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Executive Care

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Executive Care provides a domiciliary support service within Milton Keynes and surrounding areas. The service enables people to live independently in their own home.

The inspection was announced and took place on 18, 24, 27 August and 1 September 2015.

The service had 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 and associated Regulations about how the service is run.

The Care Quality Commission (CQC) had been informed by Milton Keynes Council safeguarding team and commissioners of concerns about people using the service not always receiving calls at their agreed times. The provider had agreed to stop taking on any new clients until the situation was resolved.

Summary of findings

Risk assessments for moving and handling were not always updated when people's needs had changed.

Risk assessments and care plans were not always put in place for people at risk of developing pressure sores.

People were encouraged to have their say about how the quality of services could be improved and knew how to raise any complaints if they needed to do so. However the complaints procedure was not made available within the care records held in people's homes.

The provider had informed the Milton Keynes Local Authority Safeguarding Team of safeguarding incidents; however they had not always notified CQC of incidents that affected the health, safety and welfare of people who use services.

Staff understood their roles and responsibilities to safeguard people and to report any concerns. The provider was working closely with the Local Authority in relation to safeguarding concerns.

Suitable systems were in place to manage people's medicines when they were not able to, manage them themselves.

Staff recruitment practices were robust and the staff received appropriate training. Systems were in place to ensure staff received regular supervision and support.

Peoples were involved in making decisions about their care; where they lacked the capacity to make their own decisions, best interest decisions were made in line with the Mental Capacity Act (MCA) 2005.

People were encouraged to eat and drink sufficient amounts to maintain good nutrition and hydration.

Staff contacted the relevant people in response to sudden illness or emergencies.

There was a system of quality audits, surveys and reviews, which was used to monitor the service provision.

We identified that the provider was not meeting regulatory requirements and were in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Risk assessments were not always updated or put in place as and when people's needs had changed.

Staff did not always arrive at people's homes at the scheduled times.

Staff were aware of their safeguarding responsibilities.

The recruitment practices ensured that staff were only employed once all satisfactory pre – employment checks had been carried out.

Appropriate systems were in place to manage people's medicines.

Requires improvement

Is the service effective?
The service was effective.

Staff understood people's needs and received regular training to support them in their roles.

Staff benefitted from receiving one to one supervision on a regular basis.

People were involved in making decisions about the way care was provided and staff worked in line with the principles and requirements of the Mental Capacity Act 2005.

Staff contacted the relevant people in response to sudden illness or emergencies.

Good

Is the service caring?
The service was caring.

People and their relatives were involved in planning their care and felt that the staff understood their needs and treated them with dignity and respect.

The staff maintained people's privacy and dignity.

Good

Is the service responsive?
The service was not always responsive.

People's needs were assessed and their care plans were kept under review, however, care plans were not always updated as and when people's needs had changed.

People felt able to raise complaints or issues of concern. However, the complaints procedure was not made available for people within the care records held within their homes.

Requires improvement

Summary of findings

Is the service well-led?

The service was not always well led.

The provider had not always notified CQC of incidents as required by law.

Quality monitoring and audit processes were in place and people who used the service and their relatives were invited to provide feedback on the quality of the service they received.

The provider demonstrated they were listening and taking action based on feedback from people using the service.

Requires improvement

Executive 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.

The inspection took place on 18, 24, 27 August and 1 September 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that staff and people would be available to speak with. The inspection was undertaken by one inspector.

Prior to the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also gathered information from Local Authority Commissioners.

We spoke with three people using the service and three relatives. We also spoke with the registered manager, two administration staff and three care staff.

We reviewed the care records relating to three people who used the service to ensure they were reflective of people's current needs, the recruitment files for three care staff and records in relation to staff supervision and training. We also looked at records in relation to the management of the service.

Requires improvement

Is the service safe?

Our findings

A relative informed us their [spouse] had used a walking frame to mobilise prior to them sustaining a fall in June 2015, which resulted in being admitted to hospital. The relative said their [spouse] was discharged from hospital at the beginning of July 2015, and since their return home they had been cared for full time in bed and no longer mobile. The staff also confirmed that the person was no longer mobile since their return home from hospital.

However the person's moving and handling risk assessment stated no change had taken place to the persons mobility needs, even though it had been reviewed since the person's discharge from hospital.

The person was spending prolonged periods in bed and the provider had not carried out a risk assessment to demonstrate they had taken on board the increased risk of the person developing pressure sores and how it was to be managed.

This was a breach of Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Milton Keynes Council safeguarding team and commissioners had contacted CQC to inform us of concerns that had been raised about people experiencing late and at times missed calls. The provider told us that in response to the concerns they had currently stopped taking on any new care packages and were working in collaboration with the Local Authority to resolve the situation. They told us they had reinforced with staff that they must contact the agency office to log their arrival and exit times. The manager informed us the system was designed to ensure that no person missed their scheduled visits. People told us they had given their permission for the staff to use their telephone to call the 0800 telephone number at no charge to them, to report to the agency office their arrival and departure times.

People told us they usually had the same staff to attend their care. They said the care staff carried out the care tasks required and usually stayed for the full length of time as agreed within their care packages. People said they understood that at times staff may be delayed due to heavy traffic or as a result of responding to other emergencies. However, they said that it was a regular occurrence that the care staff often arrived towards the end of their scheduled time slot. They also said they were not always contacted by the agency office to inform them when the care staff were running late and often had to call the agency office themselves to find out what was happening. One relative said, "My [relatives] time slot is 7:30am to 8:30am, I like get up before the care staff come, as I like to be washed and dressed before they get here, but often they don't arrive until almost 8:30am or even later. Another relative said, "They [staff] are often are running late it's quite rare when they arrive on time or even early".

The staff told us they believed there was sufficient staff to meet people's needs. They said that sometimes they were held up due to waiting for a driver to be available, as not all staff were drivers and had their own vehicles. They said the agency tried to schedule the calls to enable drivers and non-drivers to provide care to people that lived within close proximity of each other.

The staff logged their arrival and departure times within the daily notes, held within people's care records held within their homes. Checks of the notes confirmed that the staff regularly arrived towards the end of the scheduled times. We also observed during a visit to a person's home a member of staff arrived at 12:25pm for a call that was scheduled to take place between 12.00pm to 12:30pm, the member of staff explained to us that the allocated care worker had called in sick and alternative arrangements had to be made at short notice.

People told us they felt safe when receiving care from the staff. One person said, "I'm prone to falls, the carers help me to get safely in and out of the shower and walk down the stairs safely". A relative said, "We generally have the same care staff to provide my [relatives] care, we have a key safe outside, so the staff can let themselves in. We trust them, it's really important you have that trust when people are coming into you home".

Staff were employed after a range of satisfactory pre-employment checks had been completed. We saw that the recruitment records contained all of the necessary documentation such as proof of identity, written character references and evidence of vetting through the government body Disclosure and Barring Service (DBS) that included Criminal Records Bureau (CRB) checks.

The staff told us they had received safeguarding training on how to recognise and report abuse and they were confident that any concerns they reported to the manager

Requires improvement

Is the service safe?

would be dealt with appropriately. They also told us they were aware of the 'whistleblowing' procedure to follow if safeguarding concerns were not addressed by the provider appropriately.

One member of staff said, "Safeguarding training was provided during my induction training, I have never had to report any safeguarding matters, if I ever thought any of the people using the service were subject to abuse, I would not hesitate to report it".

We saw that the provider acted appropriately to allegations or concerns about people's safety. They had stopped taking on new care packages, which demonstrated their willingness to take action to ensure that people received safe care.

The staff told us they were aware of the accident and incident reporting procedures and reported such events following the procedures.

Appropriate systems were in place to manage people's medicines. Some people kept the responsibility for managing their own medicines, whilst others had given their consent for staff to take on the responsibility. People told us they had no concerns about the staff administering their medicines to them. We saw the Medicines Administration Records (MAR) held within people's homes were appropriately signed by staff upon administering people their medicines.

Good

Is the service effective?

Our findings

People told us they felt that the staff had the skills and competencies to meet their individual needs.

All the staff we spoke with said they thought the training they received from the agency was good.

They told us they had received full induction training when they first starting working for the care agency that lasted three days. We saw within each staff file that copies of training certificates were available to show that they had attending training such as, safeguarding people from abuse, medicines management, first aid, moving and handling, food hygiene and infection control.

The staff training plan showed when staff had attended training and when updates were due. We saw that some staff had been provided with service user specific training such as, stroke and diabetes awareness, dementia care, catheter care and mental health awareness.

The staff told us they were provided with supervision and support and confirmed they had regular meetings with their supervisors to discuss their work performance and on-going training needs.

The manager told us they had introduced a 'live chat' mobile phone application to keep in close communication with staff. They said it was accessible through the use of a mobile smart phone. The staff told us that using the 'live chat' kept them in touch with any changes as and when they happened. One member of staff said, "It's very proactive, I used it to inform the manager and staff when I noticed a signature was missed on a person's medicine chart, I put a message on to tell the member of staff I had noticed it was missing and they signed it on their next visit to the person".

We also saw that face to face staff team meetings took place and minutes of the meetings were made available to staff who had been unable to attend, to ensure they were informed of what had been discussed.

People told us that staff asked them for their consent before providing care and support and records confirmed, that their consent was always obtained. The manager and staff had completed training on the Mental Capacity Act (MCA) 2005 and they were able to explain how the requirements of the act worked in practice.

People confirmed that the staff made sure they were comfortable and had access to food and drink. Staff had received training in food safety and they were aware of safe food handling practices. They also told us that where there was an identified need for support with monitoring people's food and drink intake this was recorded at every visit. People's care records showed that where they had been assessed at risk of not receiving sufficient nutrition and hydration their food and drink intake was closely monitored by staff. We also saw some care staff had received training on caring for people who were unable to take food orally and required to get nutritional support through a percutaneous endoscopic gastrostomy (PEG) tube feeding system.

People and their relatives told us the care staff took appropriate action in response to changes in their health conditions. We saw that the staff recorded day to day observations of people's well-being and any changes in their health within the daily care logs. Relatives told us they were confident that if their relative became ill that the staff would contact them or the GP in an emergency.

Good

Is the service caring?

Our findings

All the people we spoke with told us the staff were caring and compassionate and they felt that the staff provided them with individualised care. They told us it was generally the same staff that attended their care and spoke with fondness about each of the staff.

People told us the staff maintained their people's privacy and dignity. One person said, "[name] always makes sure they cover me with a towel when I am getting a shower, they very aware of maintaining my dignity".

People said they did not feel rushed when the staff attended their care, they said the staff took the time to explain things to them and provide them with sufficient information before carrying out any care tasks. They told us they involved them in making day to day decisions. During a visit to a person's home we observed the member of staff called the person by their preferred name, they took the time to explain what they were doing, they gave the person time to comprehend what was said and actively listened and acted on what the person said.

People using the service and their relatives said they were involved in planning their care, we saw they had signed their care plans to show they were in agreement with what was recorded within them.

All of the staff we spoke with said they enjoyed working for the care agency; they were knowledgeable of the needs of each person they provided care for. They spoke about people with affection and consideration for each of their individual needs. One member of staff said, "I like to think I care for people as I would my own mother or father, it's so important that all people are treated with humanity, dignity and respect".

Requires improvement

Is the service responsive?

Our findings

We spoke with a relative who informed us that their relative's needs had changed significantly since they had sustained a fall that resulted in them being hospitalised in June 2015. The person told us since their relative had returned home at the beginning of July 2015 they were no longer able to walk and needed to be cared for permanently in bed. They told us the person received visits from the district nursing services to provide catheter care and they and had been provided with a pressure relieving mattress to prevent the risks of developing pressure sores.

We also spoke with staff that provided care for the person, they told us they were aware their needs had significantly changed and were able to describe the care they provided. Other staff said they were fully aware of the needs of people in their care. One member of care staff said, "We see people regularly, we know their likes and dislikes, when we notice that a person's needs have changed we inform the manager.

However on checking the person's care plan we found it had been reviewed towards the end of July 2015 and had not been updated to reflect the current needs of the person. We also noted no specific pressure area care plan had been put in place to address the increased risk of the person developing pressure area sores, due to being permanently cared for in bed.

This raised concerns that the process for reviewing and updating people's care plans was not sufficiently robust to ensure the information contained within care plans accurately reflected people's current needs.

This was a breach of Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were fully involved in the care planning process and their views were sought about the way in which they wanted their care or support needs to be met.

Each person had their needs assessed before commencing with the care agency and the assessments formed the basis of the care plans that were put in place. We saw the care plans contained sufficient detail to inform the staff on people's needs.

People and their relatives told us if they wanted to raise any complaints about the service, they would not hesitate to speak directly with the manager. They said the manager was approachable and felt confident their concerns would be appropriately addressed. However we noted a copy of the company complaints procedure was not made available within the care documents held within people's homes.

We looked at records of complaints held at the agency office, which related mainly to people complaining about receiving late calls, in response the provider had introduced a call monitoring system to track the staffs arrival and departure times in an effort to rectify the problem.

Requires improvement

Is the service well-led?

Our findings

The Care Quality Commission (CQC) had been informed by the Milton Keynes Local Authority Safeguarding Team and Commissioners of concerns about people receiving late or missed calls. Action plans had been put in place for the provider to work through, to show that improvements were being made, and in the interim the provider had suspended taking on any new placements until the concerns had been fully addressed and resolved.

We saw copies of safeguarding records held within the agency office that confirmed that incidents had been reported to the Local Authority (LA) safeguarding team. However the provider had not always notified CQC of the incidents as required by law.

This was a breach of the Care Quality Commission (Registration) Regulations 2009.

The service had a registered manager in post and from discussions with people using the service it was apparent that they had a good relationship with people and were aware of their needs. People said the manager was approachable, helpful, kind and considerate, they said they always made themselves available if they needed to discuss anything about their care needs.

People said the only concerns they had were around staff attending their calls towards the end of their agreed scheduled times. The manager told us that they wanted to provide good quality care and had recognised the impact of people receiving late calls and was taking proactive action in reviewing the staff time management systems.

The staff said the introduction of the 'live chat' communication system was a positive move to improving communication and would ultimately improve the experience of people using the service.

The staff said the leadership from the manager and the support from the office based staff was very good and that the manager was approachable and had an open door policy. They told us the manager provided mentoring and coaching during their induction training. They also said that on a day to day basis the manager provided 'hands on' care for people, which meant they were fully aware of people's needs. They were positive and motivated and appropriately trained to meet the needs of the people using the service and fully aware of their roles and responsibilities.

Systems were in place to monitor the quality of the service by regularly speaking with people to ensure they were happy with the service they received. Routine home visit 'spot checks' were carried out to observe the staffs care practice and to seek feedback from people on the care they received. Relatives also confirmed that telephone calls were made by the agency office to ask people if they were satisfied with the care and support they received. We saw records of the telephone conversations were held within the agency office and the provider analysed the results to identify how they could improve the service.

We saw that other quality monitoring systems were in place that included checks to staff recruitment systems, care plans and risk assessments, medicines audits and updates to staff training records.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Regulation 12 (1) (2) (a) (b) How the regulation was not being met: Risk assessments were not in place or had not been updated with particular attention to moving and handling and pressure area care. Pressure area care plans were not always put in place for people at increased risk of developing pressure sores.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 (1) (2) (e) How the regulation was not being met: The provider had not always notified the Care Quality Commission (CQC) of incidents that affected the health, safety and welfare of people who use services.