Master Quality Healthcare Services Ltd

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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:
Master Quality Healthcare Services Ltd is a domiciliary care agency. It provides personal care to people living in their own homes. The service was providing personal care to 16 people in the Leeds, Wakefield and Trafford areas at the time of the inspection. Master Quality Healthcare Services Ltd provides a service to younger and older adults.

People's experience of using this service:
● People spoke positively about the service and were happy with the care provided. One person told us, "I can't fault them [care staff] one little bit. They treat me as though I'm their mum, you can't get no better care than that." Another person said, "The carers are excellent." One relative told us, "This agency does everything that you'd hope for, in a kind and caring way."
● We found risks to the health and safety of service users were not always fully assessed and the provider was not taking reasonable steps to lessen such risks. People did not have risk assessments in place for catheter care, choking and pressure ulcers.
● We found medicines were not always managed safely. There was no allergy information recorded on the Medication Administration Records, there was no information to guide staff on what medicines were being taken, any side effects of the medicines and people's preferences for taking their medicines.
● We concluded the above demonstrated a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, safe care and treatment.
● We checked whether the service was working within the principles of the MCA. We found conflicting and unclear information regarding people's capacity to make decisions. We concluded this demonstrated a breach of regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014, need for consent.
● At the last inspection it was noted there was a limited level of detail within the care plans regarding a person's background and preferences. At this inspection we found this continued to be the case. There was no information within people's care records regarding their end of life wishes in relation to their care and support. At the time of inspection no one was receiving end of life care. The provider told us this was because no one was currently receiving end of life care.
● There were insufficient systems and processes in place to assess, monitor and improve the quality of the service. Quality audits did not adequately identify areas in need of improvement. The provider did not assess, monitor or mitigate the risks relating to the health, safety and welfare of the service users. The provider had not assessed people's risks in relation to pressure care, choking or catheter care. We concluded these issues demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.
● The provider had submitted notifications to the CQC, however we identified instances where matters had not been notified to us as required by regulation. This is a breach of regulation 18 of the CQC (Registration) Regulations 2009.This will be dealt with outside this inspection process.
● The provider was considering moving staff supervisions from six monthly to once a year. We made a

recommendation that the provider holds supervisions every three months in accordance with best practice guidance.
● Complaints were responded to, they identified any issues, actions taken and future learning. However, the provider did not keep an overview to identify any patterns and trends.
● The staff we spoke with were complimentary about the management team. Team meetings were held to discuss any issues. The minutes showed the registered manager had a focus on staff well-being and had organised a well-being workshop.
● We saw examples of staff promoting people's independence. One relative told us staff respected their family member and their wishes. They told us they were respectful of their home and responding to their requests.
● Staff recruitment records demonstrated the service was ensuring staff were subject to the appropriate scrutiny. References were obtained and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.
● We saw evidence to demonstrate that staff received appropriate training and induction.

Rating at last inspection:
At the last inspection the service was rated Good (report published 7 July 2016).

Why we inspected:
This was a planned inspection based on the rating awarded at the last inspection.

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

Follow up:
We will continue to monitor this service. We will check improvements have been made by completing a further inspection in line with our re-inspection schedule for those services rated requires improvement.

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

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**

Master Quality Healthcare Services Ltd

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. 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:
The inspection was carried out by one inspector, one bank inspector and an assistant inspector.

Service and service type:
Master Quality Healthcare Ltd provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. 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:
The inspection was announced. We gave the service 48 hours' notice of the inspection visit because it is small, and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection site visit activity started on 19 March 2019 and ended on 20 March 2019. We visited the office location on 19 March 2019 to see the registered manager and office staff; and to review care records and policies and procedures.

What we did:
We reviewed information we had received about the service since the last inspection in May 2016. This

included details about incidents the provider must notify us about. We asked the provider to complete a Provider Information Return (PIR) prior to this inspection and they returned this. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also sought feedback from the local authority safeguarding and contracting teams, and healthwatch.

During the inspection we spoke with three people and four relatives to gain their views on the care provided. We spoke with the registered manager, company director and three members of care staff.

We reviewed a range of records. These included five people's care records and three people's medication records. We looked at three staff files, meeting minutes, documents relating to the management of medicines and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; Using medicines safely

● We found risks to the health and safety of service users were not always fully assessed and the provider was not taking reasonable steps to lessen such risks. There were risk assessments in place in relation to people's home environments and moving and handling. However, we found two people were at risk of developing pressure ulcers but there were no risk assessments in place regarding pressure care. This meant there was a risk people were not receiving appropriate pressure care and a risk staff were not identifying when a person was at risk of developing a pressure ulcer and taking appropriate action. Recognising which service users are at risk of developing pressure ulcers early on is an essential part of the prevention care pathway. Staff, when asked about pressure care, did not provide clear answers as to how they would deliver appropriate pressure care.

● Another person required a catheter but there was no information within the person's care record regarding catheter care, such as how the site of the catheter should be cleaned and how to minimise the risk of a urine infection. One person, who was supported with their meals, was at risk of choking but there was no risk assessment or care plan in place regarding how to manage the person's risk of choking. The registered manager told us they would address this immediately.

● We found medicines were not always managed safely. For example, no allergy information was recorded on the Medication Administration Records (MARs). Medication risk assessments were completed annually but they did not record whether a person had any allergies. The registered manager told us they would address this immediately.

● MARS were not always appropriately completed. For example, medicines were crossed out and changed on the MARs without a date of change recorded or a signature to show who had made the change and verified the information was correct.

● There was no information within the medication care plans to guide staff on what medicines were being taken, any side effects of the medicines and people's preferences for taking their medicines.

● Two people required medication to be administered on an 'as required' PRN basis. We found there were no PRN protocols within their care records to ensure staff gave medicines appropriately when needed. The company director told us these were kept at the person's home.

● We concluded the above demonstrated a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, safe care and treatment.

Systems and processes to safeguard people from the risk of abuse

● All the people we spoke with told us they felt safe with the care staff. One person told us, "I trust them with my life."

● The provider had a safeguarding and whistleblowing policy in place which detailed the action for staff and managers to take if they had any concerns. The policy included contact details for the registered manager and signposted people to the police, local authority and the CQC.

● Safeguarding incidents were recorded, investigated and where issues were identified the actions taken and future learning were documented.

Staffing and recruitment

● Staff, the registered manager and company director told us there were enough staff to meet people's needs. The company director explained that care staff worked in specific geographical areas to account for travelling time.

● People and relatives, we spoke with did not raise any concerns regarding staffing levels. One person told us, "I need two people and I always have two carers who come to hoist me.'' Another person said, "I have two people, at a time, there's about six of them who rotate." One relative commented, "I'm impressed with all of the carers. They never give the impression of being rushed. They're overwhelmingly reliable." However, two relatives told us staff were sometimes late to the calls but they usually informed them about this.

● We asked to see the staff rota several times during the inspection, but this was not shown to the inspection team.

● Staff recruitment records demonstrated the service was ensuring staff were subject to the appropriate scrutiny. References were obtained and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. However, we noted in one recruitment file, a person's full employment history was not documented. The company director explained this had been explored but had not been noted on the staff member's recruitment file.

Preventing and controlling infection

● Staff received infection control training and had access to personal protective equipment such as gloves.

Learning lessons when things go wrong

● The provider investigated safeguarding matters, accidents, incidents and complaints. Where issues were identified, they documented the action they had taken and any future learning. However, this was done on an individual basis. There was a risk patterns and trends would be missed as there was no overview analysis of all safeguarding matters, accidents, incidents or complaints. The registered manager accepted this and was going to ensure this was done.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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.

● We checked whether the service was working within the principles of the MCA. We found conflicting and unclear information regarding people's capacity to make decisions. For example, one care record stated, '[person] does not know what's happening most of the times.' The registered manager said the person could consent to some things and that the person's husband also made decisions on the person's behalf. However, there was no information within the care record documenting what decisions the person was able to make. There was no evidence of any capacity assessments or best interest decisions in relation to decisions the person was unable to make. This meant there was risk decisions would not be made in line with the Mental Capacity Act 2005 and in the person's best interests.

● The provider's medicines policy stated, 'the service user must agree to have care staff administer medication and this consent should be documented in their support plan.' However, the care records did not have any signed consent relating to medicines.

● We concluded these issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
● We received some information of concern regarding the provider arranging to deliver care prior to an assessment being carried out. The registered manager told us Trafford council had given them an overview of the person, so they felt they were able to meet their needs. The registered manager told us they had learnt from this and in future they would now always carry out their own full assessment before agreeing to provide care to ensure they have a full and up-to-date picture of a person's needs.

● Most people had their needs assessed prior to care being delivered but the level of detail in the assessments varied. There was insufficient information within the care records to demonstrate a full and thorough assessment of a person's needs had been undertaken by the provider prior to delivering care. For

example, from an email seen from a senior physiotherapist, we saw one person had issues with breathlessness and required an inhaler. This had not been recorded in the person's assessment. The registered manager told us they would address this immediately.

● Where people were supported to eat and drink, the care records did not provide enough detail on what care and support the person required.

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

● We saw evidence within the care records that people had access to the support of other healthcare professionals such as physiotherapists and social workers. We saw evidence the provider worked with social workers to ensure a suitable service was provided. One relative told us, "The transition was very smooth from another agency."

Staff support: induction, training, skills and experience

● We saw evidence to demonstrate that staff received appropriate training. The registered manager had an overview of people's training and development needs. Staff received induction training and were supported by a more experienced member of staff as most support visits required two members of care staff.

● All staff we spoke with told us they felt supported. Staff received supervisions. However, the company director told us they were planning to hold supervisions on an annual basis instead of every six months. Best practice, 'NICE guideline [NG21], Home care: delivering personal care and practical support to older people living in their own homes' states 'Supervise workers in a timely, accessible and flexible way, at least every 3 months and ensure an agreed written record of supervision is given to the worker.' We recommend the provider follows this guidance.

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

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

● We received positive feedback regarding staff. One person commented, "They got me cards and chocolate for my birthday at the weekend. They do look after me. One of them does my toenails as well." Another person told us, "I can't fault them one little bit. They treat me as though I'm their mum, you can't get no better care than that." Another person said, "The carers are excellent."

● One relative told us, "This agency does everything that you'd hope for, in a kind and caring way." Another relative told us how the staff respected their family member's religious needs. They said, "They know Sunday is special for [my relative] and they help [them] get ready. Someone from church comes around 12:30 on Sunday to give [my relative] communion. The carers respect [my relative]." They also commented, "They make a big effort to make sure [my relative] looks smart."

Supporting people to express their views and be involved in making decisions about their care

● We saw in one person's care record English wasn't their first language. A staff member had been employed who spoke their first language to ensure the person's needs were met. One member of staff told us people were able to choose whether they wished to have a male or female carer. They told us this was respected.

● People told us staff supported them. One person told us, "Staff are friendly. They couldn't be nicer. They do ask me what I want, always."

Respecting and promoting people's privacy, dignity and independence

● We saw an example of staff promoting a person's independence when we looked at the communication notes. It recorded how they encouraged the person to use the toilet on most visits, instead of the person relying on continence products. A relative we spoke with told us they encouraged their relative to be as independent as possible. They told us, "They [support my relative] in a professional way. When they give [my relative] a shower they're patient with [them], they're gentle."

● One relative told us staff respected their family member and their wishes. They told us they were respectful of their home and responding to their requests.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● We saw evidence people's needs were reviewed. One relative commented their family member's care had been reviewed which had resulted in an increase in the care package and had improved the quality of care delivered.

● Although people's care was reviewed we found this was not always transferred through into a person's care records in a timely manner. For example, the registered manager received an email six days prior to the inspection from a senior physiotherapist regarding how a person was required to be supported but at inspection we found this had not been completed. We raised this with the registered manager who told us they would action this immediately.

● At the last inspection it was noted there was a limited level of detail within the care plans regarding a person's background and preferences. At this inspection we found this continued to be the case. Some care records did not have any information about a person's life history or where they did they were extremely brief. For example, one person had support to access the community but there was no information regarding what the person liked to do or where they enjoyed visiting. Another care plan stated, 'Please assist with feeding/drinking'. There was no detail regarding what level of assistance was required, what the person could do for themselves, what position they should be in to minimise the risk of choking or how their food should be cut up.

● The care records did not provide information about how to deliver person-centred care. They were written in terms of each care support call which included the time of the call, the number of care staff required and limited information about the level of assistance required. For example, one care record stated, 'assist me to dress into clean clothes.' There was no detail regarding the level of assistance required, what the person was able to do for themselves or what clothes they liked to wear.

Improving care quality in response to complaints or concerns

● The complaints were kept together in a file along with safeguarding matters and incidents. We saw evidence complaints were responded to, they identified any issues, actions taken and future learning. However, the provider did not keep an overview to identify any patterns and trends. We also found where the record stated that apologies had been issued or made, there were no copies kept on file or electronic copies of letters available to be printed or shown at inspection.

End of life care and support

● There was no information within people's care records regarding their end of life wishes in relation to their care and support. There was no evidence this had been discussed with people. One member of staff told us,

"I haven't seen anything like that in the files.'' The provider told us this was because no one was currently receiving end of life care.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There were insufficient systems and processes in place to assess, monitor and improve the quality of the service. Quality audits did not adequately identify areas in need of improvement. For example, people's communication notes were returned to the office monthly. The registered manager told us they checked these but there was no documentation to confirm this or to record where any action was identified, this was followed up. We found one person's communication notes stated staff had found a pressure area on a person's face. There was no further information in the communication notes or within the care record to show what action had been taken in response to this. The registered manager could not tell us what had happened in relation to this. They contacted staff members during our inspection to determine what had happened. Following these conversations, the registered manager speculated the mark was not a pressure area but caused by the person resting on a surface, such as their own hand.

● The company director told us medicine audits took place monthly. However, there was no documentation to confirm this had been done. The MAR charts were returned to the office but did not show they had been checked. There was no sign off sheet to show they had been audited and what action was required to be taken. This meant there was a risk any issues identified would continue without challenge or assurance they had been rectified.

● The issues identified at the last inspection had not been addressed. For example, at the last inspection, in May 2016, the registered manager had stated they were looking to introduce an electronic care planning system to make information sharing more efficient and so they had a planning tool to organise care and support effectively. The registered manager told us the care planning system had been used for one year since the last inspection. They told us it had not been feasible to continue to use the system, due to the number of clients. However, following this inspection the provider re-subscribed to use the care planning system.

● Despite requesting the information on several occasions, the inspection team were not able to access the staff rota, or a copy of apologies made in response to complaints. We found some policies were undated, so it was not clear when they were created or required reviewing.

● The provider did not assess, monitor or mitigate the risks relating to the health, safety and welfare of the service users. The provider had not assessed people's risks in relation to pressure care, choking or catheter

care. This had not been identified through audits. We only saw evidence the registered manager used the Wakefield CCG's quality action plan paperwork and not specific audits for their service. There was no mechanism in place to ensure the work of the registered manager was audited to ensure any shortfalls were identified and actioned.

● Following the inspection the provider sent us examples of choking, catheter care and pressure sore risk assessments they were going to put into place to ensure people received safe and appropriate care. The provider also sent a copy of a new care record format to enable more detailed information to be recorded.

● There was no clear system in place to ensure the hoisting equipment was safe to use for both staff and people. All five people who used hoisting equipment had the service due date recorded by the registered manager as 14 March 2019. The inspection took place on 19 March 2019 and the registered manager said they would follow this up to ensure appropriate action was taken in relation to ensuring the equipment was safe to use. It was not documented within people's care records who had responsibility for the maintenance and safety of the hoists. This meant appropriate maintenance may be overlooked.

● We concluded the above issues demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

● The provider had submitted notifications to the CQC, however we identified instances where matters had not been notified to us as required by regulation. This is a breach of regulation 18 of the CQC (Registration) Regulations 2009.This will be dealt with outside this inspection process.

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

● The staff we spoke with were complimentary about the management team. One member of staff told us, "I feel listened to." Another commented, "Any problem they [the management team] sort it out." Team meetings were held to discuss any issues. The minutes showed the registered manager had a focus on staff well-being and had organised a well-being workshop.

● People were sent out questionnaires twice a year. We saw the feedback received was very positive. However, the provider had not analysed the questionnaires to feedback positives or areas for improvement. None were completed by staff or other healthcare professionals to gain their feedback on the service.

● The registered manager told us they had areas they wished to improve but they had not written this down or created an action plan to show the timescales involved. They told us they wanted to put an electronic care planning system in place. They said this would help with the overview of accidents and incidents. They also wanted to employ a care coordinator in the Trafford area.

● To help with continuous learning and improving care, the registered manager had joined a registered managers' group in the local area and had joined skills for care as a registered manager to get updates and newsletters. In addition, they had recently attended training on person-centred care and support planning.

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 11 HSCA RA Regulations 2014 Need for consent It was not clear whether care and treatment of service users was provided with the consent of the relevant person(s).

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users were not assessed and the provider was not doing all that was reasonably practicable to mitigate such risks. The provider was not ensuring the proper and safe management of medicines.

The enforcement action we took:

We issued a warning notice in relation to a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient systems and processes in place to assess, monitor and improve the quality of the service. Quality audits did not adequately identify areas in need of improvement. The provider did not assess, monitor or mitigate the risks relating to the health, safety and welfare of the service users. The provider did not maintain an accurate and complete record in respect of all service users.

The enforcement action we took:

We issued a warning notice in relation to a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014, good governance.