Eternal Care UK Limited

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Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 28 June 2016 and was announced. Eternal Care UK Limited is a domiciliary care agency that provides personal care for people living in their own homes within the boroughs of Bexley, Bromley, Lewisham and Wandsworth. At the time of this inspection 161 people were using the service.

The service did not have 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.

During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Staff were not always clear on how safeguarding concern's should be escalated. The provider had had not always taken appropriate steps to protect people from abuse and improper treatment by making safeguarding referrals.

Medicines were not managed safely by the service because records relating to the management of medicines were often not fully complete. Risk assessments were not always reflective of people's needs or reviewed in line with the provider's policy to mitigate risks to people using the service.

Staff were not up to date with the provider's mandatory training requirements, and did not always receive regular supervision and appraisal in line with the provider's policy.

The provider did not operate effective systems to monitor and mitigate risks to people because regular audits were not in place, and they had therefore failed to find concerns we identified at inspection.

We also found a breach of the Care Quality Commission (Registration) Regulations 2009 in respect of notifying the CQC of changes, and notification of other incidents.

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

People that use the service told us that they felt safe. There was a whistle-blowing procedure available. Staff were safely recruited with necessary pre-employment checks carried out. There were enough staff to meet people's care and support needs.

Staff completed an induction when they started work. However, did not have a good understanding of the Mental Capacity Act 2005 (MCA) and this was an area which required improvement. People were supported to maintain a balanced diet so that their dietary needs were met. People were supported to access healthcare professionals as and when required.

People were treated with dignity and respect, and their privacy was taken into account. People's care plans provided guidance for staff on how to support them in a way which met their needs, however care planning required improvement to reflect people's involvement in expressing their views and wishes. Staff were aware of the complaints procedure and said they were confident that complaints would be dealt with appropriately. However improvement was required because records showed complaints had not always been dealt with effectively.

Staff said they enjoyed working at the service and they received good support from the management team. People's opinions were sought through an annual survey.
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.

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.

Safeguarding adult's procedures were in place, however the provider did not always follow these and people were not protected from abuse.

Medicines were not safely managed and risk assessments relating to the prompting of medication were not accurately maintained.

Risks to people had not always been adequately reviewed and action had not always been taken to mitigate risks.

The provider had appropriate procedures in place for recruiting staff.

There were sufficient staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always supported in their roles through appropriate training, supervision and appraisal.

Staff were not trained in the Mental Capacity Act 2005, and did not understand how to act according to this legislation.

Where people required support with meals this was recorded in their care plans.

People had access to health care professionals when they needed them.

Is the service caring?

Good

The service was caring.

People said staff were caring and helpful.

People were treated with dignity and respect.

Staff were familiar with the needs of the people they supported.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personalised support to meet their individual needs, however improvement was needed to ensure people's support plans reflected their views and preferences.

People knew about the provider's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary. However, records showed that complaints were not always dealt with effectively.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have a registered manager in place, and statutory notifications had not been submitted as required by current legislation.

Quality assurance systems were not effective in monitoring and mitigating risks to people.

Staff spoke positively about the management of the service and said that management were always available to help.

The provider took into account the views of people using the service through annual surveys.

Eternal Care UK Limited

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.

Prior to the inspection we reviewed information we had about the service. This included the notifications that the provider had sent us. A notification is information about important events which the provider is required by law to send us. We also looked at quality monitoring reports from the local authority who commissions the service.

Before the inspection, we asked the provider to complete 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 did not return a completed PIR and we took this into account when we made the judgements in this report.

The inspection took place on 28 June 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available on the day of our inspection.

The inspection was carried out by two inspectors and an 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.

We spoke with twelve people using the service, eleven members of staff and the director. We looked at records, including the care records of eight people that use the service, six staff files, staff training records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with us told that they felt safe. One person told us, "We (the person & their partner) both feel safe with these new people." Another person said, "I am very dependent on them and I really trust them." However, despite people's views on safety, we found the service was not safe because safeguarding incidents had occurred and had not been reported to the appropriate bodies.

We found that an allegation of abuse had been raised with the service in February 2016. However, the provider dealt with this as a complaint and the appropriate bodies had not been informed of the incident. This meant the incident had not been investigated by the local safeguarding team to ensure appropriate action had been taken by the service to reduce the risk of similar future incidents. At the time of inspection the provider told us that they had made one safeguarding alert in 2016, however records we looked at and notifications to the CQC showed that at least three incidents had occurred. The provider did not have an effective system in place to record, investigate and monitor safeguarding incidents. Appropriate action had not been taken to protect people from abuse and improper treatment,

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service had risk assessments in place, although the completed assessments did not always identify areas of risk to people or provide guidance to staff on how these risks should be managed. We saw that one person's risk assessment did not highlight their risk of falls as identified in their local authority assessment. The assessment did not make clear what the needs of the person were, placing them at risk of unsafe support . Another person's risk assessment had not been regularly reviewed in line with the provider's policy. Therefore we could not be assured that the assessment was reflective of their current needs.

Medicines were not managed safely. The provider had a medicines policy in place with appropriate guidance. The provider was not conducting regular audits of people's medicines records. We saw that where people required support to take their medicines this had not always been recorded in their support plan. This meant that there was not an up to date and accurate record of the medicines the person was prescribed. We also noted that people's medication administration records (MAR) did not always include details about the medicines they had been prescribed. For example, three people's MAR did not identify the names or doses of their medicines. The MAR also failed to provide any guidance for staff on the level of support people required to take their medicines. This placed people at risk of not receiving their medicines as prescribed which could have an adverse impact on their health.

We also found gaps in recording on all of the MAR we looked at, and no reasons had been recorded as to why people's medicine had not been administered. This meant there was a further risk that people had not received their medicines as prescribed.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

People we spoke with told us they felt that staff arrived on time, for most calls and that they were rarely missed. One person told us, "Yes, like clockwork give or take 5 to 10 minutes here and there." The provider had an appropriate system in place to allocate calls so that people received their care when required. Staff told us that they had enough time to get to their calls. We saw the scheduling rota for the past two weeks, and we could see that calls had been scheduled appropriately and attended for their duration to ensure people's needs were met.

Records showed that the provider undertook pre-employment recruitment checks including appropriate references and checks of photographic identification prior to the commencement of employment. We saw that criminal record checks had been made to make sure people were suitable to work in the health and social care sector. The provider had also made checks to ensure staff members were entitled to work in the UK before they commenced work.

The provider had an on-call system to manage emergencies, and to support staff out of hours. Staff were aware of the action they would take in an emergency situation.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they felt staff were well trained. One person told us, "I think they are very well trained." One person said "They write down every single thing they do and they are very respectful."

However, despite people's views, records showed that staff did not always receive training to support them to carry out the roles they were employed to perform. Staff were not provided with training in safeguarding vulnerable adults, or the Mental Capacity Act 2005 (MCA)). The provider told us that they provided this training to staff, but that they did not keep a record of staff having attended. Following the inspection we were provided with a training matrix that included these trainings, however 17 of the 79 staff were still not up to date with MCA training.

We looked at the training matrix provided to us at the time of inspection which showed that staff had not always completed annual refresher training in induction, medication, manual handling and first aid. They had not always completed training in line with the provider's policy. Therefore there was a risk that people were receiving care and support from staff whose skills were not up to date with current best practice.

Staff did not always receive one to one supervision to support them in their duties. The care co-ordinator told us that supervision should take place four times a year, with the fourth as a combined supervision and appraisal. Staff we spoke to told us they felt supported. However, records showed that supervision did not always take place regularly in line with the provider's requirements. For example, three of the staff files we looked did not contain records of a yearly staff appraisal, therefore there was a risk that staff were not always receiving sufficient support from the provider to enable them to carry out their duties.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff we spoke to had a good understanding of how to obtain consent, but did not know that where required they would need to undertake assessments to determine capacity and support best interest decisions. Staff were not clear on the key requirements of the MCA, or how this legislation applied to their roles in supporting people. Six of the eleven staff we spoke with told us that they had not received MCA training. Staff were not clear in their understanding of MCA. For example one staff member described the MCA as

"Gaining consent," and another referred to it as being about, "'supporting people to be independent." Staff we spoke with made generalisations about people living with dementia and their mental health. One staff members spoke of people being "confused" and another staff member said that support would be needed from a mental health professional. Care plans contained some information on people's mental health needs and capacity where appropriate through the provider's assessments that staff had conducted. However the provider did not have systems in place for staff to assess people's mental capacity in line with the MCA to ensure specific decisions were made appropriately and in their best interests. These issues required improvement.

Most of the people that we spoke with had their meals delivered or ready prepared meals which they could warm them up for themselves. Care plans that we looked at included guidance on people's nutrition and hydration needs including any dietary requirements and support they required with their meals. Where people required support with meal preparation, we noted that people's care plan provided guidance for staff on how to meet their needs and preferences. For example, one person's care plan stated, "[Person using the service] does not like his sandwich on a plate and would prefer this to be served on a piece of kitchen towel." Another person's care plan included guidance for staff on ensuring food was cut up into manageable pieces, and a third example included a reminder for staff to encourage the person to eat nutritious wholesome meals.

People were supported to access healthcare professionals at a time that they needed them. One member of staff told us, "I would call the manager if someone's needs change and enter it in the log book, or use the on call and seek advice." Another staff member told us of how district nurses supported one person using the service in managing their medicines.

Good

Is the service caring?

Our findings

People that we spoke with told us that staff were caring. One person described the regular member of staff who provided their support as being a, "Good, reliable friend." Another person said, "Nothing is too much trouble [for the staff supporting them]." A relative told us, "They are very caring and listen to [person using the service]."

Records we looked at included information about people's personal circumstances and their likes and dislike's such as their past jobs, hobbies and things that were important to them." Staff knew the people they supported. One staff member told us, "[Person using the service] likes to talk about the war. There's a lot of information in the care plan about their likes and dislikes."

Where one person was provided with companionship we could see that they were accompanied to the local shops and coffee shop and it was clear what social activities the person like to partake in, such as "enjoys being out of home, visits the Irish club."

People were treated with dignity and respect. Staff told us they maintained people's privacy, dignity and independence as much as possible by supporting them to manage as many aspects of their own care that they could. One staff member said, "I always give people a choice to do what they are capable of doing." They also told us, "I make sure it's private; doors are closed and the curtains are drawn. I ask the person if they want me in or out of the room – cover them with a towel. I talk to them throughout and let them know what I'm doing."

People were supported to express their views and be involved in making decisions about their care and treatment. One person said "Am happy with the care, it suits me". Care plans that we looked at included details about how the person felt about receiving support, and 'things I like you to know about me'. Staff told us they knew where to locate important information about people and their needs within their own home's and had access to people's identified care needs and risk assessments.

Requires Improvement

Is the service responsive?

Our findings

People were unable to tell us whether they had been involved in developing their care plans but the provider told us that people were involved in their care plan development at assessment and review.

People's care records contained referral information from local authority commissioners which included a breakdown of people's care and support needs. The files also included the agencies assessments which covered areas such as communication, mental health and behavioural considerations, health and medication and nutrition and hydration, mobility and personal care and hygiene. Care plans demonstrated that people using the service and their relatives, where appropriate, had been consulted about their needs and plan of care.

Care, treatment and support plans were not always reviewed regularly to make sure they met people's changing needs. One record that we looked at had not been reviewed every six months in line with the provider's policy, and another had no information recorded under 'social activities'. Three of the support plans we looked at only contained brief information recorded for carers on what they should do to support the people when they visit at different times. One plan did not detail the person's physical and mental health needs, and there was no information on the 'desired outcomes' section of the plan. Therefore, this required improvement.

The provider had a complaints policy and procedure in place that showed how people could make a complaint and who to contact. Staff we spoke with knew how to deal with complaints, and told us that copies of complaints forms were available to people in the care records stored in their homes.

However, improvement was required because people we spoke with were not always confident that their complaints would be dealt with to their satisfaction. One person told us, "Complaining has not changed anything. All I want are regular carers who know me and where things are." The same person reported that there had been no improvement to their request for regular staff and that they had now stopped complaining.

We saw that the provider had conducted an audit of complaints received between January and December 2015, however this audit did not fully demonstrate that all complaints had been dealt with effectively. For example, one complaint record did not have an outcome documented or action recommended and taken, with the reason recorded as "Not completed as staff left." Therefore we could not be sure that all complaints were fully investigated as they were received.

Inadequate

Is the service well-led?

Our findings

People felt that the service was well led. One person said, "I have little reason to call the agency but when I do they listen and are helpful." Staff also spoke positively of management. One staff member told us, "They are always there for me, they support me personally." Another staff member said, "I can't pick a fault; everyone is nice, welcoming and understanding."

The provider did not have a registered manager in place as required under the conditions of the provider's registration. The provider had registered the service at a new location in January 2014, however they had not registered a manager. At the time of the inspection one of the directors provided us with a certificate of registration that they had on the wall which was dated 09/02/10, however this was for the provider's previous location. The provider was unaware they were not meeting the conditions of their registration and believed the current service manager to be registered. However, the registration certificate they provided us with was for their previous location and not relevant to the services currently provided. This demonstrated a lack of understanding of their responsibilities as a registered provider.

This was a breach of Registration Regulation 15 of the CQC registration registrations.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). The provider did not return a completed PIR as requested. The provider had also failed to notify us of significant events that occurred at the service, including three safeguarding incidents. The provider had not understood their requirements as a registered provider.

This was a breach of Registration Regulation 18 of the CQC registration regulations.

The provider had no effective systems in place to monitor and mitigate risks to people's health and safety. The system in place to respond to safeguarding concerns was ineffective because we found examples of safeguarding incidents which had not been appropriately investigated or reported to the local safeguarding authority or the commission as required. We also found that there was no systems in place to monitor the management of people's medicines because the provider did not undertake medicines audits and had failed to identify the issues we found with the management of people's medicines at this inspection. The provider also told us that they did not complete audits of care files, therefore the issues we found at inspection had also not been identified by the provider.

The provider did not have effective monitoring systems in place to assess, monitor and improve the quality of the service. Staff had not received appropriate supervision or training to enable them to carry out their roles; and this had not been identified by the management.

This issue was in breach of regulation 17 of the Health and Social Care Act. Staff told us that they would implement medicines audits promptly and would devise a template to audit all MAR as they were returned to the service, although we were unable to check on this at the time of our inspection.

Staff meetings took place every three months, and included discussion topics such as on call, confidentiality, communication, manual handling and sickness reporting. We looked at minutes for the meeting that took place on 28 January 2016, however we could not see records to show that a meeting had taken place in April 2016. Staff that we spoke with had differing views of staff meetings and their regularity. One staff member said, "They are usually every 3-4 months." Another staff member said, "They're meant to be every month, but they're not every month. I can remember 2 this year, they're not as regular as they should be." A third staff member told us, "I've not attended any staff meetings, would rather be out with clients and sent an email update."

People that we spoke with told us that they were sent an annual survey by the provider. We looked at the provider's audit of quality assurance questionnaires for January to December 2015, and saw that the provider had collated an overview of responses. Records showed that the provider had acted on feedback received.

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 15 Registration Regulations 2009 Notifications – notices of change The provider did not have a registered manager in place

The enforcement action we took:

Action was taken

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted statutory notifications to the CQC

The enforcement action we took:

action was taken

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely, and people were not always supported to receive their medicines as prescribed by healthcare professionals

The enforcement action we took:

The Registered Provider must inform the Care Quality Commission of the systems in place to identify any omissions, gaps or errors in supporting service users who require support with medicines by no later than 9am on Monday 11 July 2016.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always reflective of people's needs, and appropriate steps were not in place to mitigate future risks.

The enforcement action we took:

Warning Notice issued

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse or improper treatment. The provider failed to establish and operate effectively systems and processes to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

The enforcement action we took:

The Registered Provider must immediately undertake a thorough and comprehensive review of all records to identify whether there are any matters which should have required or do require safeguarding referrals to be made and, if so to make any safeguarding referrals immediately.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems or processes were not in place to assess, monitor and improve the quality of the service

The enforcement action we took:

The Registered Provider must inform the Care Quality Commission of your programme for audits to be undertaken during the next three months and the details of what these audits are to cover, such programme and details to be provided in writing to the Care Quality Commission by no later than 9am on Monday 18 July 2016.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always supported through training, supervision and appraisal to enable them to carry out the duties they perform.

The enforcement action we took:

Warning Notice issued