

Midway Care Ltd

Midway Care Midway Support Services

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Midway Care Midway Support Services provides personal care for younger adults with learning disabilities, autistic spectrum disorder or mental health needs. People received support in their own homes or supported living services. At the time of our inspection the service was supporting 25 people living in 17 houses or flats across Warwickshire and Worcester.

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 will also consider any wider social care provided.

People's experience of using this service and what we found

There was a lack of provider oversight which meant risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service were not always effective and placed people at the risk of harm. The systems in place failed to identify the areas for improvement found at this inspection.

Risks to people were not always robustly managed. Care records and risk assessments were not always reviewed following an incident or change in a person's need.

Infection control systems were in place but needed to be consistent throughout the service and required strengthening to limit the risk of infection.

Most staff felt supported in their role. Training updates were needed, and plans were in place to address this. Staff were kind and caring and spoke in a person-centred way about the people they supported.

Relatives had mixed views, some were happy with the service and felt their family member was well cared for. Some relatives felt improvements were needed. Most relatives told us communication needed to be improved.

The provider was aware that improvements were required to the service. They were strengthening the systems in place and reviewing the structure of the service.

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

Rating at last inspection and update

The last rating for this service was good (published 28 September 2017).

Why we inspected

The inspection was prompted due to concerns about the service in relation to allegations of unsafe practice,

not reporting incidents, staff conduct issues, poor staff culture and not following infection protection and control guidelines. The local authority had also let us know they had concerns. A decision was made for us to inspect and examine those risks.

We reviewed the information we held about the service. We only looked at safe and well led during this inspection. We did not look at the key questions of effective, caring and responsive. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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

We have identified two breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we told the provider to take at the end of this report.

Follow up

We will request an action plan for 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.

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 well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Midway Care Midway Support Services

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 was carried out by three inspectors. Two inspectors visited the office location and all three inspectors carried out telephone interviews to staff and relatives.

Service and service type

This service is supported living. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission (CQC) at the time of this inspection. However, the provider was making some changes at registered manager level. So the registered manager for this service was overseeing another registered service for the provider. The person referred to in this report as the manager was in the process of registering with us.

Notice of inspection

We gave the service 48 hours notice of the inspection. This was because we needed to be sure the provider or manager would be in the office to support the inspection.

Inspection activity started on 29 October 2020 when two inspectors visited the office location. One inspector carried out telephone interviews to staff and relatives on the 29 October 2020. Further telephone interviews took place on 02 and 04 November 2020. Formal feedback to the provider took place on 10 November 2020.

What we did before inspection

We did not ask for a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

We reviewed the information we held about the service, including statutory notifications the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people at Midway Care.

During the inspection

We spoke on the telephone to nine relatives. We also spoke with 14 staff at the office location or on the telephone. This included care staff, senior care staff, team leaders, locality managers, manager and the provider.

We reviewed a range of records. This included four people's care records and three people's medication records. We looked at three staff files in relation to recruitment. We also looked at records that related to the management and quality monitoring of the service.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at information about people's care needs, staff training and quality assurance.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service was 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; Preventing and controlling infection

- Systems in place for assessing risks to people were not always robust. Risk assessments were in place but were not always reviewed following an incident to ensure the measures in place remained sufficient.
- Behaviour incidents reports completed following an incident did not always contain all the required information. The risks and triggers that occurred during the incident were not always recorded. For example, a behaviour incident report stated that the person had been aggressive towards staff, with no explanation about this or how the incident was managed. Another behaviour incident report stated that a person had hit the wall and staff left the room with no clear picture of what happened. Not all reports had been escalated to the manager so they could review the incident and take any further action that may be required.
- Some restrictions had been imposed in people's homes including the locking of clothing and food items. There was no risk assessment in place to guide staff on how and why the restrictions should be imposed. There was no evidence that consideration had been given to the least restrictive practice imposed and how people's choice, freedom and control had been considered.
- Risks in relation to people's health needs were not always managed. For example, some people required their weight to be regularly monitored because of difficulties in relation to eating. There was specific guidance in the care records about the frequency of weighing the person and action that should be taken but these had not been followed through in practice.
- Government guidance on infection control had not been consistently followed. For example, we found some inconsistent practice with staff not wearing masks when supporting people. Risk assessments regarding covid 19 were in place but not specific regarding what staff should do if a person was unsettled by a staff member wearing a mask. Information about the potential risks of this had not been shared with the local authority.

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

Following our feedback the provider told us they took immediate action on the infection control practices and reviewed the risk assessments and ensured staff were complying with infection control guidance.

- The infection control concerns did not relate to all supported living services. For example, in one service staff told us, "Everyone has been wearing mask in the service we have hand gel, we have a folder to say what we have done. They are quite tight on infection control they provide us with equipment, Gloves aprons mask, we have cleaning schedules and sanitize areas within the service daily."

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems, processes and practices to safeguard people from abuse were not fully embedded.
- Prior to our inspection concerns were raised with us by the local authority regarding incidents where people had been put at risk of harm.
- The provider shared with us an action plan they had in place (dated 29 September 2020) to address a number of safeguarding alerts and concerns that had been raised about the service. This included concerns about people's safety and poor staff conduct issues that impacted on people's care and put people at risk of harm. The provider told us they were working with professionals to address the concerns, some had been resolved and some investigations were still taking place when we inspected.
- Staff told us they knew what to do if they had concerns and would speak with a senior staff member. A staff member told us, " Any concerns I would report to the manager, or upper management and know I would be protected under the whistle blowing policy. But I am very comfortable with (line manager) and I would report anything to her."

Staffing and recruitment.

- There were enough care staff to meet people's needs. Some staff told us more senior staff and team leaders were needed. The provider confirmed that additional new posts were being created.
- Some staff told us they were due training updates. The provider's training matrix showed gaps in staff training. The provider told us that a training plan was in place to address the shortfall and the restriction related to the pandemic had impacted on some of the face to face training that had been scheduled. A staff member told us, "Because of the covid all training had to be ceased and we are doing the online training, it was informative. There is a good support network amongst the staff and we have whatsapp groups, we see the managers regularly so if you did have a query, there is always someone to help".
- Systems were in place for the recruitment of staff and this included disclosure and barring checks (DBS). Where the provider had assessed the potential risks in relation to safe recruitment practice and put a plan in place we asked for reassurance regarding this. This was provided after our site visit.
- Records confirmed that staff received a probation period of employment and staff confirmed supervision sessions took place where learning and training needs were identified.
- The provider had a process in place for when staff employment was terminated due to poor performance and conduct issues and records showed this had been followed.

Using medicines safely

- We did not assess medicine storage or staff practice and people were not able to tell us if they received their medicines on time.
- Medication administration records looked at varied in quality. Some records had gaps where medicines had not been signed for and some were difficult to read and follow and had been handwritten.
- Some staff told us they had received medicine management training and had their competency assessed to administer medicines safely.
- Training records showed some staff still required medicine management training. The manager assured us that only staff who had completed training and assessed as competent, administered people's medicines.

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 good. At this inspection this key question has now deteriorated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider's systems and processes for the management and oversight of the service had not been consistently implemented and were not effective.
- The system in place to ensure effective reporting and recording of behaviour incidents had not always been effective. Some records did not contain all the required information and were not always escalated for oversight by the manager.
- The system in place to review and monitor people's care records and risk assessment failed to identify that measures had not been put in place to reduce some risks to people. The system in place failed to ensure that risk assessments were reviewed following an incident.
- The system in place for the management of effective infection control had failed to ensure guidelines were understood and consistently followed through in practice to protect people and staff.
- Systems in place for the oversight of safeguarding management were not always robust and had not been fully embedded into the providers quality assurance systems.
- There were some systems in place to gather people's views and the views of their relatives. However, these had not always been used to drive improvements to the quality and safety of the service.

The providers systems were not always robust enough to demonstrate effective oversight. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and manager were taking action to make the improvements needed. The provider was in the process of reviewing the structure of the service and considering additional resources to strengthen the management oversight of the service.

Promoting a positive culture that is person- centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback from relatives about their family members care. A relative told us, "The staff are really good and (person's name) is always happy to return back to their own home after a family visit, which is a good sign. Another relative told us, "The care is good I am really happy with the staff that support (person's name). A third relative told us, "I have not always been happy with how things have been

communicated." And a fourth relative told us, "The service is slowly getting better but it is a bit disorganised at times."

- We shared relatives feedback comments that we had received from telephone discussions with the provider. They followed up on these and let us know the steps they had taken to address the issues raised.
- Staff were knowledgeable about people and demonstrated they took a person-centred approach to providing care. A relative told us, "The regular staff are very good and they know and understand (person's name) needs well. A staff member told us, "I only work with the same two people so I know them really well and understand their needs well." Another staff member was able to tell us how they used gestures and pictures to communicate effectively and they could tell us in good details about the person and all their likes and interests.

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

- The provider and manager recognised that improvements were needed and had begun to take action to improve the service. They told us that more thorough visits to services and spot checks would take place to ensure improvements were made and sustained.
- We received some mixed feedback from staff. Whilst many felt well supported in their role, some staff did not feel supported. A staff member told us their line manager seemed to have a lot of paper work to do and checked on their paper work but not on how they were caring for people.
- Prior to our inspection we shared whistle blowing concerns that had been shared with us about the culture of the service. The provider told us in response to this they completed a staff feedback survey. Their findings were 49% of participants stated they felt very supported by their Locality Manager and 35% felt adequately supported 7% stated they felt unsupported and 8% said they were not sure. An action plan had been implemented and steps taken to improve the visibility of senior staff in the organisation.
- The provider told us about different initiatives in place to ensure learning and development took place. For example, 'flash' meetings had been introduced to review events and to have a formal and open discussion about what happened, enable staff present to talk through the event and formally take away lessons learnt.

Working in partnership with others

- The service worked in partnership with other professionals and agencies. They were working with commissioners to make improvements to the service.
- A health and social care professional told us the provider always responded 'swiftly' to request for information following a visit to the service. Another professional told us their dealings with the provider had always been positive.

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 Systems in place for the management of risk were not always effective.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place for the oversight and monitoring of the service were not always effective.