Major Oak Homecare Ltd

Head Office

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Head Office aka Major Oak Homecare is a domiciliary care agency. It provides personal care to people living in their own homes in the community. The service operates in and around the city of Lincoln. At the time of our inspection, 43 people were using the service.

People's experience of using this service and what we found:
Since our last inspection, the provider had taken some steps to strengthen the monitoring of service quality and to mitigate risks to people's safety. As a result, there had been recent improvements in medicines management and the deployment of staffing resources to meet people's needs. However, significant inconsistencies remained and further action was required.

The provider had assessed risks to people's safety but, for some risks, staff required more detailed guidance to help manage them safely. The provider had strengthened infection control measures in response to the COVID-19 pandemic, although action was required to ensure used PPE was disposed of safely.

The provider had failed to submit an action plan requested after our last inspection of the service. The provider had also failed to display the inspection rating on their website.

Staff knew how to recognise and report any concerns to keep people safe from harm. Staff recruitment was safe. There was some evidence of organisational learning from incidents and events.

Most people provided positive feedback on the caring nature of staff. Despite concerns about call timings and staffing continuity, most people were also generally satisfied with the management of the service overall. Staff were happy in their work and spoke highly of the positive impact made by the new service manager.

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 6 May 2020) and there was a breach of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected:
We received concerns about the safety of care delivery and organisational governance. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No significant issues of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive

inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service remains Requires Improvement. This is based on the findings at this inspection. The service has been rated as Requires Improvement at the last two inspections.

Enforcement:
At this inspection we have identified a continued breach of regulations due to continued shortfalls in organisational governance and the monitoring of service quality.

Please see the action we have told the provider to take at the end of this report.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Head Office

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the registered 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak and to identify good practice we can share with other services.

Inspection team
Our inspection was conducted by two 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
Head Office aka Major Oak Homecare is a domiciliary care service, registered to provide personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. 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.

The provider had recently employed a new manager for the service ('the new service manager'). At the time of our inspection she had been in post for about a month and was in day-to-day charge of the service, with support from the registered manager. The new service manager had started the process of applying to become the registered manager, at which point the existing registered manager planned to deregister and take on a new role within the service, focusing on training delivery.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that senior staff would be in the office to support the inspection.

What we did before the inspection
In planning our inspection, we reviewed information we had received about the service. This included notifications submitted by the provider. Notifications are events which happened in the service which the provider is required to tell us about.

During the inspection
We conducted our inspection between 1 and 11 February 2021.

During the inspection we spoke with the new service manager; the registered manager; the deputy manager; the nominated individual; four members of the care staff team and 16 service users or relatives.

We reviewed a range of written records including four people's care plan, five staff recruitment files and information relating to the auditing and monitoring of service provision.

After the inspection
We reviewed further information we had requested from the provider, including data relating to call scheduling and medicines administration.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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 our last inspection, the provider had failed to ensure the timely delivery of care calls to meet people's needs, increasing risks to people's safety and welfare. Since then, the provider had taken some steps to address this issue. For example, by implementing a new electronic call monitoring system and appointing a new service manager with significant experience in the provision of domiciliary care.

• At this inspection, we found recent evidence of improvement. For example, in the four weeks preceding our inspection, the percentage of early and late care calls had reduced from 28% to 8%. Similarly, the percentage of short calls had reduced from 45% to 22%. One member of the care team told us, "Things have definitely [got better] since [the new service manager] came in. The rotas have calmed down a lot."

• However, feedback from people who used the service, indicated significant inconsistencies remained and further improvement was required. For example, one person said, "I never know what time they are coming." Another person commented, "I wish I [did] not have so many different carers. I have to go through what I want every time." Several people also told us they were not always informed when staff were running late.

• We discussed this feedback with the new service manager who confirmed further work was in hand to ensure the organisation of staffing resources was consistently safe and effective in the future.

• We reviewed recent recruitment decisions and saw the necessary checks had been carried out to ensure the staff employed were suitable to work with people who used the service.

Using medicines safely

• At our last inspection, we identified shortfalls in the provider's management of people's medicines. Since then, the provider had taken some action to address this issue. For example, by strengthening staff induction, refresher training and competency assessment arrangements and by introducing new medicines audit procedures.

• At this inspection, we found some evidence of improvement. For example, in the four months preceding our inspection, the number of medicine recording errors identified through the provider's monthly medicines audit had decreased from 867 in October 2020 to 324 in January 2021. Although we found no evidence that people had come to harm, this still equated to an average 18 recording errors for each person who received medicines support, creating potential risks to people's safety. Acknowledging these risks, the new service manager told us further work was in hand to ensure the management of people's medicines was consistently safe.

Assessing risk, safety monitoring and management

• The provider had systems in place to ensure potential risks to people's safety and welfare were assessed and managed. For example, one person had been assessed at being at risk of self-neglect and staff had been provided with guidance on how to mitigate this risk.
• However, for people who had been assessed at risk of skin damage, guidance for staff lacked important detail, increasing risks to people's health and welfare. We raised this issue with the registered manager who acknowledged our concern and told us she would take action to address it.

Preventing and controlling infection
• The provider had reviewed and strengthened existing infection prevention and control measures in response to the COVID-19 pandemic. For example, staff had been provided with additional personal protective equipment (PPE) and were tested weekly to reduce the risk of COVID-19 spreading within the service.
• However, two people we spoke with during our inspection told us of their concern that staff were disposing of used PPE in their kitchen bin, rather than taking it with them when they ended the call. We raised this issue with the new service manager who took immediate action to address it.

Learning lessons when things go wrong
• We found some evidence that the provider had taken action in response to incidents and events. For example, in response to a recent issue of concern relating to care practice, the provider had issued new guidance to all care staff. However, in response to our feedback, the new service manager told us she would take action to further strengthen the provider's approach to organisational learning.

Systems and processes to safeguard people from the risk of abuse
• Almost everyone we spoke with told us they felt safe using the service and trusted the staff who came into their home. For example, one relative told us, "[The staff] are very kind and caring when looking after [name]. [We] have never had a reason not to trust them."
• The provider had a range of measures in place to help safeguard people from the risk of abuse. For instance, staff had received training in safeguarding procedures and how to report any concerns relating to people's safety and welfare.

Requires Improvement

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection, we found the provider had failed to ensure there were effective systems to monitor the quality of the service and monitor and mitigate risks to people's safety. This was a breach of Regulation 17(Good governance) 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.

• Since our last inspection, the provider had invested in new online call scheduling and care planning platforms and used data and 'real-time' alerts from these systems, to improve the monitoring of the effectiveness and safety of service delivery. These measures had resulted in some recent improvements in the safety of medicines management and the deployment of staffing resources. However, almost a year since our last inspection, significant inconsistencies remained and additional action was required to fully embed the recent changes and deliver the further improvement required.
• The provider's quality assurance systems had failed to pick up the shortfalls in individual risk assessment and PPE disposal described in the Safe section of this report.
• Following our last inspection, we asked the provider to submit an action plan detailing how they would address the breach of regulations described above. The deadline for submission of this action plan was 3 June 2020. In preparation for this inspection, we identified the action plan had not been submitted, as required in law. The provider's nominated individual apologised for this error.
• In preparation for our inspection, we identified that the provider had also failed to display on their website, the rating from our last inspection of the service, as required in law. The nominated individual apologised for the error and took immediate steps to rectify it.

Taken together, these ongoing shortfalls in organisational governance were a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff

• Almost everyone we spoke with told us how highly they regarded the care staff who came to their home. For example, one person's relative said, "I am very pleased with the carers. They are very caring, and they go above and beyond what [name] requires. I give them 10/10."
• Despite their concerns about call timings and staffing continuity, most people we spoke with were generally positive about the management of the service overall. For example, one person said, "I haven't complained to social services which was quite common with [my last care company]. That's saying something!"
• People's general satisfaction with the service was also evidenced in the provider's recent customer survey. For example, one person had written, 'We are very happy with the service you provide. I know if I have any problems they will be dealt with.' The provider had reviewed the results of the survey and identified areas for improvement to address people's feedback.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 had a number of systems in place to support staff and promote effective communication. These included team meetings; one-to-one supervision and messaging through the online care planning system. Commenting on recent improvements in this area, one staff member told us, "I was very frustrated a few months ago but communication is getting better."
• Throughout our inspection, both the registered manager and new service manager demonstrated an open, responsive approach. One staff member told us, "The managers are very approachable [and the new service manager] has made a positive impact. They seem to be going in the right direction." Describing the morale in the team, another member of staff said, "For the most part [we] are very happy. Things have definitely improved since [the new service manager] came in."

Working in partnership with others
• Staff maintained contact with a range of other professionals including community nurses and a local palliative care service. Looking ahead, the new service manager said she planned to get involved in the local care providers' association as a potentially helpful source of advice and support for herself and her team.

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 17 HSCA RA Regulations 2014 Good governance There were continued shortfalls in organisational governance and the monitoring of service quality.