

Eunha Healthcare Ltd

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service

Eunha Healthcare Ltd is a domiciliary care agency supporting people with their personal care needs in Leicestershire. At the time of inspection, 93 people were using the service. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

Right Support: People were not kept safe from the potential risk of harm. Details of how to reduce risks to people's safety were missing from people's care plans. Enough staff were not employed to meet people's needs.

Timely calls were often not in place to provide people with the personal care they needed. Safe recruitment practices were in not place to ensure only suitable staff worked at the service.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; in contradiction to the policies in the service. People where required were not supported with their medicines. Accidents and incidents were not always reviewed to prevent this occurrence.

People and relatives said safe care was provided, with people protected against abuse, neglect and discrimination.

Right Care: Care plans reflected people's individual needs, though people and their relatives were positive about the care and support provided and were involved in discussions and decisions about care and support. People and relatives were satisfied with the personal care staff provided. They said staff treated people with respect and dignity and staff had a caring and friendly approach to them. They said they had very good relationships with staff.

Right Culture: The registered manager did not understand their responsibilities or worked in an open and transparent way. Systems and practices for oversight and governance of the service were insufficient to monitor the quality and safety of the service provided. The system of auditing had not identified improvements were needed to evidence all issues raised by people and staff had been followed up.

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

Rating at last inspection

The last rating for the service under the current provider was requires improvement (published 23 November 2022).

Why we inspected

The inspection was prompted in part due to concerns received about medicines management, staffing levels and oversight at the service. A decision was made for us to inspect and examine those risks.

Enforcement

We have identified breaches in relation to safety, staffing, staff training, staff recruitment, governance and provider transparency.

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

Follow Up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

<p>Is the service safe?</p> <p>The service was not always safe.</p> <p>Details are in our safe findings below.</p>	<p>Requires Improvement ●</p>
<p>Is the service effective?</p> <p>The service was not always effective.</p> <p>Details are in our effective findings below.</p>	<p>Requires Improvement ●</p>
<p>Is the service well-led?</p> <p>The service was not well led.</p> <p>Details are in our well led findings below.</p>	<p>Inadequate ●</p>

Eunha Healthcare Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

This inspection was carried out by 2 inspectors and 2 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered manager

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

Notice of inspection

We gave the service 2 days notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection. We also gave time for the registered manager to send us inspection information, so we did not have to spend an extended amount of time in the office of the service.

Inspection activity started on 19 December 2023 and ended on 12 January 2024. We visited the office location on 20 December 2023 and 12 January 2024.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and

improvements they plan to make. We reviewed information we had received about the service and we sought feedback from the local authority.

During the inspection

We spoke with 7 people who used the service about their experience of the care provided and 6 relatives about these issues. We spoke with 3 care staff, the registered manager and the care coordinator. We reviewed a range of records. This included 8 people's care records. We looked at 10 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection

We continued to seek clarification from the registered manager to validate evidence found, which was sent to us.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At the last inspection, the provider had failed to ensure they had sufficient staff to provide timely and effective care to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection, the provider was still in breach of this regulation.

- There were concerns around staffing levels and people receiving the care they needed. For example, we found calls where staff were logged in at 2 different people's addresses at the same time. Since the inspection, the provider has told us they have provided further training to staff in respect of the logging in and out system.
- Data provided by the service showed a number of care visits which required 2 staff members had been completed by 1 staff member. Since the inspection, the provider advised this was as a system error due to staff familiarising themselves with the new logging in and out system and has delivered additional training to staff to improve their knowledge.
- Staff did not receive support at the time they had agreed and were expecting this. For example, staff had been 45 minutes late to support people.
- Staff did not attend the full time of people's support calls. For example, we found examples where staff had stayed for less than half of the allocated time people had to receive their support. This placed people at risk of receiving rushed care or their needs not being met in a safe way. Since the inspection, the provider has told us they are monitoring this closely.

This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection, the provider had failed to ensure systems and processes for the recruitment of staff were robust and effective. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection, the provider was still in breach of this regulation.

- Staff had not been safely recruited.
- The provider had recruitment policies and procedures in place at provider level, however, these were not always followed. For example, not all staff had a full employment history so their performance previously could not be fully checked.
- Another staff member had disclosed a health condition but there was no risk assessment to mitigate the risks of working with this condition.

- Staff's previous employers were not always approached for a reference so there was no evidence of why they left this position. This meant the provider was unable to evidence they were meeting legal recruitment checks.

This was a continuing breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Using medicines safely

- Medicines were not managed safely. For example, we found multiple medicine errors had occurred and staff had not acted in line with the provider's policies.
- People prescribed medicines on an 'as required' basis were not receiving these safely. For example, a person was receiving their 'as required' medicines every night without an explanation around why they needed this. Since the inspection, the provider has told us they have taken action to address this.
- Staff had documented people had received their medicines without observing this. For example, a staff member had dispensed a person's medicines and left them in a pot next to the bed for the person to take when she arrived home. The staff member signed the MAR chart to record this administration despite the person not being home.
- A person was assessed as lacking capacity around medicines and this leaving them at risk. Despite these known risks, the provider had taken no steps to address this, until a medication safe was installed many weeks later. The registered manager confirmed that prior to the safe being installed, the person had full access to all their medicines, placing them at risk of significant harm.

Assessing risk, safety monitoring and management

- People were not fully protected from risks to their health.
- Risk assessments did not detail what action staff should take to reduce risks to people such as detailed safety measures to prevent fire from a person's smoking. For example, a person's risk assessment did not consider additional safety measures to be discussed with the person around them smoking in their home.
- People's care documents contained conflicting information for staff. For example, a person's records stated the person had a walking frame, but another document stated there was no equipment used by this person. This placed the person at risk of staff not supporting them in line with their needs.
- People at risk of choking did not always have clear records in place, in respect of their choices about the foods they ate. For example, a person on a soft diet chose to eat food that was not soft, however, this was not recorded in their care plan at the time of the inspection.
- Where people were at risk of urinary tract infections, staff had failed to follow their risk assessment process and contact a health professional. This placed people at increased risk of prolonged harm due to urinary tract infections being left untreated.

The failure to assess and mitigate risks to people using the service was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were aware of their role and responsibilities to keep people safe from avoidable harm and abuse. A staff member said, "I always check any equipment used to help people move so that it is safe to use."
- People told us they felt safe with staff and staff kept them safe. One person said: "I feel safe. They [staff] are beautiful people, gentle and soft in their approach, they take their time. Before they go, they make sure the curtains are drawn and the doors are locked." Another person said: "They [staff] do everything they are supposed to do in a friendly and nice way. I can't walk. They use a stand aid to assist me. They handle it well, and make sure I am comfortable."
- Staff followed the provider's procedure of reporting any unexplained injuries and these were reviewed by

the management team for possible causes.

Preventing and controlling infection

- People and relatives told us staff wore personal protective equipment (PPE) such as aprons and gloves. A small number of people said staff sometimes did not wear aprons. The registered manager followed this up with staff to ensure PPE was always worn to fully protect people from infection.
- Staff members described relevant infection control measures that were in place to protect people.
- Staff had received training in infection control, including COVID-19. Staff members told us there was always enough PPE available to ensure people were protected from infection.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong

- People were protected from the risk of abuse.
- People and relatives told us staff kept people safe.
- Staff members demonstrated they understood how to safeguard people. They were confident the management would take action if they reported any concerns about people's safety. A staff member said, "If a person said they had been abused I would report this to the manager straight away."
- The registered manager reported any safeguarding concerns or incidents to the local authority in accordance with the multi-agency safeguarding procedure.

Learning lessons when things go wrong

- Processes were in place for the reporting and follow up of accidents or incidents.
- The registered manager said there had been lessons learnt such as increasing staff spot checks to check all assessed care had been provided to people.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always ensure good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At the last inspection, the provider had failed to ensure staff were competent and knowledgeable to enable them to meet people's needs. The provider did not have a robust induction and training programme, or a programme of continued support through ongoing monitoring of staff's competency, including supervision and appraisal.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had not been made and the provider was still in breach of this regulation.

- Staff had not always received training appropriate to their role and the provider failed to keep evidence of the training they told us staff had received.
- Staff were not always trained in line with people's needs. For example, a staff member had no record of training for medicines awareness, falls awareness, health and safety and learning disability training. Another staff member had no record of training for 7 courses including medicines, falls, and health and safety. Failing to ensure all staff had received training in line with their role placed people at risk of not receiving safe care.
- We were not assured that the staff training matrix was a factual and accurate document and that staff had received appropriate training. For example, the training matrix stated staff were trained but when the provider was asked to submit evidence of certificates for a sample of 6 staff, a significant number of certificates were either missing or the completion date did not match the training matrix.

The provider's failure to ensure staff received sufficient training and support was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives said staff were aware of what support was needed. People said staff appeared skilled in what they do. One relative said: "They [staff] have enough training for what Mum requires. They keep me informed."
- Records showed staff had received induction. Staff members told us this training made them feel confident to meet people's needs.

Ensuring consent to care and treatment in line with law and guidance The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

- Mental capacity assessments had not been completed or were incomplete. This meant people were not always able to make day-to-day choices about their lives. Since the inspection, the provider has told us they have taken action to address this.
- Mental capacity assessments (MCA) were not decision specific and people did not always have best interests decisions in place where these were required. For example, A person had an MCA in place for administering medicines and managing finances. However, there was no robust best interest decision in place.
- People had conflicting information about their capacity recorded. For example, a person documented to have capacity also had a care plan in place stating they had fluctuating capacity however had no other documentation in relation to this. This meant staff did not have clear guidance on how to support this person to make decisions around their care.

We recommend the provider reviews best practice in relation to MCA and updates their processes for recording decisions in relation to this.

- Despite this, staff members understood the principles of the MCA and supported people to make choices.
- Staff confirmed they always asked for consent before providing care.

Supporting people to eat and drink enough to maintain a balanced diet

- People received appropriate assistance from staff with food and fluids.
- A person said: "I am not very good at drinking, they [staff] always remind me." One relative said: "They [staff] make sure dad has enough to eat and give him ongoing encouragement. They leave snacks and drinks for him."
- People and relatives said staff prepared food However, 1 relative stated that some staff lacked basic cooking skills. The registered manager said this would be followed up. Staff would be assessed on their ability to cook and provided with additional training if needed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Peoples' needs were assessed before personal care was provided.
- Risk assessments and care plans did not properly reflect peoples' needs.
- People and relatives said appropriate care had been provided by staff.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- A person with a history of urinary tract infections did not get timely support from the GP. Other records showed staff had either referred people to health care professionals such as GPs and nurses when necessary or recommended this involvement to relatives.
- Staff were aware of what to do should someone need medical assistance. They described how they had contacted the ambulance service when a person had been unwell.
- A person said: "I have problems with my circulation, they [staff] seem to understand my needs. I am amazed by their care and attention." A relative stated: "They [staff] are following a request from the GP."

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection, the provider had failed to ensure systems and processes that assessed quality and safety were effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had not been made and action was still needed to ensure quality processes were able to fully protect peoples' safety. There was a lack of oversight from the provider. This was a continued breach of regulation 17.

- Audits were ineffective and failed to identify the concerns found at this inspection.
- The provider had falsely completed an audit of a person's daily notes. The daily notes book ran from September to December 2023, meaning it was not collected by the office until December 2023. However, the provider had been completing audits of the notes (which they were not in possession of) and recording there were no issues.
- Audits were not always effective as staff were auditing their own records. An incident occurred where a staff member dispensed a person's tablets to take at a later date. However, the staff member signed the MAR chart to record they had administered the medicine. The daily care records were then audited by the same carer who made the error, which was not identified and there was no further oversight of the issue.
- Audits of medicines had not identified issues with a person's risk assessment for medicines, and a care plan contained differing medication lists.
- Quality assurance tools had failed to identify our concerns in relation to staff training and recruitment records. Following our inspection the provider submitted an email confirming they now realised there were recruitment concerns. However, it took the inspection to identify these issues, not the provider's systems and processes.
- The provider had failed to identify concerns around staffing and staff travel times. Despite people not sharing concerns around this, records showed staff did not always have travel time between care calls and staff did not stay for people's allocated time for care.
- The provider was unable to demonstrate they were meeting Right support, Right care, Right culture. For example, a person's care plan did not detail longer term aspirations. There was no detail about how the person was progressing and not all staff had required learning disability and autism training.

The failure to ensure systems and processes effectively assessed and monitored, and learning was shared, was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider failed to be honest and transparent with CQC. This occurred on a number of occasions. For example, on the first inspection day, the provider supplied the inspector with details of 56 service users and 35 staff which was stated as the full complement. However, this was only approximately half of service users and half of staff. We received information advising of this discrepancy and conducted a second site visit. Whilst the provider told us there was a system error in providing the initial information, they should have been aware of the amount of staff they employed and the people they were providing care to.
- The provider had provided incorrect information to CQC and a local authority. For example, with regards to staff, they told us they employed 35 staff at our initial inspection, but sent a training matrix to the local authority which contained 42 staff names. They also subsequently provided the local authority with a different list that contained 46 staff names. A further review of information provided by the provider identified 54 staff members but then at a later date, the provider informed the inspector there was a total of 60 staff. This meant we could not be sure how many staff they employed and could not complete our inspection processes across all staff.
- The provider sent through rotas for staff which indicated some people using the service were no longer using the service. We found a further 12 service users as part of the inspection on 12 January 2024.

This failure of transparency was a breach of Regulation 20, Duty of Candour of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Surveys people had completed were positive about the standard of care provided. However, surveys had not been provided to all people, staff or relatives on a regular basis, which could have identified issues that needed action.
- Staff meetings had been held to discuss the service. Relevant issues were discussed, which had included important issues such as training and people's care needs.
- People told us that they were treated fairly.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager stated they aimed to promote a positive culture that was inclusive and empowering to achieve good outcomes for people. This had not always been successful as the registered manager appeared to not to always know who and where they were providing care.
- Staff we spoke with said they were provided with good support from the management and said whenever they had an issue, they were able to get in touch with management who always responded positively.

Working in partnership with others

- The registered manager was aware of the need to work with health professionals to ensure people's needs were met. There was also evidence the registered manager had liaised with district nurses and occupational therapists.
- Staff understood they needed to inform the registered manager and people's families if people were ill or had an accident.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems for providing sufficient staffing and skilled staff to provide safe care were inadequate and placed service users at risk of receiving unsafe care.
Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Responses from the provider were found not to be honest and transparent with CQC on a number of issues and occasions which made it difficult to assess the risk to service users by the service they received.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems for providing sufficient staffing and skilled staff to provide safe care were inadequate and placed service users at risk of receiving unsafe care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for providing safe care were inadequate and placed service users at risk of unsafe care.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were inadequate and placed service users at risk of unsafe care.

The enforcement action we took:

Warning Notice