

Elyon Healthcare Ltd

Elyon Healthcare

Inspection report

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21 June 2018

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Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Requires Improvement



Is the service well-led?

Requires Improvement



Summary of findings

Overall summary

Elyon Healthcare is a domiciliary care agency providing personal care and treatment for disease or injury to adults and children. At the time of inspection they provided care for 11 people; two older persons, two younger adults and seven children (one child had complex needs).

Personal care is a regulated activity; CQC only inspects the service being received by people provided with 'personal care' living in their own homes or in specialist housing; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

We carried out an unannounced comprehensive inspection of this service on 9 and 11 January 2018. Five breaches of legal requirements were found. After the comprehensive inspection, the provider was asked to provide an action plan to tell us what they would do to meet legal requirements in relation to breaches in Safe care and treatment, Safeguarding service users from abuse and improper treatment, Receiving and acting on complaints, Staffing and Good governance. We received the action plan which showed how Elyon Healthcare planned to be compliant with these regulations.

We issued two warning notices to the provider in relation to Staffing and Good governance. We undertook this unannounced focused inspection to check that the provider was compliant with the warning notices by the date we had asked them to be. This report only covers our findings in relation to those requirements.

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

At this inspection we found the provider had made most of the required improvements and was compliant with the warning notices.

People received their care as planned from staff that had the skills and competencies to provide their care. The provider had a clear plan of action to improve and embed the rotas and ensure people received their care.

The provider had a clear oversight of the service. They had systems in place to monitor the quality of the service; however, these systems required further improvement to embed audits and evaluate their findings.

We could not improve the rating for Safe or Well Led above requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

There were enough staff deployed to meet people's needs.

Requires Improvement ●

Is the service well-led?

The provider had systems in place to monitor and assess the quality of the service.

Requires Improvement ●

Elyon Healthcare

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 checked 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.

We undertook an unannounced focused inspection of Elyon Healthcare 21 June 2018. This inspection was done to check the provider had taken action to make improvements to meet legal requirements to comply with warning notices issued by CQC. The inspection was carried out by one inspector.

We inspected the service against two of the five questions we ask about services: is the service safe and well led? This is because the service was not meeting some legal requirements.

Before the inspection we reviewed information that we held about the service such as notifications, which are events which happened in the service the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority and clinical commissioning groups who commissioned services from the provider.

During this inspection we spoke with the provider, the general manager, deputy manager and the children's nurse.

We looked at information relating to the running of and the quality of the service. This included quality assurance audits for areas such as medicines management, staff management, service user and relatives' surveys, safeguarding and complaints. We also looked at the staff duty rotas and electronic call log system, meeting minutes and action plans.

Is the service safe?

Our findings

At our last inspection on 9 and 11 January 2018 we found three breaches of the regulations; Regulation 12, Safe care and treatment, Regulation 13, Safeguarding people from abuse and improper treatment and Regulation 18, Staffing. We required the provider to make improvements. We issued the provider with a warning notice in relation to Regulation 18, Staffing as there were not enough staff deployed to meet people's needs. We required them to be compliant with this by 19 March 2018. This inspection was to make sure the provider was now compliant with the warning notice.

At this inspection we found the provider had made most of the required improvements and was compliant with the warning notice.

The provider had assessed their staffing requirements and found there were not enough skilled and trained staff to provide care that met all service users' needs. The provider had informed the commissioners they were giving notice to the service users they could not provide the care for; five older people, four children with complex needs and two younger adults. At the time of this inspection there were two older people and one child with complex needs who were still in the process of moving to another care agency.

The provider had ensured that staff looking after the child with complex needs had the skills and competencies they required to meet the child's needs until the notice was served later in the year. Staff providing care to children continued to be supervised and monitored by a qualified children's nurse.

There had been a recent change to the staff who created and monitored the rotas. The deputy manager had taken over the responsibility of ensuring people had their care provided at the allocated times and that staff had sufficient breaks; these were checked weekly in advance. Staff logged electronically when they provided care; this data showed that people had received their care as planned at the allocated times.

The rotas were being updated to match staff with people's needs. The manager and deputy manager recognised that these rotas required a regular pattern and were involving staff to create a manageable rota. The deputy manager told us "I work closely with the staff to make sure all the calls are covered. We do not have enough staff yet to cover the rota, but we are still recruiting." The provider was continuing to recruit staff to match the specific needs of the people receiving care. In the meantime staff were doing additional shifts to ensure people received their care.

People received their care as planned from staff that had the skills and competencies to provide their care. There were processes in place to plan people's care in the rotas but these needed to be embedded into a regular pattern and staff allocation. The provider and manager had a clear plan of action to improve and embed the rotas and ensure people received their care.

Is the service well-led?

Our findings

At our last inspection on 9 and 11 January 2018 we found a breach of Regulation 17 Good governance. We issued the provider with a warning notice in relation to Regulation 17 as the provider did not ensure there was managerial oversight and governance of key areas of the service which had an impact on the safety of people's care. We required them to be compliant with this by 19 March 2018. This inspection was to make sure the provider was now compliant with the warning notice.

At this inspection we found the provider had made the required improvements and was compliant with the warning notice.

The provider had oversight of the service and ensured the general manager had the autonomy to carry out the changes required to improve the service. The service had undergone major staff restructure and consolidation of the types of service user. The provider told us, "We can provide good care for people with specific needs that match our staff skill set." The provider continued to provide care for children without complex needs and young adults that required supported living.

The provider had initially implemented systems by means of audits to monitor the quality of the service, however, these had not been maintained or embedded. There had been a change in personnel who carried out the planned audits; the general manager had recently taken over all the quality monitoring.

The general manager worked closely with staff to assess and monitor the care people received and the systems that supported this. They held weekly meetings where all aspects of the service were discussed such as staff appraisals, spot checks, training and recruitment. The manager and staff reviewed information received through their on-call system to pick up any issues such as changes required to the rotas. Actions from these meetings were allocated and the manager ensured all the actions were followed up until they were completed. The manager told us, "This system has been valuable in closely monitoring everything; I have a clear idea of what is going on."

The provider had implemented a governance programme which included meetings to discuss findings and rate each part of the service according to risk. The general manager was implementing the audits to monitor the quality of the medicines management, daily notes, rotas and care plans. They recognised that these plans were in their infancy and required embedding into practice to be effective.

The provider had systems in place to monitor the quality of the service; however, these required improvement to ensure all areas of the service were monitored for effectiveness.