Medacs Healthcare PLC

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an announced inspection carried out on the 7, 10 and 14 March 2017. This was the first inspection of the service since they became newly registered, due to a change of address in January 2017.

Medacs Healthcare PLC Leeds is a domiciliary care agency that provides support to people in their own homes in the Leeds area.

At the time of the inspection, the service had a manager registered with the Care Quality Commission (CQC); however, they had left the service recently. A new manager had been appointed but was not in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality 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 and associated Regulations about how the service is run.

Medicines were not managed safely. We found one person was receiving doses of their pain relief medication too close together which put their health at risk. We saw gaps in the recording of medicine administration and found cream charts did not show people were receiving creams as prescribed.

A number of safeguarding concerns had been reported to CQC by the local authority. These indicated people who used the service had been put at risk of harm from missed calls, poor moving and handling techniques, issues with medication and agreed tasks not being completed. We found staff were able to describe different types of abuse and what they would do to report alleged abuse but we found the systems in place to safeguard people had not been followed at all times.

People told us they felt safe using the service and they overall received their calls on time. However, some people said they did not always know which care worker would be visiting them or receive the care they expected at the time they had agreed.

People told us staff were generally kind to them and treated them with dignity and respect. They said staff were well trained to carry out their role. People were supported by staff who had received induction training which included shadowing more experienced staff. Recruitment of staff was managed safely.

There were systems in place to ensure people's nutritional and hydration needs were met. People's physical health was monitored as required. This included the monitoring of people's health conditions so appropriate referrals to health professionals could be made if needed.

People told us they were asked to consent to their care. However, the Mental Capacity Act 2005 legislation had not been fully implemented within the day to day delivery of care for people. The service had recognised this and had planned improvements in this area.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs. The care plans included risk assessments. However, we suggested some improvements were needed to care plans and risk management plans to ensure they gave staff detailed guidance on meeting people's needs.

The service had not been well-led as the system failures identified during the inspection had not been identified through the audit systems and quality control systems in place. A number of people who used the service said communication from the agency was at times poor and the agency had been slow to respond to concerns raised.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems to ensure the safe administration of medicines were not effective.

People who used the service had been put at risk of harm from missed calls, poor moving and handling techniques, issues with medication and agreed tasks not being completed.

Care was not always planned and delivered to meet people's individual needs and preferences.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments had not been completed to ensure the rights of people who used the service were fully respected.

People's nutritional needs were met and people had support to gain access to healthcare professionals.

Overall, staff received a thorough induction with training and shadowing opportunities and were supported through regular supervision and appraisal of their role.

Is the service caring?

Requires Improvement

The service was not always caring.

Overall, people told us they were supported by staff who treated them with kindness and were respectful of their privacy and dignity.

A small number of people told us they were not satisfied with how staff had treated them.

Staff had developed good relationships with the people who used the service and used their knowledge of people to provide person centred care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always provide accurate detailed information about people for staff to be able to provide individualised care.

There were systems in place for dealing with complaints and concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

The provider did not have effective systems in place to monitor the quality of the service they provided.

Some people told us that when they raised issues with the office they were not dealt with promptly.

Staff said they enjoyed working at the service and they received good support from the management team.

Medacs Healthcare PLC

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 7, 10 and 14 March 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure the management team were able to support the inspection. This is the methodology we use for domiciliary care agencies. We had received information of concern prior to carrying out this inspection.

The inspection was carried out by five adult social care inspectors, an inspection manager and three experts-by-experience who had experience of domiciliary care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the service, including on-going safeguarding investigations, statutory notifications and incidents affecting the safety and well-being of people sent to us by the service. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection providers are asked 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 did not ask the service to provide us with a PIR prior to this inspection.

At the time of our inspection there were 237 people receiving the regulated activity of personal care from the service. We spent two days at the provider's office where we spoke with the regional manager, compliance manager, training manager, three team co-ordinators and a team leader. We spent time looking at documents and records related to people's care and the management of the service. We looked at 20 people's support plans and ten people's medication records. Following the visit to the provider's office we

carried out telephone interviews with 17 people who used the service and 17 relatives. We also visited 11 people who used the service and spoke with four of their relatives during these visits. We also spoke with 9 staff in person and 13 staff by telephone. We spoke with two health and social care professionals by telephone.

Inadequate

Is the service safe?

Our findings

People told us they received the support they needed with their medication. However, we looked at the management of medicines and found this was not managed safely.

We looked at ten medicine administration records (MAR). In the main these recorded when people had received their medicines. However on two people's records staff had not recorded this consistently on the MAR so we were unable to establish if they had received their medicines as prescribed. One of these people did not have a MAR in place for the week we visited; therefore some medications had been administered but not signed for as per the provider's policy.

We looked at medicine administration arrangements when we visited people in their homes. For one person we saw all tablets apart from paracetamol were administered from a monitored dosage system that had been prepared by the pharmacist. Staff recorded the number of tablets they administered and the dosage box contained a list of the contents to show what had been administered. Paracetamol was prescribed; one or two tablets up to four times daily and were being administered twice daily which is what the person said they wanted. No stock record of paracetamol was maintained so we could not check the balance was correct. The person's care records contained no guidance around administration of as and when required (PRN) paracetamol to guide staff and help them understand in what circumstances PRN medicines should be given.

One person was prescribed regular pain relief medication; paracetamol and codeine to be administered four times daily with each dose being four hours apart. We saw over a two week period there were eight occasions when these medications had been given unsafely, with less than the minimum four hours between doses, which put the person's health at risk. We also saw this person had on two occasions not received their pain relief as their visit had been too close to the previous dose time which meant there was a risk the person would have experienced pain. We reported these concerns to the regional manager for their immediate attention. Staff told us they received training in medication management and their competency was assessed to ensure their practice was safe. They told us they were aware of the need to ensure safe time intervals between doses of medication such as paracetamol. However, a staff member we spoke with could not explain why they had administered paracetamol less than four hours apart.

We saw some people had topical creams and ointments applied by the staff. One person had four creams prescribed yet these were not detailed by name on the MAR and only one record was made on the MAR for 'all creams' so it was not possible to find out which creams were applied and to which part of the body. There was no guidance or reference to the use of creams in the person's care plan. Another person had two creams prescribed but no records of their administration were made on a MAR and there was no formal guidance for staff to follow which would describe the appropriate circumstances when these creams should be applied.

We also saw two people's care plans stated staff were to administer their medication; yet they confirmed they or their family member administered it. The medication assessment was contradictory. One of these

people had creams that were administered by staff. There was no reference to creams in the person's care plan or medication risk assessment. There was a MAR in place which showed two creams were administered. It was unclear if these were prescribed creams.

One person was prescribed a pain relief patch. Staff were not recording where they were placing the patch. These patches should be placed in different positions on the body at each application to ensure the prevention of skin damage. Another person was prescribed a pain relief patch and staff were changing this for the person despite this not being assessed as part of the care package.

There was a system in place where medicine records were returned to the office on a monthly basis. There was no audit in place to establish if these had been looked at by the office staff. We asked the regional manager who told us ," At the moment we have nothing in place to audit the MAR charts when they come back from the service, we are looking into this to ensure this is picked up when completing a care plan audit."

We concluded the above evidence indicated a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people who used the service were protected from abuse. Staff we spoke with told us they would report any sort of abuse straight away and they were aware of the different types of abuse. Staff were able to explain who they would report concerns to and were also aware of whistleblowing. One staff member said, "They are always on to us to report anything we see."

In the last three months a number of safeguarding concerns had been reported to CQC by the local authority. These indicated people who used the service had been put at risk of harm from missed calls, poor moving and handling techniques, issues with medication and agreed tasks not being completed. Concern was also raised that safeguarding matters had not been reported to the local authority and police where necessary in a timely manner.

The regional manager told us they had identified where communication on these matters had failed and showed us full investigations were under way or completed in response to the concerns raised. This had included further training, disciplinary action and dismissal of care workers. However, it was clear that systems in place to prevent abuse had not been operated effectively and people had been put at risk.

We concluded there was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act Regulations 2014.

The majority of people we spoke with told us they or their family member were safe and received care and support from familiar, consistent care workers; that their care workers arrived on time and stayed the agreed length of time. Comments we received included; "They are on time", "It's regular lasses all the time; we know who to expect", "They've never let me down yet", "They don't cut the calls short", "They come on time and I know who is coming because I have a list with it all on", "They stay as long as they should", "They are more or less on time, they ring if there is a problem", "They usually come on time. They ring from the office if they are going to be late" and "Yes I am happy, and they usually come within a reasonable time".

However some people told us they were not happy with the service delivery and said their care workers were frequently late or early for their calls and they did not always have a regular consistent team of staff to provide their care. People's comments included: "Well it's a bit hit and miss really" , "The timekeeping is fine when the regulars come but not so much with the others", "The morning call is 8.30am, last week they

hadn't come by 9.45am", "They are absolute rubbish, a waste of space, I have to do it all, they turn up at all times" and "The times are a bit all over the place but I understand and we don't mind, they get no travel time you see between calls."

One relative said they had tried to change the time of their morning call due to a change in their family member's needs. They said, "Well you might as well talk to yourself" as the call change requests had not been acted upon and care workers were coming far too early. One person told us their morning call had been changed from 7.15am to 8.30am, and was unhappy about this. They said their call had been pushed back because the agency had taken on 'another service user'. They said this meant they had to stay in bed for 13 hours. They also said the morning call which was 45 minutes duration was not sufficient and staff could not carry out all tasks in this period of time; care workers we spoke with said they had been putting in additional time and doing it in their own time.

Another person told us they were not happy with the agency due to the lack of continuity with their care workers , care workers being changed and the agency not letting them know, and care workers not having travel time so were always running late. They said, "No I am not happy with them at all. I think they are not properly organised. It is telling on them and on their customers. They change the visit times and the carers and they don't tell you. You get established (with a carer) and they get to know you and each other. Last week I had a new carer and a new time. If they only just phoned you to tell you. It seems they don't care about you and it's just about profit." This person also said they can spend long periods of time in bed as their evening call was sometimes early and their breakfast call late.

A relative told us sometimes care workers came too early to provide their family members lunch call. They said the call should be at 12.30pm but was taking place at 11.15am. They said their family member was not hungry at that time, didn't eat the food prepared and then got hungry, anxious and angry later in the day. Another person said, "A lot are late because they have slipped calls in."

Two people's relatives told us visits had been missed in the past; usually at weekends. They told us no harm had come to their family member as they had provided the care needed. However they were not happy to do this as one of them said they had care needs of their own. They said apologies and explanations were given for the missed visits and one person said, the agency had "upped their game" recently.

We looked at surveys, collated by another agency, completed by people who used the service in February 2017 and this showed the majority of people were satisfied with the punctuality and consistency of care workers. People's comments included; 'Good service. Carers are consistent' and 'We are told if care will change, they let us know if someone is running late or if the carer is not well they will tell us to expect someone different. I am very happy with my care.' Some people's comments were not as complimentary, they included; 'Care workers never arrive on time' and 'Client is unhappy being cared for by people he has not previously met.'

Some staff told us their work and travel schedule meant that sometimes they were unable to arrive on time for people. Some staff we spoke with said this was improving and call times were being planned better. They said they always communicated if running late to the office to ensure people who used the service were kept informed.

The regional manager told us a new system of templating rotas had been introduced to try and improve punctuality and consistency of care workers. A care co-coordinator showed us this system and we saw more travel time between calls had recently been introduced.

We concluded there was a breach of regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) 2014 as care was not always planned and delivered to meet people's individual needs and preferences.

Generally, risks to people were identified and managed so people were safe. However, in one person's care plan we saw they had some behaviours which may challenge the service and others. These risks had not been assessed in relation to what care workers should do if this happened. Care workers we spoke with could however describe how they managed these behaviours. Another person was at risk from skin damage and there were no risk management plans in place to show how their skin integrity was maintained. Environmental risk assessments were in place in all the care and support plans we looked at which covered a number of areas falls, moving and handling, use of bed rails and mobility. We saw accompanying guidance for care workers showing how these risks could be minimised in these areas.

There were effective recruitment and selection processes in place, which included people who used the service on the interview panel. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

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 saw a lack of documentation related to people's capacity to make decisions about how they would like to be supported in their home. Mental capacity assessments or best interest meetings had not been completed on specific issues such as supporting with personal care, or assisting with medicines. Where people were unable to make decisions the person's family member or health professional had not been consulted to support these decisions. In order for staff to know whether a person lacked capacity, a mental capacity assessment should be carried out to help them determine the type of decisions a person can make.

The consent agreement had not always been signed by the person or relative. We saw on two occasions where the service had put 'UTA' (unable to sign) on the documentation. The mental capacity policy in the service at the time of inspection stated ' Where a service user has been assessed as lacking capacity to make a particular decision any person subsequently acting on their behalf must act in their best interests and this includes family members and those with power of attorney'.

The regional manager told us they had identified the MCA was an area they needed to improve upon. Their service improvement plan detailed this and showed action to be taken such as improved training and a review of policies and procedures and documentation.

People told us they were supported to make their own decisions and felt they could influence what care they received. People told us they were asked for their consent to care interventions and were always asked for their choices on how they wished to be supported. One person said, "They always ask what I want and if it is alright to do stuff." When we visited people we saw staff asked for people's consent before any care was provided such as assistance with medication and meals.

Members of staff demonstrated a broad understanding of the MCA legislation and what this meant on a day to day basis when seeking people's consent. Staff we spoke with told us people were supported to make their own decisions. One staff member said, "We never force anyone to do anything they don't want to do." They told us some people had signed documents within their care and support plan and these included the risk assessments. Staff confirmed they had received training on the MCA as part of other courses completed. Several staff told us they thought they needed more training to have a better understanding of the MCA. Staff showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions.

We found people's relatives mainly dealt with people's healthcare appointments, although staff told us if

people needed to see a GP or became unwell during their visit then they would call either a GP or an ambulance and would stay with the person until help arrived. One staff member said, "I would take prompt action and never leave someone on their own."

During our visits to people we witnessed an accident and saw staff took swift action to prevent harm and also took medical advice on the situation. The incident was well managed and ensured the person received appropriate care and treatment. We also saw a staff member contacted a person's GP when a query over a medication issue was raised. They said they felt confident to do this on behalf of the person to make sure things were right.

People who used the service told us staff had responded well to any changes in their health needs and said they had called GPs out for them. A relative said "[name of carer] spotted my [family member] wasn't well and called the doctor and sorted out [family member] afterwards." Another relative told us a member of staff had identified that the air flow mattress used by their family member was not working. This was subsequently looked into and a fault was found which was then dealt with. This meant staff were responsive to people's healthcare needs. However, two people told us they did not think all staff were trained in the use of medical equipment such as catheter bags as they had experienced problems with staff not knowing how to close valves properly and this had resulted in urine soaked beds or carpets for people.

People where appropriate were assisted to maintain their nutritional and fluid intake. Staff told us they would prepare meals for people and ensure people had a choice of what they wanted. They told us they always left people with a drink in reach when they finished their visit. During our visits we saw a person served a meal which looked appetising and well presented. Staff asked if the person was satisfied with the meal and if they required any further support such as help to cut it up. A person who used the service said, "I'm well catered for in that department, I get what I want and they always make it nice." We saw this person had a plentiful supply of drinks within their reach for when the staff had left.

Overall, most people who used the service or their relatives said staff were well trained to carry out their roles. A relative said "They all seem well trained, you get the young ones but they are usually with a more senior girl until they know what to do." Other comments we received included; "Yeah I think they are trained properly", "All my girls know what they are doing with everything" and "It seems a very professional set up where training is concerned." Some people raised concerns that new staff didn't always know what to do and they had to be instructed. A relative said, "They all seem well trained but sometimes they are new and don't know what to do."

Staff we spoke with told us they were well supported by the management team. They said they received training that equipped them to carry out their work effectively. Staff said they received a good induction which had prepared them well for their role. We saw the provider had introduced the Care Certificate for new staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff confirmed they undertook shadow shifts as part of their induction, which meant they worked alongside more experienced staff and were introduced to people who used the service so they could get to know their needs. We saw records were made of the shadow shifts to document progress and competency. One record we looked at showed a staff member had commenced work unsupervised without completing the minimum number of shadow shifts identified by the provider's policy.

Staff we spoke with told us they had completed several training courses, which included health and nutrition, safeguarding, moving and handling, health and safety, infection control and medication. One staff member said, "It helps us do the job right and we get a refresher every year." Another staff member said,

"Training is adequate to help us support people." Staff said they completed specific training which helped people they supported. These included personality disorder, mental health and behaviours that may challenge the service and others. We saw training being delivered during our inspection. This was completed by staff in small groups and we saw there was plenty of opportunity for staff to ask questions and discuss their learning.

We looked at staff training records which showed staff had completed a range of training as they had described. We saw any updates or refreshers had been identified and there were systems in place to ensure this training was completed. We also saw staff received regular supervision and spot checks which gave them an opportunity to discuss their roles and on-going development. There was a system of annual appraisal in place.

Requires Improvement

Is the service caring?

Our findings

Overall, people who used the service and their relatives described staff as kind, caring and competent. People's comments included; "The girls are very nice and caring", "The carers are lovely with [family member], [family member] tells us they are nice to her and she likes them", "These regulars are really good", "The girls are great, you can have a good laugh and a joke with them, they are like my family" "Girls we get do a good job, everyone is polite. It's a lovely relationship" and "They have a chat with her. They're pleasant people; they've always got a smile on their face." People told us they never felt rushed and were treated well.

However, one person's relative reported the staff did not speak to their family member and another relative said a number of staff did not communicate well in English with their family member. A person who used the service said they had been spoken to in a disrespectful manner by a staff member but this person no longer attended their call. We reported this to the regional manager who said they would commence investigation into the matter.

Our observations showed staff were encouraging and supportive in their communication and interaction with people who used the service. We saw staff were polite and respectful of people's homes. For example, asking for permission to use people's toilets and making sure they kept areas tidy and clean. We saw people who used the service enjoyed the relaxed, friendly communication from staff.

Staff told us they always treated people with dignity and respect. One staff member said, "I make sure doors, curtains are closed when providing personal care. I am aware of people's needs." They spoke warmly about the people they supported. They said they provided good care and people's wishes were respected at all times.

Most people and their relatives told us staff treated people in a dignified manner and with respect. One relative said, "They are kind and compassionate and speak nicely to [family member]. The do promote privacy and dignity." A person who used the service said, "Modesty is always considered" and said they were helped to be as independent as possible. A relative said "[names of care workers) are both very nice and polite to my [family member] and ask before they do things."

Staff were trained in privacy, dignity and respect during their induction and we were told this was monitored through spot checks and supervision of staff. The compliance manager explained they were in the process of introducing the role of dignity champions. They said the dignity champions would be expected to demonstrate good practice and challenge any bad practice with regards to respecting people's dignity at all times. We saw information on becoming a dignity champion had been distributed to staff.

We saw care and support plans were developed and with input from people and their families. For example, one person's care and support plan stated it was written by the person who was receiving the care. Another person's care and support plan stated 'This care plan has been written following review of records and changes in the care package information gained from [name of person] and their family and discussions

with staff.'

A relative told us they had been involved in drawing up the care plan for their family member at the start of the service. A person who used the service told us they and their family were involved in planning their care and support. However, one person said they did not feel they were involved in their care plan. They said when they came out of hospital the agency asked their relative rather than involving them directly. They told us, "I had no say in the plan they worked out for me."

Staff said they received enough information to know how to provide care to meet people's needs. They said care and support plans provided details to help them understand people's care needs, likes and dislikes. One staff member said, "We would be introduced if someone was new, would go over the care and support plan, would have a discussion with other staff if needed and meet with the new person."

We found staff spoke confidently about the individual needs of people who used the service. It was clear they knew people and their needs well. They spoke with warmth and showed they had developed positive relationships with people.

Staff understood people's needs with regards to their disabilities, race, culture and religion and supported them in a caring way. A staff member described the way they met the cultural and religious needs of a person who used the service. They said they had been trained in equality and diversity and how to provide care in a manner that was acceptable for the person's cultural and religious beliefs.

Requires Improvement

Is the service responsive?

Our findings

Records showed people were assessed before receiving a care package with the agency. A full initial assessment had been completed by the Service Quality Assessor (SQV). This included information on how they would like to be supported with their personal care, medicines and general day to day needs and support.

A copy of the person's care plan was kept in the person's home and a paper copy was available in the office. This was so all the staff had access to information about the care and support provided for people who used the service. During our inspection we looked at 20 care records. We wanted to see if the care plans gave clear instructions for staff to follow to make sure people had their needs met.

Some care plans gave detailed, person centred information on how people wished to be supported. For example, 'Do not rush [name of person]' and '[Name of person] likes almond milk in her tea'. All but one staff spoken with said they found the care plans useful. They said they gave them enough information and guidance on how to provide care and support people needed and wanted. Comments included; "The care plans have good information and easy to follow", "I have no problem with the care plans has all the information I need" and "Care plans are good and always kept up-to-date. Any changes made to the care plan we are always informed." One staff member we spoke with said, "The care plans could be clearer of what you need to do."

We found there was insufficient and inaccurate information in some people's care plans. We saw one person's care plan said they used a commode; however their relative told us this was incorrect and the person had never used a commode. Another person's care plan had out of date information in; stating a task they could do for themselves. The person who used the service confirmed they could no longer do this and needed staff's support. We saw some people had creams to be applied yet there was no guidance in place for all staff to follow which would describe the appropriate circumstances when these creams should be applied. One person who was at risk from skin breakdown had no skin integrity care plan in place. One person's care plan stated in January 2017 not to have any food until the nurse had attended to check the person's swallowing. We did not see any information in the care plan to indicate to staff if or when the nurse had been to see the person. Daily records indicated the person had been receiving food two days after it was stated not to have food. This meant the person could have been at risk of choking. The regional manager checked with the care co-ordinator who confirmed the district nurse had seen the person and confirmed they could have soft foods. The regional manager agreed this had not been properly documented to reflect this.

These gaps and omissions in care plans could lead to people's needs being missed or overlooked. The regional manager and compliance manager told us they had identified the need to improve the care plans and we saw the service improvement plan in place which stated; 'Improved care plans with risks and risk reduction measures clearly documented, followed and reviewed or updated as necessary'. We saw the improvement plan stated who had responsibility for this and was linked to ensuring any training needs for staff were fulfilled.

We looked at daily notes that recorded the care and support delivered to people. Overall, these showed that needs and preferences were being met and staff were spending the allocated time with people. However one person's records showed their morning call was listed as 60 minutes, but was actually 45 minutes and their evening call was 30 minutes, but was listed as 45 minutes.

People told us the service was in the main responsive to their needs and they or their family member received personalised care. Most people we spoke with said they were happy with the service and the care they received. One person said, "I wouldn't be without them. I have a nice shower on a morning. They ask me what I want to do. I'm happy with everything. They usually come on time. They ring from the office if they are going to be late."

There were mixed views from people as to whether their care was formally reviewed. One person said their care plans had been reviewed, they felt involved in this. They said, "We were involved and [name of SQV] chatted about things." And "Any concerns [name of SQV] comes straightaway. They ring and check we are ok." Another person said, "We have a review every two or three months, they come and ask about everything." A third person said, "We had a care plan before they started and a review last week." Some people said they had not had a review for some time but were satisfied staff knew what to do to meet their needs. One person said, "I had a care plan to start with, can't say I've had a review recently, they ring sometimes."

The service had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. Staff we spoke with said they knew how to manage a complaint felt and felt confident management would listen and act on their concern. One staff member said, "I record all the information in the daily notes and would speak with my line manager." Another staff member said, "I would note it in the book and then ring the office."

The majority of people who used the service or their relatives said they had been provided with information on how to raise concerns and any concerns raised had been addressed promptly. Their comments included; "I haven't had to complain in a long time and when I did it was dealt with promptly" and "I would just ring them. When I have had occasion to raise a concern this has been responded to in a timely way."

We looked at records of complaints and concerns received. It was clear from the records that people had their comments listened to and acted upon. However some people who used the service did not feel satisfied with how their complaints and concerns had been addressed. Their comments included; "The office is very good at apologising when you ring up but not much else" and "They are nice to you on the phone, just hopeless at getting it right." One person told us they had complained at length about a requested change to their call times. They said, "Over and over they are not interested. Nothing's changed."

The regional manager said any learning from complaints would be discussed with the staff team once any investigations had concluded. Staff said they felt they were kept up to date on important issues that affected the service. One staff member said, "They make sure we are all aware if things are going wrong, for definite." We saw staff meetings were held and minutes showed staff had recently been reminded of their responsibilities in a number of areas. These included; signing of medication records, time keeping and missed visits, not following rotas, confidentiality and care refusal.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection, the service had a manager registered with the Care Quality Commission (CQC); however, they had left the service recently. A new manager had been appointed but was not in post at the time of the inspection. The regional manager was currently overseeing the day to day management of the agency. They were supported by a compliance manager, a team leader, a team of care co-ordinators and a team of service quality assessors.

We received mixed views from people who used the service on how well the service was managed. Some people were complimentary and felt that by talking to management aspects of their care had been improved mainly focused on timings of visits. Comments we received included; "It is a well-managed agency", "The office is always very helpful" and "The office is very nice if you ring them." One person told us communication was good; they said, "I can't fault them and they can communicate and I think it is so important, if someone is off sick I know exactly what is happening. Communication is important and is number one."

However, other people did not think the service was well managed and said they had encountered difficulties in their communication with the office staff and out of hours service. Their comments included; "The care is alright but the management, you think ,my word", "The office is alright when you ring ,but they are a bit disorganised like that", "The office is alright when you ring but they don't seem to communicate well amongst themselves, you ring up and cancel a visit and they still turn up" and "The main problem is if you ring at night time, the calls go to Manchester and they have no idea where anything is or what to do ,they are useless."

The regional manager said they had identified there had been some recent difficulties with communication and organisation in the branch office. We saw records which indicated this had been discussed with the management team and improved systems of communication and escalation of concerns systems were currently being put in place to improve performance in this area.

Staff spoke positively about the management arrangements and said they were very approachable and supportive. Comments included "It's a good run service. [Name of office manager] is approachable, helpful and supportive", "I know who to contact in the office, "I feel supported and I have never looked back since joining" and "They are supportive and so good." One staff member told us they had noticed improvements with communication in recent months. They said, "Some co-ordinators are still learning but it's getting better."

The regional manager told us of the measures in place to check that systems were safe and working effectively. We saw records of regular 'spot checks' that were carried out to ensure staff fulfilled their responsibilities and provided the support people needed. Staff said they received feedback from these and were told of good practice and if there were any performance issues.

An audit of daily logs had been completed over the last three months and showed issues such as not

recording call times correctly, failing to sign MAR charts and calls being too early had been identified. The regional manager said there was a plan in place to feedback the actions needed to the staff. We saw only five out of 46 had yet been actioned. There was no system of audit in place for care plans, risk assessments or MARs; all areas where we found there were concerns.

The compliance manager, who had only been in post for the last month, told us they had developed an audit tool based on the five areas of CQC inspection methodology. They told us they had a full audit of the service planned for the end of March 2017. They said, "This will be a starting point to look at where we are at the moment and where we need to be. This will look at what is working and what isn't working."

There were systems in place to ensure CQC were notified of reportable events such as safeguarding incidents, police incidents and injuries to people who used the service. However, these systems had failed recently and not all events had been reported promptly. The regional manager was aware of the failings in these areas and had identified what had caused this to happen. The regional manager had undertaken a full review of incidents and events and ensured all notifications were submitted to CQC.

We concluded there was a breach of Regulation 17 (Governance) of the Health and Social Care Act Regulations 2014 as systems in place had not been effective to monitor and ensure continuous improvement in the service.

People who used the service and their relatives were asked for their views about the care and support the service offered. In March 2017 a new initiative had been introduced to allow people to give feedback on the staff who supported them and nominate them for a 'Homecare Hero' award. We looked at some of the feedback forms which were in the process of being analysed. Comments were very positive and included; 'She is an extremely excellent care worker', 'She is so caring and always does a thorough job when she is showering and dressing me', 'She is very friendly and always concerned about how I am' and 'She never rushes me but gives me the time I need.'

We also received information from another organisation who had conducted a survey in February 2017 with people who used the service and their relatives. This demonstrated an overall high degree of satisfaction with the service in areas such as consistency of staff, call times, involvement and dignity and respect. This survey showed people were happy with the staff supplied. A small number of people had made negative comments about adherence to agreed call times and poor communication from the office staff.

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 9 HSCA RA Regulations 2014 Person-centred care Care was not always planned and delivered to meet people's individual needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected against the risks associated with medicines because the provider did not always have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Suitable systems and processes to ensure people were safeguarded against the risk of abuse were not operated effectively.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place had not been effective to monitor and ensure continuous improvement in the service.