Medacs Healthcare PLC

Medacs Healthcare Stafford

Inspection report

Gloucester House, Anson Court Business Centre
Stafford Techology Park, Beaconside
Stafford
Staffordshire
ST18 0GB

Tel: 01785236209
Website: www.medacs.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We completed an announced inspection at Medacs Healthcare Stafford on 13 February 2017.

We last inspected this service in June 2016, at which time we found that improvements were needed in relation to how the service was monitoring the quality of care being delivered.

At this inspection we found that the service was not being effectively managed and that the required improvements had not been made or effectively implemented. We also identified further areas that required improvements to ensure people received care that was safe, effective, responsive and well-led. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One of these was an on-going breach in relation to how the service was being managed. You can see what action we told the provider to take at the back of the full version of the report.

The service is registered to provide personal to people in their own homes. At the time of our inspection 38 people were using the service. There were 22 members of staff working at the service.

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 and associated Regulations about how the service is run.

We found that staff felt unsupported, that they were unclear about the values and vision of the organisation and that they had little confidence in the registered manager. We found that people using the service were not always listened to and that complaints and concerns had not always been adequately addressed to people's satisfaction.

Risks to people's health, safety and wellbeing were not being identified, managed and reviewed and medicines were not managed safely.

People's care needs were not regularly reviewed. People's care plans were not accurate and up to date which meant staff didn't always have the information they needed to provide safe and consistent care.

The registered manager did not understand the requirements of the Mental Capacity Act 2005 and staff did not always understand what was meant by mental capacity, despite some people using the service having conditions which may have affected their mental capacity.

Staff training was not being monitored by the registered manager to ensure the quality of care being delivered.

Safeguarding incidents were recorded and the appropriate agencies were notified, however, the service had

not always responded to protect vulnerable people from the possible risk of abuse.

People were treated with respect and staff were able to describe how they delivered care to meet people individual needs. However, care was not being planned to ensure people received individualised care that promoted their independence.

Effective systems were not in place to ensure concerns about the quality of care were investigated and managed to improve people's care experiences.

There were insufficient staff working at the service at the time of inspection.

Staff had been safely recruited and notifications had been made when incidents had been identified as needing to be notified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Safeguarding concerns had not been adequately responded to and this put people at risk of abuse.

Risk assessments lacked detail to ensure people's safety.

Staff were not given enough information to ensure that people received their medicines safely.

There were insufficient staff to meet people's needs.

People felt safe with the staff who delivered their care and we found that staff were safely recruited at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not being effectively monitored and it was not clear what training staff had received and what they needed.

Some staff felt supported, others did not. Staff raised issues about approaching management and several staff members felt uneasy about doing this.

People's nutritional risk was not adequately planned for or monitored.

The service worked with other health professionals in the delivery of people's care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's concerns and complaints were not always responded to.

Care planning lacked a person-centred approach to care and staff were busy and rushed in their work.

People described being cared for in a respectful way and told us that staff were kind and compassionate.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care planning and delivery was not being done to meet people's individual needs.

Complaints were not always resolved to people's satisfaction.

People had some opportunity to express their views about how the service was being run but this was not always fully considered.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had failed to make the required improvements following our last inspection.

Staff were not aware of the vision and values of the service and many did not feel supported.

Risk assessments and care plans were not being audited and updated to ensure people's safety.

Staff did not have confidence in the management.

Medacs Healthcare Stafford

Detailed findings

Background to this inspection

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

This inspection took place on 13 February 2017. The inspection was announced and was undertaken by an inspector and an inspection manager. We gave the provider 48 hours' notice of the inspection as we needed to be sure that the relevant people would be available. Following the inspection visit we spoke with people who used the service. An expert by experience carried out telephone calls to people to gain people's views and experiences of their care delivery. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of home care services.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information sent to us by the provider through the submission of a Provider Information Return and we spoke with the local authority to find out their views of the care provider as commissioner of the care.

During our inspection we talked to seven people who used the service and four relatives of people who used the service. We spoke with 12 members of staff including the registered manager, the regional manager, the training manager, the care co-ordinator, two senior care worker and six care workers employed at the company. We looked at eight care records for people using the service as well as records related to the delivery of people's care. We reviewed staff files to ensure staff were recruited safely and reviewed how the quality of the service was being monitored. We also looked at call schedules, incidents, accidents and complaints.

Requires Improvement

Is the service safe?

Our findings

We found that safeguarding concerns were not always responded to appropriately at the service, nor were they managed in line with the safeguarding policy which was in place. One person using the service had made an allegation about a staff member working at the service. This had been reported to the local authority by the health professional involved and the service had notified CQC as required. However, the registered manager had not acted in line with the safeguarding policy in place which stated that "a member of staff must be suspended immediately and must remain suspended until the outcome of the investigation is agreed by all involved." Although an investigation was taking place at the time of our inspection, the staff member involved had been delivering care alone and with other care workers. The registered manager had only taken the staff member out of the calls of the person who had made the allegation. As no conclusion had been made about the allegation we found that the allegations had not been responded to appropriately in order to protect vulnerable people from abuse. Following our inspection visit the registered manager informed us that the care worker was not working alone at any time. However, the service had failed to respond appropriately at the time the allegation was made and had not taken steps to protect people using the service from the risk of abuse.

We found an allegation of abuse which had been made by someone using the service which had not been recognised as an allegation of abuse. No action had been taken to report or act upon this allegation of theft by a member of staff made by a person using the service. We raised this with the registered manager who was unable to explain why this had not been identified as a possible incident of abuse or why they had not acted on it. Action had not been taken to protect people from the risk of abuse.

Staff knew how to recognise abuse and said that they would report any incidents of suspected abuse to the office. However, we were not shown records of training in relation to safeguarding vulnerable people as the registered manager was unable to produce these for us. It was not clear how they were ensuring staff training in relation to safeguarding was up to date in the absence of these records.

The above evidence indicates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection in June 2016 we found that improvements were needed in relation to how people's risks were assessed. During this inspection we did not find that this had been addressed at the service. We found that risks associated with people's care had not been adequately identified and that staff were not being given enough guidance on how to keep people safe. For example, we found that one person was described as being 'very anxious'. There were no details on how staff should effectively manage this and this person had made an allegation against a staff member. The registered manager had dismissed these allegations on the basis of the person's perceived anxiety, however, no guidance had been given to staff on how to manage and reduce this person's anxiety whilst delivering their care.

Another person had a catheter in place. The care records we looked at did not contain enough information for staff on delivering safe care to this person. There was no risk assessment or care plan in place for this

person's catheter care. This put the person at risk of unsafe care and there was no guidance for staff to ensure that their catheter was being managed safely to avoid infection. The registered manager was unable to explain why this wasn't in place. Care was not being planned to ensure people's safety.

We found that medicines were not being managed safely. It was not clear from the care plans or risk assessments we looked at what medication people were taking, at what dose and for which condition. It was unclear from the documentation how much support people needed with their medication and how this support should be given. Risk assessments in relation to the administration of medicines lacked detail and it was not possible from looking at the care records, or from looking at the Medicine Administration Records what medicines people were taking. Care plans stated that "Meds to be administered from blister pack." The registered manager was unable to tell us what medicines people were taking from the medicine records. Some of the people using the service were taking controlled drugs. There was little detail on how and when these drugs should be administered. One person was having controlled drugs for pain relief. They told us that this had not been managed well by the service and that they had become unwell as a result. Another person had pain relief through a skin patch. This wasn't been managed safely and could have damaged this person's skin. We were not able, from looking at the records, to establish what medicines people were taking, at what dose and for which condition and so could not determine whether people were getting their medicines safely.

The above evidence indicates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with all felt that people received safe care and treatment from the care staff who delivered their care. Some staff expressed that they found the work very busy and that there was often little time for travel between calls. One staff member said, "The only challenge is getting to the calls on time." We looked at call schedules and the times at which the calls were attended. These showed that people usually got their calls around their allocated time and we saw no evidence of missed calls. People who used the service were satisfied with their calls, however, some people did raise issues about staff being rushed and over-worked. One person who used the service said, "Currently, the carers are fantastic. They do so much for me, but they are exhausted - they have so many calls to make . Some of them drive a long distance to get from one visit to another. Their routes do not seem to be well planned. There are not enough staff ." The registered manager and care co-ordinator did tell us that, at times, they had to deliver care to cover staff absence. This indicated that there were not sufficient staff working at the service at the time of our inspection as office staff were having to cover care calls as a contingency measure.

People we spoke with told us that they felt safe using the service. One person said, "I feel completely safe with all my carers. They are lovely people. They do exactly what I ask of them. They are very reliable and professional." Another person told us, "The carers know me and I know them. I am very pleased with their support. I feel safe with them and have no concerns at all. I trust them and feel safe in their company." One person we talked to raised concerns about their safety but attributed this to the way in which their concerns had been dealt with by the registered manager.

Staff were recruited using safe recruitment procedures. Pre-employment checks were carried out to ensure prospective new staff were fit and of good character. These checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that the registered manager could be sure that staff were of good character and fit to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

We asked to see how training was monitored at the service. The training manager for the provider informed us that the staff member who had monitored training within the branch had left the service in October 2016 and that the records had been on their computer. The registered manager was unable to provide the information of training across the branch as they were not able to pull this information from the system. The training manager for the provider sent us some examples of training which was scheduled and which had taken place, however, we were not given records for staff training to date and for what was due to be scheduled for all staff across the service. Staff told us that they had received an induction and that this had taken place over several days. They also described undertaking a process of shadowing to ensure they were confident in their roles. Staff felt that they had adequate training. One staff member said, "I thought it was very clear training." However, the staff member went on to say, "I haven't done the renewal training." Another staff member told us that they had not done any training since the staff member who oversaw the training left. Although we saw some evidence of staff training certificates we were not given evidence that staff training needs were being monitored and addressed.

Staff files we looked at showed that staff had completed an induction and we saw that some staff had completed the Care Certificate. However, we could not establish how training was being monitored to ensure that staff had refresher training when they needed it. Some staff told us that they had supervisions and felt supported, however, this was not the case for all staff and several staff members described feeling unsupported. One staff member told us, "There's no direction. There's no support and no leadership." We found that the staff appreciated the support from the care co-ordinator but felt uneasy about approaching management should they need to. One staff member said, "I was led to believe that a manager was there to support you but in my eyes our relationship is not supportive. I'm led to believe I am just someone there to do the work." Several staff members did not feel they could approach management and felt unsupported in their roles.

We found that staff and the registered manager lacked knowledge about the Mental Capacity Act 2005 (MCA), despite a number of people who used the service having conditions which may have meant that they lacked the mental capacity to make certain decisions about their care. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. There were no mental capacity assessments in the documentation we looked at and no evidence that where people may have lacked capacity an assessment had been considered to determine this in relation to the delivery of their care.

We discussed the requirements of the MCA with the registered manager who was unaware of their obligations in relation to ensuring that people's mental capacity had been assessed when needed in order to ensure decisions were made and documented in their best interests. We were not shown evidence of staff training in this area and so were unable to determine whether this was an area of care that staff were trained in. Staff we spoke with were not clear on the requirements of the MCA and lacked understanding about what

it meant.

We found that some people were at nutritional risk and that some were on food and fluid charts to ensure that they received enough to eat and drink and so that other professional involved in their care could monitor this. However, these were not being adequately checked and reviewed to ensure that any issues were addressed. Risk assessments lacked detail in relation to people's nutritional risk and care plans did not contain enough information for staff to ensure people's nutritional needs were met. For example, one care plan stated, "Often forgets to eat." There was no further information for staff on how this should be managed. Another person's care plan stated that, "Carers are trying to encourage to eat too much." We found that there had been an incident involving this person which was being investigated at the time of our inspection. Care plans did not provide clear direction for staff on managing people's nutritional needs and preferences and this put people at risk.

During our inspection we asked people whether they consented to their care delivery and whether staff consulted with them before they provided care. Most of the people we spoke with confirmed that their consent was sought prior to their care delivery. The relative of a person using the service told us, "The last care agency did not treat my relative as a 'person', but as a dementia patient. Yes, she does have dementia, but Medacs staff talk to her in a normal way – they really concentrate on her needs. They do things with her, rather than 'to' her. They are wonderful." Nobody expressed concerns about consent not being obtained prior to care being delivered and people and their relatives described people being involved in their care delivery where possible. One person said, "My health is steadily improving and I can do more for myself. So I have reduced my daily visits from three to one visit each day. I feel far more confident now and that is thanks to the help I have received from Medacs." People's consent was sought prior to care being delivered to them.

We saw evidence that the service worked with other health professionals to ensure people's well-being. There were referrals made to district nurses, GP's and other professionals where required. The service monitored people's health needs and acted in response to these. One of the relatives we spoke with told us, "I am impressed with the way that the Medacs staff communicate with other health carers involved with my relative's care. They work well with the GP and district nurses to make sure their medical needs are met such as their bed sores. The Medacs carers are very thorough in making sure any sores are properly cared for using creams and dressings if necessary. My relative is not suffering so much with these as they did in hospital. Now they are most definitely meeting our needs."

Requires Improvement

Is the service caring?

Our findings

Care records we looked at lacked any detail about people's personal histories and did not contain evidence that care was planned to meet people's personal preferences. We found that the documentation lacked any evidence of people being at the centre of their care planning and that staff were given minimal information about the people they were caring for. Staff described knowing people's need but told us that they often lacked the time to spend with people and the time to understand their care needs. One staff member told us, "I think there's a lack of communication, for example, with the care plans. You aren't given time to read them." Another staff member said, "I thought it would be better to keep the same people but that's not the case here."

We found that people's complaints were recorded and that people were given some opportunity to feed back to the service. However, one person told us that their complaint had not been responded to. Spot checks were done by the senior care workers who monitored how people found the care they were receiving. People felt they could approach the office staff if they needed to. Some people using the service were reluctant to approach the manager. One person told us, "I have asked for the bedtime visit to be re-arranged for a later time. But [the manager] simply doesn't listen. She can be impolite and rude. I do not like her attitude so I avoid dealing with her. Fortunately my carers understand my situation and they sometimes intentionally call later than they should do." Another person said told us that they had asked for their morning call to be made earlier but that they had not had any response to this request. This did not demonstrate a caring approach to the planning and delivery of people's care.

People and their relatives described receiving support from care workers who were kind and who treated them respectfully. One relative said, ""The carers chatter away with my relative. My relative has got to know the staff really well. At first this didn't happen because we saw too many different carers. But that has been put right. The two carers are very patient moving my relative." People told us that staff respected them and their privacy whilst supporting them. One person who used the service said, "The staff are so friendly – they are real carers, not just people doing any old job. We chat a great deal. They are good friends now, but very professional too. They respect my privacy and don't pry into my business."

We found that whilst the care workers displayed a caring approach to care delivery this was not always promoted through the way in which the care was planned or in the way in which the service was being run.

Requires Improvement

Is the service responsive?

Our findings

The care records we looked at for people lacked personal details and did not reflect a person centred approach to their care delivery. Standard statements appeared to be used and some of the care records were very factual in their descriptions. We asked to see training records for all staff, however, this was not provided to us as the staff member who had overseen training had left the company in October 2016 and we were told that the records were on their computer. It was not, therefore, possible to ascertain whether staff had been trained in relation to delivering person-centred care.

We found little evidence in the care records we looked at that people were involved in the planning of their care. Care plans were not person-centred and often lacked any detail about how people would have liked to have their care delivered to them. However, when we spoke with people and their relatives they told us that staff worked to meet people's individual needs and that staff understood their personal preferences. People using the service did raise concerns about staff lacking time to spend with them and referred to them being rushed.

Staff we spoke with described knowing the people they supported and cared for and were able to tell us how people liked their care to be delivered. Staff did, however, refer to the fact that they lacked the time to look at care plans and that care delivery was sometimes rushed. One staff member said, "I felt like the service users weren't put first. I know that there are people that want certain times and that they are just slotted in." Care wasn't always planned and delivered to meet people's individual needs.

Although we found that complaints were logged and responded to at the service, we spoke with three people who had been unhappy about how their complaints or concerns had been managed. They all told us that they felt as though the complaint had not been fully considered and had been unhappy with the outcome. One of these people stated that, "Two months ago I had a meeting with [the manager] and their regional manager about this problem. I told them it was making me really anxious, but nothing has been done to improve the situation." We found that although complaints were logged and responded to, they were not always resolved to people's satisfaction and that people's experiences of their care delivery were not always fully considered by the service.

Nobody we spoke with had been given a questionnaire or formal feedback form to feed their views of the service back and no evidence of this was provided to us by the registered manager at the service. People did describe being asked how they were through telephone contact with them and we saw that reviews of care were undertaken which involved asking people how they were finding their support.

Inadequate

Is the service well-led?

Our findings

We last inspected this service in June 2016. At this time we found that improvements were needed in relation to how risks to people's care were being managed, the administration of medicines and in how the service was monitoring and auditing the quality of care being delivered. At this inspection we found very little improvement and the registered manager failed to demonstrate how improvements had been made.

We found that risks associated with the delivery of people's care were still not being adequately identified and planned for and that the service was not being effectively managed. The service had failed to respond to the findings of our last inspection and this meant that people were still at risk from unsafe care and support. Care plans and risk assessments were being checked but these had not been updated and did not reflect the current picture of people's care needs. These were issues we identified at our last inspection. This put people at risk of receiving care which was unsafe or inappropriate as staff would not have an up-to-date picture of their care needs. As there were people using the service with some complex physical and mental health needs we did not find that staff were given enough information to ensure the service was meeting their needs.

Several members of the staff delivering care to people raised concerns with us about how the service was being managed. Staff described an unhappy culture within the service and were not sure about the aims and objectives of the organisation. One staff member said, "It would be nice to know what the company is all about." They went on to comment that, "The staff should feel that they are part of a company." Staff described feeling unsupported. One staff member told us, "It could be a good company if people would just listen. They don't listen to carers so what can you do."

We found that the majority of staff working at the service had little confidence in the management. We were told that often the registered manager was unavailable and at the care co-ordinator was running the service, speaking with staff and monitoring the care delivery. We found that several staff members felt uneasy approaching the registered manager due to their unsupportive management style. One staff member told us, "I don't have any confidence in the manager." Another staff member said, "I don't feel I can go to the manager. I don't feel I can open up to them." We were given examples of the manager being dismissive of staff's concerns and of failing to support staff when they needed it.

We asked the registered manager to provide to us records of staff training. We were told that due to them being unable to pull this data from the system this would have to obtained from the training manager who worked for the provider. The registered manager told us that they were unable to produce this information and that this was not something they themselves monitored. We found that the registered person was not ensuring staff training needs were being met as they did not have oversight of the training being delivered at the service. The registered person could not demonstrate how they ensured staff had the skills to deliver safe and effective care to people.

People who used the service were generally happy with the care they received and were positive about the staff who supported them. However, several people we spoke with raised concerns about how the service

was being managed. One person told us, "Evidently [the registered manager] should be in the office by 8.30am, but I am told they are seldom there until 9.30am. That means that there is no manager available for care assistants to contact until after their shifts have started. If there are any problems with their early calls they have no one to refer to for help." People and staff expressed concerns about the lack of management visibility. One staff member said, "You don't always get the assistance you need so you have to use your own initiative." However, all of the people we spoke with and the staff were positive about the support received from the care co-ordinator who worked in the office.

Care plans and risk assessments lacked detailed guidance for staff in relation to people's care and support. Some of these documents were out of date and this meant that people were being put at risk as staff didn't have current information of people's care needs. The registered manager was unable to explain why this hadn't been addressed following our last inspection and we were told that the senior care workers reviewed and updated the care records. It was not clear what steps the registered manager had taken to improve the service.

We found that spot checks and supervisions were being done with staff and that staff performance was monitored in this way. However, management were not clear on staff training needs and this may have impacted on the quality of care being delivered.

We found that incidents and accidents were recorded but that on some occasions these had not been recognised as needing action. One incident involved an allegation of abuse by a person using the service against a care worker. The registered manager had not recognised this as an allegation of abuse and so had not notified the local authority or CQC.

The above evidence indicates an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care were not always adequately assessed and planned for. Medicines were not managed safely. People were at risk of unsafe care.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were not effective systems in place to protect people from the risk of abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not being effectively managed. There were not adequate systems in place to assess and monitor the quality of care being provided.