MHC Peterborough Ltd

My Homecare Peterborough

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
My Homecare Peterborough is a domiciliary care service registered to provide personal care to people living in their own homes. The service is able to support younger people, older people some of who were living with dementia, mental health, people with a physical disability and people with a sensory impairment. At the time of the inspection 8 people were using the service and in receipt of personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

Some people were also supported with live-in care. This is where staff stay in the person's home for a large proportion of the day and were part of the person's household.

People's experience of using this service and what we found
The provider's oversight, governance and quality assurance systems were not always effective in identifying improvements. Records of incidents were detailed and showed actions were taken, but the provider had failed to notify the Care Quality Commission (CQC) as required. We found the provider had failed to follow their own policies in regard to recruitment and obtaining of references.

Trained staff administered people's medicines and these staff had been deemed competent. However, not all medicines administration records had been completed as required by the provider's policy.

People and relatives told us staff knew how to safeguard and support people to keep them safe. There were enough staff to meet people's needs.

Staff adhered to good infection prevention and control practises. The service and the staff team took on board learning when things went wrong.

Risks to people were identified and managed well. However, there were inconsistencies in the amount of detail in risk assessments and care plans. For instance, how to undertake moving and handling tasks or people's home environment. Staff did, however, know how to keep people safe.

Although the service had a manager registered with the Care Quality Commission, at the time of our inspection they were no longer in post and cancelled their registration before we published this report. The provider told us a new manager was going to apply to be registered, but they had not yet submitted an application.

The provider took onboard learning opportunities, and implemented actions when needed. The views of people, their relatives' and staff were sought, and this enabled them to have a say in how the service was

provided. The provider worked with other organisations, to provide people with joined up care.

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

Rating
The last rating for this service was good (published 20 March 2022).

Why we inspected
We received concerns in relation staffing, management of medicines, risks to people's safety, and management of the service. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We found evidence during this inspection that people were at risk of harm from some of these concerns. Please see the safe and well-led sections of this report.

We found two breaches of regulations. You can see what action we have asked the provider to take at the end of this full report.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for My Homecare Peterborough on our website at www.cqc.org.uk

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

My Homecare Peterborough

Detailed findings

Background to this 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by 2 inspectors 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection visit there was a registered manager but they were no longer working at the service and had cancelled their registration before we published this report. A new manager had been in post for one month but had not yet applied to be a registered manager.

This meant the provider is solely and legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 17 January 2023 and ended on 20 January 2023. We visited the office location on 18 January 2023.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service since its last inspection. This information helps support our inspections. We contacted the local authority. We used all of this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 2 other people's relatives about their experience of the care provided. We received feedback from the local authority. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the provider's project manager, a care coordinator, 7 care staff and an independent consultant.

We reviewed a range of records. This included 2 people's care records and medication records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service were also reviewed, including training records, monitoring records, incident records and various policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Not all medicines administration records had been completed, as required by the provider's policy. For example, using a tick rather than signing the medicine had been administered. This meant it would not be easy to identify who administered the medicine and created a risk as to whether the medicine had been administered or not.

● There was not always guidance for medicines to be taken as required (PRN)for people's health conditions which increased the risk of inconsistent administration. For example, one staff member told us they used different strategies to help one person to remain calm However, other staff told us they administered this medicine without trying other strategies first. The lack of PRN protocols about when the medicine should be administered, included what involvement the person had, the maximum dose and when to contact a health professional. This put people at risk of not receiving the medicine as prescribed, or being given too much.

Although staff were trained and had competency checks, we recommend the provider reviews this in line with the concerns found.

We recommend the provider seek professional support in the writing of PRN protocols.

● The provider told us they were not aware of the lack of PRN protocols due to the registered manager not being in post. The provider told us they would address this matter and put an action plan in place.

● People and relatives, we spoke with who had support with administering medicines confirmed all other medicines had been given as prescribed and staff had never missed a dose. One person told us, "I do all my own medicines. Staff remind me and prompt me if I forget."

● Staff correctly used codes for not administering, such as when the person was asleep or refused a medicine.

Assessing risk, safety monitoring and management

● The provider had completed risk assessments as part of people's care and support. However, there were inconsistencies in the detail in risk assessments. For example, a risk assessment for one person lacked detail and did not provide guidance to staff on how the risk was to be managed. For another person, there was no detail about how to manage the risk associated with bed rails. The provider told us they would correct this inconsistency. Whilst we did not identify that people had been harmed. This potentially put people at risk of harm.

● Staff described how they used equipment and what input the person had. Staff told us that in addition to moving and handling training, they undertook specific training based on the person's equipment. One staff

member said, "I have been shown how to attach sling hoops to the person's hoist." Other staff involved check what I do." One person told us they felt safe and trusted staff who were careful, helping them by always staying until all the person's needs were safely met.
● People and relatives told us they felt safe as staff were always careful, knew how to check skin integrity and repositioned people safely with equipment.

Systems and processes to safeguard people from the risk of abuse
● The provider was aware of when and how to refer safeguarding incidents to the appropriate authorities and what actions to take.
● Staff kept people safe as they had skills and knowledge on identifying and reporting any potential abuse. One person said, "I definitely do trust my (care staff). For example, my (possessions) are around the house and I trust that they won't take any of them. [Staff] always check whether I've got any (unexplained) bruises."
● Staff told us they would look for changes in people's personality, body language, increased distress or being fearful of someone. One staff member told us, "If there are any signs of self-neglect, such as not taking care of themselves and not bathing; I would report to the (provider), and if no action was taken, then to local (safeguarding) authority, or if needed the police."

Staffing and recruitment
● Whilst there was a robust recruitment process in place to help ensure staff were safely recruited. The provider had not followed this in relation to obtaining references which would demonstrate the staff would be suitable to work. This was not in line with regulations to ensure potential employees are of good character. The nominated individual told us that they would address this matter and had already changed the recruitment process by having two interviewers.
● Other checks were in place including a Disclosure and Barring Service (DBS) for adults and children. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. A recent photographic identity, permission to work in the UK, and a declaration of their health status were also checked. One staff member said, "I had a police check from my country of origin and a DBS in the UK."
● People and relatives told us staff only left after all care was completed. Staff told us they had enough time to meet people's care needs, and time for a chat or general conversation.
● People and relatives told us there were enough staff with the required skills to keep people safe without rushing care. One relative said they had a consistent staff team that always arrived on time which was important for their family member's wellbeing.

Preventing and controlling infection
● Staff adhered to good infection prevention and control (IPC) guidance, wore the correct personal protective equipment (PPE) according to each person's needs. One staff member told us how to correctly use and dispose of PPE. This helped prevent the risk of infection and cross contamination. Another staff member told us, "I wash my hands first and always have enough PPE and change it after each person's care."
● One relative told us staff adhered to good infection prevention and control practices, such as always wearing a mask, changing gloves between care tasks and regular hand washing.
● Checks were undertaken to help ensure good standards of IPC were consistently upheld. For example, ensuring staff put their training into practise for safely using PPE.

Learning lessons when things go wrong
● The provider took on board learning and made changes when required. However, it was not always clear from records if staff had had the right support to learn from their mistakes, such as for medicines

administration. Although staff had been reminded of their responsibilities, further medicines training had not been an option given to them.

● Learning was shared with staff who took on board any changes. One staff member said, "We have a (social media App) where we get informed about changes and doing things differently. However, if the matter is personal, we get called to the office to discuss what we could do better next time."

● Records of incidents were detailed and showed where the provider had learned from these. For example, ensuring staff reported if they were going to miss a care call visit if their car broke down. Staff meetings were also used as an opportunity to share wider learning across the staff team.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- At our previous inspection on 22 February 2022 we found the nominated individual hadn't always notified us without delay about incidents they are required to. This was still the case at this inspection. Although some incidents had since been reported to us, the correct CQC forms had not always been used to notify us. This created a risk of missing specific information that is asked for on the CQC forms. This was as well as limiting our ability to take action if this was required to keep people safe.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- However, we found the appropriate action had been taken and they had informed the authorities including safeguarding and the police which had helped to ensure people's safety.
- The staff team was small and knew people and their families well. However, whilst the provider had quality and assurance polices and processes, these were not effective and had not recently been reviewed and used to identify where the quality of the service was compromised.
- At our previous inspection audit processes had not identified that staff recruitment process was not always robust. The provider's oversight remained ineffective on this matter. The provider's recruitment policy had not been recorded as being reviewed since July 2021. This created a risk that staff and guidance for recruitment could be out of date.
- Monitoring systems relating to records were also not effective in identifying a lack of sufficient detail to guide and direct staff to provide care, how to administer as and when medicines and manage risks associated with people's safety.
- Should a regular staff member become ill at short notice, the records did not contain adequate information to guide other staff in the provision of care, and how and when to administer as and when required medicines.
- The monitoring systems in place also included spot checks of staff to help ensure they were upholding the provider's values of good quality care. During this inspection due to some missing records, we asked for these records to be sent to us by 26 January 2023. We received the records we requested, but they did not show that the audits undertaken by the provider had been effective in identifying the shortfalls we found. This meant there was potential to miss improvement opportunities, and also to identify what had worked well.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate management oversight and support continuous improvement of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us the provider acted promptly to any concerns raised and then checked everything was working well after changes were made.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● The provider had promoted a positive culture within the staff team. Relatives were positive about the care and support they received. Comments included, "I don't know the [management team] but when I've spoken to them, they seem okay and if they couldn't take my call then and there, they have always phoned me back" and "My [family member] has had the same staff and they are amazing. They go above and beyond."
● Staff were aware of the service's values and visions for people to live as independently as possible. One staff member told us, "The [provider] double checks we have read important information about people, such as red marks on the skin, changes to equipment and changes made to their care. I promptly report any issues to the office."
● The provider implemented changes that were under their control and escalated those outside of their control.
● The provider and management team understood the need to be open and honest when things went wrong. For example, if staff did not follow procedures and they were unable to make care visits as planned and offering apologies when things had gone wrong. A relative told us, "We did have a missed care visit. The [provider's representative] came quickly to check everything was alright. It hasn't happened since."
● Staff were clear about their roles and explained these to us in detail. For example, knowledge about health conditions and how these could affect people's mobility and mental capacity to make decisions.
● People and their relatives were complimentary and praised the support provided. One relative praised staff for how well they interpreted body language, always being person-centred about people's health conditions.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were involved as much as practicable and also through relatives and court appointed deputies in all aspects of their care, treatment and support. This included best interest decisions, advocacy involvement and day to day discussions with staff.
● Relatives and people were regularly asked to feed back about the service and about their involvement with the service.
● All staff told us they felt well supported and listened to, and that their feedback was taken on board and acted on. The nominated individual told us, "If anything was of an urgent nature, I would call staff in for an urgent meeting when they were available. I would then decide any changes to be made or actions to be taken."

Continuous learning and improving care
● Although there had been recent changes to the management team, the nominated individual was looking at ways to improve the service. Examples included building additional staff reserves to cover any unexpected absences, such as if staff were unwell and appointing a new manager.
● The provider had also engaged an independent consultant who was assisting with changes to the service.

This showed the provider's wish to create a better quality service and plans to make improvements.
● Records, such as staff meetings evidenced to us how improvements had been made following changes in people's care staff and care call visit times.

Working in partnership with others
● The provider's staff team worked with various organisations such as community nursing teams, safeguarding teams and the local authority quality monitoring team. This helped support better outcomes for people.
● Health professionals and social workers were involved when needed including Court appointed deputies and advocacy services.
● The nominated individual was working with their external consultant and the local authority to help ensure people's care was safe and joined up.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission about incidents they are required to. Regulation 18 (2) (e) (f) (5) (b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight and governance of the service was not effective in identify improvements. The provider had did not always follow their policies and audits had failed to identify this omission. Regulation 17 (1) (2) (a) (b) (f).