Emerald Care Services (UK) Limited

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Inspection report

Langport House
Overton Road
Brixton
London
SW9 7HN

Date of inspection visit:
26 January 2016
29 January 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This announced inspection took place on 26 and 29 January 2016. Emerald Care Services provides personal care and support to people in their own homes. At the time of this inspection 44 people were using the service.

This was the first inspection of a regulated activity carried on by the provider since it registered with the Care Quality Commission in 2014.

The service has a registered manager in post at the time of the inspection. 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.

People told us they felt safe. Staff were trained to recognise and report any signs of abuse. People were protected from the risks of avoidable harm and their risk assessments were regularly reviewed. The provider followed recruitment procedures to ensure staff were safe to work with people. There were enough staff to meet people's needs. People's medicines were managed safely.

People were asked for their consent to the support and care they received. The provider met the requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards. Staff knowledge and skills were subject to on-going evaluation and improvement through supervision and training. People's nutritional needs were met and the service supported people to access healthcare services when they needed to.

People and their relatives told us the staff were caring. People were supported to make choices and advocates were sometimes used to support decision making. Staff respected people's dignity and privacy and recognised the value in developing positive relationships with people.

People received person centred care. Care plans reflected people's needs and preferences and were reviewed and updated to reflect changes in needs. The provider sought people's views and responded to complaints in line with its procedures.

The management team was described by people and staff as approachable. Audits were undertaken by the manager to check the quality of service delivery and the service worked with local resources including day services and health and social care professionals to meet people's needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected from the risk of abuse because staff knew how to recognise and report abuse and neglect.
Risks to people were assessed, managed and reviewed.

There were sufficient staff to support people safely, whilst staff selection and recruitment procedures ensured staff were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective. People were cared for by staff who were supervised and received training to meet their needs. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff supported people to meet their nutritional and hydration needs and to access healthcare services in a timely manner.

Is the service caring?

Good

The service was caring. People told us the staff were caring and respected their choices. Advocacy services were used to support people to make choices and people's privacy and dignity were maintained.

Is the service responsive?

Good

The service was responsive. People received personalised care and their needs were assessed pre-admission. Care plans detailed how people wanted to receive their care and support and were regularly updated to reflect changing needs.

The service sought feedback from people and their relatives and acted on the results. The provider responded to complaints in accordance with its procedures.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in post who was supported by a care coordinator. Both were approachable to people and staff and undertook audits of

service quality.

Staff understood their roles and the service worked in co-operation with local health and social care professionals to meet people's needs.

Emerald Care Services (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.

The announced inspection took place on 26 and 29 January 2016 and was undertaken by one inspector. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager was available. This meant the provider and staff knew we would be visiting the agency's office before we arrived.

Prior to the inspection we reviewed the information we held about Emerald Care Services, including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with four staff, the care coordinator and the registered manager. We reviewed documents relating to people's care and support. We read nine people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We read six staff files which included pre-employment checks, training records and supervision notes.

We read the provider's quality assurance information and audits. We looked at complaints and feedback from people given during spot checks.

Following the inspection we spoke with seven people and three relatives and we contacted five health and social care professionals for their feedback.

Good

Is the service safe?

Our findings

People told us they felt safe when staff came into their homes to provide care and support. One person told us, "I'm always happy to see [staff name]. I always feel safe when they're around." Another person said, "I have never had any concerns about any of the staff. I am fine with them being in my home."

People were protected from harm because staff were knowledgeable about the types of abuse they were at risk from. Staff told us they received safeguarding training and understood their responsibilities in keeping people safe. All of the staff we spoke with knew about different types of abuse and the signs that may indicate a person is at risk. The provider had a safeguarding policy to guide staff. They were able to explain to us that if they suspected abuse they would report it to their manager, the local authority or CQC in line with the policy. Staff understood the provider's whistleblowing policy. Whistleblowing is a term used when staff alert outside agencies when they are concerned about the provider's care and support practice. Staff confirmed that they would be confident and prepared to report risks to people's well-being to external agencies without hesitation. This meant that people were kept free from harm by staff trained to keep them safe.

People's risks were assessed prior to receiving a service and guidance was included in care records. We saw that risks were reassessed when people's needs changed and their care plans were updated to reflect this. For example, one person's care records showed they received a pendant alarm to alert others to a fall after staff noticed a decrease in their confidence when walking and reported it. Staff we spoke with confirmed they knew what actions to take if they had any concerns about risks or if a person's needs changed. One member of staff said, "I contact the office and they liaise with the social workers, physiotherapists and nurses and we get things sorted out quickly." Another member of staff said, "I always make sure to deal with any trip hazards in people's homes and make sure people are warm enough. I talk about any concerns with them, their families, my manager and care coordinator."

Staffing levels were determined by people's care packages. For example, some people received support three times a day, whilst other people's needs meant they required one visit from staff. People told us that staff supported them on time and for the duration of their planned hours. One person told us, "[Staff name] comes on time normally. If they're running late the office lets me know so I don't have to worry." Another person said, "The carer's do their time right. It's just not long enough, which I know is not their fault." One member of staff told us, "It gets drummed into us that 'lateness is neglect'. If we are running late we must phone the office. If we are sick, plenty of notice needs to be given for cover."

Staff rotas showed sufficient staff were available to meet people's care and support needs and to cover leave. When cover has not been available the care co-ordinator had supported people.

People were protected against care and treatment being provided by unsuitable staff. We read six staff records and saw the provider had carried out pre-employment checks before they were permitted to provide care and support. Checks included identification, eligibility to work in the UK and references from previous employers. Staff completed checks with the Disclosure and Barring Service (DBS) who check

details about criminal records and those prevented from working with vulnerable peoples. This meant there were safe recruitment and selection processes to protect people receiving a service.

People were supported to take their medicines safely. Staff supported people in line with their care plans. Staff verbally prompted some people to take medicines while other people were asked if they had taken their medicines. Staff did not administer medicines. One person told us, "My carer always reminds me to take my pills and gives me a glass of water." We saw medicines administration records (MAR) charts correctly completed by staff and audited by the registered manager. This meant people were receiving the right medicines at the right time and at the right dose.

Good

Is the service effective?

Our findings

People and their relatives told us staff were capable of meeting their care and support needs. One person told us, "They [staff] are not here for very long but they get things done like their supposed to." Another person said, "The carer's help me to get up washed and dressed alright. No complaints." One relative said, "The carer's have a small window of time in which to get an awful lot done and they do it as best they can. They understand [person name] needs and choices and that's paramount."

Staff completed an induction process before working independently with people. A member of staff told us, "Before I met people I read their case histories so I knew something about them and the manager phoned to say I was coming and told them a bit about me." Another member of staff said, "Shadowing was important firstly because someone the person trusted was introducing me and secondly because I watched how they did things together." This meant newly appointed staff had knowledge about people's preferences and needs before providing care and support.

People were supported by staff who received on-going training to ensure their skills and knowledge were up-to-date. A member of staff told us, "Training is good. I learn how to do my tasks correctly and get to share ideas with colleagues." Another member of staff said, "Increasing your knowledge is important. We do that in training but it would be good to do some external training, not just training delivered by the manager. That would broaden our knowledge more." Staff records showed training included safeguarding, dementia, moving and handling and mental capacity.

The registered manager supervised staff and monitored their delivery of care and support. The manager and staff had quarterly one-to-one supervision meetings at which staff reflected on their practice. A member of staff told us, "Supervisions are straight forward. My manager reviews my work and tells me how I am doing and we talk about people's needs." Another member of staff said, "The managers do spot checks when they phone people and ask how I'm working. They ask social workers and relatives too and then tell me about it in supervision." We saw a plan for the introduction of annual staff appraisals but none of the staff had been in post for a year at the time of the inspection.

Staff sought the consent of people before delivering care and support. Care records stated people's preferences and staff demonstrated knowledge of these when we spoke with them. One person told us, "Staff always ask me before they do anything, which is good because I might not want them to do it." Another person said, "The staff are good at asking me what I want and to choose between things." One member of staff told us, "I don't go barrelling into people's homes and tell them what to do. It's their life, their home, their body. I assist as they choose. Personal care is sensitive and you have to have a trusting relationship."

The provider had a mental capacity policy and delivered training to staff on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberties Safeguards (DoLS). These are legal processes to ensure that people receive care and support in a way that does not restrict their freedom. A member of staff told us, "We cover MCA and DoLS in our dementia training. It's important because with dementia people's mental capacity can

fluctuate." Another member of staff said, "The people I am the carer for have capacity. They say what they want and make choices. If that changed, the manager would make sure a best interests meeting happened." This meant that people's rights were upheld in line with legislation.

People were supported with sufficient to eat and drink. Some people receiving care did not need support with eating or drinking. People requiring support around nutrition and hydration had their needs assessed prior to receiving the service or following a change in needs. Care records detailed the support each person required to eat. For example, one person needed a carer to cut up their food. A member of staff told us, "Support varies but for a couple of people meals on wheels provide the food. I plate it and prompt people to eat. Often it's the company and the conversation that helps people eat." Another member of staff said, "Someone without dementia training might not realise that a person could forget what the thirst sensation means or get out of the habit of drinking regularly. Dehydration is a serious risk. I make people drinks for when I am there and more for later." This meant that staff met people's eating and drinking needs in line with their care plans.

People accessed healthcare services as they needed to. Staff told us they regularly liaised with healthcare professionals. One member of staff said, "I often work alongside district nurses, particularly when people are discharged from hospital. They always have good advice about care." Another staff member said, "We do referrals to health teams on behalf of people all the time. For example, we made a referral to occupational therapy because a person had a wheelchair too wide to go into their bathroom." This meant people's healthcare needs were met by timely referrals made by staff.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring. One person told us, "I would say yes, the staff are caring." Another person said, "I do laugh with [staff member]. Every day without fail she will suggest I wear an outfit that doesn't match at all. It's our in joke. She's very funny." A relative told us, "Generally I find the carers caring."

People were supported by a small number of staff they were familiar with. Each member of staff we spoke with emphasised the importance of developing a positive relationship with people. One member of staff told us, "You have to have a good rapport with someone if you are supporting them in their own home. By allocating a small number of people to each member of staff we develop the continuity and familiarity that helps relationships to grow." Another member of staff said, "When you support a person each day you start to understand them in a way far deeper than a care plan can tell you. I know at a glance if [person's name] feels down or has something on their mind." This meant that staff met people's needs effectively and compassionately.

People were supported to make decisions and choices about their care and support. People told us they were involved in their assessments before receiving a service and in reviews of their care since. One person told us, "I know what I need help with and we have decided how I should get it. It is important that I know where I stand and that the carers do too. I want to be as independent as I can and staff support that." One member of staff told us, "I often support people with their shopping. They choose what they want and we make a list. But with their permission I check that they don't already have it. Sometimes they do, so I considerately tell them." Care records detailed people's preferences for how they wanted to be supported.

People were supported to access advocacy services. An advocate is a person independent of the provider and the local authority who supports people to make important decisions. We read records which showed advocates and staff supported people to make decisions about their health and treatment as well as to request an increase in the hours of care and support being delivered.

People told us that staff respected their privacy and dignity. One person said, "They [staff] treat me and my home with respect." A member of staff told us, "The simple things matter to people, like knocking on a bedroom door, even though I was in the room two minutes before." Another member of staff said, "Some people want you to remove your shoes before entering their home. That is fine by me and I always call people by the name in their care plan until they tell me otherwise."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People told us they received care and support in line with their preferences. One person told us, "I discussed the way I wanted to be assisted with the carers and my family and the carers do what we agreed." A member of staff told us, "People's care plans are very different. I support some people once a day others three times a day. Social workers decide this. I look at the care plans to see what support people need and then discuss with them how to provide it. Care is completely different for each person."

People's needs were assessed prior to a service being provided. The service liaised with care coordinators to ensure changes in needs were identified, assessed and planned for. For example, records showed one person's mobility in general and ability to weight bear in particular had decreased rapidly. The service referred the concern to a social worker who reassessed the person and updated their care plan. This meant the service took action when people's needs changed.

Care plans contained detailed information and clear guidance about people's health and personal care needs to enable staff to provide effective support. Care records included information about people's culture, communication, capacity to consent, nutritional support needs, drinking and personal preferences. People and their relatives told us they were involved in developing their care plans. We saw that care plans were reviewed with people and social workers.

People's care and support was commissioned by the local authority. When allocating carers to people the provider looked at a number of factors including the carer's proximity and accordingly their journey time to the person's home. When indicated in care plans, cultural and gender compatibility needs had been met and the service sought to match people's needs with staff skills. This meant the provider took factors into account when planning the delivery of care and support.
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People's needs were assessed prior to a service being provided. The service liaised with care coordinators to ensure changes in needs were identified, assessed and planned for. For example, records showed one person's mobility and ability to weight bear in particular had decreased rapidly. The service referred the concern to a social worker who reassessed the person and updated their care plan and an occupational therapist who recommended the use of a Zimmer frame. This meant the service took action when people's needs changed.

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communication, capacity to consent, nutritional support needs, and personal preferences. People and their relatives told us they were involved in developing their care plans. We saw that people and social workers were involved in the reviews of their care plans.
People received support based upon their assessed needs. People's care and support was commissioned by the local authority. When allocating carers to people the provider looked at a number of factors including the carer's proximity and accordingly their journey time to the person's home. When indicated in care plans, cultural and gender compatibility needs had been met and the service sought to match people's needs with staff skills. This meant the provider took factors into account when planning the delivery of care and support.

People and their relatives were asked for feedback about their service. The provider's care coordinator undertook daily spot checks. The registered manager and care coordinator contacted people and their relatives asking for their views on the quality of the service being provided. One person's feedback said that they felt the support they were receiving was taking place too early for them in the day. With the person's agreement the service responded by putting in the support later in the morning. This meant the service delivered support in line with people's choices.

A complaints procedure was in place. We read records which showed that complaints were investigated and responded to in line with the procedure. The registered manager said, "It will often be the case that we alert the duty desk [within the local authority social work team] when a complaint comes in." This meant the complaints process was transparent and the local authority had the information to decide if it should investigate the issue as a safeguarding concern.

Good

Is the service well-led?

Our findings

There was a registered manager in post. They were supported by a care coordinator. Staff said they found both the registered manager and care coordinator to be approachable and flexible. A member of staff said, "We can pass through the office anytime. It is good to catch up with colleagues because we work on our own. The managers are good to talk to formally and informally." Another member of staff said, "I think the management team are quite open and they can be encouraging at times."

People and their relatives said that the management team were easy to contact. One relative said, "They always answer when I phone the office and I'm never left waiting." The provider operated an out of hours on-call service for people and staff to use if support was required. The provider's office was situated on the ground floor of building that was wheelchair accessible throughout. This meant people could visit the office to meet with the registered manager if they wanted to.

Staff told us they were clear about their roles and responsibilities. Each member of staff was provided with a staff handbook which explained the visions and values of the service and what was expected of them. The manager understood their responsibilities of registration with CQC and their duty to notify us of important events that affect the service.

The quality of service delivery was subject to frequent checks. For example, the registered manager and care coordinator reviewed a sample of care records each month to ensure they were accurate and reflected people's changing needs. When necessary, the manager developed action plans to ensure improvements. The manager monitored accidents and incidents to prevent their reoccurrence.

The manager and staff worked with local resources to meet people's needs. A member of staff told us, "The office liaise with social workers, GPs, families, hospitals and day centres and we work alongside nurses and physiotherapists and sometimes speech and language therapists." This meant that the provider worked in partnership with others to meet people's needs.