Meadowvale Homecare Ltd

# Meadowvale Homecare Ltd

## Inspection report

Beehive Business Centre, Skelton Industrial Estate
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25 April 2019
29 April 2019
02 May 2019
08 May 2019
13 May 2019

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service: Meadowvale homecare is a domiciliary care agency which provides personal care and support to people who live in Redcar and Cleveland. The service supported children, adults and older adults living with physical and mental health conditions, including dementia. At the time of inspection 104 people were using the service.

People's experience of using this service: During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to person-centred care, the privacy and dignity of people, safe care of people, safeguarding people from abuse, effective governance, staffing and fit and proper persons employed.

We received mixed reviews about the quality of care which people received. People and their relatives told us their care was rushed when staff were late for calls. As a result people did not always receive the assistance needed. Staff left calls early because they did not have sufficient travel time. The high turnover of staff and lack of continuity with calls meant staff did not know people and did not have time to review care plans before supporting people. Dignity was not always protected and maintained. Staff were not always professional when carrying out care and support to people. Where people had the same staff team involved, they spoke positively of them.

Staff were not supported to deliver safe care to people. Care plans and risk assessments were not always in place where needed and did not provide staff with sufficient information to support people with the care they needed. People expressed concerns about the recruitment and training of staff. The provider did not have good practices in place to recruit staff safely and ensure they were supported to work at the service. The training programme did not support staff to deliver safe care to people. There were insufficient staff to provide care to people.

People were not safe using the service. The provider's lack of oversight and staff's failure to comply with the providers policies and procedures meant that some people had suffered abuse and current practices placed people at risk of potential harm. Quality assurance procedures were ineffective. There was no evidence to show that lessons had been learned since the last inspection by CQC. Many of the concerns identified during this inspection had been identified at the previous inspection. The provider had not addressed the action plans which they had shared with us following the last inspection.

Staff failed to understand and mitigate the risks to people. Incidents were not dealt with effectively which had led to, in some cases a delay in seeking assistance. The provider had not taken appropriate action to deal with incidents and did not have effective measures in place to minimise the risk of reoccurrence. People's personal information was not protected.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. Staff did not have any working knowledge of the Mental Capacity

Act (2008) and deemed people not to have capacity because of their health condition.

Recommendations from health professionals were not always followed and timely action to seek support when people needed medical assistance was not always carried out. Care records were not reviewed and updated when people's needs changed.

Some improvements had been identified with the management of medicines since the service had been placed into serious concerns protocol with the local authority, however continued improvements were needed to record keeping to minimise the risk of harm.

Staff had access to personal protective equipment. Some people had been supported to go into their local community to undertake social activities.

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

Rating at last inspection: The service was rated as requires improvement (Report published 9 October 2018).

Why we inspected:  This was a planned comprehensive inspection based on the previous rating.

At the last inspection we identified breaches in relation to managing the risks to people, medicines and recruitment. Staff were not supported by way of induction, supervision, appraisal and training. Staff were not working in line with the principles of the Mental Capacity Act and lacked understanding of it. Quality assurance systems were not in place; policies and procedures required review and the provider did not have the required oversight of the service. We issued requirement notices.

We issued a fixed penalty notice to the provider for failing to submit statutory notifications when required. They paid this in full.

Following the last inspection, the provider sent us action plans outlining how they intended to improve the service. We carried out this inspection to monitor the improvements.

Enforcement action: The service met the characteristics of inadequate in three key questions of safe, effective and well-led and requires improvement in caring and responsive. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor the service through the information we receive and discussions with partner agencies. We will continue to attend serious concerns protocol meetings with Redcar and Cleveland local authority.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to vary the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## 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 safe.

Details are in our Safe findings below.

**Inadequate**

**Is the service effective?**

The service was not effective.

Details are in our Effective findings below.

**Inadequate**

**Is the service caring?**

The service was not always caring.

Details are in our Caring findings below.

**Requires Improvement**

**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 well-led.

Details are in our Well-Led findings below.

**Inadequate**

# Meadowvale Homecare 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: One inspector, one pharmacist inspector, one assistant mental health inspector and one expert by experience were involved in this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, the expert by experience had knowledge and understanding of older people and dementia.

Service and service type: This service is a domiciliary care agency which provides personal care and support to people living in their own home.

The service had not had a manager in post who was registered with the Care Quality Commission since 29 March 2019 . Having a registered manager means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had been in post since 15 April 2019 and planned to become registered with the Care Quality Commission.

Notice of inspection: We gave the service 48 hours' notice of the inspection visit because we needed to visit the office to review care records and we needed to make arrangements to visit people in their own home.

Inspection site visit activity started on 25 April 2019 and ended on 13 May 2019. During this time, we carried out telephone interviews with people, their relatives and staff. We visited the office location on 25 and 29 April 2019 and 2 May 2019 to see the manager and office staff and to review care records and policies and procedures.

We asked the provider and manager to let people and their relatives know we hoped to speak with them about their experiences of using the service. They failed to let people know we were inspecting the service. With people's permission we carried out home visits on 25 April 2019.

What we did: Before the inspection we reviewed the information we held on the service. This included details of any incidents the provider must tell us about, such as any serious injuries to people. We contacted local authority commissioning and safeguarding teams and attended a serious concerns protocol meeting with Redcar and Cleveland local authority about the service. We used this information to plan our inspection.

Due to technical problems, we did not receive the information which the provider had submitted in the provider information return (PIR). This is information we require providers send us to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we contacted 32 people and nine relatives. We spoke with the provider, manager, deputy manager, two coordinators, two office staff and 13 care staff. We reviewed 11 care records, 16 staff recruitment records, ten staff induction records, ten supervision and appraisal records and the training matrix for all staff. We also reviewed records relating to the day to day running of the service.

Inadequate

# Is the service safe?

## Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At inspection in 2018, we rated this key question as requires improvement and at this inspection we found the service had not improved. At the last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. People had not been protected against the risks of abuse, medicines were not safely managed, and recruitment was not robust. These concerns led to breaches of Regulations 12 (Safe Care and Treatment), Regulation 13 (Safeguarding people from abuse) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found all these issues had not been resolved.

Systems and processes to safeguard people from the risk of abuse.

- People were not protected from the risk of abuse. People had suffered from financial abuse because staff failed to follow the policies in place.
- Safeguarding alerts were not always submitted when required.
- One person suffered abuse because they were given too much medicine. Staff ignored relatives concerns and failed to follow the medicines policy or seek assistance.
- Safeguarding investigations were not always investigated sufficiently.
- Staff did not raise concerns about the practices and behaviours of other staff when needed.

The above concerns demonstrated a failure to protect people from the risks of abuse. This was a continued breach of regulation 13 (Safeguarding people from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management.

- People were not protected from the risk of harm. Staff did not recognise when people were at risk of harm or how to minimise the risk of harm. Where risk assessments were in place they were not appropriate, accurate or up to date.
- Staff did not take appropriate action when incidents took place. Timely assistance to seek medical assistance was not always sought.
- Comprehensive investigations were not carried out when incidents took place. The provider and previous manager were unaware that some incidents had taken place because staff had not reported them.

The above concerns demonstrated a failure to provide care and treatment in a safe way in regard to identifying and assessing potential risk of harm to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
● Recruitment was not safe. The providers recruitment policy was not followed.
● People told us some staff recruited were not caring and did not have the necessary skills. Comments included, "Some staff should not be employed. Their hearts aren't in it." And, "Some [staff] have no common sense."
● Gaps in employment were not explored. Risks assessments were still not in place for people with convictions on their Disclosure and Barring Services check.
● There was a very high turnover of staff. Systems to address turnover had not been sufficiently implemented.

Effective recruitment of potential candidates of employment had not been carried out. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not enough staff to deliver the care and support which people needed. The same staff team were not routinely involved in people's care.
● People told us they were not made aware when the staff allocated to their care changed and did not always receive a rota for their care.
● Staff arrived late for calls, rushed people through calls and left calls early. Comments included, "Carers are often late." And, "They [staff] are always in a rush."
● Staff were not always allocated to calls appropriately. One comment included, "Some girls [staff] don't drive and they are here to take me out [in the car]."

The above concerns demonstrated a failure to ensure there were enough staff on duty to provide safe care and support to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely.
● Medicine records were not up to date. Records for prompting people with medicines was not in line with national guidance.
● Systems for applying topical creams were not robust. Information about topical creams were not available in all records reviewed.
● People expressed concern that staff were not confident dispensing medicines. Comments included, "Some [staff] I'm not so sure [are competent giving medicines]." And, "They [staff] don't feel comfortable giving the tablets, I can see that."
● Medicine audits had highlighted some gaps in records and these had been investigated.

The above concerns demonstrate an absence of effective systems to monitor the safety of medicines. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong.
● There was no evidence that lessons had been learned since the last inspection. The risk of harm to people had increased. The provider has not taken action to ensure people received safe care.
● Incidents were not reviewed to determine how lessons could be learned. Robust systems were not in place to minimise the risk of abuse.
● The provider and staff were not responsive and failed to follow the providers policies and procedures.

The above concerns demonstrate a lack of effective systems to ensure the safety of people using the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were protected from the risk of infection. Staff had access to personal protective equipment, such as disposable gloves. The use of this type of equipment was verified during spot checks of staff.

Inadequate

# 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.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At inspection in 2018, we rated this key question as requires improvement. Staff were not supported by way of induction, supervision, appraisal and training. Policies in relation to these had not been followed. Staff did not follow the principles of MCA. These concerns led to breaches of Regulation 17 (Good governance) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had not been made.

Ensuring consent to care and treatment in line with the law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. Where people are deprived of their liberty in their own homes, applications must be made directly to the Court of Protection (CoP). We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA).

At the time of inspection, everyone using the service had capacity to make their own decisions.

Ensuring consent to care and treatment in line with law and guidance.
- Staff had very limited knowledge of MCA despite undertaking training. Staff gave incorrect information about people's capacity. Staff said people with dementia did not have capacity to make decisions.
- Staff did not understand people could make unwise decisions despite having capacity.
- Care records identified restrictive practices were in place. They did not show any rationale or consent to carry out this practice.

Effective systems were not in place to support staff to work within the principles of MCA. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
- New packages were accepted without the information needed to determine if people's needs could be met.

● People's support needs were not robustly reviewed when changes occurred.
● Staff were not proactive in seeking advice and following guidance given.

The systems in place did not support staff to assess people's needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience.
● Staff were not supported by way of comprehensive induction, supervision, appraisal and training.
● People told us some staff did not have the values and behaviours to provide good care. Comments included, "Some [staff] are hopeless."
●The current training programme was not effective because staff did not demonstrate competency in their roles. People and relatives raised concerns about staff practices.

The systems in place did not support staff to deliver safe care and support to people. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet.
● Some care plans were not updated when changes took place. For example, one person was supported with their dietary intake, however food and fluid records did not accurately reflect the most recent dietician letter.
● People expressed concern that some staff did not have the skills to support their dietary needs. One person said, "The evening meal is a problem, some [staff] can't boil an egg."
● There were no records to demonstrate staff had undertaken training in food hygiene.

The systems in place did not support people effectively with their nutritional needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support.
● Care records were not updated when people had hospital admissions or following healthcare appointments. Staff did not know if people's needs had changed.
● Where people required medical assistance or advice from health professionals, staff did not always act.
● Staff did not follow the recommendations in place from health professionals. This included moving and handling and percutaneous endoscopic gastrostomy regimes.

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

Requires Improvement

# 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 did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence.
● Some staff used inappropriate language and derogatory terms when supporting people with their care. Comments included, "[Staff use] a bit of bad language, [it's] not directed at anyone, in general." And, "They [staff] are in another person's home, some forget that."
● When people asked for assistance, for extra time or for staff to slow down they were ignored. One person said, "They could help me a bit more. Staff tell me to 'hurry up."
● The culture of staff behaviour had not been addressed by the provider.

The practices of staff did not support the dignity of people. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity.
● People were not always treated with kindness and compassion.
● Some staff did not communicate with people when staff supported them. Comments included, "Communication needs to be improved. They [staff] don't talk to me." And, "They [staff] don't chat."
The practices of staff impacted upon the support which people received.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people were positive about their care. Comments included, "If you have a good carer they are worth their weight in gold." And, "If I ask for help I get it."
● People valued staff. Comments included, "[Staff] mixes with my friends like she's one of them. [Staff] doesn't make an issue of my disability." And, "They [staff] encourage me to be independent all the time."

Supporting people to express their views and be involved in making decisions about their care.
● The current care review process did not support people to raise a concern because the staff involved in their care were in attendance.
● When people or relatives raised concerns or asked for care plans to be updated, staff did not address these.

Systems to allow people to provide feedback about their care were ineffective. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
- People did not always receive the care and support they needed because they were rushed through calls.
- When care was rushed, topical creams were not always applied, clothes were not always put on correctly causing discomfort and people were not always seated comfortably.
- Staff did not know people well and did not review care records. Staff used social media to discuss people's care.
- Staff had limited knowledge of the Accessible Information Standard. Care records did not support staff to meet people's identified individual needs. This led to gaps in people's care.

These concerns demonstrate a failure to provide person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people experienced good care. Comments included, "[Carer is] excellent, she does everything thoroughly and with care." And, "They [staff] go above and beyond the call of duty."
- People were given information about local groups and activities to increase their social contact. One person said, "The service has made a considerable difference to my life. I now go to choir classes, music groups and folk clubs."
- The provider hosted coffee mornings for people which they said they enjoyed.

Improving care quality in response to complaints or concerns.
- Complaints had been raised, however records were not available for review during inspection.
- We heard mixed reviews about whether people could raise a concern.

End of life care and support.
- No-one was receiving end of life care at the time of inspection. A policy and training were in place to support end of life care; however, staff were not familiar with these.
- At the time of inspection, there were insufficient systems in place to support the delivery of care to people who required end of life care.

Inadequate

# 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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At inspection in 2018, we rated this key question as requires improvement. There was a lack of oversight by the provider, quality assurance systems were ineffective. Policies and procedures had not been followed and required review. These concerns led to a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements not been made.

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.

- The provider did not have oversight of the service. Quality assurance measures were ineffective and had led to deterioration at the service.
- People were not safe using the service and current practices increased the risk of harm to people. This had not been identified by the provider.
- Systems to allow staff to raise concerns were not effective. The values of the service were not promoted.
- There was no shared understanding of the current risks in place.

This failure to have oversight of the service had led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- All staff failed to follow the policies in place. This increased the risk of harm.
- Where incidents have occurred, they have not always been reported or been dealt with sufficiently.
- The current manager was not supported adequately to make the required changes.
- There were mixed reviews about the culture. Some staff said they were not listened too. Other staff said they enjoyed working at the service and said the provider was supportive.

This failure to ensure effective systems were in place to support the service led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Notifications about some incidents had not been submitted when required.

This failure to submit notifications led to a breach of regulation 18 Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

- Feedback was sought, but not used to improve the quality of the service.
- Staff meetings took place, but did not support staff to improve their practices.
- Current methods of engagement to drive improvement were not effective.

Continuous learning and improving care and working in partnership with others.

- The provider and staff were not committed to providing good care and driving standards.
- The service was involved in schemes to increase recruitment into the care sector, however the provider did not have the right systems in place to safely support new staff and embed the right practices to deliver safe care.
- Information following incidents was not used to drive improvement.

These concerns demonstrate a failure to improve the quality of the service led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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<br><br>(1) People did not receive person-centred care when their calls were rushed. Staff did not have knowledge of people they supported. Care records did not support staff to provide person-centred care because they were not up to date. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>(1) People's dignity was not respected and maintained at all times. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>(1) People were not safeguarded from the risks of abuse. Staff could not demonstrate any knowledge of MCA and carried out restrictive practices. |

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>(2) Notifications were not always submitted when required. |

**The enforcement action we took:**

We issued a fixed penalty notice. This was paid in full by the provider.