Care Quality Commission

Mariama Care Ltd

Mariama Care Ltd

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Mariama Care Ltd trading as Kangaroo Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and people with a range of physical and sensory disabilities as well as people living with dementia. At the time of this inspection, there were 68 people using the service.

People's experience of using this service: People and their relatives generally told us that they were satisfied with the care and support that they received from allocated care staff from Mariama Care Ltd. They told us that they felt safe with the care staff supporting them and that care staff were kind and caring. Negative comments made were around the lack of regular staff and not knowing who was going to attend the care call and at what time.

Medicines management and administration processes were not always safe. Records seen did not give assurance that people received their medicines safely and as prescribed.

Individualised risks associated with people's health and medical care needs were not always identified and assessed to give guidance to care staff on how to minimise those risks to keep people safe.

Care plans did not detail or reflect the care that people were actually receiving when compared with daily records completed by care staff. This was especially significant where people had known risks associated with their care needs.

Management oversight process in place to monitor the quality of care people received were ineffective and did not identify any of the concerns we found as part of this inspection.

Although people's lack of capacity had been recorded within their care plan, no further information was available about any specific decisions that had been made in their best interest.

Care staff were aware of the different types of abuse that people could be subjected to and knew the steps they would take to report their concerns.

People and their relatives knew who to speak with about any concerns or issues they had to raise. Most people and their relatives were confident that their concerns would be addressed satisfactorily.

Care staff were appropriately supported through regular training, supervisions and annual appraisals.

Staff recruitment processes followed ensured that only those staff assessed as safe to work with vulnerable people were recruited.

More information is in the detailed findings below.

We identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care and treatment and the governance of the service. We have also made a recommendation around the MCA 2005 and its implementation. Details of action we have asked the provider to take can be found at the end of this report.

Rating at last inspection: At the last inspection the service was rated Requires Improvement (report published March 2018). This service has been rated as Requires Improvement for the second time.

Why we inspected: This was a planned inspection based on the rating at the last inspection. At the last inspection we found areas of concern around staff recruitment, poor timekeeping of care calls, care plans were not always responsive to people's needs, information contained within care plans was sometimes inconsistent and ineffective management oversight processes. At this inspection we found that improvements had not been made to these areas and we continued to find further areas of concern that required improvement.

Follow up: We will ask the provider to submit an action plan detailing the steps they intend to take to ensure the required improvements are implemented. We will also continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received 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. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-led findings below.	**Requires Improvement**

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Detailed findings

Background to this inspection

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

Inspection team: This inspection team consisted of one inspector, a specialist advisor pharmacist and two experts-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: Mariama Care Ltd trading as Kangaroo Care is a domiciliary care agency. It provides the regulated activity of 'personal care' to people living in their own homes and flats. It provides a service to older adults and people with a range of physical and sensory disabilities as well as people living with dementia.

A registered manager was in post at the time of this inspection. 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: This inspection was announced. We gave the provider 48 hours' notice to ensure that the registered manager was available to support us with the inspection process.

What we did: Prior to the inspection, we reviewed the information that we held about the service and the provider including notifications affecting the safety and well-being of people who used the service. We had also received monitoring information from one local authority. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

During the inspection we spoke with six people using the service and ten relatives to obtain their feedback about their experience of the care and support that they and their relative received.

We spoke with the registered manager, deputy manager, a consultant commissioned by the provider and

seven care staff.

We looked at the care records and medicines supplies for six people who used the service and medicines administration records (MARs). We also looked at the personnel and training files of six staff. Other documents that we looked at included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Requires Improvement: 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.

Assessing risk, safety monitoring and management
• The service carried out a range of risk assessments as part of the care planning process. Risks that were assessed included moving and handling, personal care, pressure sores, falls and the environment. However, the information contained within these was generic. Assessments had not been personalised and did not give further detail on how people's identified risks impacted on their health and care needs and how care staff were to support them to keep them safe.
• We also found that risks were not assessed for some people who had significant risks associated with eating and swallowing, behaviours that challenged, health conditions such as diabetes and disinhibited behaviours. Care staff had not been given any direction and guidance on how to keep the person safe.
• Where people used bed rails to keep them safe when in bed, this had not been risk assessed so that care staff were aware of risks associated with the person becoming trapped in the bed rails and the steps to take to prevent this from happening.
• This meant that people could be placed at risk of harm as care staff had not been given clear information or guidance on what people's individual risks were and how to support them to remain safe.

Using medicines safely
• Processes in place did not give assurance that people were receiving their medicines safely and as prescribed. The service did not always follow the direction of how to administer medicines as defined by the provider's own medicines policy.
• Medicine recording books used to record medicine administration did not record the persons current list of medicines that needed to be administered, directions for administration, where the medicines were kept or any information about any discrepancies in administration.
• For one person who was administered their medicines by care staff through a tube inserted directly into their stomach, there was no detailed information recorded about the current medicines that had been prescribed and that the medicines needed to be administered in this way. Medicine Administration Records (MARs) only recorded that medicines had been administered from a dossette box. A dossette box is a pre-packed box, normally prepared by a pharmacy, for each time the medicine is required.
• We looked at MARs for one person from November 2018 to January 2019. Records confirmed that medicines from a dossette box were administered to the person on a daily basis. However, daily records documented, on multiple occasions, that medicines had not been given as the person had refused and that medicines were left with the person to take later. This was contradictory to what had been recorded on the MAR. This was brought to the attention of the registered manager who explained that as the person had capacity, they would take their medicines when they wanted to. However, this had not been clearly documented or risk assessed to ensure that person was receiving their medicines safely and as prescribed.
• Where people had been prescribed medicines that were not contained in a dossette box such as eye drops,

inhalers or medicines kept in their original packaging, there was no record made of these on the MAR on how and when to administer these medicines. However, daily records completed by care staff documented that people were supported by care staff with these medicines.
• MARs did not give sufficient assurance that people overall were receiving their medicines safely and as prescribed.

The lack of clear guidance and poor practice around medicines management, administration and managing risk meant people were placed at risk of possible harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us that they felt safe with the care and support that they received from the service. One person told us, "The carers who come are usually very nice." A relative said, "I feel confident about her [person's] safety."
• The registered manager was aware of their responsibilities around reporting any safeguarding concerns that had been bought to their attention as well as investigating concerns raised by other agencies such as the local authority or the hospital. Records seen included detailed information about the concern, findings from their investigations and any improvements or learning that had been identified.
• Care staff knew to report any concerns that they had about people and possible signs of abuse, to their managers. Care staff also knew how to 'whistle-blow' and the agencies they could contact including the local authority or the CQC to report their concerns.

Staffing and recruitment
• At the last inspection we found minor issues around the service's recruitment processes. During this inspection we found that the service had made the required improvements which gave assurance that only those staff assessed as safe to work with vulnerable people were recruited.
• The service carried out a number of checks on potential staff which included criminal record checks, obtaining proof of identity and references confirming conduct in previous employment.
• The service told us that they had sufficient numbers of staff to meet the needs of the people they currently supported. However, not all people and relatives believed this. We were told that there seemed to be a shortage of staff as some people did not always receive care from a regular care staff member. One person stated, "I would like to have a regular person, but I get a lot of different ones. I think they might be a bit short of staff."
• Some people and their relatives also commented that they were never sure of when care staff would arrive for their care call and were never given a specific timeframe within which care would be provided. One person told us, "They never come at the same time every day. It's not their fault. It's when they've got too many people to see to. They have problems finding somewhere to park so I just expect them when I see them." A relative said, "They should come between certain times, they try their best."

Preventing and controlling infection
• Care staff received infection control training.
• The service provided a variety of personal protective equipment which included gloves and aprons to prevent and control the spread of infection.

Learning lessons when things go wrong
• The service had processes in place to record all accidents and incidents that were reported by care staff whilst carrying out their role. Information recorded included the nature of the incident/accident, immediate actions taken and any follow up where required.
• However, records seen that had been defined as an accident/incident was not always the case. We saw

information exchange between the service and other health care professionals where care staff had reported concerns such as incontinence supplies running out, medicine queries and referrals for specific services. These had been recorded as an accident/incident. Therefore, it was difficult to analyse the information so that trends and patterns could be identified and improvements and further learning could be implemented. This was highlighted to the registered manager who told us that they would review their records.

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

Requires Improvement: 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
• The service aimed to assess people's needs and requirements prior to accepting a package of care so that the service could confirm that they were able to appropriately meet the needs of the person. Where the service was required to begin a package of care before they could complete an assessment of the person's needs, they used the information received on referral to begin providing care and then completed an assessment of their needs as soon as possible..
• A care plan was then written based on the information gathered at the assessment which listed the person care and support needs.

Staff support: induction, training, skills and experience
• People and their relatives told us that they believed care staff were appropriately skilled and trained to carry out their roles. One person said, "They are really good when they come." A relative told us, "When they come, they know how to handle him from the bed, to the chair and to the shower."
• Care staff received a range of training to enable them to provide care having the appropriate skills and knowledge. Topics included safeguarding, medicines management and administration, infection control, first aid and the Mental Capacity Act 2005 (MCA). Specialist training was also provided where care staff required a specific skill to support people safely and effectively. Records confirmed that training was refreshed on a regular basis.
• Care staff confirmed that they had received an induction which included a period of shadowing where they worked alongside a more experienced member of staff before they were assessed as competent to work on their own. Care staff felt able to ask for further or enhanced training where required.
• Care staff also told us that they were supported well through regular supervisions and annual appraisals which further enabled them to carry out their role effectively.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink where this was an identified and assessed need. For a lot of people, family members took responsibility for preparing food or making arrangements for their relative's meals. In this situation care staff were only required to heat up the meal and give to the person.
• People and their relatives told us that care staff supported them appropriately with their meals and made sure that they ate and drank. One person told us, "They wait to make sure I've had my breakfast. One relative said, "When getting [relative] to eat, they are better than good on that. They are persistent and patient with her."
• Care plans listed people's likes, dislikes, preferences and any cultural or religious requirements. However, care plans did not always give any detail around specialist dietary requirements such as where people required a thickening agent to be used in their drinks to prevent the risk of choking or aspiration.

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

• Care staff recorded all the care tasks they had undertaken in the person's daily care monitoring records. This supported effective information exchange so that care staff were aware and could read of any significant events that may affect the person's care needs especially where any follow up actions were noted. Where concerns were noted these were reported to the office.
• However, daily records made by care staff of the care provided did not match the package of care as defined in the care plan. We have reported on this further under 'Is the service responsive?' section of the report.
• Most people had family or close friends who supported them with their health and medical needs. However, where required, we saw records confirming that the service did support people in accessing specialist services such as occupational therapists, social workers and district nurses.
• People and their relatives commented that care staff were observant and always reported any concerns to them. They were also confident that care staff would know what to do in an emergency and would access the appropriate health care service where required.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS. We checked whether the service was working within the principles of the MCA.

• The service did not support anyone where a judicial DoLS had been applied for.
• We found that care plans did not always document consent to care. Where people had the capacity to consent to their care, they had not been asked to sign their care plan and instead a relative had signed on their behalf. There was no clear explanation as to why someone else had signed on the person's behalf, their relationship to the person and their legal authority to sign documents on the person's behalf.
• Where people lacked capacity to make specific decisions about their care and support decisions, the service had not documented any information relating to this and where appropriate, decisions that had been made in the persons best interests had not been recorded. This meant that people may not have been receiving effective care and support that followed the key principles of the MCA.
• We highlighted this to the registered manager who although demonstrated a good understanding of the MCA, had not applied its principles in practice. Care staff understood the basic principles of the MCA and gave examples of how they supported people in line with those principles. One member of care staff explained, "You look at the situation, what support people need. We use sign language, explain things and talk them through what you want to do."

We recommend that the service follows current best practice, in line with the MCA, especially when assessing and recording people's mental capacity and where decisions have to be made in the person's best

interests.

Good

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.

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People and their relatives told us care staff were kind and caring. We were told that regular care staff that supported them had become like their family with whom they had established positive relationships with. One care staff told us, "I have established relationships with people. As a daughter; that's how I am for them."
• Comments from people included, "I can't fault the carers in terms of kindness" and "The carers will go the extra mile if they can. I have my meals delivered but sometimes I might run out of something and they will pop out to the shops to get it for me. It might be just milk or bread or something, but they are very obliging like that." Relatives told us, "They are kind, I'm happy with them. If they're not kind he will tell them" and "[Person] likes most of them. They are kind, considerate people."
• Care staff understood each person's needs were different in relation to equality and diversity and told us that they would support them according to their choices and wishes. Care staff explained that they support different people from varying cultures, religions and backgrounds. One care staff told us, "It makes no difference to me. I am there to support people."

Supporting people to express their views and be involved in making decisions about their care
• People and their relatives confirmed that care staff always asked them how they wanted to be supported, talked to them and listened to what they had to say. One person said, "They will always listen to me." A relative said, "When they come, they are talking to him. Today he told them about his eyelid being swollen, they told me."
• People and relatives felt involved in making decisions about their care and formulating the initial care plan. One person told us, "Somebody came and talked to me about what I needed and checked if the house was safe and all that." A relative stated, "At the beginning they asked me, what do you want Mrs X?"

Respecting and promoting people's privacy, dignity and independence
• People and their relatives told us that care staff were very respectful of their privacy and dignity and ensured that it was maintained at all times. Feedback from one person was, "They make sure the curtains are shut if they're dressing or undressing me and they wrap a big towel round me as soon as I'm washed. They are very careful about respecting my privacy." One relative explained, "In the early days when [care staff] was ready to start, he asked me to leave the room to respect [person's] dignity so people weren't watching her. I thought this was really good."
• Care staff demonstrated a good awareness of respecting people's privacy and dignity and gave examples on how they did this. They also explained different ways in which the encouraged people to maintain their independence where possible.

Requires Improvement

Is the service responsive?

Our findings

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

Requires Improvement: People's needs were not always met. People may not have always been receiving care and support that was responsive to their needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• At the last inspection in January 2018, we found that people did not always get a choice with the care staff that were allocated to support them. We also found that care plans were very lengthy which meant that care staff may not have had access to the appropriate information in response to people's needs. At this inspection, we found that the service had addressed these concerns.
• Care plans were person centred and gave information about people's likes, dislikes and how they wished to be cared for. However, care plans were not always current and reflective of the actual care people received.
• Care monitoring sheets, on which care staff recorded their daily interactions with people and the tasks they had undertaken did not match the care plan in terms of people's assessed needs. Records evidenced that care staff were undertaking care tasks that had not been included in the care plan such as administering medicines.
• For one person, care staff had recorded that they were supporting them with fluids which had been thickened as the person had identified difficulties with swallowing. The registered manager had no knowledge of this and had to call the allocated care staff to check with them. The care staff confirmed that thickener was being added to the person's fluids. This information had not been communicated to the office and the person's care plan had not been updated to reflect this change.
• All care plans included evidence of an annual review or sooner where people's needs had changed. However, we found that where change had been noted in a person's care or medical needs, the care plan had not been updated to reflect this.
• All of the above meant that people were at risk of not always receiving care and support that was responsive to their needs. We showed the registered manager the issues we had identified, who told us that they would immediately review all care plans to ensure that these were current and reflective of people's needs.

Improving care quality in response to complaints or concerns
• People and their relatives knew who to speak with if they had any complaints to raise and were confident their concerns would be appropriately addressed. One person told us, "I have no real complaints except the times. This could be a good service and I'm very happy with the carers who come." Relatives told us, "No complaints, If I did have, I would call them" and "When I phone them, if it's not right they do it. Once they were changing carers, I told them I don't want different faces, they listened."
• The service recorded each complaint that was raised. We saw records detailing the nature of the complaint, the actions taken to investigate and resolve the issues raised and a response to the complainant with an apology for the poor level of care they may have received.

End of life care and support

• The registered manager told us that they did provide end of life care on request. Referrals received were normally from the local clinical commissioning group. At the time of inspection, we were informed that the service was not providing any end of life care.

• Processes in place included the completion of the care plan with the relevant information provided through the referral received. The registered manager told us that they worked very closely with the clinical commission group who provided a very detailed care plan for them to follow.

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.

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Regulations had not been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Management oversight processes in place only included audits of medicine administration records, daily monitoring records and unannounced spot checks of care staff whilst providing care.
• The registered manager told us that they did audit care plans to check if they were current and if they had been completed fully and appropriately, however these audits were not recorded.
• The service did not have the appropriate systems in place to monitor and oversee the quality of care and support that people received. The service had not identified any of the issues we found as part of this inspection. This included the lack of individualised risk assessments, issues with the management and administration of medicines, lack of documented evidence that people had consented to their care and support package and care plans that were not always current and responsive to people's needs.
• This meant that the registered manager and the service did not have sufficient oversight about whether people were receiving safe, effective and responsive care and support. Therefore, the service was unable to implement any learning or developments to improve the quality of care people received.

The range of concerns and the failure of the provider to systematically address them is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Working in partnership with others
• People and their relatives told us that the service was generally well-managed and there was always someone available at the office to deal with their queries. Office phones were always answered and issues and concerns were dealt with. One relative told us, "I think it is pretty good, there is always someone at the end of the phone. [Person] been phoning up, [Person] had a habit of calling them twenty-four seven, they dealt with it well and didn't complain."
• Care staff also confirmed that the registered manager and other office staff were always available and approachable and addressed any concerns they had. We were informed that the on-call (out of hours) telephone was always answered and queries dealt with.
• Regular care staff meetings enabled care staff to share experiences, learn from each other and make suggestions. Care staff told us that they were always listened to and that they felt well supported by the management team.
• The service told us that they worked in partnership with the local authority by attending provider meetings and training sessions where providers from the locality were invited to engage with the local authority and

each other to learn and share experiences and practises. In addition to this the service also worked with social workers, district nurses, occupational therapists, GP's, pharmacies and continence service to ensure people received the care and support that they required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

• The registered manager told us that they asked people and their relatives to answer questions about the quality of care and support that they received on an annual basis. However, people and their relatives did not recall completing a questionnaire. Comments from relatives included, "We've never had it" and "I'm not aware, I don't get questionnaires."
• We saw some completed questionnaires which were overall positive, however, the service did not analyse these to identify issues and trends which would enable improvements and further learning. The registered manager told us that where any issues had been identified these were addressed immediately directly with the person or their relative.
• However, people and their relatives did tell us that the service did call them to check up on things and visited them to monitor the care staff delivering care. One relative told us, "Yes about a week ago. One lady came here and checked. She said she was doing an assessment on how they do their job. I said what I like and don't like. So far they are doing what I ask for."

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 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always assess people's risks associated with their health and care needs. Sufficient guidance and instruction was not always provided to care staff to minimise or mitigate any such risks. Medicines management and administration was not safe. People may not have been receiving their medicines safely and as prescribed.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not adequately assess, monitor and improve the quality and safety of the service that they provided.