Efficiency-For Care Limited

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Inspection report

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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

We carried out an announced inspection of Efficiency-For Care Limited on 21 May 2018. Efficiency-For Care Limited is registered to provide personal care and treatment of disease, disorder and injury to people in their own homes. At the time of our inspection, the service provided personal care to two people in their homes.

During our last inspection of the service on 9 October 2017, we found significant shortfalls that placed people at risk of harm. The service was in breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 in association with risk assessments, medicine management, staff training and good governance. Following the inspection, we took urgent enforcement action to ensure the service made improvements. During this inspection, we found improvements had been made and the service has now been rated Good.

The service did not have a registered manager. There was a manager in place who had applied to be registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is run.

Relatives told us that medicines were given on time. However, there were discrepancies in people's medicine records as records had not been kept of topical cream administration. We made a recommendation in this area.

Risks had been identified and information had been included on how to mitigate risks to ensure people received safe care. Staff were aware of how to identify abuse and knew who to report abuse to, both within the organisation and outside the organisation.

Pre-employment checks had been carried out to ensure staff were fit and suitable to provide care and support to people safely. Staff told us they had time to provide person centred care and had enough staff to support people. There were systems in place to reduce the risk and spread of infection. Staff had been trained on infection control and were provided with personal protection equipment to ensure risks of infection were minimised when supporting people.

Staff had received the training required to perform their roles effectively. This also included specialist training to support people with specific health conditions.

Staff had not been trained on the Mental Capacity Act 2005 and some staff we spoke to did not know the principles of the act. After the inspection, we received confirmation that training had been booked in this area. Assessments had been carried out using the MCA principles by the management team and best interest decision made with family and health professionals where people did not have capacity to make

certain decisions.

People were cared for by staff who felt supported. Spot checks had been carried out to observe staff performance to ensure people received the required care and support. People's care and support needs were assessed regularly for effective outcomes. The service worked with health professionals if there were concerns about people's health. Staff could identify the signs people gave when they were not feeling well and knew who to report to.

People had a positive relationship with staff. Relatives told us that staff were caring. People's privacy and dignity were respected by staff. People and relatives were involved in making decisions about their care.

Care plans were person centred and detailed people's preferences, interests and support needs. Relatives knew how to make complaints and staff were aware of how to manage complaints.

Staff told us the culture within the service was open and transparent and told us the service was well-led. Relatives and staff were positive about the management team. People's feedback was sought from surveys and reviews meetings.

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 received their medicines on time. However, accurate records had not been kept of topical medicine administration.

Risks had been identified and information included on how to mitigate risks when supporting people.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

Systems were in place to monitor staff attendance and punctuality.

There were systems in place to reduce the risk and spread of infection.

Is the service effective?

Good

The service was effective.

Assessments had been carried to using the MCA principles. However, staff had not been trained on MCA. The manager sent evidence after the inspection that this had been booked.

Staff had the knowledge, training and skills to care for people effectively.

People's needs and choices were being assessed to achieve effective outcomes.

Staff felt supported in their role.

Staff knew when people were unwell and who to report this to.

Is the service caring?

Good

The service was caring.

People had a positive relationship with staff.

People's privacy and dignity was respected.

People were involved with making decisions of the care and support they received.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and included information on how to support people.

Staff had a good understanding of people's needs and preferences.

Staff knew how to manage complaints and relatives were confident about raising concerns if required.

Is the service well-led?

Good

The service was well-led.

Quality assurance systems were in place for continuous improvements to be made.

Staff told us the service was well-led and were positive about the management.

People's and relatives feedback was obtained through surveys and spot check meetings.

Efficiency-For Care 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 inspection was carried out on 21 May 2018 and was announced. We announced our inspection because we wanted to be certain that someone would be available to support us. The inspection was undertaken by one inspector.

Before the inspection, we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We also received a Provider Information Return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make.

Before the inspection, we spoke with one person's relative and two staff.

During the inspection, we spoke with the director, manager, operations manager and care-coordinator, who was also a care staff member.

We reviewed documents and records that related to people's care and the management of the service. We reviewed two people's care plans, which included risk assessments and six staff files which included pre-employment checks. We looked at other documents held at the service such as medicine, training, supervision and quality assurance records.

After the inspection, we spoke to one relative.

Good

Is the service safe?

Our findings

At our last inspection the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found significant shortfalls with risk assessments, as this had not been completed in full for four people with identified risks. We found risk assessments had not been completed for people in relation to their health condition such as motor neurone disease, weakened muscle, diabetes, Chronic Obstructive Pulmonary Disease (COPD), seizures, choking and brain injury. We also found shortfalls on risk assessments in relation to moving and handling and for people at risk of skin complication. Relatives also raised concerns about people's safety. This placed people at risk of significant harm.

During this inspection we found improvements had been made with risk assessments. A staff member told us, "The risk assessments have improved since your last inspection. The recent risk assessments are so user friendly and they give you information for each client." Risks had been identified and there were assessments in place that provided information on how to reduce risks and ensure people were safe at all times. There were risk assessments in relation to people's health condition such as tracheostomy, shortness of breath and catheter care. Attached with these risk assessments were individual care plans that detailed what the condition was and how to support people safely.

Risk assessments had been completed for people at risk of skin complications. Risk assessments included information on how to minimise risks such as repositioning regularly, applying creams and reporting redness in skin to health professionals and management. We saw records for one person who had a grade four pressure sore prior to receiving support from the service and this had now healed. The person required regular re-positioning and monitoring of fluid intake. We saw repositioning charts and fluid intake charts that showed this was occurring. The manager told us by adhering to the risk assessments and working closely with district nurse ensured the person recovered from their skin complication.

Assessments had been completed on moving and handling, which provided information about the level of risks people had on transfers and when they were mobile. This was supported with information on how to ensure people were safe during moving and handling and when they were mobile. For people that required a hoist when transferring, there was information available on how to use this safely with photos that described the hoist and slings.

Risk assessments had also been completed on infection control, nutrition and continence. For one person who was at risk of choking, assessment included information on how to support the person to eat safely such as ensuring food was in small portions, monitoring airways and ensuring the person had soft food. Information also described the difference between soft food and hard food with examples.

At our last inspection, prior to the inspection we received concerns from a relative regarding the safety of their family member when being supported by staff. Staff and the manager told us that things had significantly improved following our last inspection with training provided to staff and risk assessments in place to ensure the person received safe care at all times. We saw records that showed the relative

complimenting the staff and the support they provided to their family member since our last inspection.

The manager had records in place that required staff to read each risk assessment and care plans and sign to evidence this had been read. This meant there were appropriate risk assessments in place to support people safely at all times.

At our last inspection the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found there were discrepancies between what was recorded on people's Medicine Administration Charts (MAR) and what was recorded in the care plan. We noted that the medicines risk assessments, did not accurately reflect the medicines people were taking, as listed on the MAR charts.

During this inspection, we found improvements had been made. Assessments had been carried out with people on the level of support people would require with medicines. We were informed the service supported one person with medicines. Records showed that risks had been identified in relation to medicine management and a risk assessment had been completed that provided information on how to ensure the person received their medicines safely. We checked the person's MAR. We found that the records were accurate and there were no gaps on the person's MAR. Staff had received medicines training and told us that they were confident with managing medicines. A staff member told us, "I have been trained in medicines. I am very confident." Medicines were audited by the manager as part of spot checks and audits. A relative told us, "They do make sure he takes it [medicines] on time."

However, for one person care plan records showed that the person required cream applied to their body to minimise the risk of skin complication. The manager confirmed a prescribed cream was applied. However, there was no Topical Medicine Administration Records (TMAR), to record that the creams had been applied and at what time, in order to minimise the risk of skin complications.

We recommend the service follows best practice guidance on medicine management.

Relatives told us that people were safe. A relative told us, "I feel he is safe." Another relative told us, "Yes, they do know how to make him feel safe."

Staff were aware of their responsibilities in relation to safeguarding people. A staff member told us, "There is various abuse such as emotional, physical, verbal and financial. You have a duty of care to protect them so I will tell my manager. If nothing happens, I will then go to the Care Quality Commission (CQC), social workers and police." Staff were able to explain what abuse is and who to report abuse to. They also understood how to whistle blow and knew they could report to outside organisations such as the CQC and the police.

Pre-employment checks had been carried out to ensure staff that were recruited were suitable to provide care and support to people safely. We checked six staff records, which included a new member of staff that had been recruited since the last inspection. Relevant pre-employment checks such as criminal record checks, references and proof of the person's identity had been carried out as part of the recruitment process.

At our last inspection some people expressed concerns with staff time-keeping. We were sent an action plan after the inspection that included actions that the service would monitor staff time-keeping through digital monitoring. The system would alert management if staff had not attended an appointment, was late, or did not log in, so the management team could then contact the staff member. We found this had not been implemented at this inspection. The manager told us this was due to the limited number of people they

supported and they had other arrangements in place to ensure staff attended care visits and on time.

The manager told us that the service had a dedicated driver to take staff for care visits. This was confirmed by staff. Staff had to complete time sheets on the time they attended care visits and the duration of the call. This was then reviewed by the management team to monitor staff punctuality. The manager and care coordinator also carried out random spot checks and part of this also included an audit on staff time-keeping.

Staff told us that they were not rushed in their duties and had time to provide person centred care and support to people when needed. A staff member told us, "Yes, if I have an appointment I get there 10 minutes before." Another staff member told us, "We have a driver that takes us to care visits. If I cannot make it, there is always someone to cover me." A relative told us, "They never not turn up."

Records had been kept of accidents and incidents. This detailed the incident and the action that had been taken. The manager told us that they always analysed incidents to ensure lessons were learnt and to minimise the risk of re-occurrence, which was why there were not many incidents.

There were systems in place to reduce the risk and spread of infection. Staff had been trained on infection control. We asked staff how they minimised the risk of infection and cross contamination. They told us they washed their hands thoroughly when providing personal care. Staff were supplied with personal protective equipment (PPE) such as gloves, aprons and sanitisers when supporting a person. Staff told us they disposed of PPE separately when completing personal care. A staff member told us, "We always carry our gloves, aprons and our gel. We would use this when we are giving personal care. We would use the gel before and after supporting people."

Good

Is the service effective?

Our findings

During our last inspection the service was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Relatives we spoke to raised concerns on staff knowledge and skills when supporting people. We found that some staff members had been trained in mandatory areas in their previous jobs, prior to commencing employment with the service. These training certificates were not available at the time of the inspection and were not provided to us after the inspection when requested. In addition, we found that specialist training had not been provided to staff to support people who had specific health conditions. This was to ensure people received safe and effective support at all times.

During this inspection we found improvements had been made. Relatives we spoke to told us that staff were skilled, knowledgeable and able to provide care and support. A relative told us, "They [staff] are very good." Another relative told us, "They are good at their jobs." A staff member told us, "Training has been fantastic. I have developed a vast of experience in this role."

Records showed that new staff members that had started employment with the service had received an induction. This involved shadowing experienced members of staff, meeting people and looking at the care plan. A staff member told us, "I had an induction, it was very good." Following the induction, staff had received training in accordance to the Care Certificate. The Care Certificate is a set of standards that health and social care workers comply with in their daily working life such as safeguarding, infection control and health and safety. We found that a staff member had been trained in mandatory areas in their previous jobs, prior to commencing employment with the service. Training certificates were kept in the staff files and we saw the training was completed within 12 months.

Staff had also received specialist training to ensure people that required complex support received this effectively. Specialist training had been completed on slips and trips, autism, tracheostomy, diabetes and catheter care. This meant that staff received training required to perform their roles effectively. The manager kept a training matrix that included what training staff had completed and when training was next due. Where staff had missed training that had been booked, records showed a reminder was sent by the manager to ensure they complete training.

Supervision meetings were held between staff and their line managers to discuss staff progress, identify developments and provide support if required. Staff confirmed that they received regular supervision. A staff member told us, "[Manager] has been very supportive." Another staff member told us, "Everything I need, [manager] has always been there for me." For staff that had been working at the service for over 12 months, an appraisal had been completed. During the appraisal staff discussed their performance, objectives for the year ahead and learning and development.

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. We checked whether the service was working within the principles of the MCA.

Two staff were not able to tell us the principles of the MCA and the best interest decision process and how this should be applied for people living in their homes. Records showed that staff had not completed MCA training. We fed this back to the manager who informed us after the inspection that arrangements had been made to ensure staff complete training in this area. Care plans provided information about people's memory/cognition and recorded whether people might struggle to make decisions. Where it was identified people did not have capacity to make a decision on a certain area, a capacity assessment had been carried out using the MCA principles and a best interest decision had been made with people's next of kin and health professionals.

Staff told us that they always requested consent before doing anything. A staff member told us, "Yes, I do always ask for consent." A relative told us, "They always ask for consent." Signed consent had also been sought from people and their relatives in regard to receiving care and support from people.

Pre-assessments had been completed prior to people receiving support and care from the service. These enabled the service to identify people's daily living activities and the support that people required, which allowed the service to determine if they could support people effectively. Using this information, care plans were developed. The service assessed people's needs and choices through regular reviews. Records showed that changes in people's circumstances had been recorded and used to update people's care plans. This meant that people's needs and choices were being assessed effectively to achieve effective outcomes.

People who required assistance at meals times had a care plan for this. Care plans included the level of support people required with meals and their likes and dislikes. Care plans also included that staff should always ensure people were given a choice with meals and when a menu was created that this should be done with the person. A staff member told us, "Yes, we do ask them what they would like to eat for the day." A relative told us, "I normally handle the meals but if I am not around I know they are capable of making meals as well."

Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health. Where staff had more immediate concerns about a person's health than they called for health professional to support the person and support their healthcare needs. Records showed that a staff member had called emergency services when a person experienced chest pains. The person's next of kin was also informed of the incident. A relative told us, "Last week he had pains in his chest. Carer called the doctor to get advice and then was told to call 999, which they did and the ambulance arrived." One staff member told us, "If client is not well, we will ask them and see their body language. If they are not well, we will call the office and their nurse or doctor."

Good

Is the service caring?

Our findings

During our last inspection we found not all people or their family members had been involved in the development of people's care plans. During this inspection we found improvements had been made. Relatives confirmed that they had been involved in decision making on the care people received. There was a section where people and relatives could sign to evidence that they agreed with the contents of their care plan. A relative told us, "They include me in everything. [Person] has 100% mind and he tells them what he likes and wants. We are always included in decisions."

People's independence was promoted. Staff told us they supported people to make choices in their day-to-day lives with personal hygiene and care. A staff member told us, "We always encourage them to support themselves as much as they can. We are always here to help them if they cannot do it but we have to try. It helps them be independent." A relative told us, "They do encourage independence. The carers help him but they do encourage him to do somethings by himself." Another relative told us, "There is not much [person] can do for themselves but they do try to encourage him to do much as he can."

Relatives told us that staff were caring. One relative told us, "I have no concerns about the carers at all. They are very good." Another relative told us, "Yes, they are very kind and caring."

Staff told us how they built positive relationship with people. A staff member told us, "You just spend time with them. I watch tv with them and we go out. I also go to meetings with them. We do almost everything together." A relative told us, "He does have a good relationship with them. They [staff] are very friendly with him." The manager told us that people were as much as possible supported by the same members of staff to ensure continuity of care and positive relationships were maintained. The staff rotas we saw confirmed this.

Staff ensured people's privacy and dignity were respected. They told us that when providing particular support or treatment, it was done in private. A staff member told us, "If I give personal care in bathroom, I will close door to ensure privacy and ensure I do not expose them to others." Another staff member told us, "We make sure we cover them up and do not expose them when we give sensitive support. You have to treat them with dignity and respect." Another staff member told us, "When getting to house, I always knock on the door waiting for an answer before coming in. When giving personal care, if I am washing the lower part of body, I would cover the upper half and then do the same when I wash the upper half, covering the lower part of the body. This is to make sure they are not exposed." A relative told us, "They are very respectful." Another relative told us, "Every time they do personal care, the blinds come down. His dignity is always preserved."

People were protected from discrimination within the service. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. Relatives we spoke with confirmed that people were treated equally and had no concerns about the way staff approached them.

Good

Is the service responsive?

Our findings

During our last inspection, we found inconsistencies with care plans as not all care plans had accurate and up to date information to ensure people received personalised support. During this inspection, we found improvements had been made.

Each person had an individual care plan which contained information about the support they needed from staff. One staff member told us, "Care plans are very helpful. It tells you what to do with clients." Another staff member told us, "Care plans, it is helpful. They do it properly." A relative told us, "I do have a care plan at home. It is up to date and accurate." Care plans detailed the support people would require and described the tasks that staff would need to complete during care visits throughout the day. They also contained people's family contact details. Plans included people's personal information such as their preferred name, religion, any health conditions and date of birth. There was also information on people's life history that included people's background and likes and dislikes. Care plans were personalised based on people's preferences and support needs. In one person's care plan, information included that a person liked to go to church and religious meetings and for staff to ensure they took the person. These plans provided staff with information so they could respond to people positively and in accordance with their needs.

People were given service user guides that detailed people's rights and also included information on service objectives, privacy and dignity, security and personal care. This meant that people knew what to expect from the service when receiving support.

There were daily records, which recorded information about people's daily routines and the support provided by staff. Staff told us that the information was used to communicate with each other between shifts on the overall care people received and if a particular person should be closely monitored. A relative told us, "They write down, everything they do." This meant that staff could summarise the care needs of the people on each shift and respond to any changing or immediate needs.

Staff we spoke to were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. Relatives we spoke with confirmed that staff were responsive. One relative told us, "The two carers, definitely 100% wonderful. They are very good with him. They have done wonders with him."

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information would tell them how to keep themselves safe and how to report any issues of concern or raise a complaint. Care plans included how people communicated. Staff we spoke to did not know what the AIS was in full but told us they looked at people's care plans on how to communicate with people and how to make information accessible. For example, one person's, care plan detailed that staff should speak slowly with the person and be patient when the person talks.

There was a complaints policy in place. Relatives knew how to make complaints. The manager and staff were aware of how to manage complaints. Records showed that complaints that had been received had been investigated and a response sent to the complainant by a member of the management team.

Compliments had been received from relatives about the service people received. One comment included, "Just a note to say thank you for your kindness and help during my [person] illness."

Good

Is the service well-led?

Our findings

At our last inspection, the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. The provider had failed to ensure that adequate quality assurance and systems were in place. The provider carried out yearly staff file audits and a monthly medicine audit, visit log in sheets and care plan audits. However, the audits had not identified the shortfalls we found during the inspection, specifically with risk assessments, medicines and training.

At our last inspection, the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Records were not always kept up to date. We found the care plan records such as the pre-assessment sheet and risk assessments had not been completed in full and there were some discrepancies within people's care plans. We also found that the medicines risk assessments did not accurately reflect the medicines people were taking as listed on the MAR charts we reviewed.

During this inspection, we found improvements had been made with risk assessments, medicine management, staff training, care plan records and record keeping.

There were systems in place for quality assurance. Records showed that the manager had carried out audits on medicine management and care plans. There was a programme of audits scheduled, which also included auditing staff files. Spot checks of staff supporting people had been carried out and this had been recorded. They focused on time-keeping, appearance, staff approach and staff support delivery. This was then communicated to staff and formed part of their supervision. This meant that the service was able to identify what areas staff were doing well in and identify if further development was required, to ensure people received effective care and support.

Most records were accurate. We found records in relation to risk assessment and care plans had been reviewed regularly and had been updated, where required. Medicine assessment and MAR had been generally kept updated. We found a TMAR had not been completed for one person as mentioned under Safe. The manager told us that they would ensure this was completed and showed us evidence during the inspection a TMAR form that would be used to complete this.

Staff told us that they were supported in their role and the service was well-led. One staff member told us, "I would say [manager] is someone I can work with, very understanding. He is good. The managers solve issues as much as they can." Another staff member told us, "[Manager] does his job. He does support me." Staff told us that they enjoyed working at the service. One staff member told us, "I have much passion for this role. If you are not passionate of the work you are doing, you will not be able to give your all."

Relatives we spoke with did not have any concerns about the management of the service. A relative told us, "I have met [director] and she seems lovely." Another relative told us, "I am quite happy with them [management]. It is going well." People's and relatives' feedback were sought through telephone surveys. This was generally positive.

Staff meetings were held regularly. The meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff held discussions on rota's, supervision, staffing, appearance and a discussion also was held on the last CQC inspection and how improvements can be made as a team. This meant that staff were able to discuss any ideas or areas of improvements as a team, to ensure people received high quality support and care.