Medacs Healthcare PLC

Medacs Healthcare Old Trafford

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over several days between 6 and 14 March 2017. We gave one working day's notice before the first day of the inspection in order to enable the service to prepare lists of people using the service for us to visit and telephone.

The previous inspection of this service was in February 2015 when it had another name, Medacs Healthcare Manchester, although it had just moved to its new offices in Old Trafford. At that inspection we found the service to be 'requires improvement' in four areas and overall. We found no breaches of regulations.

Medacs Healthcare Old Trafford (Medacs) is a domiciliary care agency providing personal care and other services to people in their own homes and in one extra care facility. The service covers primarily the local authority areas of Manchester City, Trafford and Tameside. At the date of our inspection the service was providing care to approximately 550 clients in the three local authority areas.

There was a registered manager in post who had taken up her position in June 2014. 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 2008 and associated Regulations about how the service is run.

People receiving the service told us they felt safe when the care workers visited. They were however unsettled by late visits and missed visits, by visits being cut short and by unfamiliar care workers arriving.

Missed visits had been a historical problem with this branch of Medacs. The list of missed visits showed over 100 missed visits in a year, but we came across further missed visits which were not on this list. Consequences of missed visits could be very serious, although they were a small proportion of overall visits made.

Action was being taken. The causes of missed visits were analysed and disciplinary action taken when needed. One potential cause was a care worker receiving more than one call on their rota at the same time. We were assured this would no longer happen once a new mobile phone system was introduced.

We considered that the level of missed visits was unacceptable and was a breach of the regulation relating to the safety and welfare of people using the service.

Recruitment procedures were robust. Staff were trained in safeguarding and knew how to report abuse and whistleblow if necessary.

Staff were also trained in administering medication. We considered that the care plan should specify what medicines people were receiving to reduce the possibility of errors.

People using the service thought their care workers were well trained, on the whole. All new staff did a three day induction followed up by the Care Certificate. There was ongoing refresher training for all staff, and specialist courses were available.

Staff received regular supervision and were often observed by their supervisor while delivering care. Not everyone had received an annual appraisal.

The service was aware of the requirements of the Mental Capacity Act 2005 (MCA). The policy on consent was clear, but the form used to record consent if a person lacked capacity to consent did not make clear that a family member alone cannot give consent in those circumstances.

Staff supported people to access healthcare services. Where it was required, staff prepared food for people using the service which was generally liked.

People gave us positive feedback about the care they received. They particularly valued their regular care workers. We found evidence that carers were sympathetic to people's needs. People thought that care workers respected their dignity.

Care files and personal data were kept securely in the office. Staff were mindful of treating people equally.

Care plans were created using the support plan provided by the local authority. In some cases there was not enough detail to equip staff to deliver person-centred care. In other cases there was a lack of information in the care plan to tell staff how to deliver care safely. This was a breach of the regulation relating to care plans meeting the needs of people using the service.

People and relatives had been involved in writing and reviewing their care plans.

Some people were unhappy about the response to their complaints, but others were very happy and said their issues had been resolved. Records showed that all formal complaints had been dealt with inside four weeks. Complaints were being analysed to identify any common themes.

Medacs were discussing providing activities in the extra care block of flats where they were now providing personal care throughout the day and night.

Medacs conducted surveys of people using the service and also ran a "Healthcare Heroes" scheme inviting good feedback on care workers.

Some people commended their care workers but criticised what they thought was a lack of response from the office. Staff gave a mixture of views about what it was like to work for Medacs.
There was a high staff turnover and a constant recruitment campaign.

There was a good structure of support for the registered manager both within the office and from Medacs senior management.

There was regular monitoring of care workers. There were audits of staff files. There had been an audit of care files but with a limited remit.

We considered that the level of missed visits, although reported on in our earlier reports, had not been identified by the provider as a serious enough issue. Although steps were now planned to attempt to reduce

the number, the fact that so many had occurred represented a breach of the regulation relating to monitoring the quality of the service.

We found breaches of three regulations 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 end 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?

Requires Improvement

The service was not always safe.

People thought the care workers kept them safe. However, some people told us about missed visits. The office had recorded a number of these and we found others.

Medacs followed recruitment practices to ensure that staff were suitable to work with people in their homes.

Staff recorded when they gave medicines but there was no record on the care plans as to which medicines people were taking.

Is the service effective?

Good

The service was effective.

Training was thorough and equipped staff for their role. New staff took the Care Certificate.

The service applied the principles of the Mental Capacity Act 2005 The form used to record consent by family members required revising.

People were generally happy with the food provided by Medacs. Staff referred people to healthcare services when needed.

Is the service caring?

Good

The service was caring.

We received very positive feedback about the quality of care that people received. Medacs staff were commended for being sympathetic and respectful.

Personal information was stored confidentially.

People using the service were treated equally.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always provide sufficient information to enable staff to deliver safe or person-centred care.

Complaints were generally dealt with appropriately but some people told us that they had raised issues informally but not received a response.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a good structure to support and assist the registered manager.

Medacs monitored the quality of the service through surveys. There were also observations of staff as they provided care.

The level of missed visits had continued from earlier reports. There were now plans in place to reduce the number, but we considered more should have been done sooner.

Medacs Healthcare Old Trafford

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.

The inspection took place between 6 March and 14 March 2017. We gave one working day's notice before the first day of the inspection to enable the service to prepare lists of people using the service for us to telephone and visit. One inspector visited the office on Monday 6 March 2017. Two experts by experience made telephone calls to people using the service on Wednesday 8 March and Thursday 9 March. On Monday 13 March one inspector visited people in their homes by prior agreement, and another inspector visited an extra care housing scheme where Medacs provide personal care. On Tuesday 14 March the lead inspector returned to the office to complete the inspection and give feedback.

The experts by experience who conducted the telephone calls had personal experience of caring for someone who uses this type of care service. These experts by experience had experience of caring for elderly people.

Prior to the inspection we reviewed the information we had gathered about the service, including notifications received from and about the service. The provider had submitted a Provider Information Return (PIR) in June 2016. 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 reviewed the results of questionnaires we had sent out to 50 people using the service, and to relatives, staff and professionals. Altogether 26 questionnaires had been returned.

Before the inspection we contacted commissioners in Tameside, Trafford and Manchester and the contract officer of Manchester City Council responsible for Medacs.

During the inspection we spoke with the registered manager, the quality officer, the training manager, the recruitment manager, four care workers and two care co-ordinators. We looked at policies, seven care files, three staff files, training records, the results of questionnaires carried out by Medacs, complaint files and safeguarding documents.

By telephone we spoke with 18 people using the service and seven relatives. We visited people in their homes and spoke to five people receiving the service and four relatives. In the extra care housing scheme we spoke with six people using the service. We followed up some of the information gathered from the phone calls, on our second visit to the office.

Requires Improvement

Is the service safe?

Our findings

We asked people using the service and their relatives whether they felt safe when the care workers came to their homes. We received some positive responses: "Most certainly, I feel safe."
"I do feel safe; they (the care workers) tend to me and do what I want them to do." "I have two carers, four times a day. I feel safe because there are two carers together." "They're very good. I feel protected when carers are here." "They make me feel safe. They are an absolute godsend. I can't imagine not having them."

In the extra care facility people lived in their own flats and received regular visits to deliver personal care and help with the activities of daily living, from Medacs staff who were present in the building 24 hours a day. They could also summon help using pull cords if they needed. People told us that staff would usually come quickly if they needed them. People told us they felt safe and well looked after.

Relatives we spoke with by telephone and in people's homes said they felt confident with the staff and that their family members' needs were being met. There were however four recurrent themes which people using the service and their relatives raised with us. These were late visits, missed visits, visits being cut short and lack of continuity of care staff.

Medacs used a system called Electronic Call Monitoring (ECM. The care worker used the person's telephone for a free call which registered when they arrived and again when they left. This would only pick up a missed visit if the system was being monitored. In some cases where a person was particularly vulnerable or there had been previous missed visits, their visits were put on an alarm which meant that office staff would be alerted by a flashing screen if the care worker had not turned up after a set period. This was not done for all people using the service.

We received a variety of feedback about the reliability of calls. One person said, "I have no concerns at all. They've never let me down and are very reliable." But other people were less satisfied with the service. One person said: "Many times they've let me down. Over Christmas, between 28th December through to 7th January, there were two days when I had nobody at all. I'm diabetic so need to eat at regular times because of my medication. I need to have my breakfast at about 8.30 and my lunch at about 12. I phoned the office three times when it got to 11am and nobody had been, and they just said the carer was running late. It's terrible on Sundays. All they say is the carer is running late or we're short staffed or they're on their way. It's one excuse after another."

We checked this person's care file in the office and the list of missed visits which was compiled from computer records, but there was no record of them having had missed visits. This cast doubt on the reliability of the list of missed visits.

A relative said, "They are often very late and I have to phone through to see if they are coming or not because they never let us know and (my relative) gets anxious if she thinks they're not coming." Several other people reported that arrival times were erratic. They said they were sometimes informed by the office if their care workers were going to be very late, but this did not always happen. Another criticism raised by

some people was about the care workers cutting short their visits. One person said, "She is supposed to come for half an hour in the morning but stays ten minutes. She says she is too busy." Another person added that on Sundays, "They write in the book that they've stayed for half an hour but they never have. It might be ten minutes." A few other people also complained that the care workers often did not stay for the allotted time, although they wanted them to.

Medacs kept a record of missed visits which were recorded on their system. There were over 100 in the year from March 2016 to March 2017. The true figure was higher, because we found reference to a few other missed visits in paperwork provided to us. One relative described two missed visits which, we checked, they had not reported to the office, because they were not on the list.

We bore in mind that Medacs was a large provider. For the first half of this period it had around 440 people using the service, and had then taken on from two other providers an additional 130 people in Tameside in October 2016. At the date of the PIR in June 2016 staff were delivering over 7,500 care visits a week, a figure which was higher after October. This put the number of missed visits into perspective, as a very small proportion of overall visits. Nevertheless, a missed visit ought not to occur, and can have serious consequences. We had been notified of one occasion when a person had been left in their armchair until the following morning, because their bedtime care visit had been missed. In other cases medication had not been administered. This applied to some people for whom the timing of their medicines was critical. One report of a missed call came in during the inspection, where the social worker stated the person was "very distressed because the carer worker failed to attend [for] a planned visit."

We discussed the issue of missed visits with the registered manager. She explained that there had been a problem in the Tameside area following Medacs taking over a contract from another provider at the end of October 2016. Many of the staff who had been expected to transfer from the former provider chose not to do so at the last minute. This had caused the service some initial difficulties in delivering care to over 100 new people using the service. However, we noted only seven missed visits in the Tameside area in November 2016, which was not a higher rate than in other areas in other months.

We saw that missed visits were taken seriously and the causes investigated. For each reported missed call a form was completed which set out full details of the incident, whether any harm had been caused, and whether any action needed to be taken, in the form of spot checks or disciplinary action. In addition the quality officer (who had been appointed to that role in September 2016) conducted an investigation into each missed visit, took statements from the staff involved and recorded a conclusion as to where responsibility lay. This was usually either with the care worker or the care co-ordinator. For example one care worker admitted in their statement that they had made a mistake when copying the rota from an email. The quality officer decided that this care worker should receive a printed version of the rota. Often the problem arose when additional visits were allocated to a care worker during the week. The care co-ordinator was supposed to obtain the care worker's confirmation that they had received the call and could do it, but the system did not always work.

In one case an extra lunch visit each day had been commissioned for a person using the service, which included ensuring they took their medication. The care worker had received these additional visits on their weekly rota but had assumed they were an error (because they were extra to the person's usual calls). They failed to check this with the office. As a result the call was missed on five successive days. The care worker was disciplined for this, receiving a written warning.

Another problem we saw was that staff were sometimes given rotas with clashing visits, i.e. two visits overlapping or at the same time. One care worker told us this was particularly a problem at weekends. They

showed us their rota for the current week. On both Saturday and Sunday the rota required them to attend one person from 12 noon to 12.30, and a different person from 12.05 to 12.25. On the Sunday they had three different calls scheduled at 8am. The registered manager explained to us that the rotas which were sent out weekly commencing on a Monday were supplemented by a more accurate rota before the weekend. However, one example we were shown of the 'finished weekend rota' still had two clashing calls, one from 8 to 8.30am and one from 8.10 to 8.30am. Both of these calls were listed as 'time critical'. We were told that the care worker had the flexibility to rearrange calls but in our view the visits should have been planned accurately in advance. Clashing calls inevitably increased the likelihood of late or missed visits, as well as causing care workers to cut visits short in order to attend the next one.

One member of staff had used the questionnaire we sent out prior to the inspection to refer to clashing calls and the effect this had on the delivery of safe care: "My rota regularly has clashing calls, sometimes I have four or five calls at once. This means I am constantly rushing and feel I cannot provide the best care possible. I regularly get abuse from families because I cannot get to them at the specified time.

"When these calls clash, they are reported to the office, the office are informed that sometimes there will be a two hour delay because of the clashes, I have been told that there is always someone on call at the office to come out in situations like this, but this doesn't happen, instead clients are sometimes left for hours after their call time in soiled clothing because we cannot get to the calls on time and nobody from the office will come out to do the call."

The registered manager told us about two steps that were planned with a view to reducing the level of missed visits and clashing calls. Medacs had invested in a new system using mobile phones which would carry the up to date rotas so that staff would always have an accurate rota including additional visits. The software would not allow clashing calls to be scheduled. Staff would log in and out of visits and the system would automatically alert office staff if someone had not turned up for a visit. In principle this system would reduce missed visits and clashing calls. We will check on how it is performing at our next inspection.

The second new step was that the registered manager had been asked to meet with a recently appointed quality manager to devise an action plan to reduce the incidence of missed visits. This showed that Medacs were aware of the issue and taking steps to address it. However, missed visits were an issue in a previous inspection as far back as January 2014, so the action plan was overdue.

The incidence of missed visits, and clashes on rotas, was a risk to the safety and wellbeing of people using the service. This was a breach of Regulation 12(1) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at three files of recently recruited staff to ensure the correct procedures were being followed to recruit suitable staff. We found that the system had not changed from the last inspection. Each file had a checklist of necessary documents that had been provided by the job candidate. These included proof of identity, a 'registration form' (in other words an application form) and information about any gaps in working history. There was a record that a check had been made with the Disclosure and Barring Service (DBS) as to whether the person had any criminal convictions or cautions recorded. In addition on each file were recorded the candidate's answers to interview questions, and references from previous employers. This meant that precautions were taken to ensure only suitable staff were employed.

Care files confirmed that Medacs had risk management systems in place. Staff all received training in safeguarding as part of their induction and this was repeated annually. Staff we spoke with knew how to recognise abuse and how to report it. One said, "If I am worried about anything I report it. I am sure everyone

would whistleblow if they saw a colleague doing something wrong." Incidents of alleged safeguarding were reported to the local authorities and to CQC. Often a local authority would ask Medacs to investigate safeguarding allegations. This was usually done by the quality officer and we saw their reports were thorough and did not shy away from finding fault with Medacs when appropriate.

For many people assisting with or administering medication was part of the care provision. Although most of the people we spoke with administered their own medicines, or a relative did so, one person who did receive support with medicines said, "They come at 7pm; the carer gets my dosette box and checks I take my tablet. I quite happy with this." Another person told us the care workers administered eye drops at night, and did so wearing gloves in the correct way. When care workers did administer medicines, people told us they recorded them on the correct sheet. We witnessed this being done in the extra care housing scheme.

One of the care staff drew our attention to an issue regarding the recording of what medicines a person was taking. The medicines care plan did not specify what medicines a person was taking, and the Medicine Administration Record (MAR) had a box to record how many tablets were given but no information about what the tablets were. The medicines were given from dosette boxes prepared by pharmacists, which usually came with a picture of what was in them, so staff could check that the correct tablets were in each box. There was no easily accessible record of what medicines a person was taking if they needed to go to hospital in an emergency.

We discussed this issue with the registered manager who explained that it was the provider's policy and this paperwork was used across all Medacs branches. She acknowledged there was an issue and said she would raise it with senior managers.

People using the service told us they were satisfied with the hygiene precautions taken by staff. One person said, "They wear gloves, I am happy with how they shower me." Another person said, "I have a walk in shower, they help and wash my hair; they are clean and wear gloves and aprons. They fold the towels up and empty the commode." A third person confirmed, "They always wash their hands and use gloves." This evidence showed that hygiene and infection control were promoted by Medacs staff.

Good

Is the service effective?

Our findings

We asked people and their relatives if they felt their care workers were well trained to carry out their role. The majority of people we spoke with including relatives said they thought their care workers were skilled and well trained. One person said, "I think they're well trained. If carers have not been before they will come with an experienced carer. They show them what to do and they call it a double up." Another person said, "I think the carers who do come really know what they're doing, so I think they must be well trained."

Other people said: "When they come they get on with the job. They know how to use the turners and the wheelchair," and "They seem to know what they are doing and they (the office) send them for training on a refresher course." One person, however, thought more initial training would be beneficial: "I think they could do with more training."

All new staff undertook a three day classroom based induction course which was based on the Care Certificate standards. Staff who were transferred from other providers under TUPE (the Transfer of Undertakings (Protection of Employment) Regulations 1981) were also required to take the three day induction. The Care Certificate is a nationally recognised set of standards which form the basis of an induction and development course for new support workers. All care workers were expected to complete their care certificate within 12 weeks of starting. We saw the induction training workbook which was detailed and included written and oral exercises based on situations which the new staff would be likely to encounter. The topics included providing effective person centred support, safe administration of medication, fire safety, infection control, food hygiene, basic life support, nutrition and hydration, dementia awareness, safeguarding, and safe moving and handling. Following completion of the course new staff went out to shadow existing staff, initially for two four hour shifts. There was no set duration for how long the shadowing would last. This would depend on senior staff's assessment of the suitability of the new staff member to work independently. Twelve staff who responded to a questionnaire sent on behalf of CQC all responded that their induction had prepared them fully for their role before they worked unsupervised.

Subsequently there was refresher training. Basic life support, medication and moving and handling training took place in the classroom in the Medacs offices. Other courses were arranged online, and staff members' progress and completion of these was monitored. The mandatory updates were health and safety, basic food hygiene, dementia, safeguarding adults and children and basic first aid awareness. The training manager showed us spreadsheets which recorded completion and highlighted if a staff member had needed encouragement to complete the courses. We saw that a few staff failed the classroom refresher courses and had to repeat them. This showed that the service was proactive in ensuring that everyone kept their essential skills updated. Courses were also available online which were taken when relevant to meet the needs of a particular person using the service. These included epilepsy care, stoma care, catheter care, diabetes, end of life care and continence care.

One of the senior staff related an incident when two care workers had contacted them during a visit because they were not trained to use a particular piece of equipment which was needed by the person using the service. The equipment, which is not common, had only recently been prescribed. On this occasion the

senior staff was able to go to the person's house and sort out the problem. Had they not been available the person might have been left in a difficult position, although not one which impacted on their health. This was an example where the office staff should have ensured that care workers were trained in the particular equipment needed, which was mentioned in the care plan. However, this was the only such instance we came across.

The registered manager confirmed that all the care workers had a named person who provided them with regular supervision. This system had not changed since the last inspection. We spoke with care workers who stated they had supervision every six months or less in some cases, and that it was helpful. Often the supervision was preceded by an observation when the supervisor came out unannounced to watch care being delivered. We saw the list of 316 of these observations that had taken place in the year leading up to our inspection. Part of the purpose of these observations, according to the PIR, was feeding back positive comments to care workers to increase their confidence. Staff told us that the supervisions discussed what had happened during the observations as well as focussing on any other concerns the staff had.

In our previous report we noted that only a small proportion of staff who had been employed more than two years had received an annual appraisal within the last 12 months. This was still the case when the PIR was completed in June 2016. The registered manager showed us a schedule of supervisions and appraisals in the past year. The vast majority of these were supervisions, we counted only 17 annual appraisals. We acknowledged that there was a high turnover of staff – with roughly 100 staff (out of about 240) being replaced within 12 months. This reduced the number of staff available for annual appraisals. Nevertheless there was scope to increase the number of appraisals. These give staff the opportunity to look back on the previous year, and to discuss aims and objectives for the year to come.

Many of the people receiving support and care from Medacs were living with dementia. 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.

Training in the MCA was given during induction of new staff in the dementia, medication and safeguarding modules. In addition the training manager told us they had just developed a more advanced course in MCA which was being delivered to senior staff before being shared more widely amongst all staff.

We saw from the induction training course that staff were instructed to seek people's consent when delivering care. People using the service told us, "The carers say 'do you want this and are you happy with it?'" and, "My regular carer knows what to do and checks with me it is alright." We saw on visits to people's homes that if people refused care it was recorded in their daily notes.

Medacs used consent forms to record that people using the service consented to the care they would receive. A separate form was used when the person was unable to consent. This form required updating in two respects. It asked the question "Has the above Service User had a Mental Capacity Assessment?" Underneath this question it stated "If Yes a copy of the 'Lasting Power of Attorney' must be attached." This would not apply in every case.

More seriously, the form concluded "I give my consent as the next of kin/representative to engage Medacs Healthcare to provide care to the above person," with space for a signature. This is not the correct procedure under the MCA. If a person lacks capacity to consent to a specific decision, in this case receiving personal care, then there needs to be a best interests meeting. Close relatives should be consulted at this

meeting but they are not the sole decision maker. We suggested to the registered manager that this form (used in all Medacs services) needed to be revised.

The section on mental capacity in the induction training chapter on dementia set out the basic definition of mental capacity and the principles of the MCA correctly. For example, it stated, "If someone is deemed to lack mental capacity then we are legally obliged to make a 'best interest' decision on their behalf." We saw that appropriate mental capacity assessments had been completed for people where there was a reason to doubt they had capacity. This meant that except in relation to the wording on the consent form, the service was acting in accordance with the principles of the MCA.

Health care appointments and health care needs were usually co-ordinated by people themselves or their relatives. However, we also saw evidence of care staff contacting GPs on behalf of people and the service making referrals to district nurses. The service liaised with health and social care professionals involved in people's care if their health or support needs changed. One relative confirmed this: "They check her skin for bed sores. If there is a problem they will call the nurse." Another relative told us, "Once the carers found my relative's catheter to be blocked and they called the nurse."

Some people received help with cooking as part of their care package. We saw that the induction training included advice on food hygiene and on encouraging balanced diets. New staff were urged to look out for signs of poor nutrition or hydration and to react appropriately. More detailed training on fluids, nutrition and food safety formed one standard of the Care Certificate and were repeated in subsequent refresher training. This meant that staff had a good basic knowledge with which to support people who received support with meals from the service.

One person told us that their care workers cooked culturally appropriate food for them: "They give me food I like; what I have in. They ask me what I want." Other people expressed favourable comments about the food they received. These included: "I don't have a cooked breakfast, they make my porridge well and it is hot," "They cook a full English for me, they do it pretty well," and, "Everything is done brilliantly, if I ask for a drink they will bring it straight away. They ask me if I want a sandwich."

One relative told us that the person receiving the service was prompted to eat by the care worker. This was evidence that people were supported, when required, to maintain good nutrition and hydration. We talked with one person living in the extra care housing scheme who was less satisfied with the way in which some of their meals were cooked, especially by younger staff. We mentioned this to the registered manager. But this was the only negative feedback we received about the provision of cooking as part of the service.

Good

Is the service caring?

Our findings

Medacs had issued a form to people using the service inviting them to nominate their regular care worker as a "healthcare hero". All the care workers nominated received a certificate and a badge. We looked at the file of responses received. Although the exercise was designed to elicit good comments rather than bad, the forms showed that many people genuinely valued the quality of care they received. Comments included: "[Name] understands me, my likes and dislikes, and tries to make sure all my needs are met," "She is a good communicator, always pleasant in her manner, very sensitive to my needs. Has a sense of humour." Another person described their care worker as "always caring, happy, helpful and professional." One relative had written, "She treats him with dignity and respect and never rushes and always has time for a chat and a brew. She helps him with all his needs whilst maintaining his independence."

The evidence from these forms corresponded with the majority of comments we received from the people we spoke with and visited. One person said, "I have no complaints about the carers themselves. I really like my regular carer. I won't have a word said against her. She is wonderful and seeing her come in makes me feel very confident."

Another person said, "They are lovely people, the carers, and they do keep an eye on how I am. They do notice if I'm not well. They will let my family know and I think they let their office know as well." Another comment was "I'm really very happy with the carers. I have no criticism at all of the people who come; they are very good, kind and gentle."

People told us the care workers were empathetic and understood their needs well. For example, one person said, "I have a little weep sometimes if I'm feeling down and she can see straight away that I'm having a bad day and she comforts me." Another person said, "They are kindness itself. Nothing is too much trouble for them. When I have my shower, they make sure the towel is warm and wrap me in it straight away. It's lovely."

In the course of our telephone calls there was one instance where a relative raised doubts about the attitude or behaviour of care workers. The relative objected to the language used when speaking to the person receiving the service. The words used might have been construed as demeaning, and more appropriate to a child than an adult. However, it was not clear there was any intended lack of respect. We mentioned the feedback from the relative to the registered manager who said she would inform the training manager to reinforce the message about using only appropriate language when providing care.

In the questionnaire sent to people using the service prior to this inspection, although there were only nine respondents (out of 50 questionnaires sent), all nine said their care workers always treated them with respect and dignity, and that the support and care they received helped them to be as independent as they could be. We noted that care plans placed emphasis on the need to retain dignity when providing personal care. No-one raised any complaints about privacy. We saw in the staff induction booklet that detailed instructions were given to staff about carrying out personal care in a dignified way.

Care files were kept securely in locked filing cabinets in the office. This meant that people's personal data

was kept securely within the office. We knew from preparation for this inspection that the registered manager was very careful to preserve the confidentiality of personal data of people using the service. Personal information was also kept in the care files in people's homes, where security was the responsibility of the person receiving support or their family. However, daily notes and medication administration record sheets were removed at the end of each month and brought into the office. This meant that confidential information was not left in people's homes longer than it needed to be.

We considered how well Medacs enabled staff to meet the needs of people with diverse needs. One of the comments on the healthcare heroes file was from someone who wrote that they and their partner were deaf, and their care worker "communicates using sign language." The registered manager told us that some care workers had been learning sign language specifically to help them communicate with deaf people using the service. The registered manager also told us in the PIR that the training team were "in the process of developing a Cultural Awareness course to support workers delivering care to people of a different culture." We learnt that people who spoke the same language as people receiving the service were assigned when possible. This evidence showed that Medacs attempted to meet the diverse needs of people using the service.

Requires Improvement

Is the service responsive?

Our findings

When the service was contracted to provide a new care package for someone funded by a local authority they received a support plan which gave a summary of the person's care needs and set out what care was needed to meet those needs. Medacs then created its own care plan stating how these needs would be met. We saw that in some cases the information in the local authority's plan was more detailed than in the Medacs plan. However, the latter was generally more appropriate if a new care worker who didn't know the person previously came to the house and needed basic information about the person and the care that was needed to support them.

However, we considered that more detail should be included in the care plans to enable care workers to deliver person-centred care. There was currently very little information about the person's life history, health history, family, interests or hobbies, which would enable care workers to engage with them in a person-centred way. In some cases the necessary information was lacking to enable care workers to perform their tasks safely. On one care plan on the moving and handling page there was a heading, "Method used to perform manoeuvre". Underneath that was only, "Observe and report and concerns and changes." That did not provide any guidance to care workers as to what moving and handling techniques to use. We mentioned this when giving feedback to the registered manager, who agreed that this particular plan was not satisfactory. She stated that more recent care plans were more detailed, because senior staff had received an update in moving and handling. She added that all of the care plans for the 100 or so people who had been transferred from another provider at the end of October 2016 had now been rewritten, to ensure that staff had enough information to provide safe and effective care. The commissioning team from Tameside confirmed to us that the care plans had been updated.

During our visits to people living in their homes we met a person with a serious health condition. The care plan did not contain any information about their health condition or any special measures needed or action to take in the event of an emergency. One member of staff told us they had done their own research about the condition on the Internet, so they would know what to expect. That was commendable, however, did not substitute for information in the care plan which all staff could read. The registered manager explained that the person concerned was not receiving an extensive package of care. Irrespective of that, staff coming into their home needed to know more background about the person's health condition.

The lack of information in some care plans was a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In one care file we could not find the local authority's support plan. On another person's file the Medacs care plan was missing, although the registered manager was able to print one off from the system. This suggested a need for more regular checks that everything was present on the file.

Many of the people we spoke with knew there was a Medacs file in their house which staff wrote in, but did not realise it included a care plan. Most of the relatives knew about the plan. One relative said, "I know what is in the care plan, it explains the support and what the carers need to do, medical problems and

medication. We completed it with the lady from the office and we had a good chat." This was a good example of staff involving people and/or their families in compiling care plans.

Care plan reviews were done annually or if people's needs changed. Most of the people we spoke with said that they had received a visit from senior or office staff to check if they were happy with the care and support they were receiving. In one case we saw that the person had not signed the review sheet, even though they told us they had been involved in the review and were capable of signing.

We asked people whether they had made any complaints and if so what response they received. Some people told us that calls at weekends were more variable than those in the week. One person said, "It would be nice to have a copy of the rota that is accurate so that I know who is coming. They are all lovely and very obliging but, especially at weekends, I never know who is going to come." Another person said, "I've been told that I'm not eligible for an early morning call. I don't understand it at all. The regular carer comes at 8am during the week but at the weekend when she's off, it can be any time, even as late as 11am. Why can't I have the same time every day? I've asked and that's what they say – I'm not eligible."

One relative told us, "I've been waiting since the beginning of January for the manager to get back to me about the complaint I have made concerning the missed and late calls over the Christmas period."

This evidence indicated that Medacs was not always responsive to people's informal complaints and concerns about the service. However, a relative recalled a more positive experience of raising a verbal complaint: "They once sent a male carer but it wasn't appropriate. I rang to complain and they haven't sent one since." Similarly a person using the service told us, "A carer brought up my leg too high, she didn't read my file. I so rang the office and mentioned it to someone there and they talked to me about the problem. Then she called the carer. The carer has come back and is being nice, I am definitely happy with how it was dealt with." This was a good example of the service responding positively to criticism.

The complaints procedure stated that formal complaints could be submitted either in writing or over the telephone. It was not entirely clear how Medacs decided whether a complaint received over the telephone was or was not 'formal'. The procedure stated that clients and their families were actively encouraged to raise any concerns they might have.

At the date of the PIR, all 25 formal complaints which had been received within the previous 12 months had been resolved within 28 days of the complaint being made. This was an improvement since the last inspection when we had noted that several complaints had been slow to be resolved. We saw several response letters to complaints which showed that formal complaints were taken seriously and responded to in detail.

The registered manager stated in the PIR that the themes that emerged from complaints over the last 12 months had been around missed visits, late visits, changes in regular workers, continuity of care workers and communication. This was very similar to the previous inspection. There was now more analysis of complaints being done by the quality officer.

Staff providing care on visits to people's homes were generally not involved in arranging activities for people. However, in the extra care facility Medacs staff were present round the clock. The building was managed by a different provider. Responsibility for the provision of activities was not formally assigned. People living there told us there had been bingo and armchair exercises until recently, but these had ceased. We learnt that these had been provided by volunteers. The registered manager told us she was discussing

with other parties whether more activities could be provided.

Requires Improvement

Is the service well-led?

Our findings

In the questionnaire we sent prior to the inspection one relative wrote, "The service is very good and professional; it gives my relative a great level of independence in their own home and reassurance to the family." A social worker from one of the local authorities commented in response to our request for feedback, "I personally feel that Medacs seek to improve their services whenever there are concerns."

Medacs had recently issued its own survey in January 2017. 130 surveys had been returned, out of 550 which had been sent out, which was quite a good rate of return. The results had not yet been collated, but we looked at some responses. These were in the main positive, but we saw some responses about late visits, staff receiving phone calls from the office during a visit, and a missed call. The survey form was returned anonymously, and we questioned whether people should be encouraged to give their name if they wanted to, as this would allow the service to follow up on any issues raised.

Some of the people we spoke with by telephone told us they liked the care staff but thought the organisation in the office could be better. One person said, "You can never get through to the manager and when they say somebody will ring you back they never do." Another person said, "One time I rang because my carer didn't arrive and they said she was running late and would be there in ten to twenty minutes. It was two hours later when a different carer arrived and told me that my regular carer was on a training course – so why did they tell me she was on her way? The left hand doesn't know what the right hand is doing." This indicated a need for better sharing of information within the office.

One member of staff had written in response to the questionnaire we sent prior to the interview, "Medacs Healthcare is a good agency who care for the needs of the service user as well as the needs of staff. I would recommend Medacs Healthcare to everybody looking for a care agency."

Not all the staff were as complimentary about Medacs. One member of staff who had recently left the company said in their questionnaire, "I found us staff at Medacs to be bullied at times, pressurised into taking extra calls; we are numbers to get the job done that's all." We were conscious this was only one member of staff out of approximately 240 and that their view was not necessarily representative of many others, especially as they had left in undisclosed circumstances.

One problem faced by Medacs was the high staff turnover. The registered manager described to us the difficulty of retaining care co-ordinators, who played a vital role in organising rotas and ensuring that calls were delivered. One member of staff wrote in their questionnaire, "Again the turnover of co-ordinators and carers in my area causes a problem; this leads to unrest with service users and long standing carers." There was a constant programme of recruitment. In the 12 months prior to the PIR 106 staff had left the service and 98 had been recruited. These figures were in fact lower than for an equivalent time period leading up to the last inspection. This was prior to the influx of staff that had transferred when Medacs took over contracts from another care provider in Tameside in October 2016. This turnover of at least 50% of staff in a year was bound to have an unsettling effect and inevitably meant that many people using the service would receive an equally high turnover of care staff.

The registered manager was supported by a team of service quality assessors (SQAs), a quality officer, a care manager, training manager and recruitment manager, care co-ordinators and senior care workers. We saw that the registered manager was ready and willing to delegate, which was necessary given the size of the organisation. For example, a disciplinary hearing was allocated to one of the other managers. The registered manager also received support from senior managers within Medacs. She told us she felt she was well supported by the organisation.

Staff told us they felt that Medacs as a company communicate well with them and listened to their views. There were regular 'patch' meetings in which staff who worked in a particular area could get together and share experiences and ideas for improvement. Staff also were engaged by the Healthcare Heroes project where they could receive recognition for providing high quality care.

Medacs monitored both the care workers and the care delivered by conducting monitoring phone calls, home visits, spot checks, observations, and reviews. People using the service received phone calls every three months to check they were happy with the service, and annual reviews which included revising the care plan if necessary.

The form used for observations of care workers was designed to "evaluate the competence of the worker to deliver all care required to an acceptable standard." There was a series of tick boxes, each with space for a comment. The questions covered punctuality and presentation, and whether the care worker checked the care plan, whether they treated the person receiving the care with dignity and respect, and how they carried out all aspects of the visit. Staff told us that these observations often formed the basis of their supervision. They enabled staff to identify and areas for improvement and management to monitor and improve the service.

There were also audits to monitor the quality of the service. The recruitment manager conducted a rigorous ongoing audit of staff files to ensure that all documents were present and correctly completed. There was also an audit of care files conducted by head office, although the one we saw was of a small sample and only checked that all the documents were present on the file. The registered manager told us that a new quality manager had recently been appointed who intended to develop a new style of auditing files.

In terms of reducing missed visits, which we identified as the most pressing problem, the service was already analysing every missed visit, with a view to identifying patterns and causes. The planned new mobile phone system, although not yet used in this service, had been trialled in other Medacs offices and been found to contribute to a significant reduction in missed calls.

We nevertheless considered that the level of missed visits, which had been an issue in previous inspection reports going back to 2014, represented a failure by Medacs at a corporate level as well as a local level to tackle the issue, which could have a serious impact on the safety and wellbeing of people using the service. Coupled with the shortfalls in care plans which we identified at this inspection, we found there was a breach of Regulation 17(1) and (2)(b) 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 Care plans did not always meet the needs of service users Regulation 9(1)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was practicable to reduce the risks caused by missed visits to service users Regulation 12(1) and 12(2)(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not adequately assessing, monitoring and mitigating the risks to the health, safety and welfare of service users Regulation 17(1) and (2)(b)