Empathy Care24 Limited

Empathy Care24 Northampton

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

About the service
Empathy Care24 Northampton is a domiciliary care agency providing personal care. The service provides support to children, younger adults and older people, people with dementia, mental health, physical disability, sensory impairment, learning disabilities or autistic spectrum disorder. At the time of our inspection there were 68 people using the service.

Not everyone who used the service received personal care. 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
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.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Support:
Risk assessments and associated care plans were not consistently in place or updated to reflect people's current needs and mitigate risks. Medicines were not always managed safely. Staff understood the signs of abuse and how to report it to protect people. Accidents and incidents were recorded but action was not always taken where needed to prevent re-occurrence.

Staff were recruited safely in line with the regulatory requirements. Staff told us there were enough staff to support people and meet their needs. However, care calls were not always completed at the planned times and some people felt their care was rushed and told us staff arrived late.

People were protected from the risk of infection and staff used personal protective equipment (PPE) appropriately in line with the latest government guidance.

People were leading their care and making their own decisions and choices in there day to day care delivery. People were mostly happy with care staff and found them to be kind and caring.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice.

Right Care:
Staff received regular training and supervision. However, not all staff had the skills and knowledge to carry out their role effectively. Senior members of staff needed further support to ensure they were competent to complete the tasks assigned to them.

People's care plans did not always provide staff with information and guidance on how to support people safely and in a person centred way. Initial assessments took place to ensure that the service could meet people's needs. However, people's records were not always updated following a change in support needs.

There was evidence of partnership working and seeking guidance from other health care professionals to meet people's needs. However, there was some evidence that staff hadn't always followed guidance. People were supported with eating and drinking where required.

Right Culture:
Systems and processes were either not in place or not effective in maintaining oversight of the safety and quality of the service and identifying concerns and areas for improvement. The provider had not implemented a robust action plan to learn and improve from the previous inspection. The provider was in the process of improving how they sought feedback from people to help with driving improvement. Staff had the opportunity to share ideas and felt listened to.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 01 January 2023). The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 24 October 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve need for consent. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. We also checked whether the Warning Notice we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

This report only covers our findings in relation to the Key Questions safe, effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Empathy Care24 on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to the safety and managerial oversight of the service at this inspection.

Since the last inspection we recognised that the provider had failed to submit notifications of other incidents and had not met the requirement as to display of performance assessments. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress and 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.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Empathy Care24 Northampton

Detailed findings

Background to this inspection

The 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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspectors 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 21 March 2023 and ended on 18 April 2023. We visited the location's office on 21 March 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. 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 used all this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service and 8 relatives of a person using the service, about their experience of the care provided. We received feedback from 17 care workers and spoke with the registered manager and the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 8 people's care records and a variety of records relating to the management of the service, including policies and procedures. We looked at 3 staff files in relation to recruitment.

Requires Improvement

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. The rating for 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.

At our last inspection the provider had failed to assess the risks to the health and safety of people using the service, manage medicines safely and ensure staff had the skills and competence to support people safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Assessing risk, safety monitoring and management

- Risk assessments and associated care plans did not consistently include current and correct information and guidance for staff on risk mitigation. One person was a very high risk of choking and therefore received nutrition and fluids via a percutaneous endoscopic gastrostomy (PEG). Their care plan gave staff unsafe guidance around foods to treat hypoglycaemia (low blood sugars) which meant they were at high risk of choking. Another person's care plan did not contain detailed guidance for staff on preventing choking or what action to take if they did choke, this put them at increased risk of harm.
- People at risk of pressure sores or who had developed pressure sores, had not had their risk assessments and care plans updated to reflect their current needs. We found one person's risk assessment had been miscalculated, this had identified them at a lower risk than they actually were. Another person's care plan had not been updated to reflect a deterioration in their pressure sore, information around supporting them was found to be generic and did not guide staff on how to mitigate their individual risk. This meant people were at increased risk of their wounds deteriorating further.
- One person required assistive technology to help keep them safe. Planned equipment checks were not taking place. This meant the person was at risk of not being able to summon urgent help should they need it.

Using medicines safely

- Medicines were not always managed safely. For one person who received their medication via a PEG, the medicine protocol for 'as needed' (PRN) medicines did not state that the medicine was to be given via the PEG. This put the person at risk of receiving their medicine via a route that did not meet their needs and put them at increased risk of choking.
- Another person who was receiving several PRN medicines did not have all their protocols in place to provide staff with guidance on when and how to administer the medicines. This meant the person was at

increased risk of not receiving their medicines as prescribed.
● Care plans contained generic information regarding skin creams. For example, "Apply creams if prescribed" and "Apply to affected area". Care notes evidenced that care staff were applying creams for people without guidance on where, how, or how often to apply as this information was not included in care plans or always on medicine charts. This put people at an increased risk of their skin care needs not being met or them not receiving their skin creams as prescribed.
● Some people's medicine charts had gaps in recording, therefore, we could not be assured that people had always been given their medicines as prescribed. One person was prescribed medicines to be taken at specific times during the day. A relative told us staff arrived late which meant they received their medicines later than they should. There was no evidence that people had been harmed however, was an increased risk of people not receiving their medicines as prescribed.

Learning lessons when things go wrong
● There was a system in place for staff to report accidents and incidents and the provider kept an oversight document to monitor for trends and patterns. However, this had not always been effective. We found 3 incident and accident report forms had been completed by staff following acts of aggression or physical violence. This had not prompted the provider or registered manager to update the risk assessments and care plans to assess the risks to people or staff and put measures in place to mitigate risk. This meant staff and people remained at risk of further incidents occurring.

Systems were not effective in assessing, monitoring and mitigating risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff told us there was enough of them to meet people's needs and we found no evidence of missed calls. However, improvements were required to staff time keeping and ensuring that people's needs and preferences were met. One person told us that staff were sometimes so late for their visit they had done their own care before staff arrived. One person told us, "They don't phone to say they are going to be late; the visits seem rushed; they fly in and out". Another person said, "They have never missed a visit but are sometimes a bit late. They don't let me know if they are going to be late."
● Staff were recruited safely. The provider had completed reference checks and Disclosure and Barring service (DBS) checks to ensure no previous concerns about employment or character had been raised and to check for criminal convictions. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Staff were trained and understood the principles of safeguarding. Staff knew the signs of abuse and how, where and when to report any concerns. The provider had a safeguarding and whistle blowing policy and procedure.

Preventing and controlling infection
● People were protected from the risk of infection. Staff were trained in infection prevention and control and protecting against and preventing the spread of COVID-19.
● Staff had access to enough supplies of appropriate PPE and understood the requirements around wearing it. Staff understood the importance of effective hand washing.

Requires Improvement

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 the rating for this key question has remained requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Ongoing assessments of people's needs were not in place. This meant staff lacked clear guidance on how to deliver safe care. We found a number of assessments to be outdated or with missing information that would affect the level of risk to people including medication and skin integrity.
- Initial assessments were completed prior to people starting to use the service in partnership with care commissioners to collate the information needed to meet people's needs.

Staff support: induction, training, skills and experience

- Staff did not have the skills needed to provide safe care.
- The provider had a programme in place to provide staff with an induction, ongoing training and support. This included competency checks and supervisions. One staff member said, "I had an induction before starting work and by the end of it I had most of the things I needed covered and felt confident to start work unsupervised." However, the training and competency checks were not of a standard to ensure staff had the knowledge and skills to carry out their roles effectively.
- We were not reassured that all staff were competent in administering medicines as we found several errors that meant people hadn't always received their medicines as prescribed, including missed antibiotics and a medication error. Some medication charts were found to contain conflicting or incorrect information which did not support staff with clear guidance on the task. There was an increased risk of staff making errors as they did not have the guidance needed to support them.
- Senior members of staff who were responsible for auditing and updating people's care records needed further support and training in this role. We found errors and outdated information in care records which was not being identified and actioned by staff. This meant there was an increased risk people's needs would not be met.

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

- There was evidence in care notes of the provider working with other professionals to support people's health care needs, including pharmacists, social workers and GP's. However, for one person there had been a lack of communication with the district nurse team to establish the grade of a pressure sore and there was evidence of staff not following district nurse advice. The person's risk assessments and care plans had not been updated to reflect their changing needs and district nurse guidance.

● People told us staff alerted them if they noticed changes that may need medical attention. One relative told us that staff had identified a new pressure sore and contacted the community nurse team to review for treatment. A person told us, "A carer noticed I had a rash that I hadn't seen", this meant the person sought early treatment and prevented further complications.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

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

At our last inspection the provider had failed to ensure they acted in accordance with the Mental Capacity Act 2005.This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● Staff received training in MCA and we're able to demonstrate a good understanding of the principles and people's right to refuse. One staff member said, "We mustn't just assume people's mental capacity."
● People's records evidenced that where people had refused support or an intervention, this had been respected by staff.
● Where people did not have capacity to make decisions for themselves, individualised mental capacity assessments were in place with evidence of family input.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they were well supported with food and fluids. Staff respected people's choices and ensured people were left with drink at the end of the visit. A relative told us, "[Person] has difficulty chewing, the carers do always take their time with them and don't rush them."
● Staff had received training in fluid and nutrition support.

Inadequate

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.

At our last inspection the provider had failed to ensure systems were either in place or robust enough to demonstrate the safety and quality of the service was effectively managed. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- We found systems and processes were either not in place or not effective in ensuring the safety and quality of the service. Auditing of people's care and medicine records was assigned to staff who did not demonstrate the skills and knowledge to identify the concerns we found during the inspection. The registered manager had not maintained oversight in this area and therefore had not taken action to improve the quality and safety of the service and rectify previous failings for which we had issued enforcement action.
- The provider did not have a system in place to maintain oversight of the quality and safety of the service. The provider had not implemented an action plan to address the shortfalls identified at the last inspection to ensure they would be compliant in meeting the regulatory requirements.
- There was evidence of concerns being raised with the provider about staff workload and time keeping impacting the quality and safety of the service and action had not been taken to address this. The provider had failed to implement a system to monitor and action staff time keeping and call duration since the last inspection, therefore, this issue had continued.

Systems were either not in place or robust enough to demonstrate the safety and quality of the service was effectively managed. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At our last inspection, a review of records indicated we had not received statutory notifications for notifiable incidents. We had met with the provider and registered manager to discuss this and help them understand the regulatory requirement and possible enforcement action should they not comply. At this

inspection, a review of records indicated we had not received statutory notifications for notifiable incidents. We have raised this with the provider and are currently looking into this matter.

Continuous learning and improving care; Working in partnership with others

● The provider has continued to be in breach for areas where we have previously issued enforcement and had failed to identify shortfalls and take action prior to inspection.

● The local authority have provided support to the provider to improve the safety and quality of the service. However, the provider has failed to take action and address a number of areas for improvement identified in the local authority action plan.

● Following the inspection there was a change in the management team and the provider told us they are seeking professional guidance to improve the quality and safety of the service; improvements will need to be embedded and continued in practice.

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

● Care records contained high levels of generic information or outdated guidance which in some cases posed a risk to people, including choking and pressure sore deterioration risks. We found some evidence of copy and paste in care notes and a person regularly referred to as "her" instead of him.

● Some people's preference around visit times and preferred staff was not always met. One person told us "I'm not really happy with the management as there is no continuity of carers." Another person told us that a male staff member was sent to their female relative to deliver personal care, however, this had since been rectified.

● People had a mixed experience of person-centred care and being included in planning. One person said, "There is a distinct lack of a care plan, I've not seen one [in the time] my [relative] has been with them." Another person said, "There was confusion over my care plan as I was given a copy and then emailed another with changes which I didn't see until carers came to visit." Another person told us, "They are coming from the office tomorrow to talk about my care plan."

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

● People were complimentary about the staff delivering their care, describing them as kind and caring but did not always feel listened to by the management team. One person said, "I wouldn't recommend the service, the office staff use the right words, but it doesn't change things. We don't get asked for our opinions at all." Another person said, "The care staff are fine, but the company needs more organisational skills. I have complained about timings [of visits]." Another person had a positive experience and told us when they had called the office to raise concerns they had been dealt with promptly.

● The provider had recognised the need to improve how they sought feedback prior to the inspection and were in the process of implementing a new system which would need to be continued and embedded in practice.

● Staff received regular supervision and told us they felt well supported by the management team, attended regular staff meetings and were able to raise concerns and were confident they were actioned.

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 were not effective in assessing, monitoring and mitigating risks to the health, safety and welfare of people using the service.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate the safety and quality of the service was effectively managed.

The enforcement action we took:

We imposed a condition on the providers registration.