Essex Cares Limited

Essex Cares North

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?	**Good**

Summary of findings

Overall summary

Essex Cares North provides services as a provider of last resort where other support agencies are not available. They were supporting 15 people when we inspected on 7 and 12 October 2016. This was an unannounced inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our comprehensive inspection of 8,16 and 17 March 2016, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which were: Regulation 9 Person centred care, Regulation 12 Safe care and treatment, Regulation 18 Staffing and Regulation 17 Good governance.

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

There were improvements in the management of people's medicines. However there had been a delay in the monitoring of medicines records which meant errors had not always been promptly identified.

Risk assessments for specific health conditions were included in some records but lacked guidance for staff to know how to support people with these conditions.

Care plans remained task focussed and lacked detail. Support tasks were listed but gave no indication of people's preferences or what was important to them. Despite the shortfalls in the care records, people and their families told us they received personalised care which was responsive to their needs and their views were listened to and acted on.

Staff were provided with training and guidance in how to keep people safe and what they should do if they were concerned that a person was at risk or was being abused. People knew how to raise concerns and were confident that any concerns would be listened and responded to.

There were enough staff to deliver people's assessed care needs. Staff demonstrated empathy, understanding and warmth in their interactions with people. People were confident in the ability of the staff and felt that they knew them well and understood their care and support needs. Staff understood the importance of gaining people's consent to the support they were providing.

Staff were provided with the basic training they needed to meet people's needs and preferences effectively. There were future plans for further equipping the staff by delivering more specific training in subjects such as diabetes or chronic obstructive pulmonary disease (COPD).

People were mostly satisfied with the support they received with their nutrition. Where appropriate the service had made referrals to health care professionals such as the community nursing team and GP's.

The provider had quality assurance systems in place which were used to identify shortfalls and to drive continuous improvement. The management team were responsive to any concerns raised through the inspection and quickly responded and used the feedback they received to make immediate improvements.

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.

Risk assessments for specific health conditions lacked detail.

A delay in the monitoring of medicines records meant errors had not always been promptly identified.

Procedures were in place to safeguard people from the potential risk of abuse.

There were enough staff to meet people's needs. Recruitment checks were completed to make sure people were safe.

Is the service effective?

Good

The service was effective.

People were supported by staff who knew how to meet their needs.

Staff received the support and training they needed to provide effective care for people.

People received support from staff who respected people's rights to make their own decisions, where possible.

People were supported to maintain good health

Is the service caring?

Good

The service was caring.

People valued the relationships they had with staff and were positive about the care they received.

People felt staff always treated them with kindness and respect.

Staff demonstrated empathy, understanding and warmth in their interactions with people.

People were supported to have choice and control.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were task focussed and lacked detail.

Despite the shortfalls in the care records, people and their families told us they received personalised care which was responsive to their needs.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well led.

The service provided a positive, open culture. People were asked for their views about the service and their comments were listened to and acted upon.

The provider had quality assurance systems in place which were used to identify shortfalls and to drive continuous improvement.

The management team were responsive to any concerns raised and quickly responded and used the feedback they received to make immediate improvements.

Essex Cares North

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 unannounced inspection took place on 1 and 7 October 2016 and was carried out by one inspector.

Before the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

During our inspection we visited the offices of Essex Cares North where we looked at the care records of seven people, training and recruitment records of staff members, and records relating to the management of the service. We visited two people in their own home accompanied by a member of care staff. We spoke with seven people receiving care and support from the service and three family members. We spoke with the registered manager, area manager and head of quality for the provider. We also spoke with four members of care staff.

Requires Improvement

Is the service safe?

Our findings

Improvements were still needed in how the service assessed and recorded risks in people's daily living. On the first day of our inspection we found that care records did not include detailed risk assessments to provide staff with guidance on how the risks to people were minimised. For example, one person's records indicated that they were at risk of falling but did not give sufficient details to show how this risk could be minimised.

Risk assessments for specific health conditions were included in some records but lacked guidance for staff to know how to support people with these conditions. For example a diabetes risk assessment for one person indicated that they were not always aware of the symptoms if their blood sugar levels were causing them to become unwell. However, there was no guidance for staff to tell them what they should do if they noticed these symptoms. Another person with chronic obstructive pulmonary disease (COPD) gave very limited information to show the risks they faced in relation to this or how staff could help them to manage these. The care records of a person who smoked stated, "[Person] smokes and has been made aware of the risk by the local fire brigade." However, there was no other assessment in place in relation to this. This meant that the provider was missing opportunities to ensure that staff had access to information that could support people to keep themselves safe and reduce risk of harm.

The management team immediately responded to our concerns relating to lack of appropriate risk assessments. By the second day of inspection new paperwork had been implemented in order to assist staff in assessing and monitoring risk. These were in the process of being added to all care plans and were due to be discussed further at a management meeting later that week.

One person's medicine medication administration records (MAR) showed that there were gaps in the records for some medicines so it was unclear whether or not they had been taken. "Could not find," had been written several times for another medicine. Another record showed "Not given as too close to morning." However the member of staff visiting the next day had administered the medicine despite there only being a two hour gap between doses. These issues had been identified when the MAR charts had been checked by a senior member of staff and discussed with the staff involved. However, these checks did not take place until a month later which meant the person had been at risk of not receiving prescribed medicines for some time. Records of another staff member's supervision showed that gaps they had left in the MAR charts had been addressed with them, however the gaps had occurred in June and their supervision had taken place in August 2016.

We discussed the monitoring of medicines with the management team. They acknowledged that any errors or omissions in medicines needed to be identified promptly. They showed us a copy of a weekly medicines audit which was due to be introduced to managers and implemented the following week.

At our last inspection we found that people were not always receiving their medicines at the correct time due to the timings of their visits, There had been improvement in this. Where people were receiving support with their medicines which needed to be given at specific times the scheduling of calls was non-flexible to

ensure that the correct amount of time was allowed between doses. A person told us, "They do my [relative's] medication and they watch me do my own at night. They write it down each time and it is always done on time." A relative said, "There were some issues initially, if a visit was late and the next visit early. Because [person] is on a slow release morphine, there needs to be 12 hours between doses. This was sometimes difficult…The visits are much more settled now." A member of staff demonstrated their understanding of this, "The AM and PM call have to be 12 hours apart. It's to do with the [pain relief]."

The service had increased the amount of medicines training provided to all staff and this was also discussed with individuals at their one-to-one supervisions. A member of staff confirmed, "We've had MAR [Medication Administration Record] chart training to make sure it's being done properly." Prompt cards had been issued to all staff to ensure that that they were giving the correct level of support when assisting with people's medicines, promoting independence wherever possible and if it had been assessed that the person was able to administer their own medicines.

Staff were gentle and compassionate in their approach when administering medicines. We heard a member of staff speak with a person as they assisted them, "Are you ok to take these now? Do you want me to sit you up a little bit? You say when. Do you think you can take them at that angle? Where do you want these?" They explained the medicines to the person and added, "There's your water." This demonstrated that staff were guided by the wishes of the people they were supporting and encouraged people to have independence and control.

People told us they felt safe whilst receiving care in their homes. One person said they, "Definitely," felt safe when receiving care. Another person explained that they felt safe but that if they had any concerns they had been given the information they needed to let the appropriate people know. They commented, "There is information in the book about the care line and how to raise any concerns you may have."

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received up to date safeguarding training and understood the provider's safeguarding adults procedures. They were aware of their responsibilities to ensure that people were protected from abuse. Details of how to report concerns were displayed in the office and staff members we spoke with demonstrated that they knew about the procedures they should follow if they were concerned that people may be at risk. A member of staff told us what they knew about safeguarding, "If there are any issues, to report them immediately." Another staff member said. "It is about keeping people safe."

There were enough staff to deliver people's assessed care needs. We asked people whether staff arrived when they expected them to. One person told us, "Yes, very good. They stay for the full time. Two for my [relative] and one for me, in the evening." Another person said, "Yes, unless something holds them up terribly, then they phone to let me know." However one person commented, "The times are variable, usually within the hour but not much routine." None of the people we spoke with had ever had a missed visit. Call visits were closely monitored by the service. The business support centre received an alert if a member of staff had not arrived at a support visit within the allocated time. The visits were also checked at regular intervals throughout the day to ensure that all staff were completing the calls as scheduled.

People were protected by robust procedures for the recruitment of staff. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. DBS checks help employers make safer recruitment decisions and help prevent unsuitable care workers from working with people.

Good

Is the service effective?

Our findings

People were confident in the ability of the staff. One person said, "They do a very good job." A relative commented, "Oh yes, they know how to care for [person], I would definitely say if I thought they didn't."

At our last inspection we found that training was inconsistent. There had been improvements in this and staff were provided with the basic training they needed to meet people's needs and preferences effectively. A member of staff told us, "Training and supervision is all up to date. I had observation last week and the week before. They [assessment and review leads] stay for the whole visit. It includes medication." Staff records confirmed that any identified areas for improvement were discussed with staff during their supervision session. Another member of staff said they had received training in, "Medication, manual handling, first aid, mental capacity and others." They added they felt it was effective as, "It has all been classroom or face-to-face, none of it has been on line." The registered manager explained their plans for further equipping the staff by delivering more specific training in subjects such as diabetes or chronic obstructive pulmonary disease (COPD). Staff had received dementia friends training to give them additional insight in to the specific needs of people living with dementia.

Communication amongst the staff team was effective. They made use of the communication and significant event records in people's care plans to pass on relevant information relating to people's individual support needs. A member of staff told us, "They are a good team. They talk to each other to update." Staff were also supported by the management and office team who advised them if there were any changes in people's needs. One staff member said, "They'll give you a ring. They've always done that if there is something they need to let you know urgently before you go [to visit people]." Staff meetings were held where staff were given the opportunity to discuss the individual needs of the people they were supporting. This meant that staff were all up to date with people's current support needs.

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 checked whether the service was working within the principles of the MCA. We found that people had been involved in determining how they wished to be supported. People had signed their care plans to demonstrate their agreement. We observed that staff sought people's consent and acted in accordance with their wishes. For example we heard a staff member ask, "Do you want me to change your nightdress?" rather than assuming that this was what the person wanted. A member of staff commented, "I would always ask the person. From things being written to getting there [the person's home], things could have changed." This demonstrated that staff understood the importance of not assuming that a person does have capacity and gave people every opportunity to be able to make decisions for themselves.

Where needed as part of their care provision, people were mostly satisfied with the support they received with their nutrition. A relative told us, "With food [person] has meals on wheels but they [staff] knock [person] up a sandwich of whatever [person] wants." People and their relatives also told us that they were supported to drink adequate fluids to reduce the risks of dehydration. Drinks were made available when staff visited, a relative commented, "They will ask [person] what [they] want to drink," and drinks were left within people's reach when staff left so they were able to help themselves through the day.

There was some information included in people's care plans about their dietary needs but records lacked detail about their preferences. For example, one care plan stated, "Appetite is good but unable to get own food and fluids." However no further information was given about what this person liked to eat and drink, how they liked it prepared or at what time. We pointed this out to the management team and on the second day of our inspection further work had been completed in relation to this. One person's care record read, "Make [person] a drink and sandwich of [their] choice. [Person] will advise support staff of [their] choice on the day of the visit." Records in relation to people's nutritional needs could be strengthened further with the addition of further information regarding people's likes, dislikes and special dietary needs. This is particularly important for people who may be unable to express this for themselves.

Care plans demonstrated that where appropriate the service had made referrals to health care professionals such as the community nursing team and GP's. Care staff demonstrated a knowledge of the additional support being provided to people by the community nursing care team and understood how this related to the care they were providing to people.

Good

Is the service caring?

Our findings

At our last inspection we were concerned that people were not able to develop relationships with care staff as they were visited by a large number of different care staff during the time they were supported by Essex Cares. There were improvements with regard to this. People told us they felt staff knew them well and understood their care and support needs. One person commented "We get a lot of different staff but they are a regular team and we know them." Another person explained that the staff had got to know them, "Because of the length of time they have been coming." A relative told us, "They [staff] are all nice enough people, they come in bouncy and bubbly."

People were positive and complimentary about the care they received. One person told us, "I find it excellent." Another person said, "They are very careful," and a third person commented, "They are very good for both of us." A relative also told us, "They are friendly and we are very pleased with the service and the care [person] is given."

People mostly felt that they were given the time they needed each time the staff visited. One person said, "They seem not to be rushed. They go when they are finished." However, they added, "It would be nice if they had time to sit with [person] and encourage [person] to eat." Another person told us, "It depends on what is needed. They stay until they are finished. They are good company." A third person commented, "I think most of the time they have enough time and can have a chat." A member of staff told us, "If it takes longer, it takes longer, they [managers] don't mind." However this did mean that at times calls could be later than expected for the next person to be visited. Another member of staff said, "We work to the given times… The problem is it can mean we are late." However, there was a robust system in place to monitor calls and ensure that people were informed if staff were going to arrive later than expected.

Staff demonstrated empathy, understanding and warmth in their interactions with people. They spoke compassionately about the people they supported and helped them to make their own decisions about the way their care was provided. For example, we heard a member of staff providing reassurance to a person and ask, "What do you want to have washed? Are you going to do your face? Do you want me to do it or are you going to do it? Is that warm enough?" When talking with the person about the support they needed and preferred with their personal care needs, the member of staff spoke quietly to preserve the person's dignity. The person indicated that they had a pain so the member of staff asked, "What hurts?" and talked with the person about how they could make sure they were comfortable as they helped them to move, talking through what they were doing all of the time so that the person knew what was about to happen.

People's privacy and dignity was promoted and respected. A person told us, "They are lovely [staff], very respectful." We heard a member of staff tell a person as they were about to provide care, "I'm going to shut the curtains [person]." A relative of this person confirmed that this was something the staff always did, "There is a window by [person's] bed which we can see from the house. Although we can't see in, whenever they do personal care they close the curtain." Another person told us, "They do my back, I do the rest. They put a towel over me and keep me covered." This demonstrated that staff recognised the importance of privacy and dignity as core values and worked together with people to promote them.

Some people using the service were being supported due to a physical or mental illness which could be improved with rehabilitation. These people's care records did not provide sufficient details to show how the service was assisting them in regaining independence. For example, there were no details to show what people were able to do for themselves or plans to help them to work towards a greater level of independence. Care records for one person showed that they had been completely independent prior to falling and injuring themselves. The referral document stated, "[Person] wishes to regain [their] independence as soon as possible." However, although daily notes showed growing independence, there was no re-ablement plan in place to show staff how they could help this person to achieve their goals.

However, despite the lack of information recorded, there was a culture of re-ablement amongst the staff team and we saw how this was benefiting people receiving care. For example, a relative told us, "We got the physio involved. They encouraged [person] to walk using a [walking] frame. Now [person] can walk to the toilet with [their] frame." A member of staff told us how the mobility of one person they had provided support to had improved so they no longer needed visits from them, "You are promoting independence… doing exercises the physio left with [person]. [Person] was starting to get out of bed and doing a lot better." One relative commented they felt there were times when independence could be further promoted, "When [person] needs help with something they will do it for [person] perhaps rather than encouraging [person] to do it for [themselves]. If [they] need say 50% help they might hurry it along by doing it for [person]." However another relative said, "With little things the [staff] do encourage [person]. They have got [person's] measure and know [person] will let them do things given half the chance. So they do try and involve [person] as much as they can."

People and their families had been involved in reviews of their care plans but records showed limited input from people. One person's support assessment recorded, "Did not comment." In the section which asked for their views. There was no indication whether or not they had been able to comment or given the opportunity to do so. We discussed this with the management team who were planning to address this as they restructured their care plans and review process. On the second day of inspection we saw that care plans had been updated. One of the people we visited had received a visit from a member of the management team and their care plan now included a record of their conversation,"[Person] described how [their relatives] are very important to [them].
[Person] loves a cup of tea and a slice of fruit cake. [Person] also requested two cups of water to be left beside [them] so [they] can have drinks as and when [they] wishes. [Person] will choose what [they] fancies as [they] like a variety of food." This meant that staff were provided with additional information which would help them to better understand people and improve the quality of care and support they provided.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that care plans were task focussed and lacked detail. These still needed improvement. Support tasks were listed but gave no indication of people's preferences or what was important to them. As a 'provider of last resort' the service was responsible for taking on support packages where other providers had been unable to provide care. This meant that there was often a limited amount of time from referral to provision of care. The assessment process therefore needed to be comprehensive to ensure that staff were provided with all of the details they needed to be able to support the person from the first visit. Staff were provided with a summary of each person's support needs on an electronic device which they carried with them. One of the assessment and review leads we spoke with told us that staff were also told that they needed to read the care plan to familiarise themselves with each individual.

Although referral paperwork gave details about people's medical conditions we found that this had not always been transferred into the main care plan. For example, in one person's referral it was recorded that they were living with dementia however, this was not referred to at any other point in the care plan and there was no information about how this affected the person or how they wanted their care to be provided. This meant that staff were not being made aware of key information regarding the specific needs of people.

The management team responded to our concerns about the lack of information provided in the care records. By the second day of inspection new paperwork had been implemented in order to provide more personalised details in people's care records. The new paperwork included sections where the things which were important to people could be recorded including their choices and preferences. Further detail was also to be included about people's physical and mental health conditions and how this affected their daily lives. The new documentation had been added to all care plans and the process of making care plans centred on each individual had begun. For example, once care plan read, "[Person] likes to have a shower two days a week. This is usually a Wednesday and Saturday however this may change so [person] will advise if [they] would like to have a strip wash or a shower on that day. Person will pick [their] chosen nightwear."

The new care plans also included details about people's perception of the support they needed and how they felt about it. For example, "[Person] is not sure how [they] will cope from being independent….to needing more support." This additional information and insight into how people were feeling will assist staff to have a holistic approach to people's care to ensure their whole well-being.

Staff were positive about the new care plans and confirmed that the new documentation was now in place for all people they supported. One staff member commented, "Sometimes there used to be small snippets on the [electronic device issued to staff] but now it's nice to be able to see and not have to keep asking." Another staff member told us that the care plans were now, "Really detailed, especially now we've got the new person centred papers."
People and their families told us they received personalised care which was responsive to their needs and their views were listened to and acted on. A relative commented, "I think it [care] is personalised." Another relative gave an example of how staff knew what was important to a person and said, "It [care] is personalised, for example [person] often complains of being cold so with personal care they keep [person]

covered up."

Staff were responsive to changes in people's care needs. A member of staff in the office told us, "Staff are feeding back changes in people's needs. I took a call this morning with an update." One person's daily notes showed how a member of staff had identified that a person did not seem their usual self and subsequent records showed that staff were monitoring this. The person's health continued to deteriorate and staff called 111 for advice before calling for an ambulance. A relative told us how staff worked together with them to ensure all of their relative's needs were met, "There are a couple of things I have picked up on. They keep their professional notes but I have left a notebook so I can pass on information to them. They seem happy with that and respond with bits of information too. I think they take notice of the things I say."

There was a complaints procedure in place which explained how people could raise a complaint. Records of complaints showed that they had been responded to appropriately and in a timely manner. For example, complaints which had been made regarding late or missed calls had been investigated and followed up by a senior member of staff. The implementation of a new robust system for checking calls throughout the day had meant that complaints about this had reduced.

Good

Is the service well-led?

Our findings

There was an open culture at the service. One person said, "We can't find anything not to be happy about." People and staff felt able to approach the management team and were complimentary about them. One member of staff said, "[Registered manager], has always been on the ball and ready to help."

At our last inspection we found that some decisions affecting the running of the service had been taken by the provider rather than the registered manager and there was a lack of effective assessment of how these decisions would affect its day to day running. At this inspection we found that the registered manager now had more control in the way the service was run and was supported in their role by the area manager. The nature of the service had changed from a predominantly re-ablement service supporting people on a short term basis following a stay in hospital to a 'provider of last resort' supporting fewer people but for longer periods of time. A member of staff commented that there was now a, "Much improved level of control under [registered manager]. The planners and assessment and review leads are available to staff. Staff know who to go to."

The registered manager gave an example of one way they were now able to have better control. When they received a referral to provide support for a person it stated the times the person needed to be visited each day. They explained, "If we can't allocate we will go back and say we can't accommodate that time but what we can offer is…" This demonstrated that the registered manager was aware of the capacity of the service and did not take on additional referrals which may mean staff would be unable to provide the allocated time and appropriate level of support to people.

Staff were encouraged and supported by the management team and were clear on their roles and responsibilities. Records showed and staff told us that they had regular supervisions which enabled the management team to set clear expectations about standards and gave staff the opportunity to discuss issues openly and develop in their role. For example, we saw how supervisions with staff had taken place when concerns relating to the way they were recording administration of medicines had been raised. Additional training had also been arranged to provide these staff with the knowledge and skills they needed to provide a high quality of care. The service had implemented a 'good customer service and excellence award' to recognise good practice and highlight where staff had worked well together. This meant that staff felt valued and were motivated to drive continual improvement within the team.

One staff member told us how they felt about the management team and said they were, "Very good. They are very accommodating. The [registered manager] is very good, very supportive. I asked for a change in shift pattern and they did their best to accommodate me." Staff also told us how they were encouraged to report any issues of concern and explained that they understood the provider's whistleblowing procedures and how they would be supported with these. This demonstrated that staff were confident that they could raise any concerns and that these would be dealt with appropriately.

The provider had quality assurance systems in place which were used to identify shortfalls and to drive continuous improvement. Quality assurance questionnaires given to people in September 2016 showed that

the majority of people felt that the support they were receiving was excellent or good. One person had commented, "The care that I have had over the last seven months has been very good." Another had said, "[Staff] made the care I've received feel very relaxed and un-intrusive." Some people had fed back that they would like the timing of the calls to be better however one customer support review also showed that when the times of support calls were not meeting a person's needs these has been rearranged. This showed that people were empowered to voice their opinions and could be confident that they would be listened to and appropriate actions would be taken to improve the service.

Whilst significant improvements had been made since our last inspection, the quality assurance systems in place had failed to recognise that the care documentation in place was not fit for purpose. However, the management team were very responsive to the concerns we raised in relation to this and acknowledged where changes were needed. In the five days between the first and second days of our inspection they had devised and implemented new documentation to ensure that people were being supported in a safe, effective manner in line with their wishes and preferences. The new care documents had been added to people's care plans and reviews carried out to ensure information was up to date. A member if staff commented, "It's going in the right direction. Like this morning I went to a new person and it was all there in the care plan." The implementation of the new systems had been further strengthened by communication with staff and the addition of an information sheet to guide staff entitled, "Ensuring personalised care planning," which explained what this was and why it was important. This demonstrated that the management team were open to challenge and used the feedback they received to drive forward improvement in the service.