

Essex Cares Limited

# Essex Cares North

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service caring?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Inadequate** ●

# Summary of findings

## Overall summary

This inspection took place on 8, 16 and 17 March 2016. The inspection was unannounced.

The service provides reablement support to people for up to six weeks when they leave hospital. It also provides services as a provider of last resort where other support agencies are not available. It supports between 120 – 150 people at any one time. It receives between 45 and 50 referrals a week.

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

People did not always receive their medicines as they were prescribed. This related in particular to the time which people should receive their medicines. This was due in part to the way in which the provider organised the timing of calls. Although the registered manager told us that action had been taken to address this issue it had not always been effective.

People's care plans contained risk assessment in respect of the care and support provided. However, risk assessments were not carried out relevant to particular conditions people may be living with, for example diabetes and epilepsy.

The service assessed the level of support a person needed but the time it would take to deliver that support was not always fully considered. It was expected that the support each person required would reduce as their support package progressed. This had led to some people telling us that there was insufficient time for the support they required. The service had a two or four hour window in which people could expect their support worker to attend. This meant that people did not always get their support at times they preferred.

Staff received training in mandatory areas such as moving and handling and safeguarding. However, the service primary objective is 'reablement.' There was no evidence in records or from speaking with staff to show that staff had received training specific to reablement.

Due to people receiving support from a high number of support workers people were unable to build up relationships with the people providing their care.

Care plans were written with the person when they first began receiving support from the service. These identified goals which the person wished to achieve during the period the support was provided. However, the service could not demonstrate how progress to achieving these goals was monitored. This had particular relevance where a number of different support workers worked with a person.

The provider did not have an understanding of the day to day challenges of the service. The registered manager, although aware of their responsibilities as a registered person, were not always supported by the provider to deliver what was required.

You can see what action we told the provider to take at the back of the full version of the report

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not consistently safe.

People did not always receive their medicines as prescribed.

General risk assessments were carried out but risk assessments relevant to specific conditions were not always completed.

There were sufficient staff to provide support to people safely.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

Staff did not always have up to date training to enable them to perform their role effectively.

It was unclear as to whether staff had a full understanding of the Mental Capacity Act 2005.

People received support with nutrition when required.

### Is the service caring?

**Requires Improvement** ●

The service was not consistently caring.

People did not develop positive relationships with care staff due to the high number of different staff providing care.

Regular reviews of the support being provided were carried out with the involvement of the person receiving support.

People's privacy and dignity was respected.

### Is the service responsive?

**Requires Improvement** ●

The service was not consistently responsive.

Systems in place for initial assessment of an individual meant that at times the service had undertaken a support package before they had carried out an assessment to ensure that they could meet the individual's support needs.

Care plans did not reflect how people would like to receive their support.

Feedback from people receiving support was sought at the end of their support package.

The service had a complaints procedure in place.

### Is the service well-led?

The service was not well-led.

The provider did not assess the impact of changes effectively before making major changes to how the service was run.

Statutory notifications were not being sent to the CQC.

Quality assurance processes were not used to drive improvement.

Roles and legal responsibilities and accountability were not fully understood.

**Inadequate** ●

# Essex Cares North

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8, 16 and 17 March 2016 and was unannounced. The inspection team consisted of three inspectors.

Prior to the inspection we reviewed the information we held on the service. This included notifications we had received from the provider about incidents that affect the health, safety and welfare of people the service supported. We also checked to see if any information concerning the care and welfare of people being supported had been received.

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

# Is the service safe?

## Our findings

Records did not always demonstrate that people received their medication at the times they needed them or as they had been prescribed. Medication Administration Records (MARs) included details of the level of support people required, information about people's allergies, where medicines were stored and accessed and how it was obtained. However, there were gaps in some places on the MAR's which meant that it was not clear whether people had received their medicines as prescribed.

The service did not give people specific times for their visit but gave a two or four hour time frame within which the support worker would arrive. The registered manager told us that if times needed to be specific, for example due to the administration of medicines, the time of the visit was fixed so that the interval between administration would be correct. However, we saw entries in people's care plans which showed that medicines had not been administered because there had not been a long enough time since the previous dose. This meant that people had not always received their medicines at the correct time. The registered manager told us that this was being addressed and people who required medicines at a particular time had the time of their visits set.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this people told us that they received the support they needed to take their medicines. There were medication assessments for staff to refer to which gave details of the medicines being taken and the level of support required. The registered manager told us that medication administration was discussed at staff meetings and that MAR's were monitored by a registered nurse to help identify any concerns and address any errors.

People told us they felt safe whilst receiving care in their home. One person said, "Yes I felt safe. They did everything I asked."

Staff had received safeguarding training. A safeguarding policy was available and staff were able to describe signs of potential abuse and were clear about the relevant reporting procedures. They were also aware of the service's whistleblowing policy, and told us that they would be confident to report any concerns to the registered manager and that they would take action. Discussion with staff and a review of records showed that safeguarding incidents were addressed appropriately, with referrals and investigations being carried out. Records showed that a safeguarding exercise was carried out at a recent staff meeting to ensure all staff could recognise and report safeguarding concerns appropriately. The provider maintained a record of safeguarding referrals which they were able to share with us and demonstrate what action they took.

People who used the service had risk assessments in place for their home environment, mobility and moving and handling. However, risk assessments with regard to specific conditions were not in place. For example, where a person living with diabetes was being supported there was no risk assessment in place to inform staff about the impact of the condition on the person or identify and reduce any risks, such as the

importance of receiving meals and medication at specific times.

Staff told us that they would always read the care plan and risk assessment prior to providing support. Staff signed the care plan to confirm they had read the risk assessments and people we spoke with confirmed this happened before staff provided support. This ensured that the staff were aware of any changes in a person's care plan before providing support.

There were enough staff to deliver people's assessed care needs. However there were some inconsistencies because some people felt their care took longer to deliver than had been assessed as requiring. The registered manager told us that they did not accept new referrals for support if they did not have sufficient staff to cover the call. Reports supplied by the provider confirmed that referrals had been declined due to a lack of capacity. Most people told us that staff had the time needed to support them. However, some people said that staff did not have sufficient time and therefore could not provide the support they needed. One person said, "There is not enough time. They are supposed to help me wash, shave and put on shoes and socks. There was not enough time to do that." Another person said, "They try and give you what time you need." We discussed the amount of time allocated for each call with. The registered manager explained as people became more able the amount of time they required usually reduced. Care staff we spoke with said they had sufficient time to provide the support required. One member of care staff said, "If you go over time you can ring the office." Another member of staff said, "If we do not have enough time we tell the office and it will be increased."



## Is the service effective?

### Our findings

Training was inconsistent which resulted in people not always receiving their care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities effectively and safely. Despite this one person told us that, "On the whole they know what they are doing." Another said, "They know what they are doing."

The service Statement of Purpose states one of the aims and objectives of the service was to 'enable and support customers to regain and retain their independence.' Staff we spoke with and records provided did not show how staff were trained and supported to do this. We asked a member of staff if they supported people with daily exercises but they told us that exercises would be carried out by a physiotherapist.

Staff received regular training and could request training in areas which they may require such as dementia. The service could not demonstrate that all staff had received training in infection control, food hygiene or lone working. Not all staff had had an annual observation of their medicines administration practice to ensure their on-going competency. It was confirmed by the services' registered nurse that a medicines observation should take place annually as per their policy.

It was unclear whether staff understood their responsibilities relating to the MCA. Two senior members of staff were unaware whether anyone receiving support had a mental capacity assessment in place. Records showed that not all staff had received training in the MCA and their associated responsibilities.

We were concerned that effective systems to ensure that staff had up to date and appropriate skills and competencies to provide effective care, were not in place or being monitored.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Care plans did not show that a person's capacity to consent to their care had been assessed. Particular care plans for medicines assessed whether a person was able to take their medicines independently but did not contain a clear MCA assessment. If a person was assessed as able to self-medicate a nine page risk assessment was still completed.

There was evidence on the files we inspected that staff had received an induction into the service. This included areas such as code of conduct, confidentiality and dress code. New staff confirmed that they had completed shadow shifts prior to working in the service. However, the service training record supplied did not show that all staff had received an induction. An effective induction introduces new staff to the culture and values of the service and ensures they provide effective care.

Staff received regular supervision. Part of the supervision process was announced and unannounced checks by senior staff to observe staff practice. Feedback is also gathered from three people who have received support from the care worker prior to the supervision meeting. Care staff told us that supervision meetings were constructive and they received the support they needed to provide an effective service.

As this is a reablement service support with eating and drinking is only provided when assessed as being required. Where people were supported to prepare food this was done appropriately. One person said, "Yes they heat my meals in the evening."

When the service carried out an assessment of person's needs they referred them to health care professionals such as the occupational therapist where appropriate.

## Is the service caring?

### Our findings

People told us that the care staff providing their support were kind and provided care in a compassionate manner. One person said, "They were very polite and friendly," another said, "The carers were all very pleasant."

However, people were not able to develop relationships with care staff as they were visited by a large number of different care staff during the time they were supported by Essex Cares. For example one person who was supported twice a day for two weeks received support from 10 different care staff. Records showed that care staff had expressed concern about this. In one member of care staff's supervision record it had been recorded, "Not going to the same customers is strange when I do the same shift each week." We discussed this with the registered manager who advised that it was, in part, due to the staff rota's being controlled from the provider's office at a different location. We are aware that since our inspection this has been addressed with staff moving from the provider's office to the service offices.

Each member of care staff carried an electronic device which gave them basic information about the person and the tasks they will need to perform at each visit. The care plan kept at each person's home contained an Independent Living Plan with more details. This was still limited in detail about people's preferences and what was important to them. Further development was needed to demonstrate that the approach to care reflected and respect these preferences. For example the service does not guarantee to provide a care worker of the gender preferred by the person receiving support. One person told us that they would have preferred a female to provide their support but had, "Got used" to the male who sometimes provided their care.

The registered manager told us that each person's support plan was regularly reviewed with them to ensure it met their needs as they became more able. One person said, "They discussed what was needed." An assessment was carried out with the person when they first began receiving care and at regular intervals thereafter. We observed two assessments being carried out by a supervisor and saw that they discussed people's needs with them in an open manner providing explanations when required. However, care plans did not demonstrate that these reviews had taken place.

People told us that staff treated them and their property with dignity and respect. One person said, "Yes, they are very good around privacy and dignity." Personal information about people which was kept on an electronic system which was password protected. Information that was in paper form was kept in locked cabinets with only appropriate people having access.

## Is the service responsive?

### Our findings

The service provides care to two different groups of people. Firstly those requiring reablement for a and secondly as the provider of last resort for those where no other support service can be engaged.

The service had an 'assessment and review' lead working at a local hospital to complete assessments before people were discharged. However they were not always able to complete this task before the person returned home. Referrals from the hospital for support and care went through the providers Business Support Centre. We asked the Registered Manager if this meant that the service may accept a referral before they had assessed that the person's needs could be met. They told us this could happen but that action was being taken to strengthen communication about referrals between the Essex Cares North office and the Business Support Centre.

Each person had an independent living plan which gave details of the support they required. However, this contained little detail about people's preferences and what was important to them. There was limited information regarding people's medical history and health concerns. For example in one person's plan it stated that they lived with seizures but there was no additional information or risk assessments in place to tell support workers what action they should take to support the person if they were to have a seizure. One person we visited in their home had been supported to have a strip wash as part of their reablement. During their review it became clear that they would have preferred to have a shower. The senior carrying out the review immediately amended the care plan to reflect this. Another person told us that they had had no offer of a shower and they were now supported with this by a member of their family.

The majority of people were receiving support from the service on a reablement basis, usually following discharge from hospital. This provided people with support for up to six weeks to live at home and rebuild confidence with daily tasks leading to independence. Details were provided in the independent living plan about people's goals but there was limited information about how people should be supported to attain their goal. For example, tasks listed for one person were showering, dressing and personal care. However, there was no indication what the person was able to do for themselves or what level of support was needed. One person told us, "Each carer comes up with their own ideas." This meant that people may receive a different level of support from the different care staff who visited.

The registered manager told us that people's progress was discussed at a fortnightly meeting when the staff team shared how best to support someone as well as discussing reviews and a reduction in support. However, the forms contained in the independent living plan entitled 'Weekly Progression' had not been completed in the care plans we looked at and the service could not demonstrate how they formally monitored and reviewed a person's progress.

People did not always receive care and support which reflected their preferences. The provider gave people a two or four hour window in which they may expect the support worker to call. This was between 7am and 11am, 12 midday and 2pm, 4pm and 6pm and 7pm to 11pm. Some people we spoke with said this was not a problem and they simply waited for their support worker to arrive. However, others told us this did cause

them a problem. One person said, "They were a bit useless I needed someone at nine but they did not come until twelve." Another said, "I had to go to bed earlier than I wished due to the time window." We asked the registered manager about the timing of calls. They told us they were unable to provide a firm time for visits but that when a person was first being supported by the service visits would be put earlier in the call rota so that, if for example a person needed support getting up, the support worker would be there when they wanted to get up. When the person had been receiving support for some time the call would be moved later in the rota as it was anticipated that the person would be more able. This wide window for scheduling calls meant that not everybody got support when they required and preferred to receive it.

The service also supports people as a provider of last resort and is commissioned to do so by the local authority. This means that other agencies have been unable to support the person. These people may also have complex care needs and the service may then need to support some people for longer than the usual six weeks. We were given an example of a person who had been receiving support for a number of months. The Independent Living Plans for these people contained no additional details and were task focussed with no details about people's life history and what was important to them. There was limited information about people's physical health, emotional and mental health and social care needs.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the end of their six weeks of support, or earlier if a person has reached their goals, people are visited by a senior member of staff to confirm they no longer require support. During this visit a feedback form regarding the quality of service is completed. The visit had recently been introduced as previously the form had been left with the person and there was a low return rate. The registered manager told us that negative comments were collated centrally by the Business Support Centre. Positive and negative feedback was used as an opportunity for learning being passed to staff at team meetings, specific mention of an individual was recorded on their personnel file.

The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales. We noted that the folders in people's homes contained details of the complaints procedure.

## Is the service well-led?

### Our findings

The service was not consistently well-led and we found that this impacted on people's experience of receiving the service. One person said, "Organisation is bad, carers are good."

The registered manager is legally responsible and accountable for the service, as a registered person, alongside the registered provider. Some decisions affecting the running of the service had been taken by the provider and there was a lack of effective assessment of how these decisions to run the service would affect its day to day running. For example the provider had decided to transfer support services to the Business Support Centre in another city. The registered manager and their line manager told us that all support services, such as the acceptance of referrals and the planning of staff rota's had initially been transferred. They told us that this had resulted in a deterioration of the service they provided including missed calls and the acceptance of care packages without proper assessment of the needs of the person. As a result they had taken some functions back to their local office. This had resulted in some improvement. However they advised that all support services had now been returned to the business support centre.

The registered manager had only limited control over improvements that could be made. For example in October 2015 the provider had commissioned an independent consultant to carry out an inspection based in part on the key lines of enquiry used by the Care Quality Commission. We were given an action plan that had been developed to address the shortfalls identified at this time. Some shortfalls addressed in the action plan had a recommendation that they should be carried out by the registered manager, such as organising safeguarding children training, disclosure and barring checks for staff and checking that there was a process in place to verify that staff who were required to be registered with a professional body were appropriately registered. These actions were shown as 'awaiting organisational decision.' Therefore the responsibility for addressing these shortfalls had been removed from the registered manager who was unable to advise us how they were being addressed.

The business support centre was not able to provide an effective support service to ensure the service provided was of a good quality and safe. Comments recorded by care staff at their supervision meetings included, 'Frustrated as cannot contact the business support centre or reablement office when I am on shift,' 'Frustrated as mapping of calls does not always take account of the best use of time and travel,' and 'I have contacted the business support centre on several occasions and given messages. These have not been passed on.' We experienced difficulties with the business support centre, when we contacted them by telephone and were put through to the incorrect office. Staff told us that following feedback the provider had taken action to 'zone' calls to post code areas to avoid staff traveling long distances and reducing time between visits. However, this had been carried out without consultation with the local office and registered manager. Staff told us that the zoning had not resolved the issues and the organisation of their work was still not effective.

The service had not been complying with their legal obligations to notify us of events which happen in the service and affect the service. During the inspection we found that not all of these notifications had been sent to us. We discussed this with the management team and they could not demonstrate that they had

taken appropriate action. Subsequent to our inspection the service have sent us the notifications that should have been sent.

The head of quality and corporate governance for the provider gave us a variety of management reports relevant to the provider's services. Much of the management information did not identify the performance of Essex Cares North as a separate entity. For example the internal audit report on risk management and the Senior Leadership Team, key performance indicator report dated 4 March 2016. This meant that there was not an understanding of the challenges, achievements, concerns and risk for this service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  Care plans contained limited information about people's physical health, emotional and mental health and social care needs and were task focussed.
Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  People did not always receive their medicines at the correct time.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Management information was not specific to this service which meant that there was not an understanding of the challenges, achievements, concerns and risk for this service.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  Lack of effective systems to ensure that staff had up to date appropriate skills and competencies to provide effective care



