MidCo Care Limited

MidCo Care

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

MidCo Care is registered for, and provides, personal care for people living in their own home. At the time of this inspection personal care was being provided to 32 people living in Peterborough.

This announced inspection took place on 19, 23 and 28 December 2016.

The service had a registered manager in place. However, they were not present during this inspection. There was an acting manager in place to oversee the service during the registered manager's absence. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Arrangements were in place to make sure that people, where needed, were supported and protected with the safe management of their prescribed medicines. However, detailed guidance for staff on when to administer 'when required' medicines were not always in place.

People had care and support plans in situ which recorded their care and support needs at each individual care call as a prompt for staff. Individual risks to people were identified. Plans were put into place to minimise these risks to enable people to live as independent and safe a life as possible.

The registered manager sought feedback about the quality of the service provided from people. They had in place quality monitoring checks to identify areas of improvement needed. However, these checks had not always identified the areas of improvement required found during this inspection.

Recruitment checks were undertaken before new staff were employed to make sure that they were suitable to work with the people they were supporting. However, these checks were not always completed robustly and inconsistencies were found.

We saw that there was a sufficient number of staff available to support people with their care calls.

Staff received training and understood the principles of the Mental Capacity Act 2005 (MCA).

There was an 'open' culture within the service. People and their relatives were able to raise any concerns that they might have with staff and the management team. Records showed that these were responded to and resolved where possible.

People were supported to access external health care professionals where needed, and were assisted to maintain their health. Where this support was required, people's health and nutritional needs were met.

Staff were trained to provide effective care which met people's individual support and care needs. However, not all training, such as catheter care training, was documented within the provider's records as having been completed.

Staff were supported by the registered manager to develop their skills and knowledge through supervisions, competency checks, training and further qualifications. However, we found that staff supervisions did not always take place regularly.

Notifications are information on important events that happen at the service that the provider is required to notify us about by law. The registered manager and the acting manager was aware of and provided us with notifications of all of the important events they needed to notify the Care Quality Commission about.

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.

Checks were carried out to make sure that only suitable staff were employed to work with people. However, there were inconsistencies in how robust these recruitment checks were for all new staff members.

People's medication was administered by staff as prescribed However, detailed guidance for staff on when to administer 'when required' medication was not always in place.

Risks to people had been identified and plans were in place to reduce these risks. However, information as guidance for staff about these risks was sometimes limited.

There were enough staff to provide the necessary support and care for people. People were protected from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had been trained and understood the principles of the MCA 2005.

People's health and nutritional needs were met.

Staff were trained to support people. Not all specialist training undertaken was recorded.

Staff had supervisions and competency checks to make sure that they carried out effective support and care. Supervisions were not always carried out on a regular basis.

Is the service caring?

Good

The service was caring.

People said staff ensured their dignity and respect was maintained. People said staff were caring and kind.

Records showed that people were involved in the decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's care and support needs were assessed, planned and evaluated.

There was a system in place to receive and manage people's suggestions or complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager in place.

People who used the service and staff were asked to give feedback on the quality of the service provided.

There were systems to monitor the on-going quality of the service provided. However, these checks did not always highlight all areas of improvement required.

MidCo Care

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 19, 23 and 28 December 2016 and was announced. The inspection was announced so that we could be sure that staff would be available during our inspection. The inspection was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the home that the provider is required to notify us about by law. We also received feedback about the service from representatives of the local authority's contracts monitoring team; this helped with our inspection planning.

During the inspection we spoke with the acting manager. We also spoke with three members of staff, two people who used the service and five relatives of people by telephone.

We looked at four people's care records; three staff recruitment files; quality monitoring documents; medication administration records; and records in relation to the management of staff.

Requires Improvement

Is the service safe?

Our findings

We found that two out of three staff files we looked at showed that pre-employment safety checks were carried out. Recruitment checks included references from previous employment and a criminal record check that had been undertaken with the Disclosure and Barring Service. Proof of current address, a health declaration and photographic identification had been obtained, and any gaps in employment history explained. However, one out of three staff recruitment files we looked at did not have robust documented evidence that all of the required checks had been completed in full. We saw that there had been no request to the previous employer to confirm that the staff member was of good character. We also noted that gaps in the staff member's employment had not been explained. This meant that there were not always robust recruitment checks in place when employing new staff members. One staff member said, "They checked the police and the references before the job [was offered] to make sure everything was secure (safe) for clients (people who use the service)."

People and their relatives told us they felt safe using the service. One person said, "I do feel safe most of the time. There are one or two staff I don't feel comfortable with. There isn't any particular reason, it's just some people you do feel comfortable with and some not." One relative said, "I do feel [name of family member] is safe. They guide him and take time doing it."

Care records documented whether the person, a relative or a staff member was responsible for prompting or administering people's medicines. There was also clear guidance for staff about who was responsible for the ordering, collection and disposal of people's medicines. Records documenting this support from staff were kept and reviewed as part of the provider's quality checks. Where improvements in the recording by staff of people's medicine administration were needed, documents showed that this was discussed with the staff member involved. Only one person we spoke with had staff administer any medication and that was creams. The person told us there were MAR charts in place and staff recorded when they had administered the creams.

Records showed that staff were trained to assist people with their medicines and were subject to observed checks by management. This was to monitor their competencies. One relative told us there had been senior staff who had come to check that staff administered their family member's medication correctly. One staff member said they had yearly refresher training in administering medication safely and had been observed to check that their practice was correct. The staff member told us how they would report any gaps in medication administration to the office staff. They said to ensure people were safe they would await further instructions before they administered any further medication.

We noted that there were instructions for staff in respect of how and when medicines were to be administered safely. However, we saw that information for staff on how and when to administer medicines prescribed to be given 'when required' was limited. This meant that there was an increased risk of misinterpretation of these records and potential unsafe care by other staff members. The staff we spoke with told us there were no medicines that they administered that were 'when required' medicines. They said that should it be necessary they would expect to fine appropriate protocols in place.

People had risk assessments in place. These records gave information and guidance to staff about any risks identified and the support people needed in respect of these. Risks included people at risk of falls, their environment, medicines, and their health and mobility. However, we noted that this information was sometimes limited.

People and their relatives told us that members of staff completed daily notes at each care call to demonstrate that they had completed all of the support required and set out in the persons care record during the care call. One relative said, "They record everything they do. They even record the catheter output from the leg bag." We noted that staff were asked to check if (where appropriate) people were wearing their lifeline. A lifeline is a personal alarm that a person can activate to request help. However, our review of a random selection of daily notes showed that staff were not recording whether the person's lifeline was in situ. This meant that we could not be sure that people were being supported by staff in the safest way possible.

People told us, and records showed, there were enough staff to safely provide the required care and support needed. The acting manager said and documentation confirmed that there were enough staff available to work, to meet the number of care hours contracted / commissioned. One person told us, "Sometimes I don't know who will be coming [to provide care]; sometimes they [staff] don't even know. Most are efficient and don't rush me. There have not been any missed calls, although sometimes they [staff] have been late." They went on to say that they had telephoned the office staff and "they [office staff] sent someone round straight away." People and relatives we spoke with said there had been no missed calls, although there had been late calls. However there were only two occasions when there was a call that was over 15 minutes late.

Staff confirmed that they had undertaken training in safeguarding people from harm and were able to explain the process to be followed when incidents of harm occurred. One member of staff said, "There could be verbal or physical abuse or the way you treat a person. I would 'phone the office [staff] about any problem." We saw notices within the service's office that prompted staff to report any suspicions of poor care and harm. Training records we looked at confirmed that staff received training in respect of safeguarding adults which was in line with safeguarding policies. This showed us that there were processes in place to reduce the risk of harm to people who used the service.

Requires Improvement

Is the service effective?

Our findings

The acting manager told us that all training that staff undertook (with the exception of moving and handling) was carried out using specialised training DVDs. Records showed that training included, dignity and respect; equality and diversity; fire safety; health and safety; moving and handling and infection control. Staff were also trained in the MCA 2005; basic life support; safeguarding adults; and medicines administration. However, we noted that staff supported people with their catheter care. Although we saw records of spot checks undertaken by management to review staff safe practice, the provider was unable to show robust documented evidence of who had carried out catheter care training. One relative told us, "If it [the urine bag] bypasses the catheter the staff ring for the district nurse." One staff member said, "The [district] nurses deal with the catheters. We [staff] only empty it [the catheter bag]. If the catheter comes out or [the bag] overflows, or anything, we call the nurse to come and deal with it. We do not touch it."

The acting manager talked us through the development of their and their staff members' skills and knowledge. They told us that they were all being supported to complete national vocational qualifications in health and social care. This demonstrated to us that staff were supported by the provider to develop their knowledge and skills.

Records we looked at showed that staff had supervisions where they could discuss their performance and on-going development. However, these supervisions were not always a regular occurrence. The acting manager told us that only one staff member had worked at the service for over twelve months and they had not yet had their appraisal.

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 spoke with the acting manager about the MCA and Court of Protection. We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. The acting manager told us during this inspection that none of the people being supported by the service lacked the mental capacity to make day-to-day decisions or bigger decisions. This meant that there had been no applications made to the Court of Protection.

Records showed, and staff confirmed, that they had received training on the MCA. One staff member said, "We have had training in the MCA. It was not on line and I think it was by the [local authority]."

Care records we looked at documented whether the person required assistance from staff with their food and fluid intake and meal preparation. Where staff assisted people with their food preparation, there were prompts for staff within people's care records around any specific health care conditions. For example, "staff

were not to add sugar." Staff said they provided people with a choice of ready meals that they (the staff) then heated in the microwave.

Staff had an induction period which included mandatory training and the shadowing of a more experienced member of staff. People and their relatives confirmed that new staff had been with a more senior member of staff to 'learn the ropes'. We saw evidence that the provider had adopted the Care Certificate induction training programme, which staff completed whilst they were out working. This is a nationally recognised training scheme. All new staff had to complete an induction period until they were deemed competent and confident by the registered manager to deliver effective care and support.

Records showed where people were also supported by external health care professionals such as the district nurse team. One relative told us that staff had spoken with their family member on two occasions about skin issues they had noted. The relative said, "The staff [member] said [name] must tell the district nurse [who visited regularly as the person was a diabetic]." Another relative told us that staff encouraged and supported them to telephone the district nurse (and other health professionals) when necessary. This showed that external healthcare professionals were involved in people's care.

Good

Is the service caring?

Our findings

Records showed, and staff confirmed, that people or their relatives were involved in the development and review of their care package. One relative told us they had been involved when their family member returned from hospital. They commented, "Yes I was involved because it's [the care] exactly how we want." People and their relatives knew the times they expected staff to call to provide the care the person needed.

People said they were able to speak up on their own behalf or were supported by a relative who would speak up for them if it was necessary.

People told us that their privacy and dignity were valued. One person said, "They [staff] do help but I manage where I can. They [staff] wait until I ask for help." One relative said, "They [staff] treat him as a person. They don't talk down to him and are not patronising."

People and their relatives told us they had not been asked if they would have preferred to have their personal care provided by a male or female staff member. However, staff understood that most ladies, who had personal care provided, wanted to have a female member of staff. Staff confirmed that male staff were often part of a double up call (with the second person being a female member of staff) where moving and transferring was required, but did not provide the personal care for the person. One person confirmed they only had female care staff to provide them with their personal care and said, "I would not feel comfortable with a male". One relative said their family member was happy with male or female care staff. They said, "They are all very kind and gentle and egg him on if necessary [to do as much as possible to maintain his independence]."

People and relatives made a number of positive comments about the staff who provided their care and support. One person said, "Most of the carers [staff] are very nice. They don't talk about other people [who receive the service]. I have several regular carers and they are all very kind and if I need anything they will do extra things." They went on to explain a number of small household tasks staff helped them with. A relative said, "The staff are absolutely fantastic. They are friendly and helpful. They also look very smart in their uniforms." Another relative told us, "They [staff] are kind. [Name of relative] gets on with them [staff] and has a laugh and a joke. And that makes his day."

People and their relatives told us that they liked it when they had regular staff who provided their personal care. One relative said, "The regulars [staff] know what you like or what annoys you. It's different at the weekend." One member of care staff said that, when they looked after the same people, they came to know what the person liked. They said, "Everything is there, I know the clients [people who use the service] and they know me."

Good

Is the service responsive?

Our findings

People told us that they or their relative had been involved in the initial assessment before the care was provided. One person told us this had been done whilst they were in hospital so that care was ready when they were discharged, and the correct care was provided. Commissioning authorities provided details of people's needs before the provider agreed to provide a service. This was so that the provider could ensure the service could meet the needs of people.

Care plans included limited information on people's social history and any interests they may have had. People's preferences were recorded, but these records were sometimes limited. These were used as prompts for staff on how the person wished their care to be provided. People and their relatives told us that they had care plans and risk assessments in their home. One relative told us, "They [staff] keep a file [in the house]. They record [family members] urine [output], record what he's eaten for his meals. There are skin relief records." Staff said that care plans were usually in place before they were required to provide people's personal care. However one staff member said, "There are times when people come out of hospital and need a quick package [of care put in place so that they can be discharged]. In that case [name of acting manager] would inform us [and give details] as we go out and give us the low down [of the care expected]." They went on to confirm that when care was arranged in advance the care plans and record books were in the person's home prior to care commencing.

Reviews were carried out to make sure that people's current support and care needs were documented and up-to-date. Staff told us they were informed if there were any changes to people's health or wellbeing through a phone call from staff in the office and that care plans were updated as soon as practicable. One relative told us, "Yes they [staff from the office] have come out and checked [that the care provided by the service was correct] and there has been no change [to the care package required]."

People and their relatives told us they knew how to raise any complaint with the service and had the telephone numbers for the office should they need them. They all told us they had not made any formal complaints. One person said, "I have got something in a brochure [about how to make a complaint about the service] but I would ring the council, I know them there." One relative said, "I would telephone them [staff in the office] and I am sure they would listen and deal with any concern. But I have never had to do that."

Records of complaints received showed that they had been investigated and the complainant responded to, to their satisfaction where possible. Any actions taken were also recorded to reduce the risk of reoccurrence. However, we noted that the provider's service user guide, which was given out to all new people using the service, did not contain information for people and their relatives about the provider's complaints policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. However, they were not available during this inspection. There was an acting manager in situ who was responsible for the running of the service during their absence. The acting manager was supported by office and care staff.

People and their relatives told us they were not sure who the registered manager was but staff in the office were very helpful. One relative said, "I talk to the office [staff] most days. They are very good and try to accommodate any changes I need."

Quality monitoring systems were in place to check the quality of the service provided. The provider had recently engaged an external company to undertake an audit of the service. However, the action plan as a result of these audits findings had not yet been shared with the provider at the time of this inspection.

We saw that provider checks included people's daily notes and medicine administration records. Where improvement had been noted we saw documented records of the actions taken with the responsible staff member. However, some of the MAR sheets we looked at had been completed by staff in an untidy and unclear manner. This posed a risk of misinterpretation of these records by other staff members. At this inspection we found that not all areas requiring improvement had been noted and acted upon.

Records showed that staff meetings and office staff meetings were held and these were used to update staff on any 'trends' found from recent quality monitoring, the areas of improvement needed and any actions taken as a result of any concerns. These meeting were also used to update staff about the service. Staff told us meetings were often held every two weeks and were used for example to update staff on people's health, discuss any issues and talk about any training staff wanted to attend. One staff member said, "We discuss the clients [people who use the service], [given advice in areas such as] not giving personal details and make sure we are doing our job. We are free to speak and discuss any ideas we have [to improve the service]."

There was a mixed response when people and their relatives were asked about any checks in relation to the quality of the care they received. One relative told us, "I've had a form to say what I think [about the care provided to family member]. There were lots of different questions and you had to rate them as excellent, good, fair, poor or very poor." However one person and two relatives could not recall any request for information about the service. The acting manager told us they checked the quality of the service provided so that people and their relatives could be confident their / their family member's needs would be met. We saw that a survey had been sent out to people to ask questions under the headings, is the service safe, effective, caring, responsive and well-led. Records showed that there were positive responses received back, but that there were also areas of improvement noted. However, the responses to the survey had not been analysed to identify any trends that could improve the service provided.

It is a legal requirement for a provider to display the rating of their most recent CQC inspection within a communal area of a service and on their website. During this inspection the acting manager downloaded and displayed their current inspection rating and after the inspection they informed us that their rating was

now displayed on their website.

Management was aware of the incidents that occurred within the service that they were legally obliged to inform the CQC about. We saw evidence that they notified the CQC of any of these incidents in a timely manner.