Eagle Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Eagle Care Ltd is a homecare agency based in Barnet that provides services to people of any age. At the time of this inspection the agency was providing a regulated care service to two people in their own homes. It was providing additional services to other people such as domestic and community support; however, those are not services that we regulate.

The service had a registered manager, which 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.

At our previous inspection of this service in January 2016, breaches of legal requirements were found. These were in respect of safe care and treatment, record-keeping, and the need for consent to care. At this inspection, we found some of these matters had been addressed, but further improvements were required.

The management of people's medicines support, although improved, was not robust enough to ensure people always received their medicines safely. Recording shortfalls relating to this had not been identified for improvement. There was therefore a continuing breach of legal requirements.

We found the oversight of the service was inconsistent. Whilst people's views on service quality were regularly sought and acted on, systems were not embedded to ensure for example staff training and appraisals were always kept up-to-date in support of making sure good quality care was being delivered. This meant there was insufficient oversight of the service as a whole, despite a positive and open culture being in place.

People and their representatives fed back positively about the care and the approach of staff and the registered manager. People received the same staff member wherever possible, which helped positive and caring relationships to develop and their needs and preferences to be addressed.

People were supported to eat and drink enough and maintain balanced diets, and were provided with support for health matters where needed. Staff had the knowledge and skills needed to carry out their roles so that people received effective care and support.

People were supported to express their views and be involved in decisions about their care. The service was working within the principles of the Mental Capacity Act 2005 in terms of acquiring appropriate consent for care. People received individualised care that was backed by appropriate care plans that were kept under review. The registered manager responded to any service delivery issues identified.

Whilst the service could not guarantee they could always provide suitable staff to people, they informed people of this in good time to help ensure alternative arrangements could be made. There were therefore

enough staff to meet people's needs and keep them safe.

The service had systems to help ensure people were protected from abuse. It paid good attention to the prevention and control of infection, and to the management of many care delivery risks in people's homes.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe. The provider's management of people's medicines support, although improved, was not robust enough to ensure people always received their medicines safely. Recording shortfalls relating to this had not been identified for improvement.

Whilst the service could not guarantee they could always provide suitable staff to people, they informed people of this in good time to help ensure alternative arrangements could be made. There were therefore enough staff to meet people's needs and keep them safe.

The service had systems to help ensure people were protected from abuse. It paid good attention to the prevention and control of infection, and to the management of care delivery risks in people's homes.

Is the service effective?

Good

The service was effective. Staff had the knowledge and skills needed to carry out their roles so that people received effective care and support.

People were supported to eat and drink enough and maintain balanced diets, and were provided with support for health matters where needed.

The service was now working within the principles of the Mental Capacity Act 2005 in terms of acquiring appropriate consent for care.

Is the service caring?

Good

The service was caring. People and their representatives fed back positively about staff. People received the same staff member wherever possible, which helped positive and caring relationships to develop.

The service treated people respectfully. People were supported to express their views and be involved in decisions about their care.

Is the service responsive?

Good

The service was responsive. People received individualised care based on their needs and preferences, backed by appropriate care plans that were kept under review.

The service was set up to listen and learn from any concerns people experienced.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. The registered manager responded to any service delivery issues identified. However, audit processes were not consistently supporting the service to ensure good quality care was being delivered. For example, by not identifying the medicines concerns we found at this inspection. There was insufficient and ineffective oversight of the service as a whole, despite a positive and open culture being in place.

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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 was an announced inspection that took place on 12 October 2017. We gave the provider 48 hours' notice of the inspection. This was because of its smaller size and we needed to be sure the registered manager would be available.

The provider completed a Provider Information Return (PIR) in advance of the inspection. 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.

Before the inspection, we checked notifications made to us by the provider, safeguarding alerts raised about people using the service, and information we held on our database about the service and provider.

The inspection was carried out by one adult social care inspector. There were two people receiving regulated activities from the service, and two care staff, at the time of our inspection. During the inspection, we received feedback about the service from one person using it, two people's relatives, and one community health and social care professional. To help keep their views confidential, we have referred to them as 'people and their representatives' throughout this report. We also spoke with both staff members and the registered manager.

During our visit to the office premises we looked at the care files of both people receiving a personal care service, the personnel files of the two staff members, and other records relating to the care delivery and management of the service such as staff meeting minutes and survey results. We were also provided with, on request, copies of certain policies and the service user guide following our visit.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found risk was not adequately assessed in people's homes, including for medicines management and supporting people to move. There was therefore a foreseeable risk of the care and support of people not being undertaken safely or appropriately. Additionally, the service's record-keeping approach was not consistently accurate and contemporaneous. This meant the provider was in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found many of these matters had been addressed, but there remained some concerns with safe medicines management and associated records.

There was improved management of individual risks relating to care visits. People's risk assessments covered a range of relevant potential hazard areas including the care environment, mobility, choking, nutrition and skin integrity. There were specific checks and questions relevant to each hazard. Attention was paid to the equipment people used, such as which organisation supplied it so that faults could be easily reported if needed.

The service was supporting one person to take medicines. There was an improved risk assessment in respect of this support, as a broader range of potential hazards were considered. Staff were guided through the person's care plan on what the medicines were, where they were stored, and to provide prompting support. There was now a medicine administration record (MAR) that specified each medicine the person was to be prompted for and when. There was also a record of why they took each medicine. Staff told us of safely handling and keeping the medicines secure, which the person confirmed as occurring. This all indicated the person received their medicines as prescribed.

However, when we checked the previous three month's MAR for the person receiving medicines support, at a frequency of four times a day, we found unexplained administration gaps and discrepancies. This was primarily for the July 2017 MAR, when three medicines had not been signed as taken on two consecutive days despite others being signed for on those days. Furthermore, care records showed the staff member signing had not visited on those days. Additionally, most medicines had not been signed as administered on the first two days of that month. We also found a once-weekly tablet had been signed as administered on two consecutive days from 31 July 2017.

The MAR did not indicate how many of each tablet was to be administered on each occasion. A copy of the prescription stated for two paracetamol to be taken on each occasion, but the MAR did not record this and stated a dose of 500mg instead of the 1000mg that represented two tablets. The MAR across the last three months also omitted a prescribed vitamin that was taken daily. Before we left, the registered manager showed us she had corrected the MAR to address these omissions.

Staff, the registered manager and records informed us the person had a dosette box medicines system. This meant all their tablets were pre-prepared for each administration. Therefore, despite the above recording

omissions, there was a lower risk the person did not receive their medicines as prescribed. However, the omissions demonstrated failures to maintain accurate, complete and contemporaneous records in respect of decisions about the person's medicines care and treatment and of the medicines support provided.

The registered manager confirmed there were no records of auditing people's MAR. There were no such audits recorded at the previous inspection either. The registered manager told us she had not identified the concerns we found at this inspection when she checked the MAR upon collecting them from the person's home for office storage. However, she pointed out she had improved on the ease-of-use of the MAR after identifying ways in which it was hard to follow. Checks of the MAR confirmed this.

We concluded the provider's management of people's medicines support, although improved, was not consistently safe. The evidence above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their representatives told us the service was safe. Comments included, "There's no safety concerns." Staff told us of ways in which they paid attention to people's safety. This included for transferring between seats, checking on environmental safety during care visits, and ensuring they left people's homes securely. The registered manager told us there had been no accidents relating to people's care. Except for medicines management, this helped assure us people received safe care.

People and their representatives told us staff were generally on time. Comments included, "They're punctual", "They're not late" and "She's sometimes late but can't help it." We were informed agreed visits were never missed, although one person informed us there had been occasions when the agency cancelled the planned visit as the regular staff member could not attend and could not be replaced. They added they were given a number of days' notice when that occurred, enough time to make alternative arrangements. The registered manager informed us there were only two care staff and herself to attend to all visits. She told us recruitment was ongoing, but no-one had been employed for care purposes since our last inspection. Therefore, whilst the service did not guarantee that they could always provide suitable staff to people, they informed people of this in good time to help ensure alternative arrangements could be made.

The service had systems to help ensure people were protected from abuse. Staff told us examples of what could be seen as abuse. They knew how to document any concerns and report to the registered manager immediately so further action could be taken where necessary. They confirmed they had received training on safeguarding, one staff member told us this was from a local authority's safeguarding team. Records and the registered manager confirmed this.

Staff files included annual updates of their DBS disclosure, which represented good practice. The DBS service checks on whether a person is barred from working with vulnerable adults or has any form of police record. The service contract between the provider and people included some guidance on safeguarding matters, including for staff to never request loans and to accept gifts only of a token value. Records also showed the registered manager had undertaken in-house reviews of safeguarding procedures with staff. She told us there had been no safeguarding cases since our last inspection.

The service paid good attention to the prevention and control of infection. People's care plans provided guidance on how to ensure cleanliness at care visits and how to control infection risk at each person's home. The registered manager told us staff had highlighted infection control concerns which she had followed-up on. She added care staff could collect personal protective equipment such as disposable aprons and gloves from the office, but if needed, she would drop them round to staff when working at people's homes.

Good

Is the service effective?

Our findings

At our last inspection, the provider had not developed systems to ensure the service was working within the principles of the Mental Capacity Act 2005. This undermined the effectiveness of the service. This meant the provider was in breach of regulation 11 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. We found the service was now working within the principles of the MCA.

There was now direct reference to the MCA within people's care records, including mental capacity assessments for consent to care packages where it was not clear the person receiving care could provide informed consent. Where capacity was not established, there were records formalising the best interest decision making process that involved the person's representatives.

Staff told us of gaining consent from people each time they provided care and support. If someone refused care they considered necessary, they said they would try to explain to them why the matter was important. They said they would contact the registered manager to discuss any concerns if the refusals were ongoing. They told us they had received some training on the MCA through a local authority. One staff member explained this included practical applications such as how to encourage someone with dementia if they were refusing care. The registered manager confirmed this occurred but told us no certificates were provided for attending that course.

People and their representatives told us the service was effective. Their comments included, "I think it's very good", "They're very capable" and "It's fine." They informed us the service provided good support with health matters. For example, if the person was unwell, relatives were informed and the service "deals with it." One person's review meeting record showed healthcare professionals had reviewed and updated prescribed pain relief as a result of the service recognising the person was experiencing increased pain.

People were supported to eat and drink enough and maintain balanced diets. People's care plans guided staff on what food and drink support they needed and how to respect their preferences. Care records provided indications of the plans being followed, by sometimes stating exactly what food or drink the person had. A staff member told us of supporting one person to eat fruit regularly, which also indicated the plan was being followed. One person's plan clarified the service was not responsible for food shopping but explained how it was acquired. However, the registered manager told us the service bought the person small

amounts of goods such as bottles of milk if things ran out.

Staff had the knowledge and skills needed to carry out their care roles effectively. Staff told us they received training and support for their care work. Their files showed up-to-date training certificates on most relevant topics, including safeguarding, infection control, and fire safety. One staff member also had a national care qualification, which the registered manager told us the service had supported them with. It included components relevant to the needs of the person they provided care for. Their updated training had therefore been online; however the other staff member told us of face-to-face refresher training, which certificates confirmed, including for moving and handling people safely.

Staff spoke of attending monthly staff meetings. They described them as supportive, for example, to discuss people's ongoing care needs and welfare. Records of the meetings showed they had recently occurred monthly and had been used to remind staff of appropriate service standards such as keeping people informed if running late for a visit.

Good

Is the service caring?

Our findings

People and their representatives told us the service was caring. Comments included, "The care is fine" and that the visiting staff member "comes across as a patient and caring person." They told us there was consistent staffing at the service. Comments included, "It's consistently the same staff member; I like that." We were told of people retaining the same staff member for a number of years, and as people's representatives put it, "They get on well" and "They know his nuances." The service's guide informed people that consistent staffing was an aim of the service. This helped positive and caring relationships to develop.

Staff spoke positively of the people they supported, showing affection for them. They knew people well, and so for example, could tell if they were upset or anxious, and had ways of supporting them in a positive and caring manner. One person's care records showed that, after the service was told they had had a fall which did not result in an injury, staff stayed for longer than usual to make sure they were still ok. The registered manager told us she encouraged staff to make sure people were safe and comfortable, and to "treat people as their own parents." Their recorded checks of care in people's homes included consideration of how caring the staff member was, noting for example if they were respectful and did not rush the person. This helped to demonstrate a caring approach as a core value of the service.

Staff knew how to treat people respectfully. One staff member told us, while helping someone to wash, they always talked with them so as to fully involve them in the process. Another spoke of trying different responses to the person if they were upset about something. People's care plans provided some guidance on respectful support, such as identifying how staff were to address the person.

People were supported to express their views and be involved in decisions about their care. People's care plans included signatures of them or their representatives, which helped to show their involvement in agreeing the plans. A staff member told us of the importance of listening to what people told them, and of supporting them with requests at visits as long as it was safe to do so. Staff also spoke of enabling people to make choices. The service had an advocacy policy containing contact details of local advocacy groups, which the registered manager told us had been circulated to people using the service.

Good

Is the service responsive?

Our findings

People had care plans in place based on comprehensive risk and needs assessments. Care plans identified people's care needs and relevant preferences, and guided staff on the agreed support to be provided. This included for personal care, skin care, communication, mobilising, nutrition and hydration, and property access. Plans were sufficiently individualised. For example, it was agreed for one person to receive support to shower once a week. Care records demonstrated this occurred. The plan clarified different coloured flannels for different aspects of personal care, which the involved staff member told us was now routine practice. Care plans were kept under periodic review and were updated as needs changed.

People and their representatives confirmed there were care plans in place in their homes for care staff to refer to if needed, and records of the visits were kept. Staff confirmed they had access to people's care plans in their homes.

Our discussions with staff and the registered manager showed they knew people's needs, preferences and routines well, as outlined in their care plans. This helped people to receive an individualised, responsive service.

Staff and the registered manager told us of ways in which they supported people to be independent, and confirmed they encouraged this. For example, where one person had physical disabilities, staff told us of supporting them to hold their cup so they could manage their drink themselves. Another person's care plan stated many ways in which they did things for themselves, but clarified where staff were to offer support, such as with management of their hearing aid.

Care assessments included people's cultural background and religion, and whether or not this impacted on the how the service provided support. For example, one person received visits from a religious practitioner, but this was for staff information only as it did not impact on the service they provided the person.

The service was set up to listen and learn from any concerns people experienced. The provider had an appropriate complaints policy in place, and it was referred to within the guide given to people. People and their representatives told us the registered manager was approachable and addressed any matters they raised. Comments included, "If we have any concerns <the registered manager> is more than happy to talk to us." One person had the agency's number on speed-dial so they could easily contact them if needed.

A staff member told us of taking the time to listen to people if they had concerns about the service, and then of reporting to the registered manager if they could not resolve matters directly. The registered manager told us there had been no complaints since the last inspection, but that she reminded people and their representatives to contact her about anything, so that matters could be quickly addressed. She noted this did not affect the service people received.

Requires Improvement

Is the service well-led?

Our findings

The registered manager of the service had been in that role for many years. She was also the sole director of the company at the time of the inspection. She told us due to the small size of the agency, she ran the office and management aspects herself, and provided cover for some care visits. She spoke of ongoing efforts to recruit new staff, which she considered necessary before starting to provide new people with care services. However, she was proud of having provided care for many years to the people using the service.

People and their representatives expressed no concerns about the registered manager's responsiveness. For example, one representative told us of the registered manager visiting to help sort out a medicines delivery, and of contacting them when appropriate.

The registered manager told us of auditing the quality of services. This included through regular care review meetings and viewpoint surveys. We saw people's relatives had returned surveys this year. They were predominately positive about the service.

The registered manager gave examples of how improvements to the service had been made, such as by making medicines administration records easier to use. However, she confirmed there was no documented system for checking service quality by reviewing records of care and medicines administration, albeit she undertook this informally. Care records available in the office were over five and nine months old in respect of the two people using the service, which did not help to demonstrate good oversight of the quality of current records or the identification of welfare concerns. Audits had not identified the medicines safety risks we identified at this inspection. Audit processes were not therefore consistently supporting the service to ensure good quality care was being delivered. This demonstrates ineffective establishment and operation of systems for assessing, monitoring and mitigating health, safety and welfare risks of people using the service. The registered manager agreed to start documenting these checks.

One staff member's file did not contain records of supervisions, spot-checks (unannounced visits to check on how they cared for people) or an appraisal in 2017, despite records of working. They had recent refresher training certificates for many subjects, but not for health and safety, despite a file front sheet that pointed out when previous training expired. This did not demonstrate proactive leadership of the service by means of good oversight of the staff member's development. However, the staff member told us of good support and a spot-check this year, which we subsequently identified as another document within the file of a person using the service. The registered manager agreed to ensure the outstanding refresher training was attended to.

We noted the provider's website for the service showed latest news from 2014. It did not display the rating from the last inspection, a legislative requirement. However, after informing the registered manager of these points during our visit, we found the rating was displayed just a few days after the inspection. This demonstrated both the inconsistent approach to service management but the registered manager's responsiveness to any concerns raised with her. She confirmed she had no formal support structure for ensuring good practice and considering service risks, although she spoke of informal discussions with

people in similar roles. We therefore found the leadership of the service to be reactive rather than proactive.

The evidence above contributes to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff fed back positively about the culture of the service. They told us the registered manager was supportive and always available for advice if needed. One staff member told us if they reported any concerns to the registered manager, "She gets on top of it, gets to it right away." They cited infection control matters as example, which with the registered manager's intervention had been resolved. Another staff member felt the agency listened to people and looked after them well.

There were positive and supportive appraisal records for staff. The staff member audited their performance, and then the registered manager recorded an individualised set of encouraging comments on the staff member's work across the year and ongoing training needs. The records were signed by the staff member and the registered manager.

We noted there was a contract of services in place between representatives of people using the service and the provider. These informed the representatives of their rights and responsibilities, and included costs and invoicing processes. These had been reissued in late 2016. There were also contracts of employment signed by staff members.

The office kept such information securely, and the provider was registered with the Information Commissioner in respect of appropriate data protection practices. There were also privacy and data protection statements in people's files, with indication of them being discussed with people or their representatives.

We noted the provider had a broad range of homecare policies that had been purchased from a specialist provider. The registered manager told us this meant she was kept up-to-date on legislative changes. As example, she showed us the new Duty of Candour policy, which was new to care legislation and set expectations around the service being open and transparent in its dealing with people, particularly where accidents or injuries occurred.

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 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the regulations. This included failures to: • assess, monitor and improve the quality and safety of the services provided; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; • maintain securely an accurate, complete and contemporaneous record in respect of each service user in respect of medicines decisions and medicines support provided. Regulation 17(1)(2)(a)(b)(c)