Medacs Healthcare PLC

Medacs Healthcare - Croydon

Inspection report

Saffron House 2nd Floor
15 Park Street
Croydon
CR0 1YD

Tel: 02086863842

Date of inspection visit:
01 May 2019
03 May 2019

Date of publication:
18 July 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Medacs Healthcare – Croydon is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, younger disabled adults, and children. The service was providing personal care to 311 people when we visited.

People's experience of using this service:
The quality of care had improved since the last inspection in October 2018, after which we rated this service 'inadequate' in four key questions and overall. However, at this inspection we found continued breaches of the regulations in relation to safe care and treatment, staffing, receiving and acting on complaints and good governance.

People did not receive a service that was safe, because risks were not adequately assessed and managed. Risk assessments did not include information about how to protect people from risks associated with their health conditions, malnutrition, pressure ulcers or other areas where they may have been at risk. Where people had experienced harm or poor care, the provider did not review risk management plans or take other action to prevent this from happening again.

The provider took action to improve leadership and governance, including increased managerial presence, improved audits and better processes to receive and act on feedback from people and staff. However, they had failed to identify and act on the shortfalls around risk management that we found and failed to make adequate improvements in other areas such as staffing.

Although staff recorded people's food and drink intake, the provider did not monitor this to ensure people had enough to eat and drink.

People continued to feed back that staffing was unreliable at times. Staff often arrived for visits late or not at all. Although this had improved since the last inspection, further improvement was required. The provider had improved the provision of staff training and supervision since our last inspection, but the provider's records did not show staff always received annual appraisals.

Complaints were not always dealt with in line with the service's complaints policy, because the provider did not always record outcomes or action they had taken and it was not always clear what they did in response to complaints.

The provider had improved the assessment process since our last inspection, meaning the service had enough information about people to produce detailed person-centred care plans. The provider had also made significant improvements in the way they planned people's care. Care plans were person-centred and detailed so staff had the information they needed to meet people's personal care needs and provide care in line with people's preferences. However, this did not include support people may have needed around managing their health conditions. We recommend that the provider takes appropriate steps to ensure they

are aware of any support people using the service may need to access healthcare services.

People received a more consistent service than previously, with care workers changing less frequently so people had opportunities to build relationships with the staff supporting them. People generally found staff polite and respectful, with reports that this had improved since the last inspection. There were robust recruitment processes to protect people from risks associated with being cared for by unsuitable staff.

Although the provider obtained information about people's diverse characteristics, they did not always consider how this would impact on the delivery of their care.

The provider had improved standards around medicines management, although staff were not recording the application of topical medicines appropriately.

Staff followed procedures to protect people from the risk of infection.
People who had capacity to consent had signed their care documentation to indicate consent to their care. However, it was not always evident that the provider had followed the appropriate processes the law says they must follow when planning and delivering care to people who do not have capacity to consent.

The service promoted people's privacy, dignity and independence.

More information is in the full report.

Rating at last inspection: At the last inspection, the service was rated Inadequate (published 10 January 2019).

Why we inspected: This inspection was brought forward from the planned date in response to information of concern. This included safeguarding reports and information we received from people who used the service and their relatives.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: This service is rated 'Inadequate' in one key question and therefore remains in 'special measures.' The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not
enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-Led findings below.	**Requires Improvement**

Medacs Healthcare - Croydon

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors and two experts-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.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community.

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because we needed to be sure that managers and other key staff would be in the office.

Inspection site visit activity started on 1 May 2019 and ended on 3 May 2019 and included telephone calls to people and their relatives. We visited the office location on 1 and 3 May to see the manager and office staff, and to review care records and policies and procedures.

What we did:

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, feedback from local authorities about the service, notifications the service had sent to us about safeguarding concerns and other key events, and feedback we received from people who used the service and their relatives.

During the inspection we spoke with 18 people who used the service, seven relatives of people using the service, six members of staff and both of the two registered managers. We also spoke with the Head of Operations and Managing Director during and after the inspection. We checked 14 people's care plans and five staff files and we looked at other records such as the scheduling system and call monitoring data, complaints records and safeguarding records.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● At our previous inspection in October 2018 we found there was a lack of detailed risk management plans. The service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection we found there had been improvements to the level of detail within moving and handling risk management plans. Information from these was added to care plans so staff were clear about how to reduce those particular risks. Where people had been assessed as being at risk of falls, staff had drawn up plans about how to support them to move safely, using walking aids and equipment. However, more work was required to improve the level of detail about other risks.

● Where people were at risk of pressure ulcers, there was not a clear assessment of this level of risk. There was some information within initial assessments and moving and handling assessments, but records lacked detail about the level of risk people faced. For example, four people had a personal care plan that included measures to protect their skin, such as staff checking for redness and applying prescribed creams. However, the risk of pressure ulcers had not been assessed using a reliable tool, which meant the measures applied in response may not have been appropriate for the level of risk and that the provider had no way of reliably monitoring pressure ulcer risk levels over time when reviewing risk assessments. Other people's assessments identified that they may have been at risk from pressure ulcers but no information about the risk or how to reduce it was included either in risk assessments or care plans. One person was admitted to hospital in December 2018 with pressure ulcers, but staff were recorded as saying they did not see any signs of pressure ulcers before the admission, which may indicate that they were not familiar with the signs of skin breakdown. This person had no risk assessments relating to pressure ulcers, skin care or neglect.

● One person had a diagnosis of diabetes but did not have a risk assessment or any information for staff about the risks associated with diabetes. Other people had health conditions that may have put them at risk from infection, seizures or other medical conditions but there were no risk assessments for these. This meant staff may have been unaware of signs that people needed medical attention, or how to protect them from avoidable harm as a result. One person had no risk assessments for either neglect or malnutrition despite having been involved in a safeguarding investigation four months before our inspection, where it was alleged that the person was suffering from neglect and did not have enough to eat. In other cases, local authority assessments had identified potential risks to people, but Medacs had not carried out any risk assessments in relation to these and there were no risk management plans.

Learning lessons when things go wrong

● At our previous inspection in October 2018 we found a lack of systems to deal appropriately with incidents. At this inspection we found the service had a quality officer who gathered information about incidents which could be used to identify trends. However, while incidents were being more reliably reported and recorded, there was not always sufficient documentation of the action the provider took in

response so we could not always be sure how lessons were learned from incidents.
● There was not always timely action taken in response to incidents. The person who was admitted to hospital in December 2018 with pressure ulcers was found to have additional skin damage arising from poor personal hygiene. Records showed there had been 11 missed visits to this person within 26 days leading up to the hospital admission. The registered manager explained this was because the person often declined to receive a visit. During this period staff had only recorded three times that they had supported the person with personal care. There was no evidence of any action taken to review how often the person had declined support or why staff had not reported this to the office. The provider had not reviewed the person's risk management plan in response to their hospitalisation and there was no information in their file about how to prevent the person from coming to harm in a similar way again.

The service was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● At our previous inspection in October 2018 we found serious concerns about staff arriving very late or not arriving at all to provide care to people. There was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which we initially identified at our inspection in March 2018.
● At this inspection, some people and relatives told us there had been a significant improvement in this area and office staff were better at calling to let them know if care staff were running late. One person told us, "I have the same carer every day. She's always on time – she's wonderful!" However, other people, relatives and staff said there were still serious problems with staffing including late and missed calls, staff not arriving at the same time for "double up" calls, staff rushing or leaving early because they did not have enough time to complete their tasks, and unreliable staffing at weekends with late and missed calls. A relative told us they could not rely on Medacs to meet their relative's time-sensitive needs at weekends. Another relative said they sometimes had to help their family member into bed because staff were so late, which put both the person and the relative at risk of harm. In total, six people and three relatives told us staffing issues were still having a significant impact on their day to day lives.
● The provider's data showed improvements in call punctuality as well as a reduction in missed calls since our last visit. The most recent data showed 60% of care calls took place within 15 minutes of the scheduled time. However, this meant two fifths of calls still deviated significantly from the time they were due.
● The provider carried out appropriate checks on new staff to ensure they were suitable for their roles, including application forms and interviews to assess competency. Staff files contained evidence of checks such as work histories, references and a check with the Disclosure & Barring Service (DBS). The DBS carry out criminal records checks and hold a database of staff that would not be suitable to work in social care.

The service was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● At our previous inspection in October 2018 we found a lack of guidelines for staff about handing medicines safely. Records did not demonstrate staff supported people to take their medicines safely.
● At this inspection people told us they received the support they needed to take medicines. One person said, "My carers understand my condition and they remind me to take my meds".
● We found there had been improvements to the level of checks of medicines. Records showed medicines administration records (MARs) were returned to the office regularly and audits of these were carried out. However, these did not always pick up issues with medicines. One person's medicines audit stated that they

did not use topical medicines, but the person's daily logs showed staff supported them to use a topical cream. The audit had not identified that staff did not use a topical MAR to record this in line with best practice.

● Records of medicines did not always follow best practice. Where people received medicines within blister packs, staff signed MARs to show all tablets had been administered rather than signing for each individual medicine. There was a list of prescribed medicines but no pictures or descriptions of what each tablet looked like. This meant if people did not take one or more of their tablets staff would not know, and records would not show, which medicines they had missed.

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us they felt safe using the service. One person told us, "I feel safe, I'm happy with the service and I'm ok". A relative said, "Everything is great, we have no concerns. They help with everything." Some people told us they had previously felt unsafe using the service, but things had improved over the last few months.

● Staff said they had training in safeguarding adults and it was discussed at meetings. One staff member said, "We discuss it at meetings, they always ask us if there is anything we are concerned about."

● Staff understood how to identify and respond to abuse. One staff member told us how they would respond to suspected abuse. They said, "Depending on the situation I may call emergency services, the office or the GP. Depending on what I encounter I'd call social services or CQC." There was a clear procedure for reporting suspected or alleged abuse.

● Safeguarding investigations did not always have a clear outcome recorded and it was not always clear whether investigations were still under way or what the next steps were. This meant it was not always possible to confirm whether the service dealt with safeguarding concerns appropriately.

Preventing and controlling infection

● People told us staff took precautions to prevent the spread of infection. This included the use of personal protective equipment and good food hygiene practices.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- At our last inspection we found there was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not always have up to date training or access to regular supervision.
- At this inspection, people told us some staff were better at their jobs than others. Staff told us they had seen an improvement in training since our last visit. One staff member said, "We have done more training now, we had training on the care plans and writing daily notes." Another staff member said, "We get lots of training. I did online training in December. When there is a need for training they will let me know and I come in." Records showed staff had received refresher training since our last inspection.
- Staff files contained evidence of an induction that included courses around important areas of care such as health and safety, food hygiene and manual handling. The provider had facilities to deliver moving and handling training in-house and records showed staff had received this training.
- Staff had opportunities to gain qualifications. The provider had recently developed links with the local college.
- Staff said they got regular supervision. One staff member said, "It is an opportunity to discuss what we're doing and to improve." Records showed most staff were up to date with supervision.
- However, for almost half of the staff it was not clear in the provider's records whether appraisals were taking place when due. There was a risk that people received care from staff who were not performing to satisfactory standards, because this was not being monitored in line with the provider's policy on staff appraisals.

The lack of appraisals was part of the continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that we found at this inspection.

Supporting people to eat and drink enough to maintain a balanced diet

- We received mixed feedback about the quality of the support people received to eat, with some people saying the support was good and others saying staff did not have enough time to make sure their food was prepared and presented to their taste. One person's relative told us, "The carers do come and warm [my relative's] food. I worry though because I'm going away for a month and the last time I left he was so dehydrated. He has problems swallowing and they don't have much time".
- Care plans recorded people's food preferences and records showed the level of detail had improved where people's nutritional needs had been reassessed. Staff recorded what people had eaten on each call to enable food intake to be monitored. However, we did not find evidence that this monitoring took place. For example, one person's logs showed they often declined meals or only ate yogurt but there was no

evidence that this was followed up and there was no information on how the provider monitored the person's risk of malnutrition. Records of a safeguarding concern raised by the person's local authority in January 2019 showed they reportedly complained they were hungry and did not have enough food in their house, but Medacs had not assessed the person's risk of malnutrition and staff had not reported any lack of food in their home. Another person's local authority assessment had identified a risk of malnutrition but Medacs had not followed this up or produced their own risk assessment or risk management plan for this.

The lack of risk management around malnutrition was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● At our last inspection in October 2018 we found assessments of people's care needs were poorly completed and did not contain enough information to produce comprehensive care plans that directed staff to achieve good outcomes. This meant the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had not been any new admissions to the service since our last inspection. The provider had introduced an improved assessment process and all people's needs had been reassessed using the tool as part of improvements. One person's relative confirmed their family member's needs had been reassessed although they did not feel there had been any improvement in the person's outcomes since then.

● Assessments had been used to gather important information for care planning. For example, one person's care needs had been reassessed and the assessment had picked up important information about their background and preferences, as well as more detailed information about risks associated with their mobility. For others, health conditions were picked up that had not previously been known to the service. However, there was still little information about how to support people to achieve their desired outcomes. For example, one person had a goal to improve their mobility but there was no information on whether they used any other services, such as physiotherapy, to help them achieve this or whether Medacs staff could be involved by, for instance, supporting the person to do exercises.

● People's care plans contained contact details for their GPs. However, there was a lack of other information about people's healthcare needs and other services they used to meet those needs. This meant there was a risk of people's healthcare needs being overlooked.

● We judged that the service was no longer in breach of the regulation in relation to person-centred care. However, we recommend that the provider takes appropriate steps to ensure they are aware of any support people using the service may need to access healthcare services.

Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

● One person told us, "[Member of staff] always asks permission, everything is beautiful." Another person's relative told us, "Some [staff] ask for [the person's] permission when caring for him but some don't."

● Two people's care plans stated a relative had the legal authority to make decisions on their behalf. Their relatives had signed to consent to their care but there was not a copy of the document authorising them to sign on these people's behalf within records. For people who did not have capacity to consent, there was not always evidence of appropriate procedures being followed to ensure decisions about their care were made in their best interests, in line with the MCA Code of Practice. We raised this with the registered manager, who told us they would obtain the necessary documentation.

● People who were able to consent to their care had signed care plans to indicate they consented to their care being delivered in this way.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

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

Ensuring people are well treated and supported; respecting equality and diversity

● At our last inspection in October 2018 people fed back to us that they were unable to build good relationships with staff because the staff assigned to visit them kept changing. At this inspection we found there had been improvements to consistency of staff. The system to schedule calls enabled people to have preferred staff and we saw that effort was made to ensure consistent care staff visited people. We received mixed feedback from people and their relatives about this. One person said, "I know [regular staff member] very well. She is very good at what she does." Relatives told us, "I know that [my relative] doesn't like that the carers keep on changing. She has dementia and they don't like change" and "I don't like the constant change of carers. When it comes to washing [relative], he has to be relaxed as he has spasms – when it comes to change he can get quite stiff." Although the service had made progress in this area, further improvements were needed.

● All but one of the people and relatives we spoke with fed back that staff were kind, respectful and caring. Comments included, "They are kind and do their job" and, "I found them most polite."

● Most people told us office-based staff were more polite and respectful than before, although one person felt this was not the case. Office staff had undergone customer service training since our last inspection to help improve their relationship with people and relatives.

● One person told us, "My carer understands me. Sometimes we pray together too". Another person's relative told us they had requested male staff and now had three regular male staff visiting. Although the provider gathered information about people's diverse characteristics, they did not always use this information to ensure equality and diversity were respected. For example, there was information about people's religious beliefs but not about how this might impact on how their care was delivered, such as whether they needed to receive support from staff of the same gender.

Respecting and promoting people's privacy, dignity and independence

● One person said, "[Staff member] very much supports my independence" and another person's relative told us, "[Relative] has one particular carer that is fantastic. She supports him and encourages his independence with his [equipment]. I've even seen them having a dance." Staff understood the importance of maintaining people's independence. One staff member said, "We have to encourage them, some of them need encouragement to help themselves independently. I am proud when I can help them help themselves." The staff member described how they always asked one person how to show them their dress, as a way of prompting them to dress independently.

● Care was planned in a way that promoted people's independence. One person had mobility problems that meant their ability to carry out personal care tasks was limited. They had a detailed personal care plan that informed staff about aspects of care that they could do themselves. For example, they attended to their

own oral care, but staff supported them to prepare a toothbrush.

● People and their relatives said staff promoted people's privacy and dignity. One person told us staff supported them in a dignified way with personal care and avoided looking when they were getting out of the shower. Another person's relative said staff were careful to ensure their relative was comfortable when using lifting equipment.

Supporting people to express their views and be involved in making decisions about their care

● One person told us, "I've got my care plans at home. There is a folder I can access." Another person told us their care plan was recently reviewed and they were involved in this process. They said, "I'm happy with the way it was handled." However, a third person's relative told us they had asked to change the times of their visits, but the service had not been able to accommodate this.

● People told us staff helped them remain independent. One person's relative told us, "My [relative] can hear but he can't talk. I do tell [staff] to communicate with him more as I want to build independence and confidence. They need to do that more." The provider gave examples of how they supported people for whom English was not a first language. They told us about one person who spoke Mandarin and they were able to recruit staff to attend their calls who spoke the same language as them. However, care plans did not always fully consider people's diverse needs in this area. For example, one person's care plan said they only spoke a few key words of English, but there was no information about which words or how to ensure the person understood staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns

● At our last inspection in October 2018 we found the provider did not respond adequately to people's complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● At this inspection, people told us they knew how to complain and felt comfortable doing so. Some people felt the service had improved their response to complaints. One person said, "I've got the office number. I can call if I have any problems. I'm quite content, they do the job – I'm happy." However, other people told us they did not get a satisfactory response to complaints, with comments including, "I complained twice but nothing improved" and, "Sometimes I think it goes in one ear and out the other."

● Staff told us they knew how to respond to complaints. One staff member said, "If it is not something I can sort there and then, I call the office and tell them what is happening."

● Complaints were not always recorded appropriately. Some records clearly showed the action the provider had taken, while for others this information was missing or unclear. In one case, the relative complaining had sent three emails asking for a response but there was no evidence that the provider had responded at all. The quality officer advised us that in some cases this was because they did not document telephone conversations where complaints were resolved. This meant the service was not complying with its own complaints policy which stated that any action taken to reduce complaints should be fully documented.

The service was still in breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● At our last inspection in October 2018 we found care plans were not person-centred and did not contain sufficient detail about people's care needs, preferences, health conditions or end of life care needs. Care plans were not reviewed at an appropriate frequency. The service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection, people gave us mixed feedback about the quality of care. One person said, "Some of the carers are good, and some are not. I like [name], she's good". Another person said, "I have a very good carer. She helps to wash, shower and dress me. Anything you want, she helps you with".

● The majority of care plans had been updated and improved since our last inspection. There were step by step, person-centred instructions about how staff should support people with personal care, including information about people's preferences. Areas covered included continence care, mobility and support needed around meal preparation.

● One person had friends who were important to them and had complex mobility needs. There was detailed guidance for staff about this person's background and how they liked to spend their day. Their care plan recorded how their mobility affected them with tasks and there was a detailed description for staff about

how to provide care to the person. Another person's care plan informed staff they liked to discuss current affairs and have support to put on makeup.

● However, care plans did not contain information about the support people needed to manage their health conditions, including symptom control and pain management. A staff member told us care plans had improved, but more work was required. They said, "They have added some things to them and taken some bits out. They still need to do more."

● Although improvements were still needed in this area, the service was no longer in breach of the regulation in relation to person-centred care.

End of life care and support

● At the time of our inspection, the service was not supporting anybody with end of life care. We therefore did not look at this area in detail, but we will check this at our next inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

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

- At our last inspection in October 2018 we found there was not a robust governance system, which meant the provider had not identified the issues we found at the inspection. The service did not adequately monitor incidents, visit schedules, record keeping or staff training. The service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection, we found there had been improvements to the management presence at the service. The numbers of senior staff had increased, and the provider had brought in staff from other branches to assist with the improvements since our last inspection. This helped the provider to monitor and improve the quality of the service. At the time of our inspection, there were two registered managers working at the service. This meant there was a higher level of oversight than usual, so the provider was able to focus more resources on addressing the concerns we found at the last inspection and the current one.
- The provider had also significantly improved the quality of the assessment and care planning process and now had better systems to monitor medicines management. However, they had failed to identify and act on a significant lack of risk assessment, and had not made enough improvements in other areas such as complaints management and staffing as outlined elsewhere in this report. We also found that while there was a matrix in place to monitor mandatory staff training, there was no system to monitor more specialised training staff may have needed to meet people's individual needs, such as awareness of health conditions that affected them. This meant the provider had no reliable way of checking staff had the right expertise to provide care to people.
- There were still some issues with records. One person's relative told us staff did not leave accurate records of their visits. They said, "On some occasions, when only one carer instead of two have visited, the log book is signed as if both did attend." Another person did not feel the records staff made of their visits were accurate. The registered manager acknowledged there had been some issues with the accuracy of the visit log system, but said this was related to agency staff who were no longer used.
- The provider obtained people's care records from their homes to audit them. This helped them assess the quality of people's care and identify issues that needed to be addressed. However, this was not always done consistently, meaning people's care was not always monitored. Of the files we looked at, two people's records had not been checked for five months and another had no records on file from the last six months. This meant there was a risk that the provider would not identify if people were not receiving their care as planned.

Although the provider had made significant improvements in this area, the service continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● At our last inspection in October 2018 we found the provider did not act on people's feedback. There was a lack of systems to improve the attendance and punctuality of staff, which people had fed back about. Staff had a lack of opportunities to feed back their views and be involved in the running of the service.

● At this inspection, we found the provider had taken significant action to improve the punctuality of visits and the consistency of staffing in response to feedback.

● People told us the provider regularly contacted or visited them to check they were happy with the care they were receiving. However, one person said, "I'm not sure if the agency is well managed. They have too many people to care for. The office lacks communication. They don't listen. When I call, they tell me that they don't have time and ask me to call back. When I do call back, I can't get hold of them." Other people also fed back that they had trouble contacting the office. The registered manager explained that there had been a problem with the telephone lines, but this was in the process of being resolved.

● Service user surveys showed response rates as low as 8% in some areas, which may have been because people were unaware of them. One person and one relative told us they rarely or never received satisfaction surveys to complete. However, the responses the provider had gathered from surveys in the last six months were positive with most people saying they were satisfied with the service. Themes included people saying the office staff did not communicate well with them, which the provider was in the process of addressing through staff training.

● The provider made sure staff knew about improvements that needed to be made to the service and what their roles were in doing this. For instance, they discussed the need for clear and accurate records of people's care and good practice in medicines management. Staff said they had been involved in improvements at the service. Staff told us there had been increased training and they had benefitted from improvements to care planning.

● There were regular opportunities for staff to express their views at meetings and there was also a staff newsletter to keep them up to date with changes. The provider had a number of schemes to boost staff morale including a "Star Care Worker" award people could nominate their favourite staff for.

● Since our last inspection the provider had reviewed and audited people's care plans and medicines records as part of their action to improve the quality of care. Medicines record audits showed there were still some records with gaps, but this was improving. However, the audits did not all contain details of what action was to be taken in response to any issues or when it should be completed by.

● An audit in January 2019 had identified a lot of documentation missing from staff files. By the time of our inspection the provider had taken appropriate action to fill these gaps.

Continuous learning and improving care; Working in partnership with others

● We received mixed feedback from people and their relatives, but on the whole people felt the quality of the service had improved. People told us, "They weren't great before, but that's going back a while. They've sorted themselves out now" and, "Now it's better. They're happy to make changes."

● Senior staff carried out regular spot checks to look at the quality of the care staff were providing and make sure they were competent to carry out their roles. When issues were identified these were fed back to staff and extra spot checks were used to monitor improvements.

● Senior staff had regular meetings to discuss improvements they needed to make to the service. This included consideration of the views of people who used the service and staff. One of the meetings identified an issue with accurate recording of visit times that may have led to inaccurate data about punctuality. They also discussed improvements to areas such as staff supervision and infection control.

● Office staff continuously checked the provider's monitoring systems and followed up late or missed visits. Office staff showed us an example of one staff who had been late to a number of calls and this had been

escalated and addressed. Records showed calls on the week of our visit for this staff member had all been attended on time. However, at the time of our visit there were still significant issues in this area.

- The provider kept commissioners and CQC up to date with their progress in making improvements to the service.