prescription.

Recruitment checks were inconsistent, this meant the provider could not be sure staff were fit for the role.

Accidents and incidents had not been managed in line with company policy and procedure. A serious incident highlighted failure in the management of accidents and incidents. There was limited evidence in learning when things had gone wrong. The manager understood their responsibility regarding safeguarding and reporting concerns.

There was inconsistency in staff training and induction. The lack of training schedules and training certificates meant that the provider did not have oversight of when training renewals were due.

One person had not been cared for or well supported during a serious incident. Other people told us staff were kind and caring and their dignity was respected and maintained. Personal information was stored securely.

Staff were often late, this had not been well managed by the provider who had failed to monitor time keeping and attendance of staff effectively. People were not consulted on changes in their visit schedule.

The provider had not maintained oversight of the safety and quality of the service. During the inspection on 2 May 2019 the provider informed us there was no governance structure in place to support the service and they were exploring outsourcing this support.

People had been involved in the planning of their care and support and their choices were supported. However, they were not asked for feedback on their satisfaction of the service. Information could be made available in different formats where needed such as large print or easy read.

People told us their complaints or concerns were responded to. One person found the provider approachable and was confident that if they raised concerns they would be dealt with. The provider had not logged or monitored complaints for patterns in line with internal policy and procedure.

Staff had access to personal protective equipment (PPE) to prevent the spread of infection. People told us

they felt safe with staff.

Rating at last inspection: This was a new service that had not yet been rated.

Why we inspected: This was a first inspection brought forward due to information of risk.

Enforcement: The provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and one regulation of Care Quality Commission (Registration) Regulations 2009.

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

The overall rating for this service is 'Inadequate' and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up: We will keep the service under review and if we have not taken immediate action to propose to cancel the providers registration of the service, we will inspect it again within six months. We expect that providers found to have been providing inadequate care should have made significant improvements within this time frame.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Eagle Care

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks see list below.

Risk Assessments □□□□□
Staff scheduling and time management
Accident and incident management
Staff training
On call support
Management oversight □□

Inspection team: This inspection was carried out by three inspectors.

Service and service type: Eagle care is a domiciliary care agency that was providing personal care to older and younger adults living in their own houses. At the time of the inspection on 17 April 2019 there were 10 people using the service. On our second visit on 2 May 2019 there were 0 people using the service.

The service did not have a manager registered with the Care Quality Commission (CQC). Having a registered manager means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been appointed and had applied to register with CQC.

Notice of inspection: This was an unannounced inspection.

We visited the office location on 17 April and 2 May 2019 to see the provider and the manager; and to review care records, policies and procedures. On 17 April 2019 we visited people in their houses. On 24 April 2019 we spoke with staff.

What we did:
Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report. We reviewed other information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We contacted Healthwatch Leicestershire. Healthwatch is an independent consumer champion created to gather and represent the views of the public. Healthwatch plays a role at both national and local level and makes sure that the views of the public and people who use services are considered. We also contacted the local authority safeguarding team and the local authority quality monitoring team for feedback.

During the inspection we spoke with two people who use the service and three relatives. We had discussions with five staff members including the manager, provider and three care and support staff.

We looked at the care and medication records of five people who used the service. We also examined records in relation to the management of the service such as staff recruitment files, staff training and supervision records, safe guarding information and accidents and incident information.

Following inspection, we requested and received:
Staff Handbook
Latest version of interview notes
Internal investigation report for a specific incident

Following inspection, we requested but did not receive:
Service user guide
Evidence of Mandatory training as per internal policy
Evidence of training booked to address any back log
Evidence of staff induction

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management:

- Risks to people were not assessed appropriately. We identified errors in records and risk assessments had not been completed in line with internal policy and procedure. For example, one person had mobility equipment in place including a hoist and sling this had not been risk assessed to ensure the persons safety. Another person had not had the risk of using flammable creams assessed.
- A serious injury incident highlighted multiple failing in the service including lack of management of electronic call monitoring for staff (ECM). ECM is a system that staff log into to reassure the provider that they have arrived at person's home and are on time to deliver care and support. The provider did not monitor ECM this meant that people were at risk of missed calls and poor time keeping.
- There were not enough staff available to meet people's agreed call times, people told us staff were persistently late for visits. For one person we saw their care visit had been two hours late and they or their family had not been informed. One relative told us, "We don't always know who is coming and they can turn up at times we haven't agreed to, we have sent them away before and asked them to come back later." Another person told us staff are often late, they don't always know who is coming and they don't receive phone calls with an explanation. The manger advised that this was due to the poor planning of staff schedules.
- Staff schedules did not include travel time between people's homes. One staff member told us travelling time is difficult as it's not included on the rota. This meant that staff were consistently late for calls which people confirmed.

Using medicines safely:

- There were several errors on people's medicine records. One person's medicine frequency was incorrectly recorded. Staff had failed to notice the error and had continued to add their signature to the medicine chart even though staff hadn't given the medicine to the person. One person's medicine name had been incorrectly recorded and again staff had continued to give the medicine without highlighting the problem. Another person's medicine had been given to them and recorded in the notes, but staff had failed to sign the medicine chart. This highlighted the staffs lack of knowledge and understanding around administering medicines safely and left people at risk of not receiving their medicines in line with their prescription.

Medicines were not managed safely, and risk assessments were not completed effectively to keep people safe. The management of staff in relation to time keeping, attendance and staff scheduling was inadequate. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:

- Pre-employment checks for staff were inconsistent. Not all staff had received reference checks or had had

previous work history validated by the provider. We saw that interview questions did not fully explore staffs experience or suitability for the role. One staff member had declared an injury at interview which had not been followed up by the provider. This meant that the provider could not be sure that staff employed were suitable or fit for the role.

● Disclosure and Barring Service (DBS) checks were completed prior to staff working with people. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The provider had not completed sufficient pre-employment checks to ensure staff were suitable for the role. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong:

● Accident and incident forms had not been completed in line with company policy. Internal procedure had not been followed effectively to ensure that people were safe until an internal investigation was completed. Internal investigations were not thoroughly completed to include lessons learned and explore preventive measures.

Systems and processes to safeguard people from the risk of abuse:

● Staff training in how to recognise signs of abuse and safeguard people was inconsistent. At the time of the inspection the local authority was investigating organisational safeguarding concerns within the service. The provider had not understood their responsibility to safeguard people from the risk of abuse and had failed to follow policy and procedure to safeguard people following a serious incident. However, people told us they felt safe, one person said, "I feel safe they are nice girls."

Preventing and controlling infection:

● Personal protective equipment (PPE) was readily available to staff. One person told us, "They (Staff) wear gloves they change them and throw them away when they have finished with them."

● Staff told us the PPE was available when needed.

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience:
● Staff told us they had received some of their training. However, two of the staff we spoke with had received training via other services prior to starting their role with Eagle care. The provider had not sought sufficient evidence of previous training and ensured that staff were competent to carry out their role. One member of staff told us they had not had training in The Mental Capacity Act 2005 (MCA) and could not recall if they had trained in safeguarding.
● We found that staff had not all received training that the provided detailed as mandatory to carry out their roles. We saw that the provider had been delivering care to people but could provide no evidence of the training they had completed to ensure they had the knowledge and skills needed for the role and to ensure people were safe. The manager told us they had concerns around the lack of training for staff and was preparing an action plan to address this at the time of the inspection. People were at risk of receiving care from staff that did not have the skills to do their jobs.

We found Inconsistency and lack of evidence in staff training and support for staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
● One staff member told us, "[I am] concerned about the lack of care plans (hard copies in people's homes) because if an ambulance needs to come there is not always information to give to the paramedics." A recent incident had highlighted that information had not been available in an emergency when needed.
● People's care records confirmed that the service had liaised with district nurses and GP's when required.

Supporting people to eat and drink enough to maintain a balanced diet:
● People we spoke with did not require support with eating and drinking. However, we viewed other people's care records and saw that likes and dislikes for food had been detailed and included instruction for staff on how to support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Ensuring consent to care and treatment in line with law and guidance:
● People were receiving care and treatment in line with law and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA and found that people were supported in the least restrictive way possible.

●The management team and staff understood the principles of MCA. One person told us they lead their own care and staff supported their choices.

● People had been included in the planning of their care and had signed records to agree to care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence:

- One person had not been well supported or cared for following a serious incident. A relative told us that a staff member had left the person alone and injured to wait for emergency assistance. The staff member told us they had alerted the provider to the incident before they left. However, the provider had failed to deploy a replacement staff member to offer support until family could be contacted.
- People told us staff respected their dignity when providing personal care this included, closing curtains and doors and covering people with towels when supporting with personal care.
- People told us staff were caring. One relative said, "They (staff) are kind and caring, [they] have a chat." A person said, "They (staff) are nice girls with good manners."
- People's personal information was stored securely in locked cabinets and the electronic systems were password protected.

Supporting people to express their views and be involved in making decisions about their care:

- People told us they were not consulted on changes to their care rota or given choices on which staff would attend. One person told us, "(I) would like a rota."
- People told us they and their family had been involved in the planning of their care. One person told us they had discussed their needs with the provider and had agreed a plan of care.
- The manager told us information could be made available in various formats such as easy read or large print.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● Staff had access to electronic records which were accessed on their mobile devices. We saw that this system contained personalised information on people's choices and preferences. One staff member told us the information is not always available and they have to contact the office and ask for advice and support or ask the other carers about the routine for people. One relative told us that their family member had been left at risk of falls as staff had not had access to the persons door code via the electronic system. Staff had resorted to knocking on the persons door meaning the person had to mobilise to the door unnecessarily.
● One person told us that staff ask them what they want and offer choices. However, we saw care was task focused with staff ticking of a list of jobs on their mobile device without making detailed notes of what care had been delivered, how the person was feeling or what they had eaten or drank. This meant that the manager and provider had limited information to be able to review peoples care to ensure it was meeting their needs, preferences and choices.
● Staff gave a mixed response regarding how they were kept informed on changes to people's needs. They said, "The manager will tell the care staff if a person is unwell or needs [have] changed before they go to do a planned care call." However, another staff member told us they have never been informed of changes in people's care needs and they rely on other staff to provide information.

Improving care quality in response to complaints or concerns:
● People told us they had not received information on how to make a compliant. One person that had made a complaint told us, "Times they (care call times) were all over the place, I had a word and since then they have been good." Another person said, "Any concerns have been dealt with promptly.
● The manager and provider had not kept an accurate log of complaints to monitor patterns or to evidence they were responding to complaints in line with internal policy procedure.

End of life care and support:
● The service was not currently supporting anyone at the end of their life. End of life care had not been routinely discussed or recorded on the care plans we saw this to be blank. We saw no evidence that staff had received training in end of life care.

Inadequate

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:
● The provider had failed to provide appropriate support to a person that had received a serious injury, did not complete a thorough investigation or provide a written apology and explanation in person to the family of a person who had died following a serious injury.

This was a breach of Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (part 3).

● The on-call system was not being managed effectively, a staff member had been unable to get management guidance during a serious incident. The staff member told us, "It was devastating. I was really panicking because I didn't know what to do next."
● A contingency plan had not been implemented when a failure to the electronic care plan for the person had been identified by the provider.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
● Policies and procedures and staff file documents had not been reviewed in line with company policy. We discussed this with the manager who agreed to review all policies and procedure to ensure they reflected current legislation and best practice.
● The provider had not maintained oversight of the service. The manager and provider were open and transparent in telling us there were no systems and processes in place to monitor the safety and quality of the service including, medicine chart checks, care plan and risk assessment checks or staff training schedules. This meant that people were at risk of potential harm and the provider was not working within their own policies and procedures.
● At the time of our inspection date of 2 May 2019 the provider no longer had access to a governance framework via their franchise agreement as this agreement had been terminated. The provider was in the process of outsourcing this support.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● The manager and provider told us they did not have systems and processes in place to gain feedback from people using the service or staff via for example, questionnaires or quality monitoring calls.
● Staff meetings did not routinely take place. Supervisions, competency checks, spot checks and appraisals

were not routinely completed or scheduled. The manager had taken steps to address this and a staff meeting was scheduled for the first day of our inspection.
● Staff gave mixed feedback on the provider with one staff member saying the provider did not have a good attitude towards staff and people. Another staff member had found the provider supportive and encouraging. A person described the provider as, "Down to earth" and felt confident if they had concerns or complaints the provider would deal with them. Staff spoke positively of the new manager and described them as approachable and helpful.

Continuous learning and improving care:
● The manager and provider were open and transparent when discussing a recent serious incident. However, there was little evidence that lessons had been learned to prevent a reoccurrence. For example, the manager and provider had not reviewed their practices and procedures around electronic call monitoring for staff to ensure that staff arrived at agreed call times and to reassure themselves that calls would not be missed. They had also not assured themselves that hard copies of information were in place for people should there be a further electronic systems failure and information was needed in an emergency. A staff member said, "Care plan files are missing from at least three people's homes."

Working in partnership with others:
● The manager had worked in collaboration with another service to ensure a smooth transition process. However, the failure to follow internal policy and procedure had meant not all information collated had been used effectively to ensure a smooth transition and records had not been available for staff in a timely manner.

The provider did not have systems and procedures in place to maintain oversight of the quality and safety of the service. At the time of our inspection on 2 May 2019 there was no governance framework in place to support the operation of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Improvements were required to the provider's understanding of the notifications required to be submitted to the Care Quality Commission (CQC). A notification is information about important events that the service is required to send to us by law, in a timely way. During the inspection we identified that the provider had failed to submit a change of location notification to the CQC. The provider confirmed they had misunderstood the regulations in this regard.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009. CQC are considering their regulatory response to this.