Equinox Care

Equinox Care

Inspection report

Unit 1
Waterloo Gardens, Milner Square
London
N1 1TY

Tel: 02036689270
Website: www.equinoxcare.org.uk

Date of inspection visit:
16 June 2016

Date of publication:
18 January 2017

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

This inspection took place on 16 June 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to make sure someone would be available to support us with the inspection. Equinox Care provides care and support for two people in their own home. The service works with people living with complex needs including mental health, drug and alcohol dependency and people living with physical and sensory disabilities.

This was the first inspection of this service since they registered with the Care Quality Commission (CQC) in June 2015.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not present during the inspection.

Medicines were not always accurately recorded on the Medicine Administration Records (MAR). The registered manager did not complete medicines audits. Staff had received training on medicines administration.

Risk assessments were often a tick box format and did not give staff guidance on how to mitigate risks. Risk assessments failed to provide staff with appropriate information with regards to the people they were taking care of.

Staff had not received an appraisal. Staff did receive supervision. However, this was not documented.

Audits on any aspect of the service were not completed. There was no management oversight of quality assurance.

Care plans were not person centred and did not state people's likes, dislikes or how they wanted their care to be provided. Care plans were brief, often several sentences and did not provide staff with an appropriate level of knowledge to be able to work with people and meet their needs.

People were not involved in decisions about their care. People were not consulted around creating their care plan. People and staff that worked with the people had not signed their care plans.

Procedures relating to safeguarding people from harm were in place. However, staff were not always aware of what safeguarding was or who to report it to if people were at risk of harm.

Staff had not received training around the Mental Capacity Act 2005 (MCA). Some staff had an understanding

of the systems in place to protect people who could not make decisions outlined in the Mental Capacity Act 2005 (MCA). However, other staff were unaware of how the MCA would impact on the people that they worked with.

There were no systems in place to monitor missed visits.

People received continuity of care from regular care staff. The provider always tried to ensure that the same care workers looked after people. This promoted good working relationships with people who used the service.

People said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

There was a complaints procedure in place and people were given copies of the procedure giving guidance on how to complain when they began using the service.

The service operated an on-call system for any issues that arose out of hours.

We identified breaches of regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. We will publish what action we have taken at a later date.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risk assessments were brief and did not provide staff with guidance on how to mitigate risks.

Documented audits of medicines were not completed. Staff were administering medicines. However, the registered manager was unaware that staff were administering medicines. There was contradictory information around administration and prompting of medicines in people's care plans.

Some staff were able to tell us how they would recognise abuse and knew how to report it appropriately. However, other staff were unable to explain what safeguarding was or how to report issues of abuse.

Staffing levels were sufficient to support the people that used the service.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not received appraisals. Supervision was completed by the registered manager. However, this was not documented.

Staff had received training in the Mental Capacity Act (MCA). However, some staff were unable to explain what the MCA was or how it impacted on the people that they cared for.

People were supported with eating and drinking. However, people's care plans did not document their preferences around food.

Is the service caring?

Requires Improvement

The service was not always caring. People's preferences around their care were not documented. However, staff knew people well and understood their needs.

People were treated with respect and staff maintained people's privacy and dignity.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care was not person centred and care plans were not detailed. People's likes and dislikes were not noted.

Initial referral assessments to the service were not documented.

Staff were knowledgeable about individual support needs, their interests and preferences.

Complaints were responded to in an effective and timely manner. People were provided with information on how to complain.

Is the service well-led?

Inadequate

The service was not well led. There were no systems in place to assure quality of care provided. Audits were not carried out for any aspect of the service.

The service failed to document and maintain records of meetings, assessments, monitoring visits.

Team meetings did not take place.

People were positive about the support they received from the manager.

Equinox Care

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 took place on 16 June 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service. The inspection was carried out by one inspector.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at two people's care records and risk assessments, seven staff files and other records that the service held, such as health and safety, audits of systems, policies and procedures. We looked at policies in place at the service. We spoke with one person that used the service and three staff. We were unable to speak with relatives of people that used the service due to people's wishes.

Inadequate

Is the service safe?

Our findings

The service had a medicines policy, which staff had access to. The medicines policy stated, 'Assistance with medication will only be provided by the personal care staff where the service user is unable to administer their own medication (in full or part) and there is no other appropriate person to do so. Assistance with medication will only be provided with the agreement of care managers, district nurses or other appropriate healthcare professional noted on the care plan'. The registered manager told us that the service did not administer medicines to people that they supported.

One of the people supported by the service received their medicines in blister packs, provided by the local pharmacy. A blister pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one-month supply. The person's care plan noted that the person required prompting with their medicines and stated, 'Personal care worker to remind service user to take medication. Personal care staff should not administer medication not in dosset boxes'. Staff told us that they sometimes removed the medicine from the blister pack and left it in a pot so that the person could take it later. The registered manager told us that staff members, "Don't sign a Medication Administration Record (MAR) chart as staff leave it [the medicine] out for them and don't sign a MAR chart as it [taking the medicine] is not witnessed." However, one staff member said, "He has it [medicine] three times a day, morning, lunch and evening. We put it in a small container and give it to him with a drink. We make sure that he takes it. We supervise him to take them [the medicines] and then write it in the log book." This meant that staff were administering medicines.

Equinox care's medicines policy stated, 'Details of assistance required will be included on the care plan'. However, for the care plan for one person was not clear on staff responsibilities around prompting and administering of medicines and there were no records signed and no MAR charts were completed. We raised this with the registered manager who told us that she was not aware that staff were administering medicines.

There were no records to show that medicines for this person were checked or audited by the registered manager to ensure that they had been given. The registered manager said that, "I check them informally when I visit by checking the daily logs but I haven't got a record in that respect [documenting regular monitoring of the person's medicines]."

When we discussed this with the registered manager, she said that there was, "Some confusion" around what constituted administration of medicines and that she would look into this matter.

Training records showed that all staff had received training in the safe administration of medicines. We saw, and the registered manager confirmed, that there were no competency assessments completed around medicines for staff members.

Risk assessments were brief and did not provide staff with guidance on how to mitigate risks. Risk assessments were often a tick box format which provided little detail. Where there was information, this was

often only one or two lines. For example, one person required assistance to go out and use a wheelchair. There was no guidance for staff on how the person should transfer to the wheelchair safely or if there were any risks associated with the person using the wheelchair. There was also no information if the staff had been trained during manual handling on how to push the wheelchair. In caring for another person, there was a risk to staff and the person of needle-stick injury. Staff were advised to ask the hostel, where the person lived, for protective gloves when helping clean the person's room. However, the risk assessment failed to provide staff with adequate guidance on how to mitigate the risk or what action should be taken if the risk occurred. A needle stick injury policy was not available and staff were not aware of what the service's policy was in the event of a needle stick injury.

Risk assessments failed to ensure that any known risks were accurately recorded and appropriate guidance given for staff to be able to mitigate the risks.

Following the inspection, the service manager provided updated risk assessments for the two people that used the service. These risk assessments gave staff guidance on how to mitigate risks. However, they did not provide enough detail on the risks and what staff should do if the known risks occurred. An updated needle stick injury policy was also provided which gave staff information on what to do if a needle stick injury occurred.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a detailed safeguarding policy which included information on how to recognise and report abuse. Some staff were able to tell us what safeguarding was and how they would keep people safe or report issues where people were at risk of harm. One staff member said, "Safeguarding is protecting someone from harm or abuse. I would report it to my manager, social services or the police if necessary." However, other staff members said, "No, I don't know that [what safeguarding was]" and "Is that about the client damaging themselves?"

Information in staff files was inconsistent. Three staff members only had one form of identification and two staff had one reference. Providers are required to check staff identity and ensure two appropriate references. We spoke with the registered manager about this matter who told us that it was Equinox Care's policy to request two satisfactory references for staff before they start work. The service had moved to a new head office in June 2015 and the registered manager told us that some of the staff files may have been misplaced. The registered manager told us that there was a plan in place to update criminal records checks for staff that had been with the service over two years. We observed a member of staff attending the office to update their criminal records check during the inspection. However, there was no information around criminal records check on any of the seven staff files that we looked at. Following the inspection, the service manager sent confirmation that staff members had criminal records checks before staring work.

The registered manager said that continuity of care was important for the people that used the service and that the service always ensured that people had regular staff members that they got to know. Staff and people told us, and rotas confirmed that people often had the same staff members visiting them, which enabled people to experience continuity of care. One person told us, "It's the same two geezers that I see."

There were no documented accidents or injuries. Staff knew what to do if someone had an accident or sustained an injury and were able to tell us what the procedure was.

Requires Improvement

Is the service effective?

Our findings

There were no staff appraisals documented for the past year. The registered manager told us, "Equinox is reviewing their appraisal policy. They [appraisals] have not been done."

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a supervision policy which stated that staff supervisions should be, 'At least one hour and that all staff receive a minimum of 10 sessions per annum'.

There were no documented staff supervisions for the past year. However, the registered manager told us that she did meet with staff informally but did not document the meetings. The registered manager stated, "There are no written supervision notes. I talk to them [the staff] on the phone and I see them." One staff member said, "She [the registered manager] makes an appointment and we meet, but because there is no office space we meet in the open, parks and cafes. We talk if there is any problem with clients, if they are not happy, how the person is. We talk about going out with the clients." Another staff member said, "Yeah, we do get supervision, impromptu visits [by the registered manager]. No, she doesn't send minutes but writes up some of what was discussed." Equinox Care's supervision policy stated, 'Supervision records are subject to internal and external audit. Supervisors must therefore keep a supervision file for each worker with signed notes available for inspection'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The registered manger told us that all people using the service had capacity.

We received mixed feedback from staff around their understanding of the MCA. One staff member said the MCA was about, "When someone cannot take decisions for themselves. Someone has to [make decisions] on their behalf, they need to be assessed." However, other staff members told us, "Their [people's] mental status. The people at work sort that out. I don't know."

People that the service supported had capacity. However, care plans had not been signed by people or a staff member. We discussed this with the registered manager who confirmed that the person had not been asked to read or sign their care plan.

Training records showed that no staff had received training in the MCA.

Staff training was completed by means of on-line training. Records showed that staff had completed training in subjects such as, diversity and equality, infection control, safeguarding, safe administration of medicines and first aid. One person that the service worked with required manual handling. Training records showed that staff had completed training in manual handling. Staff that had completed this training in 2012 and 2013. There were not dates for any refresher training. There were no documented monitoring visits to ensure that best practice around manual handling was being maintained by staff members. Staff told us that generally, the registered manager reminded them, via text message, when they needed to update or complete any training.

The service had a staff induction policy outlining what induction staff should receive on commencement of their employment. We saw an induction checklist for two staff. This included, information around the people they would be working with, policies and procedures, safeguarding and how to ensure appropriate documentation was maintained. However, there were three staff that had been transferred from another organisation to Equinox Care. The registered manager confirmed that these staff had not received an induction to the company.

The service provided support with meals for one person. Staff told us that they went shopping with the person and the person was able to tell them what he wanted them to cook for him. One staff member told us, "We always ask [the person] what he wants to eat before we prepare it in case he changes his mind." There were no specialist dietary requirements. However, there was no information contained within the person's care plan to inform staff of what the person's preferences were around food.

People and staff told us that the service did not attend healthcare appointments with people. However, the registered manager told us that if a person required support they would ensure that this was provided. There were no records of people's healthcare visit. However, the registered manager told us that this was recorded in people's daily logs. Records showed that staff documented when they had gone shopping with people.

Requires Improvement

Is the service caring?

Our findings

We asked people if they thought the staff that visited them were caring. One person said, "I haven't got no complaints. The big geezer helps, I mop my floor but I do it slowly. The little geezer, I get on with him. He's alright."

Care plans were not person centred and did not note any information on how the person wanted their care to be delivered. However, staff knew the people they worked with well and were able to tell us about their likes and dislikes. One staff member said, "[Person] loves his movies, he's got a huge collection and we know what he likes to watch. When we go out shopping we know what type of things he likes." One person told us, "They help with my clothes."

Staff members told us about the importance of treating people with dignity and respect. One staff member said, "We respect their home, opinions, personal space and religion. When we help him have a bath we make sure the door is closed and respect him. We don't use his things; we make sure his home is clean and tidy. We ask him what he wants before we do things for him." Another staff member said, "We ask if he is ok with what we're doing for him, make sure he knows what's going on."

One person was supported to go out into the community on a regular basis with staff. The person was also supported to attend a local gym. Staff told us that this helped with his mobility.

Staff were positive about working with people who identified as gay, lesbian, bisexual or transgendered (LGBT). Staff told us that this would not make any difference to how the person was treated. One staff member said, "I respect anyone's way of life. I'm not in a position to judge. It's about the person and the care they need. I respect boundaries."

Care plans did not note people's faith or if they required help maintaining their faith.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not written by the service following the initial referral. We saw, and the registered manager told us that care plans were copied from the care review completed by social services. Equinox Care did not consult the people that they worked with regarding how they would like their care delivered and how they wanted staff to work with them. Care plans stated, 'based on the information provided from care manager, your needs are as follows'. There was no collaborative planning between the person and Equinox Care.

Care plans that we looked at were not person centred and did not include details of people's likes and dislikes. Information contained within care plans was often very brief, consisting of only a few lines. One person's care plan was four lines long. There was very little information about the person and around what the carers should do to support the person and how this should be achieved. Care plans were task focused and not detailed.

One person required a lot of support around their mobility. However, their care plan had three lines on how staff should deliver this aspect of their care. The registered manager told us that there was a file in the person's flat that gave further guidance but this information was not recorded on the care plan.

Care plans were not signed by staff or people. People were not involved in planning their care and their views and opinions were not documented on their care plans. The registered manager told us that they regularly attended reviews by the placing authorities for the people the service supported. However, there were no records of reviews or information around care plans being updated if there was a change in the persons care needs. The registered manager confirmed that this information was not written down.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care files did not document their initial referral assessment to the service. The registered manager told us that she did not document this, "I get a call, I go out and meet them and make notes on my pad. I do not document it apart from on my pad."

There were no documented complaints since the service opened in July 2015. The registered manager told us, "I do get phone calls, but it's not complaining." One person told us, "I haven't got no complaints." We asked if people knew how to complain, one person said, "I'd tell [the registered manager]." The service had a service user guide which was given to people when they were referred to the service, this included details of how to complain and contact numbers of both the office and external bodies such as social services and the Care Quality Commission (CQC).

Inadequate

Is the service well-led?

Our findings

Staff were generally positive about the registered manger. One staff member said, "[The registered manager] is nice. I've met her so many times. I text her and say I need to talk and she's always ready. I feel supported by her." Another staff member said, "She's [the registered manager] prompt to everything. Communication is usually by text. She prompts and reminds us, especially in any training I need to do. Anything regarding the clients she is very prompt. She is hands on and will help out if need be. However, despite staff being positive about the registered manager, there was no documentation to support what we were told by staff members.

The registered manager told us that there was no policy around missed calls or monitoring missed calls. We asked how the registered manager monitored missed calls. The registered manager told us, "I monitor via the clients, they call me. I do occasional spot checks but it's not written down. There has only been one time where [person] called to say that [staff member] was late."

There were no documented audits for any aspect of the service. The registered manager confirmed that she did not complete and document audits in a way that supported that there was adequate oversight of the service and allowed for issues to be formally addressed and dealt with. The registered manager told us, "I do them without recording them. I go and speak to the service users', speak to the staff and feedback. However, there was no documented management oversight for quality assurance of the service.

We found that documentation around staff recruitment was inconsistent. The registered manager was unable to explain why there were missing documents such as references and identification for staff.

There was no documentation or audits that looked at medicines management. The registered manager told us that she checked people's medicines informally when she visited them but did not document this. Staff members were administering medicines for one person. The registered manager told us that she was not aware that staff were administering medicines.

There was a lack of management oversight of the service. There were numerous issues that we identified as part of this inspection around documentation and ensuring that information was recorded. Staff supervisions were completed but not recorded. Annual appraisals were not carried out. There were no documented audits of medicines, care plans and risk assessments or staff files. Assessments of new clients, background histories, monitoring visits, spot checks, missed visits had not been documented.

There were no records of team meetings and the registered manager confirmed that they were not held.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service completed a 'Service User Involvement Study' in January 2016. However, this involved service users across all of Equinox Care locations. The registered manager was unable to confirm that people using

this service were involved and what their responses were. We asked the registered manager if she completed surveys for people using this service and we were told, "I do, but it's part of checking, informal and not recorded." The registered manager explained that she asked people if they were okay and happy but did not write responses down or record them in any formal way.

The service operated an on-call system for out of hour's issues that arose. This operated seven days a week between 17:30 and 09:00 and at weekends. The registered manager told us that people had her telephone number and that arrangements were made for when she was out of the business.

The registered manager told us that the service worked closely with the care teams of the people that they supported, attending people's reviews and healthcare professionals meetings. However, this was not documented.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager failed to ensure the proper and safe management of medicines. 12(2)(g) The registered manager failed to ensure that risk assessments gave adequate information and guidance for staff on mitigating known risks. 12(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager failed to ensure that staff appraisals were carried out. Staff did not receive appropriate appraisal to enable them to carry out their role. 18(2)(a)

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 9 HSCA RA Regulations 2014 Person-centred care The registered manager failed to ensure that care plans were person centred. People were not involved in planning their care. There was no background information on the people that the service worked with. Assessments were not documented. 9(1)(a)(b)(c)3(a)(b)(c)

The enforcement action we took:

Warning Notice