Medacs Healthcare PLC

Medacs Healthcare - Leicester

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 16 February 2017 and was announced. The provider was given 48 hours' notice of the inspection. This was because the location provides a domiciliary care service. We needed to be sure that the registered manager would be available to speak with us.

Medacs Healthcare-Leicester provides personal care to adults with a variety of needs living in their own homes. This included older people, people with a sensory impairment, people with physical disabilities, people living with dementia and younger adults. At the time of the inspection there were 140 people using the service. On 7 November 2016 Medacs Healthcare – Leicester started to provide care packages to people who had previously received care from other care providers as part of a new contract. This meant that they had a large number of care calls in one geographic area where they had not worked prior to this date. As part of this process Medacs Healthcare – Leicester transferred staff from other providers to be employed by them. Since this date we had an increased number of concerns about the service raised directly with us. This prompted the inspection to be brought forwards.

The service had a registered manager. 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 were protected from the risk of harm at the service because staff had undertaken training to recognise and respond to safeguarding concerns. They had a good understanding about what safeguarding meant and how to report it. The provider dealt with accidents and incidents appropriately and reviewed these to try and prevent reoccurrences. Risks to people's well-being had been assessed.

We found there were enough staff to support people safely during our visit. However, we found that in November when the provider had started to support people in a new geographic area there had been times when people had not had all of their care calls. People told us that had improved. Staff had been checked for their suitability before starting work.

People's medicines were handled safely and were given to them in accordance with their prescriptions. The provider agreed to make sure that all medicines that were to be given were written down individually. We found that guidance for staff when to give medicines that were as and when required was not in place. The registered manager agreed that this would be developed.

Staff received appropriate support through an induction and regular supervision. There was an on-going training programme to provide and update staff on safe ways of working.

People chose their own food and drink and were supported to follow a specific diet if this was required. Staff prompted people to contact healthcare services when required to promote their well-being.

People were asked for their consent before they were supported. People were encouraged to make decisions about their care.

People felt that they did not always receive care from the same staff team. Staff told us that they were beginning to work more regularly with the same people to improve this.

People received support from staff who usually showed kindness and compassion. Their dignity and privacy was protected.

People knew how to make a complaint. The provider had a complaints policy in place that was available for people and their relatives. Some people felt that their complaints were not always responded to.

People felt that staff were sometimes late and they were not always contacted about this when it happened. Some people felt rushed while they were receiving support.

People and their relatives had contributed to the planning and review of their support. People had care plans that included information about their likes, dislikes and history. Staff knew how to support people based on their preferences and how they wanted to be supported. People were supported to be as independent as they could be.

The service was led by a registered manager and a manager who understood their statutory responsibility to report to CQC and other agencies significant events that occurred within the service.

Systems were in place which assessed and monitored the quality of the service. The regional operations manager told us that a new audit to review the whole service was to be implemented. People and their relatives were asked for feedback about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse and avoidable harm. Staff knew about their responsibilities for supporting them to keep safe. Incidents were recorded and investigated.

There were sufficient numbers of staff to meet people's needs safely. The service followed safe recruitment practices when employing new staff.

People's medicines were handled safely and given to them as prescribed. Staff were trained and deemed as competent to administer medicines. Guidance for staff when to give medicines that were taken as and when required was to be developed.

Is the service effective?

Good

The service was effective.

People received support from staff who had received guidance and training to meet their needs.

People were encouraged to make decisions about their support. Staff asked for consent before they supported each person.

People were prompted and supported to contact healthcare professionals for advice. People were given support with eating and drinking where this was needed.

Is the service caring?

Good

The service was caring.

People were usually treated with kindness and compassion from staff. Their privacy and dignity was respected. People did not always receive support from the same staff team.

People were supported to remain independent by staff who knew their preferences.

People were involved in planning their own support where they

could.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were sometimes waiting for staff to arrive for their visit. They were not always informed when staff were running late.

People had contributed to the development and review of their care plan. These contained information for staff about people's needs, their likes, dislikes and history.

There was a complaints procedure in place. People felt confident to raise any concerns. However, people did not always feel that their concerns were addressed.

Is the service well-led?

Good

The service was well led.

People had been asked for their opinion on the quality of the service that they had received.

The provider had checks in place to monitor the quality of the service. A new tool to review the whole service was being developed.

The provider had taken action and kept people informed when there had been problems within the service.

Medacs Healthcare - Leicester

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 on 16 February 2017 and was announced. The provider was given 48 hours' notice of the inspection. This was because the location provides a domiciliary care service. We needed to be sure that the registered manager would be available to speak with us.

On 7 November 2016 Medacs Healthcare - Leicester started to provide a large contract to provide care packages to people who had previously received their care from other providers. This meant that they were providing care calls to over 80 people in the second week of November in a geographical area they had not worked in before. As part of this process Medacs Healthcare - Leicester had transferred staff from other providers to be employed by them.

The inspection was carried out by one inspector and an expert-by-experience. 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 had received information of concern from people who used the service, their relatives and staff. We reviewed the Provider Information return (PIR). The PIR is a form that asks the provider to give some key information about what the service does well and improvements they plan to make. We reviewed information we held about the service. We also contacted the local authority that had funding responsibility for some of the people who used the service. We also contacted Healthwatch (the consumer champion for health and social care) to ask them for their feedback.

We reviewed a range of records about people's care and how the service was managed. This included ten

people's plans of care and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service and policies and procedures that the provider had in place. We spoke with the registered manager, the regional operations manager, two senior quality assessors, the branch trainer, a care co-ordinator and three care workers.

We spoke with 4 people who used the service and six relatives or friends of different people by telephone. This was to gather their views of the service being provided.

Good

Is the service safe?

Our findings

People told us that they felt safe when they received support from staff. One person said, "The staff are very careful. I have not had any accidents with them." Another person told us, "I am very safe with them." Relatives agreed that people felt safe. One relative said, "'I'm not worried at all for [person's name] safety." Another relative commented, "[Person's name] says that she feels safe with them." Staff members we spoke knew and understood their responsibilities to keep people safe and protect them from harm. They were aware of the signs to look out for that might mean a person was at risk. Staff knew the procedure to follow if they identified any concerns, or if information of concern was disclosed to them. One member of staff told us, "If I have ever had concerns I raise them straight away." Staff we spoke with confirmed that they had received training to support their knowledge and understanding on how to keep people safe and recognise abuse. One member of staff told us, "We have had training in safeguarding. We do refreshers in it each year." Policies and procedures in relation to the safeguarding of adults were in place and the actions staff described were in line with the policy.

Staff we spoke with told us that they understood whistleblowing and felt they could raise concerns. One staff member told us, "If they don't listen I will use the whistleblowing policy. It is not about protecting my job or the company. It is about doing the right thing." The registered manager had an understanding of their responsibility for reporting allegations of abuse to the local authority. We found that the process in place did inform staff of their right to contact outside professionals if they felt this was needed. We saw that the registered manager had reported concerns appropriately to the local authority. The concerns had been investigated either internally when this had been requested or by the local authority.

Risk assessments were in place where it had been identified that people may be at risk of harm. We saw that actions were taken to minimise risk. For example, one person was at risk of falling. We saw that an assessment was in place to identify the person's history of falls and what could be done to reduce the risk, such as making sure the floor was clear from trip hazards and using the correct equipment when walking. We saw that risk assessments had been reviewed regularly or when a person's needs had changed. This meant that staff had up to date guidance on how to support people in a safe way.

Where accidents or incidents had occurred these had been appropriately documented and investigated. The documentation included a description of what had happened. Where investigations had been needed these had been completed. We saw that if changes were necessary in order to protect people these issues had been addressed and resolved promptly. For example, a member of staff had reported an incident to the management in relation to one person's medicines. The senior quality assessor had visited the person and reviewed their medicines and made changes to the care plan to make it safer for the person and for staff.

We saw that there were plans in place should the office become unsafe to use. This meant that should an emergency occur staff had guidance to follow to keep people safe and to continue to provide the service.

People told us that there were usually enough staff to meet their needs when they had carers who visited regularly. One relative said, "[Person's name] has a regular carer and they are good. When they are off they

cannot find other workers who can replace him." Another relative said, "There seem to have quite a few different staff." However one person told us, "They've not got enough spare staff round here." Staff told us that they felt there were enough staff available to meet people's needs currently. One staff member said, "There is enough staff to cover all of the calls until someone goes off sick. Then we have to try and find cover." A care co-ordinator told us that staff were available on standby to provide cover in case of staff being unable to complete a call. They also told us that staff would pick up additional calls to make sure that people received all of their care. The rota showed that staff had regular calls where possible and that these were in a similar geographic area to make it easier to travel between calls. The registered manager told us that initially in November there had been problems when staff had transferred to Medacs. They told us that these had now been resolved and that there was recruitment on-going to make sure that staffing levels remained appropriate.

People had not always received all of their required care visits. One relative told us, "It started very badly. Early on they did not turn up a couple of times. It has got better now." Before our inspection we had been contacted by people when care workers had not turned up. We discussed this with the registered manager. They told us that when they had taken new packages in November there had been some calls that had been missed. The registered manager confirmed that when this had happened this had been recorded and reported to the local authority as a potential safeguarding concern. Records showed where missed calls had occurred and actions taken to rectify these. People told us that the service had now improved. One person said, "It stared badly but It has got sorted now."

People were cared for by suitable staff because the provider followed safe recruitment procedures. The process included obtaining references, checking people's right to work documentation and undertaking a Disclosure and Barring Service (DBS) check. The DBS check helps employers make safer recruitment decisions and aims to stop those people who are not suitable from working with people who receive care and support. We looked at the files of four staff members and found that appropriate pre-employment checks had been carried out before they started work. This meant that people could be confident that safe recruitment practices had been followed.

People received their medicines safely. A relative told us, "They prompt [person's name] to take medicine from the dosset box." The service had a policy in place which covered the administration and recording of medicines. Staff told us that they felt confident with the tasks related to medicines that they were being asked to complete and that they had been trained to administer medicines. One staff member said, "I have had training in medicine administration. If there was an error I would record it and report it straight away." Another staff member told us, "I will contact the pharmacy or doctor if I need advice on what medicine a person is taking." Records confirmed that staff had completed training and were assessed to make sure that they were competent to administer medicines. Each person who required support with their medicine had a support plan around medicines to determine the support they needed and a medication administration record (MAR) to record what medicine they had taken.

We saw that when medicines were taken as required there was not always guidance in place to advise staff on when this should be given. We discussed this with the registered manager. They told us that these were being developed for each person. We found that some medicines had been hand written on to the MAR chart. When this happens it is good practice that two staff sign the entry to confirm that it is correct in line with the guidance on the medicine label. This had not been done. The registered manager told us that they would review this and make sure that two staff signed any handwritten entries. We also found that MAR charts did not record the actual medicine that was given but did record the number of tablets that the person had taken. If staff are supporting people to take medicine there must be a record of what tablets the person is taking so that staff are sure what medicine has been taken. We discussed this with the registered

manager. They agreed that they would review how it would be best to record each medicine and implement a new system. A senior quality assessor told us that MAR charts were returned to the office each month and checked to make sure that they had been completed correctly. They told us that if there were any problems with how the MAR chart had been completed this would be discussed with individual staff members.

Good

Is the service effective?

Our findings

People received support from staff who had the skills to meet their needs. One person told us, "It is mainly the same one who assists me. She is well enough trained." Another person said, "They seem well trained enough." Relatives agreed that most staff had received training to enable them to meet people's needs. One relative told us, "Some are better trained then others." Another relative commented, "They are well enough trained. They are aware of dementia."

Staff told us they received the training they needed to support people. One member of staff told us, "We always have training. It is very high quality. I have been in today to do a refresher." Another member of staff said, "We are always doing training." One staff member commented, "We have done training to meet the needs of each person we work with." One of the senior quality assessors told us, "There are a lot of options with training. They will always source training if we ask for something specific. We had three staff complete training so that they could work directly with one person." Discussions with staff confirmed that an induction was in place when they first started working at the service. One member of staff said, "I did an induction. It was really useful. Although I am not new to care I learnt a lot." The trainer explained that staff competence was checked through a quiz sheet as well as observations of staff in practice. Records showed that staff had completed a range of training including training that was specific for the needs of the people who they supported. For example, staff told us that they had been trained in how to support someone with dementia.

People were supported by staff who received support and guidance through supervision. One staff member said, "I have supervision every other month. It is quite frequent. If I need to discuss anything I won't wait I can always ask for an extra supervision." Another staff member said, "I can talk to my manager. They listen to me." During supervision staff's competency in their role, training and support needs were discussed. This enabled the registered manager to evaluate what support staff required. Records we saw confirmed that supervisions had taken place.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People were asked for their consent before staff supported them. A relative told us, "They help [person's name] if she will let them." Staff told us that they always asked for consent and respected people's choice. One staff member said, "It is important that we give people choice and control. If someone says' no you cannot force them. There are always other options." Care plans prompted staff to ask people for their

consent before providing care.

We saw that people had been asked to consent to their care and to a call log in system being used in their home. Where people had been able to they had signed this themselves. Where people had not been able to sign this other people had signed on their behalf. We found that it had not always been recorded why someone else had signed on behalf of a person. We discussed this with the registered manager. They told us that they would ensure that the reason for someone being asked to sign on behalf of someone would be recorded. They confirmed the reason why someone had signed on behalf of their relative for most of the files we looked at. The registered manager told us that they would confirm the reason for one person who had not been able to sign their own plan and record this. Records showed that where people had a legal representative who could make decisions on their behalf this had been identified as part of the person's initial assessment.

People were supported with preparing food and drinks and eating where this was needed. One relative told us, "They help [person's name] with her meals. She is eating and they give her choices." Another relative said, "They help [person's name] with meals. She eats them and it seems to be presented okay." We saw that people were supported with specific diets, where required, that met their needs with guidance from health care professionals. A relative told us, "[Person's name] has been put on soft food. They try to coax her to eat more." Information in people's care plan identified that they had a specific diet and what this was. There was also a signpost to the relevant guidance that had been developed by a health professional so that staff knew that there was guidance in place to follow.

People were supported to maintain good health. One person said, "They will alert me if they think I need the doctor." Another person confirmed, "They alerted me to get a doctor when I was not well and helped me with this," A relative told us, "They are good at alerting me if there is a problem. If [person's name] has had an accident and they find her they will call the paramedic. They stay with her." Another relative said, "They tell me if they notice any rash or a pressure sore."
Care plans contained contact details of people's relatives, GP, or other involved health professionals so that staff were able to contact them when they needed to. Staff were aware of their responsibility for dealing with illness or injury. One staff member said, "If someone is unwell I would take them to the GP, or support them to call the GP. It is part of my duty of care. I would report it to the office." We saw that records tracked all appointments that had been made when staff had requested the appointment. This meant that people's health needs were being monitored and met.

Good

Is the service caring?

Our findings

People told us that they did not always have the same staff and this was something that was important to them. One person said, "I have four visits a day. They are mostly regulars but some I have not seen for a while. Some are just not as good. If the best ones were coming they'd be fine." A relative told us, "If [Regular care worker] is not around they send anyone. If they are new I have to explain things to them. We could use more regular staff." Another relative said, "I met someone last week who had not been there before. They had no pre preparation for the call. We have to monitor at the present to make sure that things are done. More regular staff would be better." One relative told us, "[Person's name] used to have the same staff and they got to know her well. She is not getting the same people and this does upset her." Another relative commented, "They are trying to provide people with the same staff." A relative said, "Once we had a main carer it all settled down."

Staff told us that they worked with the same people as much as possible and that this was becoming more frequent. They told us this helped them to get to know the person. One staff member said, "I work with the same people regularly. When you work with someone a long time you get to know them, how they communicate and what they mean." Another staff member told us, "We are getting nice regular runs that are settled and working now." Staff told us that information about what people liked and disliked was included in the care plan. We saw that each person's care plan contained information about what they liked and disliked. For example, we read in one person's care plan 'I like to have my hair towel dried.' The registered manager told us that staff were now working with the same people as much as possible. They told us that they would continue to try and make sure that people received a core team of staff on a regular basis.

People told us that most of the staff were caring. One person commented, "They are good," Another person said, "My worker is good. Some of the others are not that nice." One person told us, "One of the carers is not so good. She is just not very caring." Relatives agreed that they found the staff to be caring. One relative told us, "The staff are nice enough." Another relative said, "The staff are fantastic." One relative commented, "We are at ease with [care workers]. They are considerate."

People and their relatives told us that staff treated them with dignity and respect. One person said, "My personal care is done with dignity." Another person told us, "The staff are polite and respectful." Relatives agreed with this. One relative said, "They assist her with dignity. I have seen this." Another relative commented, "[Person's name] care is done with dignity and carefully." Staff told us they promoted people's privacy and dignity. This included involving people in making their own decisions, asking people before supporting them, knocking on people's doors and offering people privacy while being supported with personal care.

People were encouraged to maintain as much independence as possible. One person said, "They respect my independence." A relative told us, "They respect [person's name] independence." Staff told us that part of their role was to encourage people to do what they could for themselves. One staff member said, "Care is moving to enablement. It gives people a sense of achievement. You can encourage people." Another staff member told us, "It is a big achievement for some people. I am happy when someone achieves something

themselves." We saw that care plans included information about what the person could do for themselves and what they needed help with. For example, in one person's care plan we read, 'I will wash my own face and the front of my body I need support with washing my back.' This meant that staff were encouraging people to maintain the skills they had instead of doing things for people that they could do for themselves.

People were involved in making decisions where they could. One person said, "We agreed the times and things." Another person told us, "I choose where I want to go." A relative told us, "They give [person's name] choices." We saw that care plans prompted staff to offer people choice. For example, one person's care plan told staff to offer them food of their choosing. Staff told us that they encouraged people to make decisions about their support. One staff member said, "I use Makaton to give [person's name] choices for what activities they want to do." Makaton is a form of sign language. We saw that as part of their assessment people were asked what support they needed, how often they needed this and how they would like it delivered. This meant that people were supported to be involved in decisions about their care.

People's relatives were supported to feel involved in the care and the staff team who were providing care in their home. One senior quality assessor explained to us how they had worked with the trainer to provide support to staff on how to meet one person's needs. They had identified that staff needed specific training and had completed this in the person's home so it was individualised for the person. The senior quality assessor explained that the person's family had been involved in completing this training so that they felt that they had the skills to offer help if needed when staff were not present. They explained that this was very important for the younger member of the family as they were made to feel that they were part of the team and had been given a certificate and lanyard as an honorary member of staff.

People's sensitive information was being handled carefully. We saw that the provider had secure lockable cabinets for the storage of records. When information about people was shared between staff this was done discreetly and in a sensitive way so that conversations were not overheard. The provider had policies about confidentiality and data protection. This meant that people's privacy was being protected.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were sometimes late and they were not always contacted about this. One person said, "They should let me know sooner when someone rings in sick. I have had to ring them about this sort of thing once a week lately. They need to improve the timekeeping." Another person told us, "They turn up on time but sometimes they are a bit late. They do not let me know." One person said, "They are usually on time." Relatives agreed with this. One relative said, "The main problems are them not calling if they run late. There are too many late calls. I have asked them to let [person's name] know if they are running late but they don't do this." Another relative told us, "I do sometimes have to chase them. They don't rush to let me know [if they are going to be late.] The person this morning did turn up but it is hit and miss." One relative commented, "They are not as late now. They do not always ring to let me know." The staff told us that they sometimes had enough time to get between calls but this depended on the traffic and finishing calls on time. A care coordinator told us, "If a worker is going to be late we do ring the person and let them know. We encourage staff to ring to tell us if they are going to be late so we can let people know. The system alerts us if staff have not turned up after a certain time. We do all we can to cover."

We saw records that monitored the time that staff arrived to the call against the planned time. These showed that there were differences. These ranged from nearly 30 minutes early for a call to two hours and fifty minutes late. However, we found that most calls were within a twenty minute window of the planned call time. We also found that there were a number of times when staff did not log in or out. This showed that there were times when staff were not following the correct process to record the time they arrived at and left. The registered manager told us that the call times were monitored to try and see if there were reasons for late or early calls. They told us that they were working with staff to improve them logging into and out of calls. Records of team meetings showed that this had been discussed with staff.

People told us that they sometimes felt rushed although this did not always happen. One person said, "One carer is rushing and does things all wrong. The others do take their time to do my wash. They have to be quick but I do not feel rushed by them." Another person said, "They do rush a bit. They are fine with my shower but after that they do not have enough time to wash my pots right." Relatives felt that staff usually took their time when providing care. One relative said, "They take the time to do it right." Another relative told us, "The staff help in the morning when [person's name] has a shower and gets dressed. They do seem to have to do it quickly. One relative said, "[Person's name] bath is done carefully. They take the full time." People all agreed that staff stayed for the full time they were allocated and recorded this correctly. One person commented, "They put the right times in the book." Another person said, "They stay the full time." A relative told us, "They take time and make sure all care is done." Staff told us that they tried to make sure that people did not feel rushed when they were receiving care. Records showed that staff were staying the allocated length of time within five minutes of the length of the call on most occasions.

People told us that they would speak with staff or the registered manager if they were worried or had any concerns. However some people felt that they had raised concerns and these had not always been addressed. One person said, "I have told them it is not good enough yet but they've not got it solved." Another person said, "I would phone the office. I would just call them directly." A relative told us, "They have

not met us to deal with it. I have rung them a few times. I still had the same problem. It seems to fall to me." Another relative said, "I had to speak with someone urgently and one of the bosses came around. It is very good now." One relative said, "I don't have any complaints." We saw that there was a complaints procedure in place that was available to people and their relatives. Records showed that 22 complaints had been received in 2016 and 2017. Six of these had been received since November 2016 when Medacs Healthcare – Leicester had started to provide support to people under the new contract. All complaints had been investigated and responded to. The registered manager told us that where changes had been needed to improve the quality of care that people received this had been done.

People had contributed to the planning and development of their support plans. One person told us, "They came to see me and I went through the care plan." A relative said, "They came to do an assessment when I was there and I was able to talk them through it all." We saw that people's care plans contained information about how people preferred to be supported. For example, we saw that one care plan showed that the person preferred a wet shave and anther care plan identified that the person did not like water on their face and guided staff to be mindful of this when supporting them with personal care. This meant that staff had information about how to support people in the way that they wanted to be supported.

People told us that they had been involved in reviews of their support. One person said, "They do reviews. My last review was last month. They listen to me." One senior quality assessor told us, "Now that things are more settled I am reviewing all care plans to make sure that they are individualised." Another senior quality assessor said, "I have done reviews six to twelve weeks after people started to use the service. I have done most of them now. There are five left to do. We do reviews over the phone as well to make sure people are happy." We saw that care plans had been reviewed following people starting to use the service within 12 weeks or if someone's needs had changed. Where people had been receiving support from Medacs Healthcare- Leicester for a longer period of time we saw that care plans had been reviewed at least annually with phone monitoring having taken place on a more frequent basis. This was important to make sure that staff had up to date information and guidance on people's needs and how to support them.

People's care plans included some personalised information and provided details about the person, their history and what was important to them. Staff were able to describe people's preferences and this matched the information included in each person's support plan. One staff member told us, "It is really important that we know how people want things doing and do it that way." This meant that people received support based on their preferences.

Good

Is the service well-led?

Our findings

People and their relatives told us that they felt that the service was good or improving. However, some people felt they should receive a better service. One person said, "They are very good. I would recommend them." Another person told us, "They have not yet managed to get all things sorted. They have had had long enough. It did start to get better but it's slipped back again." A relative said, "They need to improve reliability and regular staff and then they would be good." Another relative commented, "They have got it now with [person's care]." One relative said, "It would not be very suitable to recommend them at the present. They could improve. They need to get to know the clients, the territory and the staff."

The provider had recognised that from the beginning of November people had not received the quality of service the Medacs Healthcare – Leicester would usually provide. The Regional Operations Manager explained to us that it was important to all at Medacs Healthcare that things were improved quickly. They told us, "As a company we value our reputation and the care that we provide. We all had a stake in getting this right. We have learnt as an organisation from what went wrong and what we would do again. It is important to us that we do not take on more than we can cope with. We want to take on a smaller bit of work and do it well and maintain it." The Regional Operations Manager described support, systems and processes that were in place, or had been identified to improve the service delivery. This included staff coming from other branches to support the office based staff, senior workers being in post so that they could go and provide support to the care workers, and having regular meetings with staff who transferred from other organisations to welcome them to the organisation and to explain the expectations on them as workers for the organisation.

The Regional Operations Manager also told us that initially the system in place to alert staff in the office of missed or late calls had not been working correctly. In order to rectify this a member of staff had been appointed to monitor this system so that they could identify when calls were missed or late. They told us that information about call times had been monitored on a daily basis and people had been contacted and visited to ensure that care was provided if calls had not taken place at the planned time. They explained that the registered manager had been supported by senior managers in the organisation including the quality manager who had been based at the branch for a month to provide additional resources.

People told us that they had been given information from the provider to explain what had not gone as well as planned. One person said, "They tell me things that are happening. For example, I got a recent letter due to changes and it included an apology. They have kept me informed." We saw that letters had been sent to people, relatives and staff on the 10th, 23rd and 30th November 2016 to update them on who people were in Medacs Healthcare – Leicester and how to contact them, to acknowledge feedback that had been received and provide an update on actions taken and to apologise. This meant that the provider had recognised areas of concern, been open and honest with people about this and taken action to address the concerns.

The service had an experienced registered manager who had worked there for a number of years. Staff told us that they felt supported in their roles. One staff member said, "The registered manager is approachable. A senior worker visits me when I am out working. I feel supported." Another staff member said, "I had support

to make sure that any issues were resolved." One senior quality assessor told us that they worked in the local areas with the staff who they managed. They explained that this was important so that staff and people who used the service got to know them. They also said that this helped them to understand people's needs and the support that they needed. They said, "People have my number. They can contact me for anything at all." Another senior quality assessor told us that they had support staff as part of the transition to take on the new work. They said, "We worked in [geographical area] for the first few days to provide support. We helped with calls and making sure people had all of the correct paperwork. We visited people to try and resolve any problems that they had. It was important that we all supported each other. The staff have been fantastic." We saw that the registered manager was available in the office for staff to speak with them. The senior quality assessors were either available in the office or were working with staff directly. They were available to staff to answer questions and provide support. This showed effective leadership.

Staff received regular feedback and guidance on their work from a manager during individual supervision meetings to understand the provider's expectations of them. Staff described these meetings positively. One staff member said, "I feel that I get enough time to talk to my manager and they listen." We saw that team leaders carried out spot checks on staff to review their practice while they were working with people in their own homes. Staff told us, and records confirmed that these checks had taken place. We saw that staff meetings took place and covered topics such as changes in the management team, good practice and feedback. One staff member said, "They update us with what is happening. It is very good." This meant there were opportunities for staff to reflect on their practice and on the service as a whole to improve outcomes for people using the service.

People and their relatives had opportunities to give feedback to the provider. We saw that people had been contacted by telephone to ask for their thoughts on the service they had received. This had been done regularly for people where they had identified problems with the service they had received. Questionnaires had been sent to people who used the service in May 2016 asking for comments on the service that had been provided. The feedback provided was mainly positive. The main areas where people identified that improvement was needed was with communication. Following analysis of the responses recommendations had been made including actions to be taken.

We saw that audits had been carried out on the paperwork that had been completed. This included the medicines records, the daily notes and monitoring charts. Senior quality assessors completed these checks. They told us that they if they identified any areas for improvement these were addressed with staff. The Regional Operations Manager told us that a quality manager had been appointed to carry out audits on the whole service. They explained that a tool was in the process of being developed that was designed to drive quality improvement.

The Regional Operations Manager told us that the main mission for the provider was to get the right people to the right place at the right time and the business aim for this year was to improve quality. They explained that part of this had been employing a trainer specifically for the branch to ensure that all staff were appropriately trained. They also told us that staff had completed 'promise' based training. Staff we spoke with confirmed that this had taken place and that they found it very useful.
The Regional Operations Manager explained that promise based training was to develop a culture where all staff had made a promise that was either personal or focused on service delivery. The theory was that staff would own the promise if they had made it themselves. The promises were displayed on the wall in the service and were used to promote staff's desire to achieve what they had promised. This meant that a culture was being developed where staff had the drive to make improvements to the service and were involved in this.

Records were well maintained at the service and those we asked to see were located promptly. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, the MCA, whistleblowing and safe handling of medicines. These provided staff with up to date guidance.

The registered manager was aware of their registration responsibilities. Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. The registered manager had informed us about incidents that had happened.