Pro Solutions Ltd

ECC Care

Inspection report

379 Southchurch Road
Southend On Sea
Essex
SS1 2PQ

Tel: 01702597793
Website: www.ecccare.co.uk

Date of inspection visit:
07 June 2022

Date of publication:
29 July 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
ECC Care provides personal care and support to people who require assistance in their own home. At the time of our inspection approximately 23 people were being supported by the service. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

The service is registered to be at the address 379 Southchurch Road, Southend on sea, Essex SS1 2PQ. However, when we announced the inspection we were informed the offices had moved to Suite 1 Chalkwell Lawns, Westcliff on sea, Essex SS0 9HR. This location is not part of the provider's condition of registration. We are therefore considering our next enforcement action for this different location. Our inspection occurred at Suite 1 Chalkwell Lawns address, to ensure people were being supported safely.

Care and treatment was not recorded in detail or in a person centred way to provide safe support to people. Staff training had not been reviewed or kept up to date for all staff. There was limited information to support the administration of medication and staff had not had their competency checked. The provider was not able to demonstrate how they learned lessons and shared this information when things go wrong.

The provider had a lack of oversight at the service and there were poor governance systems which meant issues had not been addressed.

People's experience of using this service and what we found
Generally people told us they were happy with the staff that supported them with their care. People told us they had consistent staff members supporting them.

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

Rating at last inspection
The last rating for this service was good (published 20 November 2018.)

Why we inspected
We received concerns in relation to the management oversight at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

The provider has taken action by appointing a management consultancy firm to address the issues identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for ECC Care on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, recruitment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below

ECC Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 7 June 2022 and ended on 11 June 2022. We visited the location's office on 7 June 2022.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We reviewed the last provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they

do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with one person and nine relatives. We spoke with seven members of staff including the provider and a care co-ordinator.

We reviewed a range of records. This included five people's support records. We reviewed three staff records in relation to recruitment, training and supervision.

After the inspection
We continued to review information supplied by the provider including their action plan, training records and support records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Staff did not have detailed guidance to follow to mitigate risks to people. People were at risk due to the lack of information provided in care plans and risk assessments.
- One person's care plan and risk assessment was blank. We saw from the local authority referral document the person was at risk or pressure sores, falls and had other medical conditions. None of these were included in their care plan and risk assessments. This meant we could not be sure staff had all the information they needed to support the person and mitigate these risks from reoccurring.
- Care records contained lists of tasks for staff to complete, for example, one care plan under nutrition stated food was to be blended and thickener added to drinks. There was no further guidance for staff to follow or risk assessments to mitigate the risk of choking.
- Where people needed support with moving, for example using a hoist, there were no detailed moving and handling care plans or risk assessments to support staff with understanding how to do this.
- We highlighted these issues to the provider, and they informed us they hoped care documentation would be updated when they had a manager in post. We wrote to the provider asking them to provide us with a clear plan of how this would be addressed to mitigate risks.
- There were no risks assessments in place to support staff or people with the risks associated with COVID-19. This meant we could not be assured staff knew how to support people safely or protect themselves from COVID-19.
- The provider was unable to evidence they were monitoring late or missed calls and had been relying on people or relatives ringing the office if they had a late or missed call. Whilst we were at the inspection the care co-ordinator for the service activated an alert system for late or missed calls so that they could monitor these in the future.
- One relative told us, "It has improved recently as I think there has been a change in management. It was very hit and miss before with a lot of late and missed calls." Another relative said, "We have had hiccups in the past but the last couple of months it has improved."

Using medicines safely

- Medicine administration records had been moved to an electronic system. We found the system contained very minimal information on how people should be supported with medication.
- We found no evidence of risks assessments in place to support people with medication or any medication protocols to support staff when assisting people with as and when required medication.
- Staff we spoke with told us they had not had their competency to support people with medication regularly reviewed. Staff also informed us they found the digital medication system did not support them to give medication safely due to the minimal information contained on it.

● We found no reviews or audits of medication administration records.

Risks management systems were not robust and placed people at risk of unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider did not have safe recruitment practices at the service. We found not all staff had an up to date Disclosure and Barring Service (DBS) check in place. (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● We found one staff file we reviewed did not contain any references, record of interview, right to work documentation or DBS. Another staff file contained a DBS from a previous employer and no checks had been made to verify if this was still accurate. We found two staff had not had a DBS check for a number of years and the provider had no systems in place to ensure they remained of good character.
● Staff did not receive regular supervision or checks to ensure they were supporting people safely and there was a lack of evidence that induction or training was completed promptly. A member of staff new to care had not completed the Care Certificate or equivalent induction program. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Recruitment procedures were not effective to ensure the safety and suitability of persons employed. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider employed a management consultant to address the issues identified and supplied an action plan with how they would meet the regulations.

Systems and processes to safeguard people from the risk of abuse
● The provider knew how to raise safeguarding concerns but informed us they did not have any safeguardings concerns for people.
● Staff we spoke with had an understanding of safeguarding and told us what they would do if they had a concern. One member of staff said, "I would raise any concern with the CQC, social services or someone with authority."

Preventing and controlling infection
● Staff told us they had access to Personal Protective Equipment (PPE) and were wearing PPE during care calls.
● Staff had completed training on Covid-19.
● Staff informed us they continued to test regularly in line with government guidance

Learning lessons when things go wrong
● There was not a robust system in place that the provider could evidence how they learned lessons when things go wrong.
● Staff did not complete accident or incident forms, for example if people had a fall. We could not be assured lessons were learned and shared with staff.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- There was a lack of leadership and oversight at the service. The provider had difficulty recruiting a registered manager for the service. This had led to the service running without management supervision.
- Governance systems at the service had lapsed which meant issues raised at the service had not been addressed or followed up by the provider.
- The local authority had placed a suspension on using the service following an inspection by a local authority quality team in November 2021. The provider was given an action plan to work through to address issues raised at the service. The provider had not taken action to meet the requirements of this action plan and the suspension by the local authority remained in place.
- The provider had moved offices and had failed to notify the Care Quality Commission of their new location address, this was a breach of their condition of registration. The provider has now made the application to change address.
- There were no person centred care plans to support people's care needs. Care plans we reviewed consisted of a list of tasks for staff to complete rather than detailing how people could be supported to have their needs met safely.
- We saw no evidence of reviews to ensure staff had up to date information to support people.
- Relatives we spoke with told us they rang staff directly if they needed to discuss their care needs rather than going through any management system. Although, some people and staff said since a new office administrator had started communication had improved.
- The provider had changed to an electronic note system however, this had not been updated fully to meet all aspects of people's care needs. Where staff needed to detail their observations during each visit, we found some of these entries contained minimal information. Staff we spoke with told us they found it difficult to follow up on people's care needs when staff had not completed these in detail.
- Staff training had not been consistently updated and we found in some cases the provider had relied on the training staff had received from third parties such as other employers. We found there was no system in place to check if this training was adequate to equip the staff with the knowledge and skills, they needed to perform their role. There was a lack of staff supervision or spot checks of their competency and the provider had failed to ensure staff completed refresher training.
- Staff were updated of any changes through a messaging system. This was reliant on staff scrolling through

these messages to read them before delivering care. This meant staff could potentially miss important information being shared about people's care.
● In addition, the provider had no system in place to remove staff who had left from the messaging system in a timely way. This meant ex-employees could still be receiving confidential information. The provider was able to show us they had removed five staff from the system, but they were unable to tell us when their employment had been terminated.
● Following a member of staff being taken through disciplinary procedure, we found no clear action plan was put in place to support the staff member or to review their performance in relation to the disciplinary.
● We found a complaint made by a person using the service did not have an outcome recorded although the provider told us this had been addressed.

We found no evidence people had been harmed. However, systems and processes were not robust enough to demonstrate safety and quality were effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We asked the provider to inform us how they would take immediate action to address the issues we had identified during the inspection. As a result of this they provided an action plan and informed us they had employed a management consultant to address the issues whilst they were recruiting a new registered manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● We found the provider did not have any adequate systems in place to gain feedback from people or staff. The provider told us there had not been any staff meetings.
● Relatives told us that staff had engaged with occupational therapist to ensure they had the equipment they needed to provide care.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices were not being completed to ensure appropriate checks were in place to protect vulnerable people form unsuitable members of staff.

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 17 Registration Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the MHA Quality assurance and governance arrangements were not effective to identify shortfalls at the service and promote improvements.

The enforcement action we took:

We have served the provider a warning notice to make improvements.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans were not person centred and did not mitigate against risks safely

The enforcement action we took:

We have served the provider with a warning notice to make improvements.