Medstar Domiciliary Care Services Limited

Medstar Domiciliary Care Services Limited

Inspection report

200 Green Lanes
Palmers Green
London
N13 5UE
Tel: 0208 882 5222

Date of inspection visit: 18 January 2016
Date of publication: 24/03/2016

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

Overall summary

This inspection took place on 18 January 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to make sure that the registered manager would be at the head office. Medstar Domiciliary Care service provides care and support for 17 people in their own home. 15 of who receive 24 hour care. The provider also supports nine people in a supported living scheme. The provider works with people living with dementia, learning disabilities, people with autistic spectrum disorder, and people with sensory and physical impairment.

The service was last inspected 12 September 2014 and was meeting all the regulations we inspected. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality

Summary of findings

Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were no medicines audits in place across the service. Weekly monitoring visits checked medicines. However, this was not documented in detail and did not allow the provider an overview of medicines.

People had not received Mental capacity Act Assessments (MCA) to determine how they could make decisions around their care. The service did not find out people's capacity at the point of referral. There were no records that families and healthcare professionals been involved in making best interests decisions on a regular basis.

There were individualised care plans written from the point of view of the people that were supported. Care plans were detailed and provided enough information for staff to support people. We saw that care plans were regularly reviewed and updated as changes occurred. However, care plans were not signed by anyone and there were no records of who had been involved in creating the care plan.

Risk assessments gave staff detailed guidance and ensured that risks were mitigated against in the least restrictive way. Risk assessments were reviewed and updated regularly. However, risk assessments were not signed by anyone and there was no evidence of people being involved in creating the risk assessments.

Staff did not receive regular, effective one to one supervision or appraisal.

People told us that they felt safe within their homes and felt well supported by staff. We visited one person and saw positive and friendly interactions between staff and the person. People and relatives told us that they were treated with dignity and respect.

Procedures relating to safeguarding people from harm were in place. Staff understood what to do and who to report it to if people were at risk of harm. Staff had received training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People received a continuity of care. The provider always tried to ensure that the same care workers looked after people. This promoted good working relationships with people who used the service.

Staff received a comprehensive induction. Staff were matched to people according to needs.

Senior staff completed regular monitoring of care staff via monitoring visits. Issues identified were immediately addressed.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

There was an open, supportive culture between management and staff. People and relatives also told us that they thought the service was open and encouraged them to voice their concerns and opinions.

We found that the service breached two regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. Where there were breaches of regulations, you can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe. Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against. However, people had not signed risk assessments. There were no records that people, relatives or healthcare professionals had been involved in creating the risk assessments.

We were unable to check if the service supported all people to have their medicines safely. The service had not completed audits for medicines.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met.

Is the service effective?

Requires improvement

The service was not always effective. Staff did not receive regular one to one supervision. Appraisals were brief and lacked detail.

Staff understood their responsibilities in relation to meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

People's food and dietary preferences were noted and adhered to in their care plans.

Staff were trained in the specific needs of the people they were working with.

Is the service caring?

Good

The service was caring. People were supported and staff understood people's needs.

People were treated with respect and staff maintained their privacy and dignity.

People were encouraged to be as independent as possible and supported to make decisions about the care they received.

Is the service responsive?

Requires improvement

The service was not always responsive. People's care plans were presented in a way that was person centred and tailored to individual care and support needs. However, people had not signed their care plans and people's capacity to make decisions was not recorded.

Staff knew the people well and were knowledgeable about each person's support needs, their likes and dislikes. However, activity plans were not in place for all people receiving 24 hour care.

Summary of findings

A system for complaints was in place. People and relatives were aware of how to complain.

Is the service well-led?

The service was not always well led. Audits and surveys to assess quality of care were not completed. The manager had not ensured that people's input into their care had been documented.

There was an open and transparent culture where good practice was identified and encouraged.

Complaints were used as a learning opportunity to improve quality of care.

Requires improvement

Medstar Domiciliary Care Services Limited

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 took place on 18 January 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at six care records and risk assessments, eight staff files, medicines records and other paperwork related to the management of the service. We spoke with two people who used the service, six staff and five people's relatives. Where people were unable to communicate with us, we spoke with their relatives.

Requires improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe. One person told us, "Safe? Yes, I do feel safe with them." One relative said, "They [the staff] do take care of him. I'm not worried." Another relative told us, "He's safe. It means I don't have to worry."

Risk assessments were tailored to the individual and gave staff guidance on how to mitigate specific risks in the least restrictive way. Each risk that had been identified had a separate page on how to manage that specific risk. Risk assessments noted the potential hazard, a proactive strategy (how to work with the risk) and a reactive strategy (what staff should do if the risk occurred). Risk assessments also included how staff should respond to emergencies and what action should be taken. For example, a fall from a hoist, blocked PEG feed or severe epileptic seizures. The registered manager and staff told us that people and relatives were involved in completing the risk assessments. However, risk assessments were not signed by anyone and there were no records of discussions with people or family involvement. The provider was unable to show that people had been consulted.

There were risk assessments for staff, individualised to each person that they worked with. This identified any risks that staff faced when working alone in people's homes. This meant that the service recognised and mitigated risk for staff when working alone.

The provider had a detailed policy on medicines and administration which all staff had access to. Medicines were administered in people's homes and recorded on 'medicine administration records' (MAR) charts. Records were kept at people's homes. They were not returned to the office. We were able to check two people's MAR charts for October, November and December 2015. There were no omissions in recording and medicines were being given as prescribed. We were unable to check how the provider identified if medicines were being given appropriately and safely overall. The registered manager told us that office staff complete monitoring visits weekly and check that medicines are given. However, there were no specific records of medicines monitoring visits or auditing. There were no systems in place to ensure that medicines were monitored or issues identified and addressed.

This was in breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that staff were only allowed to administer or supervise medicines once they had completed medicines training. Staff were also observed in the person's home by more experienced staff before being allowed to administer medicines alone. One staff member said, "I give medications or supervise them [people] to take them. We go by the care plan."

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member said, "It's about making sure service users are protected from abuse." Another staff member said that safeguarding meant, "Keeping vulnerable people safe and reporting anything we think is abusive." Staff told us, and records confirmed that they were trained in safeguarding during their induction.

Staff understood what whistleblowing was and knew how to report concerns if necessary. There was a detailed policy on safeguarding and whistleblowing that was available to all staff. The policy gave clear guidance for staff on how to report concerns. The provider had a named person responsible for safeguarding that staff were also able to contact.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Staff told us, and we saw, that people often had the same care workers working with them, which enabled people to experience continuity of care. When a person was referred to the service, the provider allocated staff based on a needs assessment. The staff allocated remained with that person as their permanent care workers. One person told us, "It's the same people who come." A relative said, "Yes, they're the same, sometimes for years." Many of the people supported by the provider received 24 hour care.

Staff that visited supported living schemes were allocated between 30 and 60 minutes per visit and provided support

Requires improvement

Is the service safe?

with medicines and personal care. Other needs were met by staff within the supported living scheme. Staff said that they felt they had enough time to complete tasks and were not rushed.

Requires improvement

Is the service effective?

Our findings

Staff that we spoke with were knowledgeable about the people they were supporting. Records showed that care workers had group supervisions. Office staff had one to one supervision sessions. Care staff did not have one to one supervision sessions. One staff member told us, "It's usually group supervision." Another staff member said, "Not one to one meetings." Staff said that they discussed people that they worked with and any issues in the group supervisions. The registered manager told us that staff could request a one to one meeting at any time. However, staff were unable to discuss individual progress and learning and development within the group supervisions.

Appraisals were completed yearly. However, on reviewing staff appraisals documentation we found that they lacked detail, often consisting of one or two lines. Appraisals did not support staff to carry out the duties they were employed to perform. Appraisals did not address staff performance or learning and development adequately. One staff member told us, "Appraisal? I'm not sure, I don't think so."

This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA). One staff member told us, "The MCA is about people's ability to make their own decisions and if they are able to do so." Another staff member said that the MCA meant, "To be aware of what decisions people are able to make by themselves that sometimes needs to be assessed." Staff were also able to tell us what DoLS was and how it could impact on people's care if they were working with a person who was subject to a DoLS. One staff said that DoLS was, "If clients lack capacity. For example, if someone isn't safe and they want to go out. It [DoLS] is to restrict certain things for their [people's] safety, depriving people of their liberty in the least restrictive way."

The registered manager told us that the majority of people the service worked with lacked capacity. However, this was not noted on any care plans and no capacity act assessments had been completed. The provider did not find out people's capacity at the point of referral. We saw records of one best interests meeting. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests. The registered manager told us that family were always consulted around people's care if the person lacked capacity. However, there were no records to show that this had been done.

We saw that staff had a comprehensive induction when they started work to ensure that they understood people's needs. This included meeting and getting to know people, and understanding local policies and procedures. Staff told us that they shadowed more experienced staff for a period of time before being able to work alone. The provider had produced a detailed staff handbook which was regularly updated. This was given to all staff when they began work.

Training records showed that staff received regular training and noted when refresher training was due for mandatory training such as manual handling and safeguarding.

Care plans showed if people required help with meal preparation when care staff visited. Some people were supported to cook meals and others required prompting to eat regularly. Staff were trained in food hygiene. One person told us, "They [staff] support me to cook." A relative said, "[My relative] needs a lot of help. If the food preparation is something he can be involved in staff always involve him. Even if it's just putting butter on toast or pouring some milk into a cup." Two people had specific dietary needs. Staff that worked with these people had received training on how to manage their needs. People's care needs around nutrition were clearly documented in their care plans. Risk assessments were in place specific to working with people who had specialist nutritional requirements.

Requires improvement

Is the service effective?

Where people had specific needs, they were supported only by staff that had been trained to meet these needs. For example, some people had epilepsy. All staff members that worked with them had completed epilepsy training. Other people had been diagnosed on the autistic spectrum. On talking to staff, they were able to explain how they worked with people living with autism and how the training had helped them to support people. For example, how to respond if a person became upset or anxious in specific situations.

The providers referrals and admissions policy stated, 'Clients will be matched appropriately to their care workers, taking into consideration the service to be delivered, the client's preferences, language, culture and skills'. The registered manager told us that before a staff member is assigned to work with someone, a senior member of staff sits down with them and goes over the person's care needs. The staff member then works with the person for between four and six weeks, shadowing a more experienced staff member, before being able to work alone. If the person was a new referral there was a monitoring period of four to six weeks.

People's healthcare visits were not recorded in their care files. The registered manager and relatives told us that records of healthcare visits were kept in people's homes. Where people received 24 hour care, family members often were in charge of healthcare appointments. The provider supported people to attend appointments where identified. Where staff were working in supported living schemes they did not support people with healthcare. However, staff were aware of how to report concerns to other agencies if needed. Records showed that people were supported to attend regular annual reviews of their health care.

Good

Is the service caring?

Our findings

People and relatives thought the service was caring. One person said, "They listen to me." One relative told us, "My [relative] is very happy with the staff and the care they give him." Another relative said, "They [staff] are so good. They understand where he [relative] is coming from."

Care plans were person centred and aimed at ensuring people maintained as much independence as possible. They noted what people were able to do by themselves and what they needed help with. People and their relatives told us they were involved in developing their care plans and identifying what support they required from the service and how this was to be carried out. However, care plans were not signed by anyone.

Each person receiving 24 hour care had a key worker. A key worker is someone who is responsible for an individual and makes sure that their care needs are met and reviewed. Relatives were aware of who keyworkers were. One relative said, "The service operates a key working system. It is really good because [my relative] gets to know and trust the keyworker."

Staff that we spoke with were able to tell us about individual's needs and life history. Staff were also able to discuss what was in individual's care plans. One staff member said, "care plans are about creating the best life for someone."

We saw that people were encouraged to maintain relationships. A section of the care plan was entitled, 'relationships and peer interaction'. This section noted what was important to individuals in regards to family and friends. Care plans stated what issues may arise when the person interacted with people and how they would be likely to behave in certain situations. For example, large crowds or meeting new people.

We asked staff how they would work with lesbian, gay, bisexual or transgendered people. One staff member said, "It's the same as I would work with any other client unless there was something specific for that person. We're all people at the end of the day." Another staff member told us, "I wouldn't treat them any differently. Why would I?"

People were treated with dignity and respect. Staff were able to tell us how they would ensure that people's privacy and dignity was maintained. One staff member said, "When I give personal care, I make sure that the door is closed and that I listen to what my client wants. Their voice is important." Another staff member said, "When you go into a service user's home, it is their home and that must be respected. You respect their private space. If my client is in his bedroom, I always knock and wait for him to answer before going in." We looked at a monitoring visit forms from December 2015. The monitoring visit looked at dignity and respect asking; 'Is the service user being treated with respect at all times?' and 'Are staff respectful when providing intimate care'. Monitoring visits found that people were asked if they were ready to receive personal care and that personal care was carried out ensuring that doors were closed and privacy was respected.

Requires improvement

Is the service responsive?

Our findings

We looked at people's care plans and saw that staff responded to people's needs as identified. Care plans were reviewed regularly and updated as changes occurred. Staff knew about individual needs and had read the care plans. Care plans were detailed and person centred and contained practical information as well as information on people's personal preferences. The registered manager told us that people and relatives were consulted when developing and reviewing the care plans. People and relatives said that the provider always consulted them and their views were always included. However, this had not been recorded in care plans and they had not been signed. There were no MCA assessments in place for people who may have lacked capacity.

The service had a clear referrals and admissions policy. The policy stated the application process and details of care and support the service could provide. The registered manger told us that the policy was given to all new people referred, healthcare professionals and relatives. People's needs were assessed when they were referred to the service and a tailored package of care was devised according to the outcome of the assessment. People's initial assessment included physical care needs, practical needs such as personal care, meal preparation and overall wellbeing.

People who received 24 hour care and were more mobile and able to access the community had a weekly activity timetable. These noted things people enjoyed doing in the community and at home. Each person's activity plan included things that they enjoyed, such as, going for a walk to the park, playing computer games and having lunch out. However, we noted that where people were unable to communicate and had poor mobility there were no activities plans in place. The registered manager told us that staff knew people well and gave examples of what people enjoyed doing.

When we spoke with staff they were able to explain what people enjoyed and what their likes and dislikes were. One person has a large projector and enjoyed films. Another liked listening to a certain type of music. Where the provider supported people in a supported living scheme, they were not contracted to provide activities.

The registered manager told us that there had been no missed visits to people in the last year. However, there were no records to show that this had been monitored. The registered manager said that the majority of people that they worked with had 24 hour care and staff were rostered on to cover shifts. If there were any issues with visits, families would call the office. One relative told us, "They've never missed but I would call the office if they did."

We saw records of regular monitoring visits. Monitoring visits were carried out by a senior member of staff and looked at all aspects of care being provided to a person. If an issue was identified, the registered manager told us that this would be addressed with the staff member.

There was a clear complaints procedure. The registered manager told us that relatives were given copies of the complaints procedure. We saw that complaints were responded to in a timely manner and resolved. Relatives told us "I know how to make a complaint but I just call the manager to discuss anything. I haven't needed to complain.", "They [Medstar] told me how to complain when they first came round but I call the office. We have a good relationship and I haven't needed to complain." There had been six complaints since January 2015. We saw that complaints were investigated and action taken to improve practice if appropriate. For example, the medicines protocol was updated following an error in August 2015.

Requires improvement

Is the service well-led?

Our findings

Records showed that office staff had monthly management meetings. These meetings went through people's needs, issues arising and any action that may be needed. Staff told us that they felt able to voice their views and opinions and felt that they would be heard. Care workers told us, and records showed, that there were staff meetings every two months. These looked at any issues that had arisen and how they were addressed. They also gave staff an opportunity to raise ideas and concerns.

People and relatives told us that they were always consulted around care. However, there was a lack of documentation that showed this. This included care plans and risk assessments not being signed and no best interests meetings recorded. The service did not assess capacity around every day decisions. We saw that some people had their capacity noted by the placing authority on referral forms but this had not been carried through to people's care plans. Documentation for people was inconsistent.

There were no one-to-one supervisions recorded. Appraisals were brief and did not address staff performance or identify learning and development adequately. There were no audits of medicines recorded.

Staff and relatives told us that the provider worked closely with other healthcare professionals when necessary for people's care. However, much of this joined up working was not documented in people's care files.

All staff that we spoke with said that they found the registered manager approachable and could discuss anything with her. One staff member said, "She's a good manager, she listens to you and is easy to approach." Relatives told us, "The manager always tells me to pick up the phone and call them if I have any worries, never hide anything" , "I'm not afraid to talk to them if I need to, I can tell them anything. I give them 100% for that."

We found that there was an open culture amongst the staff, both in the office and between care workers. Staff that we spoke with said that they felt supported and listened to by the registered manager. Staff felt able to discuss problems and ideas openly and felt that they would be listened to. Relatives also said that the provider was open with them and 'valued their views'. One relative told us, "If there is an issue she [registered manager] will go out of her way to support us."

The provider operated an on-call system for out of hour's issues that arose. This operated seven days a week between 17:30 and 09:00 and at weekends. Relatives said that someone was always available out of hours to deal with any issues that arose.

The registered manager ensured that staff training was up to date and all training is recorded on a database. The service planned to introduce the 'Care Certificate' in March 2016. The Care Certificate is a set of standards that social care and health workers use as guidance in their daily working life. It is planned that all new staff will work towards this certificate.

The accident and incident records showed that the registered manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read. Staff told us that they knew how to report accidents and incidents.

The director of Medstar showed us an annual audit that had been completed. This was based on feedback throughout the year from families and people who use the service. However, this could not be shared with anyone outside the office as it discussed individual's progress and issues. The audit gave a good overview of the service. The provider employs an external contractor to audit services provided to people. We saw seven audit visits that provided detailed reports and outcomes. following these visits the provider addresses any concerns and the external auditor then re-audits.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 provider did not have effective systems in place for the safe management of medicines. **Regulation 12(2)(g)**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have suitable arrangements to fully support staff in their roles, in that staff did not receive effective supervisions and appraisals. **Regulation 18(2)(a)**