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Maxnom Care Agency

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on the 15 May 2015 and was announced. We told the provider two days before our visit that we would be coming to make sure that the provider would be available.

Maxnom Care Agency is a domiciliary care service registered to provide personal care to people living in their own homes. There were six people receiving care at the time of our visit.

The location the service was operating from had moved from the address on the provider's registration with the Care Quality Commission (CQC). However, the provider did not inform CQC about the changes, which meant that they were in breach of the conditions of their registration. They provider has since submitted an application to amend their registration.

We found that many of the records we requested at this inspection were not available. The provider told us that this was because the records had been removed from the office by an ex-employee.

The provider when recruiting new staff did not use safe systems.

People did not always receive their calls on time

Summary of findings

Staff were aware of their responsibility to protect people from harm or abuse.

Staff received training but this did not cover all areas to meet people's individual needs.

Medicines were not safely managed.

Staff were knowledgeable about the Mental Capacity Act (MCA) 2005). Staff gained consent from people whenever they could and where people lacked capacity, we saw that arrangements were in place for staff to act in their best interests.

People were not always provided with appropriate care.

People were not always treated with dignity and respect.

There were no risk assessments in people's care plans and one person did not have a care plan.

The provider had a complaints policy and people we spoke with knew how to complain. However not all complaints had been investigated or documented.

The provider did not have effective quality assurance monitoring in place to monitor the service for safety and quality and to recognise areas that required improvement.

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Summary of findings

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 safe.

Safe recruitment practices were not followed.

There were no risk assessments for people who used the service.

People did not always receive their calls on time.

Medicines were not managed safely.

Requires improvement

Is the service effective?
The service was not effective.

People may not have had appropriate training and the provider could not produce the certificates requested.

Staff we spoke with understood the importance of choice and told us they always seek peoples consent.

There was not adequate guidance for staff in peoples care plans.

Requires improvement

Is the service caring?
The service was not always caring

People did not always receive good care.

Staff understood the importance of protecting people's dignity privacy.

People we spoke with had mixed reviews about the care received.

Requires improvement

Is the service responsive?
The service was not responsive.

Peoples care had not been regularly reviewed.

People knew how to complain but not all complaints had been documented.

The care was not person centred

Requires improvement

Is the service well-led?
The service was not well led.

The provider did not have systems in place to monitor the quality and safety of the service.

The provider had no evidence of audits that had been done, there were no action plans or service improvement plans available.

The provider did not promote an open culture, not all people felt listened to.

Inadequate

Maxnom Care Agency

Detailed findings

Background to this inspection

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

This inspection was announced and took place on 15 May 2015. We gave 48 hours' notice of the inspection because we needed to make sure that the manager available. The inspection team consisted of one inspector who visited the service to carry out the inspection and then on the 18 May 2015 we telephoned people who used the service and staff.

Before we visited, we reviewed information we held about the service including statutory notifications that had been submitted. We spoke with the monitoring officer for the local authority and reviewed their report. Statutory notifications include information about important events, which the provider is required to send us.

During our inspection we spoke with two people who used the service and three relatives, we also talked to three staff members and the provider. We looked at two care records and two staff files. We were not able to review many documents such as audits and service plans as these were not available to us during and after our inspection.

Requires improvement

Is the service safe?

Our findings

People we spoke with gave us mixed feedback about whether they felt safe. Two people told us that they felt safe. One relative told us, "I do not feel safe because we do not know who is coming." Another relative told us, "We are constantly having changes to staff and they don't know what they are doing." We found that the care plans did not contain risk assessments for people in areas such as specialist feeding and pressure care. There was no guidance for staff about how to assist and care for people safely.

We were told by the provider that they had enough staff to meet the hours of care that were needed. We saw from the times on the staff signing on sheets that calls did not always match the times allocated for people who used the service. We found that calls were regularly attended late. We saw calls were at times more than an hour late and other calls were attended more than an hour earlier than required. This meant that people did not always receive their care at the times they had been assessed as needing it. One person who required assistance with moving told us that when staff were late, "I can be in a lot of discomfort".

Staff we spoke with confirmed that if they were running late that they would contact the office. However, people told us that the office did not always let them know when people were running late.

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

We were told that staff had received training in medicines. However, we were only able to confirm that two staff had completed the training, one of these was the provider. There were no medicine administration records (MAR) available at Maxom Care Agency office, no competency assessments for staff and no systems in place to monitor how staff support people with their medicines. Before our visit to the service, we received concerns about staff not being trained to give medicines and that medicine records were not completed. The provider was not able to show us evidence that all staff had received training to enable them to administer medication safely. We spoke to one relative who confirmed that their [Relative] required medicine to be given by staff. The person requires staff to administer the medicine every four hours. The relative told us that staff recorded the medicines they had given on records kept at the person's house. The names of the staff we were told had signed the administration record, had not received the medicines training. We had asked the provider to produce evidence that all staff had completed this training but this was not made available to us.

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

People were supported by staff who had received training in safeguarding adults. Staff members we spoke with were knowledgeable about types of abuse. Staff were aware of their responsibilities to the people they provided care and knew that they were required to report any concerns they had to the provider and told us that they felt able to do this should the need arise.

Safe recruitment procedures were not followed. We looked at staff files, we found that complete employment histories were not in place, and that gaps in employment had not been investigated by the provider. There were no records of checks being carried out to make sure staff from overseas could legally work in the UK. We contacted the immigration services to report this so they could investigate further.

We were told by the provider that there were systems to manage emergencies, for example if a staff member went sick after the office had closed there was an on call system in place. When the office was closed, all calls were diverted to the on call person, who would respond to calls if required.

Requires improvement

Is the service effective?

Our findings

Staff told us they had received supervision from the provider. One staff member said, “I have had supervision.”

We found there were limited records for staff supervisions and appraisals. We saw that the staff files we looked at only contained a single supervision for staff. However, staff we spoke with said that they had received supervisions, inductions and shadowed staff until competent. There were no records of any competency checks or spot checks that had been completed to assess the competency of the staff. One relative told us that their relative has certain medical needs and only two staff have received the correct training to manage this safely. They told us that they have had to send staff away and call on family members to help support their relative instead because staff that were not trained were sent by the agency.

The providers training matrix stated that staff had received training in areas such as, safeguarding and manual handling. Staff had recently attended safe administration of medicines training. The provider told us that all staff had attended this training however, the organisation that provided the training told us that only the provider and one other member of staff had been trained. The provider was not able to provide us with evidence that all staff were trained to administer medicines . We saw evidence that two staff had received training in how to give specialist care to one person although the provider stated that all staff had received this training at the home of a person who used the service. The relative told us that only two staff received the training in their home and that sometimes staff arrive at their home without the training to provide the proper support for their relative.

One person’s care plan noted the person had a pressure sore on their sacrum but there was no guidance for staff on how they should support this person in relation to pressure care. Their relative said, “Staff don’t have the correct training because we are constantly having changes to staff and they don’t know what they are doing”. They went on to give examples of how the staff were not meeting the needs of their family member in relation to their care.

The lack of suitably skilled and competent staff was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood their responsibilities under the Mental Capacity Act 2005 (MCA). They explained the importance of giving people as much choice and freedom as possible. One staff member said, “We should assume the person has full capacity.” Staff we spoke with understood the importance of choice and told us they always seek peoples consent whilst giving personal care.

Requires improvement

Is the service caring?

Our findings

People we spoke with gave mixed views about the staff, one person said that, “We are quite happy with the service so far, staff are caring.” Another person said, “Staff are not caring.”

Not all people we spoke with felt they had a voice one relative said, “We are not involved with the care planning. “ People told us that they did not always know who was coming to deliver the care and when staff changed or were running late were not informed. One person told us, “We have asked for regular carers and were told that [Staff member] would come regularly but this has never happened.”

People we spoke with about dignity and respect gave mixed views about their treatment by staff One person told us that staff were very respectful. Another person said, “Happy with the service.” A relative told us, “staff are caring and respectful but they don’t ask you what [Relative] wants. More task led than person centred.” Another relative Said, “lack of care, lack of understanding, there are a lot of things that have gone wrong that shouldn’t have happened.”.

Staff we talked with were all aware of the importance of protecting people’s dignity and staff member said, “I make sure doors are closed for privacy and always communicate to the person, this is important. Get them involved in what we are doing and encourage them to do as much for themselves to promote their independence. All Staff told us that they supported people to do as much for themselves as they could and understood the importance of a person's independence but supported people where required.

Requires improvement

Is the service responsive?

Our findings

We received mixed views from people and their families some told us they had been involved with their care. One person said, "We have just updated the care plan." However, one relative said, "We are not involved with the care plan."

We looked at the care plans kept at the office. The care plans had not been reviewed regularly. The provider told us that care plans were reviewed regularly but the office copies had not been updated. This meant office staff did not have access to updated information about people's care needs. The care plans we saw did not have adequate risk assessments and did not detail people's individual needs, preferences and wishes in a personalised way. We spoke with a relative who told us, "We don't have a care plan and have not had one in the house since we started. The provider told us that they would come back to go over my relatives personal care and we have not seen them since, that was about three months ago."

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

One relative told us, "This weekend the staff that turned up were not known and were not aware of my [Relatives] needs. They washed my [Relative] no cream or deodorant was used. My [Relatives] trousers and pad had not been put on properly and they ended up soaking wet. We are trying to move agency. We have spoken with [Provider] and asked them not to send one staff member to our home because they are rude and my [Relative] gets all agitated but I am told that they are trained. I have said I don't care but [Provider] does not listen."

The provider had a complaints policy and procedure and people we spoke with knew how to make a complaint. We saw the complaints log and there had only been one complaint. The complaint had been responded to and the service's policy followed. All people we spoke with knew how to complain and felt able to do this. The provider told us that there had only been the one complaint and that was why there was only one complaint recorded. However, one relative told us, "I have complained over the telephone about the care, This is resolved for a short time, then it starts all over again. I am sick of them because I have to keep on and on." Another relative said I have complained between fifteen and twenty times since December. There was no record of these complaints in the complaints log. We were told by one relative that they ring the Manger with their concerns but the manager never gets back to them.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We received mixed views from people who used the service about the management of the service. One person said, "The provider is approachable, if I had a problem I could speak to them." However, another person said, "Never asked what we want, never see the provider.", Another person explained how the provider had failed to meet with them as agreed. They had not contacted them to explain or to rearrange the meeting.

There was a lack of systems to monitor and audit the quality of the service. The provider told us that they had enough staff to meet people's needs and that they had recently taken on a new administrator. However, the provider did not have an effective system to make sure that staff arrived to provide care to people at the agreed time. There were no records of any checks being carried out to make sure staff were attending calls as at the agreed times or for the agreed duration. We asked the provider about people's calls being on time. The provider told us that there were no problems in this area. The provider had not identified the concerns we found in relation to call times.

The provider was unable to demonstrate how they assured themselves that people using the service had their assessed needs met. There were no completed audits or checks on the quality or the safety of the service. There were no records to show how the provider planned to improve the service. There were no records to show that the provider sought feedback from people using the service. The provider had not identified the concerns we found during our visit.

We asked the provider for records in relation to accidents and incidents and administration of people's medicines. These were also not available during our visit. Although the provider did have a complaints log, we found that this did not include complaints that we were made aware of by people using the service and relatives.

Records of staff training and supervision were inaccurate and incomplete. The provider had a training matrix, which showed staff were trained in areas relating to the needs of people using the service. However, the provider was unable to verify that this training had occurred with training certificates. We received conflicting information from the training provider and from a relative, which stated that, not all staff were trained in areas as shown on the training matrix. All Staff we spoke with said that they had had an induction when they started and had also had supervision from the provider and felt supported by the provider. However, there were no records to show staff had any induction and there had only been a single recorded supervision for each staff member.

Records relating to the care people needed were not all available or up to date. One person did not have a care plan or any risk assessments available to inform staff of the person's needs and the support they required. Care plans in the office had not been reviewed or updated. There were not records of any audits or checks being carried out on care records to check that they were accurate and up to date.

The lack of systems to monitor and ensure the quality and safety of the service and the lack of records relating to the people's care and to the running of the service were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the service had a statement of purpose, which set out the provider's aims staff, we spoke with about the vision and values of the company gave different answers to what the vision and values were.

At the time of our visit, the provider was in breach of the conditions of their registration as they had moved from the address that they were registered for to another address without appropriately notifying the Care Quality Commission.