Manorcourt Care (Norfolk) Limited

Manorcourt Homecare

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Manorcourt Homecare is a domiciliary care service providing personal care to people in their own homes. 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. At the time of the inspection approximately 98 people were receiving personal care.

People's experience of using this service and what we found
People had not always received their medicines correctly and the provider had not ensured that people's consent had been obtained in line with the relevant legislation.

There were enough staff available to ensure people received their care visits and that they were safe. However, there were not enough to deliver care in line with people's preferred call times as much as was practicable. People said staff were often late or their calls were at inconsistent times, particularly at weekends. This they said, affected their day and wellbeing. The registered manager had recognised this and was trying to recruit more staff to the service to improve this area.

The provider's governance systems had not been robust at driving improvement within the service since our last inspection. Audits had not always been effective at identifying mistakes or concerns so they could be thoroughly investigated. The provider had recognised they did not have robust oversight and were introducing new systems to improve this in the new year.

Staff were kind and caring. However, the service had not been designed to ensure the care people received was fully person-centred or caring.

Staff had received training and supervision, but we found some issues with their competency in some areas. We have therefore made a recommendation the provider reviews how they assess staff practice.

People told us there was an open culture at the service where they could raise complaints without fear. Some people felt their complaints had not been listened to and the service did not always have records to show that people had complained.

Systems were in place to protect people from the risk of abuse. Most risks to people's safety had been assessed and managed well. Staff took precautions to protect people from the risk of the spread of infection.

People received support to eat and drink enough to meet their needs and received assistance with their healthcare needs when required. The service worked well with other professionals.

Staff treated people with respect. They upheld people's dignity and encouraged their independence. People's end of life wishes had been captured and were respected.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published December 2018). The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches at this inspection in relation to the management of people's medicines, consent, providing person-centred care and good governance.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will also 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. 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?

The service was not always safe.

Requires Improvement

Is the service effective?

The service was not always effective.

Requires Improvement

Is the service caring?

The service was not always caring.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Requires Improvement

Manorcourt Homecare

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 Care Act 2014.

Inspection team
The inspection team consisted of 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
This service is a domiciliary care agency. It provides 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.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 10 November 2019 and ended on 26 November 2019. We visited the office location on 26 November 2019.

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 this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
We obtained feedback from eight people and four relatives about the quality of care provided by Manorcourt Homecare. We gathered feedback from nine staff which included care and office-based staff. We also spoke with the registered manager, quality manager and director of quality who both represented the provider.

We looked at three people's medicine records, six people's care records and three staff recruitment, training and supervision files. We also reviewed records in relation to how the registered manager and provider monitored the quality of care provided to people.

After the inspection
We continued to seek clarification from the registered manager regarding the information we received during the inspection. This included data in relation to the reviewing of care documents, how the provider monitored the quality of care provided and staffing levels.

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.

Using medicines safely; Assessing risk, safety monitoring and management

- Medicine administration records (MAR) had not always been completed correctly to demonstrate people had received their medicines when they needed them. Some MAR contained gaps and staff had consistently used incorrect codes when people had not taken their medicines.
- One person had refused a medicine for four days in a row in September 2019 and continued to refuse some of their medicines in October 2019. The person's GP had not been alerted to ascertain if this would have a detrimental effect on the person's health. Staff told us they felt the person may not have capacity to understand the importance of their medicines, but they had not re-assessed this risk.
- Another person had not been given a medicine regularly to help them with constipation as required by the GP. The GP had not been alerted to this and staff told us the person lacked capacity to understand the importance of taking this medicine.
- Audits of people's medicine records had not been effective at establishing whether people had received their medicines correctly. Issues we found had either not been identified or where they had, not investigated robustly.
- Good practice had not always been followed when medicine records had been hand-written. The MAR had not been checked or signed by two staff to demonstrate the entries written on it were correct. It had been written on one MAR that a medicine was PRN (as and when required) when it had been prescribed for daily use.

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

- Other risks to people's safety had been assessed and managed well. For example, in relation to skin care, falls, choking and malnutrition. There was clear information available to staff on how to manage these risks. Staff demonstrated a good understanding of how to support people to be safe in these areas.

Staffing and recruitment

- People and relatives told us they always received their care visits. However, most of them said they felt the service required more staff as their calls were often either late or at inconsistent times. One person said, "About two weeks ago a carer didn't come. I called Manorcourt as they didn't send the timetable, so I didn't know what time they were supposed to come. They were very late, so my husband had to come home from work to cover it."
- Staff confirmed they were able to complete people's care visits, but some told us they felt rushed. Some staff also told us they were often asked to cover extra care visits that were not on their schedule.

●The registered manager said there were enough staff to complete people's care visits but not to always meet people's call time preferences. They were aware of this issue and were in the process of recruiting more staff to the service. They also said they had stopped taking on new packages of care to improve the situation.
●Required checks to ensure staff were of good character before they started working for the service had been conducted.

Systems and processes to safeguard people from the risk of abuse
●People told us they felt safe when staff provided them with support. One person said, "Yes very safe indeed. They are all pleasant girls and they always ring the bell before coming in." A relative told us, "Yes from the way they work. They tell [family member] what they are going to do. They introduce themselves."
●Staff had a good understanding of safeguarding and had received training in this area. The registered manager had investigated and reported any concerns appropriately.

Preventing and controlling infection
●People and relatives told us staff took precautions to reduce the risk of the spread of infection. One person said, "They wear gloves and aprons and shoe covers too."
●Staff understood how to protect people from infection and had received training in this subject.

Learning lessons when things go wrong
●Staff told us they understood the importance of reporting incidents to the office for investigation. However, we found opportunities had sometimes been missed to learn lessons. For example, staff had not reported that people were not always receiving their medicines correctly at the time this occurred. Therefore prompt action had not been taken to correct this. If people's calls were late, this had not been recorded as an incident for investigation.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- Records did not support that assessments of people's capacity had taken place when it had been appropriate to do so.
- Staff told us and records showed, that one person often declined support with personal care and medicines. Staff said they felt the person may lack capacity to understand any risks associated with taking this action. However, the service had not assessed the person's capacity in line with the MCA to determine whether this was the case. No consideration had been given that staff may have to act in the person's best interests, such as giving them their medicines covertly (hidden in food and/or drink).
- Another person had been deemed as lacking capacity to consent to their care, but there was no capacity assessment or best interest decision to support this conclusion.
- Where people did lack capacity to consent to their care, relatives had been asked to sign consent on their behalf when they did not hold the appropriate authority to do so.
- It was noted in one person's care record that an individual held Power of Attorney to consent on their behalf. However, the record did not determine who the person was or what type of PoA they held. This could be confusing for staff.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
- People and relatives told us they felt staff were well trained.
- Staff said they received a good level of training to enable them to provide people with the care they

required. However, we found concerns in some areas to suggest that staff training, and supervision had not been fully effective. For example, some people had not received their medicines correctly and the principles of the MCA had not been applied when appropriate.

We recommend the provider reviews guidance in how to assess staff competency to ensure they have the necessary knowledge and skills to provide people with effective care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Care was not always delivered in line with standards and regulatory requirements including the Mental Capacity Act 2005 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
●A holistic assessment of people's needs, and preferences had taken place. This included people's physical, mental and social needs. People's life history had been captured to enable staff to learn about them as a person.

Supporting people to eat and drink enough to maintain a balanced diet
●People told us they received support to eat and drink enough to meet their needs. They said they were offered choice and that staff knew what they liked and disliked.
●Some people commented the timings of their care visits meant they sometimes had to wait for their meals or that the gaps between the visits were not enough which meant they had meals close together.
●Staff understood the importance of ensuring people had good nutrition and hydration. Where there were concerns, they monitored people and involved the relevant professionals if required.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●In most cases, people had been supported with their healthcare needs appropriately. People and relatives confirmed this.
●Conversations with staff demonstrated they were vigilant to people's health needs.
●Records showed, and staff told us they involved other professionals when needed such as district nurses and social workers.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives told us staff were kind, caring and compassionate. One person said, "They are excellent, all of them, they do everything for me, wash me, dress me, get my breakfast, everything I need." A relative said, "They are very caring and thoughtful."
- Although people and relatives felt the staff were kind and caring, the provider had not ensured that a wholly caring approach had been embedded within the service as detailed within other areas of this report. For example, some people had not received their medicines correctly to aide their health and welfare. Other people and relatives reported their/their family members wellbeing was often impacted when carers were late or visited them at inconsistent times.
- People and relatives said staff knew them/their family member well. The feedback we received from staff confirmed this.
- People said they were treated with respect. Some told us how staff always ensured they wore shoe covers to respect their home which was important to them.

Supporting people to express their views and be involved in making decisions about their care

- People and relatives told us they felt able to make decisions about their care. One person said, "I make all the decisions to when I have the care and how long they are here for." A relative told us, "We have both been involved. We have talked it through with social services and Manorcourt."
- People's care needs had been regularly reviewed. Everyone we spoke with said they had been involved in this process.
- People had been sign posted to other services where appropriate for advice and guidance. For example, staff assisted one person to arrange a visit from the fire service to make improvements to their home in relation to fire safety.

Respecting and promoting people's privacy, dignity and independence

- People and relatives, we spoke with said staff promoted their privacy and dignity. One person told us, "Certainly. When I am washing in the morning I am covered with a towel, everything is discrete."
- Staff demonstrated a good understanding of how to protect people's privacy and dignity and to enhance their independence whilst providing them with care.
- People said staff helped them remain at home and promoted their independence. One person told us, "They help me to walk if I can walk and transfer from one place to another, they help me quite a lot." A relative told us how the staff encouraged their family member to continue with hobbies that were important to them and aided their independence.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs or preferences were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

●People and relatives were happy the support they received met their/their family member's care needs when staff arrived at their home. However, they said their preference in relation to the time of their visits was often not met. One person told us, "I like to eat at 12.30pm to 1pm and 5.30pm to 6pm but they come too early. They come between 3.30pm and 4.30pm. I am not happy with the dinner call as I must have sandwiches as they come too early." Another said, "They come too early in the evening. Last night they came at 7.30pm and they were due at 8.45pm. We had hardly finished eating." A relative told us, "[Family member] can be sitting for an hour waiting. Two or three weeks ago [Family member] was freezing cold and fed up. They turn up at a different time to the timetable. I tell her to get back into bed to keep warm."

●Some care staff told us that travel time was not always considered when planning people's calls. Office based staff confirmed this saying they could not always plan in travel time, particularly at weekends, when the number of staff available to do care visits decreased. This would impact on the time staff arrived to provide people with their care.

●People and relatives said they were not always told if staff were running late or if any changes had been made to the times. Some said they received a rota in advance telling them the call visit times, but others said they didn't. A person said, "About two and a half months ago they were over an hour late, I was sitting and waiting, they didn't let me know, everything I wanted to do had to be put back." The registered manager said people should be told about any changes made to their call times or if staff were running late. However, office staff said they did not always have time to inform people of these changes.

●Records we viewed in relation to people's call visits confirmed people did not always receive their care visits in line with their preferred times. For example, all six morning calls we checked for two people, had been made outside of their preferred time.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People and relatives had been involved in the initial assessment of their needs and preferences. People told us their preferences regarding gender of carer who provided their care had been met.

●Care records had been developed that in the main, contained clear information for staff on how to provide them with care in line with their needs and wishes.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●People's communication needs had been fully assessed. There was clear information available to staff on how they could support people with their communication when required. Staff we spoke with demonstrated they understood people's individual communication needs.

Improving care quality in response to complaints or concerns

●People and relatives told us they knew how to make a complaint and felt confident to do so.

●People gave us mixed views as to whether any complaints they raised were listened to and acted upon. One relative said, "Yes I know who to go to. I complained recently when they wanted to give [family member] another carer, that has been resolved." However, two people told us they had complained to the service about their call times but said that nothing had changed. One said they had done this on four occasions. Staff told us there was no record of these complaints on their system and they had not been brought to the registered manager's attention.

●Where the registered manager had been made aware of complaints, these had been thoroughly investigated and dealt with appropriately.

End of life care and support

●Where people had wished to give this information, details regarding their wishes at the end of their life had been captured. This included any spiritual preferences people had.

●Staff worked with other professionals at this time to ensure people had a comfortable death.

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.

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

- Existing governance processes had failed to be effective at monitoring the quality of care people received. Audits of people's medicine and daily care records had not always identified shortfalls. Where these had been found, a thorough investigation had not taken place to give the provider assurance that people had received safe and appropriate care.
- People's daily care records had not always been audited in a timely manner to aid the prompt identification of any potential concerns. This was not in line with the provider's requirements. For example, one person's records from February 2019 had only been audited in August 2019 and another's had not been audited since at least March 2019.
- There was no system in place to monitor for late calls. Therefore, the provider and registered manager did not have an overview of how many calls were late, so they could not investigate them and make any necessary improvements.
- Records had not always been completed correctly. Gaps were found in medicine records and assessments of capacity had not been made where appropriate.
- The system in place to ensure people or relatives were made aware of changes to their call visits were not effective. Staff were not always following the provider's process which left people and relatives uninformed.
- The provider had failed to ensure the governance systems in place had driven enough improvement to move their overall rating to Good.

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

- The provider had identified that audits needed to be more effective at identifying and driving improvement within the service. Therefore, a new system was being implemented from January 2020. Plans were also in place to implement an electronic system in early 2020 to monitor the completion of people's care visits. This would help the provider identify and deal with any concerns in this area in a timely manner.

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

- Most people we spoke with were happy with the service they received. However, eight of the twelve

people/relatives we spoke with told us they felt there was a need for more staff to ensure care was provided in line with their individual preferences.

●People and relatives gave us mixed views regarding the management of the service. One person told us, "It isn't too bad. There can be issues at times, but we usually sort them out." However, another person said, "I feel the carers do a very good job, but I feel the organisation is not top of the pops."

●People and relatives told us there was an open culture at the service. They felt comfortable speaking to staff and the registered manager. They said staff were available to speak to when needed, including out of hours.

●The staff we spoke with reflected this feedback telling us they could approach senior staff at any time. The registered manager had recently introduced an 'employee of the month' scheme to enhance staff morale.

●The registered manager and provider understood the duty of candour and had followed the required procedures when needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

●People were asked for their opinion regarding the quality of care on a regular basis. This was conducted by telephone surveys, face to face meetings and an annual survey.

●Most staff told us they were regularly asked for their views about the service through the completion of an annual survey or during supervision meetings. Records showed for example, staff had requested extra training in various subjects to improve their knowledge. This had been provided to them.

●The registered manager and staff told us they had developed good relationships with various professionals including GPs, district nurses and occupational therapists.

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 9 HSCA RA Regulations 2014 Person-centred care Care had not been designed with a view to achieving service users' preferences. Where these could not be met, the provider had not explained the impact of this to them. Regulation 9 (1), (3) (b).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always acted in line with the MCA or associated code of practice. Regulation 11 (1).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines had not been managed safely. Regulation 12 (1) and (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been effective at assessing, monitoring and improving the quality and safety of the service provided or in mitigating risks relating to the health, welfare and safety of service users. Furthermore, a complete and contemporaneous record in respect of each service user had not been kept.

Regulation 17 (1) and (2) (a), (b), (c) and (f).