Mevtec 360 Locum Limited

Carlton Court

Inspection report

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20 February 2023
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27 February 2023

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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
Carlton Court provides personal care and support to people who require assistance in their own home. At the time of our inspection approximately 20 people were being supported by the service. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People and relatives told us they were happy with the support they had received and were positive about the staff. One relative said, "It is not always the same staff, but they introduce themselves and have been lovely and caring."

Care and treatment was not recorded in detail or in a person centred way. Care plans and risk assessments did not contain enough guidance for staff to mitigate risks and provide safe support to people.

Recruitment processes were not always robust. We have made a recommendation about the recruitment of staff.

The registered manager had failed to implement effective systems to monitor the safety and quality of the service and improve care.

The registered manager had been working in partnership with stakeholders to implement further training with staff to improve their knowledge and mitigate risks to people. Staff were aware of how to raise concerns around safeguarding to keep people safe.

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 good (published 27 September 2019.)

Why we inspected
We received concerns in relation to the safe care of people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Carlton Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of one inspector.

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

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 20 February 2023 and ended on 27 February 2023. We visited the location's office on 20 February 2023.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We reviewed the last provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they

do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with 2 people and 5 relatives. We spoke with 5 members of staff including the registered manager and operations manager.

We reviewed a range of records. This included 5 people's support records. We reviewed 2 staff records in relation to recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Staff did not have detailed care plans to follow. This placed people at risk due to the lack of information in care plans and risk assessments.
- The registered manager relied on discharge information which came as a list of tasks people required support with such as assistance with personal care, mobilising and medication. This did not provide detail on how people should be supported or what staff should do to mitigate any risks from harm.
- Where people had complex support needs such as assistance with stoma care, there was no information for staff to follow on how this care should be given. Risks were not identified and no guidance was in place for staff to follow to mitigate risks.
- Where people had health needs they may need support with, such as diabetes and Parkinson's, there was no supporting documentation, care plans or risk assessments for staff to follow. This placed people at risk of staff not having adequate guidance on how to identify if their health conditions deteriorated and what they should do to support them.
- 1 person was receiving oxygen therapy at home. We found no associated documentation or risks assessments in place to mitigate risk and support the use of oxygen safely.
- The registered manager had no system in place to monitor late or missed calls and relied on people or their relatives being able to ring them, or by following trackers on staff cars to identify their location.

Risks management systems were not robust and placed people at risk of unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager has reviewed documentation they are used to provide better guidance to staff.

Using medicines safely

- We could not be assured people were receiving medicines safely as there were no reviews or audits of medication administration records (MARS) available to review.
- Staff had received training in medicine administration and told us they had their competency to do so checked. However, we did not see any evidence of competency assessments and noted five staff were waiting to have medicines training.

Staffing and recruitment

- The registered manager needed to improve their system for recruitment. We reviewed 2 staff files for recruitment and found a full employment history had not been obtained in 1 and only 1 reference had been

obtained.
● Disclosure and Barring Service (DBS) were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The registered manager had recruited staff from abroad under the government sponsorship scheme and we saw they had been inducted into the service. One member of staff said, "I had a 2 week induction before I started at the service. Then I worked with a senior and went out on shadow shifts and observed care."

We recommend the registered manager reviews their application form to ensure a full employment history is obtained and references are sourced and recorded including telephone references.

Systems and processes to safeguard people from the risk of abuse
● The registered manager told us they knew how to raise safeguarding concerns and would work with the local authority to investigate these and keep people safe.
● Staff told us they would raise any concerns they had with the registered manager. One member of staff said, "I would assess the risk and if it was something dangerous such as sharp knives or medicines being left out and the person had dementia I would move them out of reach and inform the office and the family."
● Another member of staff said, "I would raise any concerns to the office and there is an external phone line I can ring."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

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 found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● When staff first met people, they recorded their consent to provide care was given.

Preventing and controlling infection
● Staff had received training in infection prevention and control (IPC). The registered manager completed audits and carried out spot checks on staff to review their IPC practices.
● Staff told us they had access to Personal Protective Equipment (PPE) and were wearing PPE during care calls when appropriate.

Learning lessons when things go wrong
● The registered manager held regular meetings with staff to discuss and share any findings from lessons learned. Where people had complained about call times the registered manager had shared with staff to be clearer about the times calls and provided additional information to people on call times.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider took short-term packages to provide support to people when they were first discharged from hospital. However, we found the process to implement this care was not being provided safely to mitigate risks to people.
- There were no person centred care plans to support people's care needs. Care plans we reviewed consisted of a list of tasks for staff to complete rather than detailing how people could be supported to have their needs met safely.
- Where the service supported people, who needed longer term care we found these care plans lacked detailed to provide person centred care and missed important information to mitigate risks to people.
- The registered manager had failed to put systems in place to adequately assess the needs of people they were supporting and provide documentation in the form of risk assessments care plans and guidance to provide safe care.
- Governance systems had not been fully implemented. A quality audit carried out by the service identified audits needed updating, however we did not find this to be an effective outcome due to the lack of documentation in place for care plans and risk assessments.
- An audit of staff files did not identify the application form had not required staff to give a full employment history including recording why staff had gaps in employment. The audit had also not identified a missing reference.
- Actions from staff meeting minutes were not recorded so there was no evidence issues raised had been addressed. It was noted staff had highlighted the length of time to assess new packages meant this could cause other care calls to run late. We noted no outcome or action recorded to address this. Staff had also asked for an additional care round to be added, again there was no action or outcome recorded for this.

We found no evidence people had been harmed. However, systems and processes were not robust enough to demonstrate safety and quality were effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager understood their responsibility under duty of candour to be open and honest

when things go wrong.

● The registered manager had been working closely with other stakeholders to address issues that had been highlighted at the service. For example, they had provided additional training to staff on complex care issues.

● The registered manager had implemented check lists for staff to use when they first met with people to try and minimise the risks of failed discharges from hospital and highlight issues that needed addressing with care packages immediately.

● Contact details had been shared with people and their relatives to provide them with the information they needed to raise concerns promptly.

● Reviews were carried out of people's care packages with them and their relatives when they were using the service for longer term care.

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 Person centred care plans and risk assessments providing guidance to staff were not in place. This put people at risk of receiving unsafe care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider needed to improve systems they had in place to provide oversight and person centred care for people

The enforcement action we took:

Warning notice to meet the regulation.