Eleanor Nursing and Social Care Limited

Eleanor Nursing & Social Care Ltd - Poole Office

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

Eleanor Nursing & Social Care Ltd - Poole Office is a domiciliary care agency. It provides personal care to adults living in their own houses and flats in Poole and Bournemouth. Not everyone using Eleanor Nursing & Social Care Ltd - Poole Office receives regulated activity; CQC only inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. Around 160 people were receiving personal care at the time we inspected.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection, we found the service remained good and met all fundamental standards.

People were protected from abuse, infection and avoidable harm. There were checks that staff were of good character and suitable for their role. Risks to people were assessed and managed, whilst their preferences were respected. Medicines were managed and administered safely. We have made a recommendation about auditing medicines.

Overall, there were sufficient trained and skilled staff to provide people's care, although there had been pressures on staffing over the summer holiday period. This meant that for a while rotas were not sent out to let people know who would be coming to them and at what time. This was not the case when we concluded our inspection.

Things that went wrong were addressed in an open and transparent manner. There were reviews to ensure all necessary action had been taken following accidents and incidents, and analysis to identify any trends that could suggest further improvements were needed.

Staff mostly understood what people needed and had the skills and experience to provide this. Where people had support with preparing and consuming food and drink, they were satisfied with this and had food of their choice. Staff liaised with health and social care professionals where there were concerns about people's health and people wanted the service to organise this for them. Staff were supported through regular training, supervision and appraisal.

People were supported to have maximum choice and control over their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were treated with kindness and compassion, and their privacy and dignity were respected. Staff had respect and affection for people and got to know them over time. People said their regular staff understood

how they liked things to be done, but this was less often the case with unfamiliar staff. Where people had gender preferences in relation to staff, these were respected. People's independence was promoted.

People were happy with their care, which was tailored to their individual needs. They were involved in decisions about their, or where appropriate their family member's, care. Regular staff had a good understanding of people's care plans, which were up to date. Assessments and care plans flagged up sensory loss or impaired communication and the way in which staff should support people with this; staff provided the support required.

Complaints were taken seriously and resolved promptly with the appropriate action taken. People and their families were given information about how to complain about their care.

The service had a positive, open, person-centred culture. There was open communication with staff. Staff were motivated to provide a good service. During the inspection the registered manager returned as planned from long-term leave. People and staff had confidence the registered manager would bring about improvements to the staffing and rota situation. People, relatives and staff told us they could readily contact the office, or outside office hours the on-call service, if they needed to. Equality and human rights were promoted.

The service worked in partnership with other agencies to ensure its sustainability. Managers were knowledgeable about quality issues and priorities, understood the challenges, and addressed them. Quality assurance arrangements identified current and potential concerns and areas for improvement. Legal requirements were understood and met. When required to do so, such as if there was a significant injury or a safeguarding concern, the service had notified CQC.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service remains good.	**Good**

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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 was a routine comprehensive inspection. We gave the service four days' notice of the first day of the inspection, so staff could arrange for us to telephone and visit people who used the service.

The inspection was undertaken by an adult social care inspector and an expert 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.

Before the inspection we reviewed information we held about the service. This included notifications of significant events such as the registered manager's long-term leave and information about safeguarding investigations. We obtained feedback from a local authority safeguarding adults team and from a local authority contract monitoring team. A Provider Information Return had not been requested within the year prior to the inspection. A Provider Information Return is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather this information during the inspection.

Inspection site visit activity started on 29 June 2018 and ended on 14 September 2018. It included shadowing care staff during their visits to people. We spoke with five people who used the service and one relative face-to-face, and eight people and four relatives on the telephone. We also spoke with six care workers, an office-based member of staff, two quality assurance managers and the registered manager. We visited the office location on 29 June, 6 and 11 July, and 14 September to see the manager and office staff and to review care records and policies and procedures. We reviewed seven people's care records, including

assessments, risk assessments, care plans, records of care given and medicines administration records. We also reviewed seven staff files, staff schedules, accidents and incidents, and quality assurance records.

Good

Is the service safe?

Our findings

People were protected from abuse. The registered manager and staff understood their responsibilities in relation to safeguarding people and knew how to raise concerns within the organisation and to outside agencies. The service worked cooperatively with the local authority to resolve concerns that had been identified. An isolated potential safeguarding concern reported to a member of the office staff had not been acted upon. When we raised this with the management team they immediately contacted the person's care manager, who was aware of the circumstances and did not think a safeguarding referral was warranted. This had happened during the registered manager's leave and the member of staff who had omitted to act had since left the service.

Risks to people were assessed and managed so people were protected from harm, whilst their preferences were respected. Risk assessments were undertaken when packages of care were first taken on and were taken into account in planning care. They were reviewed at least annually or where the person's circumstances changed. They covered areas such as: moving and handling, medication and the use of bed rails. Risks people's home environments presented to themselves and staff, such as smoking or pets, were also assessed and managed.

There were systems for responding to emergencies, such as severe weather or staff shortages. The service's database flagged calls that should be prioritised, such as time-critical calls where people required medication at a set time. A member of the office staff held the on-call telephone outside office hours. They were able to view the database, including details of people's care plans.

Over the summer holiday period there had been pressures on staffing due to leave and sickness. This coincided with the registered manager's long-term leave and a turnover of office staff, including coordinators responsible for organising rotas. Call times had changed, people had stopped receiving rotas and there was less continuity of staff.

However, there were overall sufficient trained and skilled staff to provide people's care. The registered manager had returned to work by the second day of the inspection and new coordination staff were in place or in the process of being recruited. Between the second day and the end of the inspection, the registered manager had reviewed the rotas with a view to introducing runs based on local areas to improve consistency for people, in terms of staffing and time slots. This was not complete, as the service was seeking wherever possible to respect people's preferences for familiar staff to continue working with them. Rotas were once again being sent out to people in advance. One person told us staff stayed for only 20 minutes of their half hour call, but otherwise people told us staff stayed the full time or only left after all tasks had been completed. Staff told us they generally had enough travel time allocated between calls.

There were checks that staff were of good character and suitable for their role. Appropriate Disclosure and Barring Service checks (criminal records checks) and other recruitment checks were carried out as standard practice. These included interviews, obtaining a full employment history with an explanation of any gaps and taking references.

Medicines were managed and administered safely. People who received assistance with medicines said they received these as they should, although a relative commented that their family member could receive assistance any time between six and nine pm. For example, a person said they received help with their medicines "morning and night time without fail". Care staff were trained and had annual competency assessments in order to administer medicines. A sample of medicines administration records (MAR) returned to the office each month was audited, although these did not record what action had been taken if discrepancies were identified.

We recommend medicines audits make clear how discrepancies have been followed up.

People were protected from the spread of infection. Staff had supplies of disposable gloves and aprons with them when they visited people and told us these were readily available to them. They visited the office to collect fresh supplies during the inspection. Staff had training in infection control, including hand hygiene.

Things that went wrong were addressed in an open and transparent manner. The registered manager reviewed accidents and incidents reported by staff to ensure all immediately necessary action had been taken to ensure people's safety and wellbeing. Each item was logged on the database, so the provider's management team could have oversight. They analysed accidents and incidents for any trends that could suggest further improvements were needed.

Good

Is the service effective?

Our findings

People's needs and preferences were assessed and care delivered in line with current good practice guidelines. Each person had an assessment before their care package began. Sometimes this was done in conjunction with people's social workers, if social services were arranging their care. Information about people's needs and preferences was used to develop care plans that instructed staff how to meet their particular needs. Areas covered typically included a summary of what was needed at each call, instructions for entering the property, arrangements for medication, moving and handling, eating and drinking and health conditions. Care plans were reviewed annually or when people's needs changed, such as following a hospital admission.

People were supported to eat and drink enough, where this formed part of their care package. People we spoke with who received assistance with preparing and consuming food and drink were happy with this aspect of their care and said they had meals they had chosen. People talked with workers about what meal they fancied. While we were visiting one person, their worker asked them what they wanted to eat and cooked for them. The person told us this member of staff made "brilliant omelettes". Another person said care workers always offered them a choice of food and prepared it properly, although they thought some were better cooks than others.

The service worked with other organisations to ensure people had the care they needed. This included liaising with people's social services care managers where there were concerns that people's care needs had changed. For example, a person who had previously had extensive care needs had become more independent and no longer needed everything that was in their care plan. With the person's agreement, the service liaised with the person's care manager and the level of assistance provided was reduced. Another person had particular moving and handling needs. Their care records contained photographic instructions from a physiotherapist for how to position the person in bed. There were timely referrals to health professionals, such as doctors and district nurses, where there concerns about people's health and people needed and wanted the service to organise this for them.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005 (MCA). People gave consent to their care, or if they were found to lack the mental capacity to do so, a best interests decision was made and recorded so care could be provided in their best interests. People told us staff checked before providing assistance that it was okay to do so, for example, "Oh yes, they ask me when I want to be washed and so on" and "Yes, they ask if its ok to start the jobs". The 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 the least restrictive possible.

Staff had the skills and knowledge they needed to provide people's care. When asked if they thought staff had training and skills to support them, people and relatives were mostly positive, expressing confidence in their regular care staff. Comments included: "As far as I am concerned yes, they are", "Oh yes, the regular

carers I have are brilliant", "Most seem to be fine", "At the moment all regular carers know what [person] likes doing. If it's new carers, then we have to show them what has to be done", and "Most of the time yes. If carers have not done any personal care or moving and assisting, it can be a struggle". Staff told us they readily got the training they needed. One care worker said, "I think the training here is amazing. If I am not confident with something, like with hoists, I can ask for more training when I come into the office."

Training in key topics was provided at induction and at regular intervals thereafter. These included moving and handling people, handling medicines, safeguarding adults and children, infection control, food safety and equality and diversity. Staff new to care completed the Care Certificate, which represents a nationally-recognised set of standards expected of staff working in health and social care. Following induction, staff were encouraged to work towards diplomas in health and social care.

Staff were also supported through supervision and appraisal. This included supportive conversations with a more senior member of staff every three months to reflect on their role, how it was affecting them, and any training and development needs. A care worker told us their supervisor "always asks me if there's anything I want to talk about" and confirmed that spot check observations of their work were discussed at supervision.

Good

Is the service caring?

Our findings

People and their relatives told us staff treated them with kindness, compassion and respect. Comments included: "I think they are all very kind and caring", "We have never had an unkind carer", "All very kind and caring" and, "They always treat my husband with respect and dignity." This was reflected in the way care staff related to people during our visits and the way office staff spoke with people on the telephone. Staff told us how important it was to them and to the people they were supporting that they had a caring approach; for example, a care worker told us that one of the things they liked best in their job was "treating clients like human beings".

Staff respected the people they were caring for and got to know them over time. People told us their regular staff understood and respected how they liked things to be done. For example, a person told us, "[Name of care worker] – she's fantastic! When you have a regular [care worker] it's nice. You get to know them, and they know you." Care plans contained information about people's interests, preferences and social histories, such as where they grew up and the work they did. This was to help staff understand people as individuals. Managers and staff spoken with had a good understanding of people's backgrounds and histories, recognising things they valued and that caused them sadness. They talked about people with respectful affection; for example, a care worker said, "All my clients are lovely. We have a relationship of mutual respect."

People were supported to express their views and be involved in decisions about their, or where appropriate their family member's, care. People told us they were involved in care plan reviews, for example: "I am sure I am due one [a review] soon, but yes, I am involved in decisions", and "We had a review of my husband's care plan a couple of months ago". Managers and office-based staff visited or telephoned people every few months to check they were happy with their service.

People's independence was promoted. People told us they thought the care they or their relative received helped them stay independent. For example, someone said their care "helps keep me independent". Care plans highlighted what people were able to do for themselves, for example when they were having a bath or shower.

People's privacy and dignity was respected. People told us staff upheld their dignity and that their preferences regarding the gender of care staff were respected. For example, someone said they had only female care workers as this was their preference. Gender preferences were discussed at assessment and were recorded in people's care records and the staff scheduling system. The service had supported someone who was going through gender transition; whilst all staff have equality and diversity training, only care workers with the maturity and understanding to support the person with sensitivity were allocated to this care package. Staff understood the importance of confidentiality. Access to staff phones and computers was password protected.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. They were positive about staff following their care plans and doing what was needed, in relation to their personal care. For example, a person told us, "I can't fault the care." Care plans were up to date and personalised, reflecting people's physical, mental, emotional and social needs. People, and where appropriate their relatives, were involved in care plan reviews. Although there had been some issues with staffing over the summer, calls were generally scheduled according to people's needs and preferences. For example, some people needed care before they went out to work or to day centres and this was organised accordingly.

The service met the Accessible Information Standard. The Accessible Information Standard requires that health and social care providers ensure people with a disability, impairment or sensory loss can easily understand information provided and get the right support to communicate effectively. Assessments and care plans flagged up sensory loss or impaired communication and the way in which staff should support people with this. Staff provided the support required. For example, a person told us that staff took account of their short-term memory difficulties and gave them information in a way they could understand.

No-one using the service was known to be at the end of their life, although the service was supporting people with life-limiting conditions. Staff had awareness training about death, dying and bereavement.

Complaints were taken seriously and resolved promptly with the appropriate action taken. Information about the provider's complaints procedure was provided to people and their families. People and relatives told us they knew how to raise concerns, for example, "There is something in the book to tell me who to contact if I had a concern". If people had raised complaints or concerns, these mostly related to care staff not turning up on time or changes of times. A relative told us they had not been happy with a particular member of staff: "There was one incident where I was not happy with the behaviour of a carer. The agency removed her, so yes, I was happy with the outcome."

Good

Is the service well-led?

Our findings

The service had a positive, open, person-centred culture. Staff we spoke with were proud to work there and expressed enthusiasm about their work, making comments such as, "I love my job" and "I'm so grateful and so happy". All of them were committed to providing a quality service to people. One care worker told us how they tried their hardest "to add a little bit extra" in their work, in the sense that they attended carefully to what people wanted them to do. Some staff had worked for the service for several years. A care worker told us they had felt better supported at this service that they had in care roles elsewhere. Despite the staffing pressures the service was experiencing at the start of the inspection, the atmosphere in the office was calm and welcoming. Another worker commented that their experience of contacting the office was generally positive, although they felt that one of the office staff had been pushy towards them on occasions. A further worker told us, "The office staff are absolutely lovely."

The registered manager was based in the office and was readily available to people and staff. They had been on long-term leave for several months and returned to work as planned, following the first day of the inspection. This was welcomed by some of the people we spoke with, who referred to the registered manager by name expressed confidence they would bring about improvements to the staffing and rota situation. A care worker commented that they found it easy to speak with the registered manager. Whilst the registered manager had been away from work, the service had been supported by the quality assurance manager, who visited weekly in the registered manager's absence. The quality assurance manager had a good understanding of the service and a relaxed and professional relationship with the office staff and care workers who called in. People, relatives and staff told us they could readily contact the office, or outside office hours the on-call service, if they needed to.

The registered manager had worked at the service since it opened and was well supported. As well as regular contact with the quality assurance manager, they attended the provider's quarterly management meetings for updates and development.

The service sought to recognise and communicate openly with staff. Apart from ad hoc conversations when staff came into the office and quarterly supervision, there were staff meetings every few months. These were held on alternative dates so as many staff as possible could attend. At staff meetings, staff received positive feedback about areas that had gone well, such as the way they had coped with severe weather earlier in the year, so people continued to receive a service. Learning was also shared from incidents, safeguarding investigation, audits and external quality monitoring. The provider produced a staff newsletter every few months, which gave information about developments, and celebrated staff achievements and special events. There were local 'carer of the month' and provider wide 'carer award' recognition schemes; one of the service's care workers had recently won a carer award. Staff took part in social events and charity fundraising initiatives, which reflected the provider's ethos of social responsibility.

Equality and human rights were promoted. All staff had training in equality and diversity. The registered manager and quality assurance manager were sensitive to diversity in the staff group. A care worker had been supported to undertake literacy classes in view of their difficulties with writing. Staff were from diverse

ethnic backgrounds and the registered manager took appropriate action where staff reported discrimination from people or their families. The provider belonged to organisations that promoted equality and human rights within organisations and accredited employers for good practice in equalities.

Managers were knowledgeable about quality issues and priorities, understood the challenges, and addressed them. Quality assurance arrangements identified current and potential concerns and areas for improvement. The provider's most recent annual survey had taken place in October 2018. Key issues identified were the low response rate, staff turning up on time and an expectation that more could be done for people. These had been acted on; for example, the new system soon to be introduced in part of the service would make it easier to monitor timekeeping. Expectations related to the commissioning and services, but the service continued to monitor quality through ongoing spot checks and satisfaction checks, ensuring that changes in needs were escalated to people's social services care managers. Staff received feedback about their performance through supervision, for example, discussing the results of spot checks. There were regular audits within the service, for example reviewing care records, staff files and medicines. There were also audits overseen by the quality assurance manager, to give them an overview of all aspects of the service.

Accidents, incidents, complaints and safeguarding concerns were logged on the provider's database and analysed to identify trends and to highlight risks to the service. There was a recognition that staff recruitment was challenging and changes to the pay structure had been introduced with a view to helping overcome this.

Legal requirements were understood and met. When required to do so, such as if it was made aware of a safeguarding concern, the service had notified CQC.

The service worked in partnership with other agencies to ensure its sustainability. This included participating in the local commissioning framework and working transparently and cooperatively with commissioning organisations to support good care.