Morecare Services (Uk) Ltd

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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
Morecare Services (UK) Ltd is a domiciliary care agency. It provides support and personal care to people living in their own homes. The agency supported 38 people at the time of our inspection.

People's experience of using this service and what we found
The provider had not always recruited staff safely. Two staff about whom safeguarding concerns were raised were found to have provided false documentation when they joined the agency, which had not been identified through robust checking and verification.

The provider had not always provided information in good time when safeguarding concerns were investigated. In safeguarding investigations involving members of the agency's staff in 2020, there was a considerable delay in the provision of information, which hampered the investigations and addressing any concerns identified.

People did not always receive consistent, well-planned care. Some people were happy with the service they received. They told us staff timekeeping was good and that they saw the same care workers regularly. People who saw the same staff regularly were happy with the support they received. They told us they felt safe with the care workers who supported them and said staff understood their needs.

However, other people said staff were often late for their calls and they saw a number of different care workers. People told us late calls meant they had to wait for aspects of their care, such as meals, and could not plan their day. Some people said frequent changes of care workers affected their experience of care because staff did not know their needs well.

People's experience of communication from the agency was also variable. Some people told us the agency was flexible if they requested changes and kept them informed about any changes to the staffing rota. Other people told us the agency did not communicate important information to them, such as changes to their regular care worker or if staff were running late.

People told us staff wore appropriate personal protective equipment (PPE) when they visited their homes and provided their care. Since our last inspection, the provider had improved the management oversight and auditing of medicines.

Staff told us they were well supported by the agency's management team. They said support was available to them when they needed it and that they had regular one-to-one supervision online. Team meetings also took place online. Staff told us these were used to keep them up to date about people's needs and their working practices, such as government guidance regarding COVID-19.

Rating at last inspection and update:

The last rating for this service was requires improvement (published 1 April 2019) and a breach of regulation was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We carried out an announced inspection of this service on 18 January 2019. A breach of legal requirements was found in relation to of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We undertook this focused inspection to check the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained 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 Morecare Services (UK) Ltd on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to safeguarding, recruitment and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
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. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Morecare Services(UK)Ltd

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. 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
One inspector carried out a site visit to the agency's office. Two inspectors contacted people who used the service and their families by telephone.

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

The service had a manager 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. This was because we needed to be sure a representative of the provider would be in the office to support the inspection.

Inspection activity started on 28 January 2021 and ended on 17 February 2021. We visited the office location on 28 January 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our

inspection.

During the inspection
We visited the agency's office to speak with the administrator. We met with the registered provider and the agency's registered managers virtually as they were working remotely during the COVID-19 pandemic.

We asked the provider to send us information electronically, including risk assessments, support plans and care records for four people, rotas for four staff, records of staff training and recruitment, quality monitoring surveys and audits.

We spoke with eight people who used the service and seven relatives by telephone to hear their views about the agency. We received feedback from 12 care staff by email about the training and support they received.

After the inspection
The provider sent us further supporting evidence, including records of staff supervision and spot checks.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
- When investigations of safeguarding concerns took place, the provider had not always provided information in good time when asked to do so by the local authority.
- In two safeguarding investigations which took place in 2020, the local authority had to request information from the provider several times over a period of months before it was supplied. This delayed the investigation of the allegations and prevented lessons being learned from adverse events.

Failure to operate systems and processes to prevent abuse of service users and to effectively investigate allegations of abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff attended safeguarding training and told us they understood how to report any concerns they had about abuse or poor treatment.

Staffing and recruitment
- The provider's recruitment procedures were not always safe. Two staff who had been involved in safeguarding allegations in 2020 were found to have provided false documentation at the time of their recruitment.
- The provider advised that one member of staff about whom a safeguarding concern had been raised had been recruited from another agency who had carried out appropriate recruitment checks. However, when contacted as part of the safeguarding investigation, the agency named by the provider said they had not carried out recruitment checks on the member of staff.
- The provider had audited staff records since the safeguarding concerns. These audits failed to provide evidence that all documentation required in respect of staff employed had been obtained.

Failure to operate effective recruitment procedures was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider employed enough staff to meet the agency's care commitments. None of the people we spoke with had experienced missed calls. The provider told us there had been no missed calls in the previous six months. The provider had arrangements in place to cover calls when staff were unavailable, including at short notice.

Using medicines safely

● At our last inspection, we recommended that the provider improve the management oversight and auditing of medicines.

● Since our last inspection, the provider had implemented an app which staff used to access people's care plans and medicines administration records.
Staff also recorded the care they had provided and any medicines they had given using the app. This enabled the management team to maintain an effective oversight of medicines administration and management.

Assessing risk, safety monitoring and management; Preventing and controlling infection

● People told us they felt safe with their current care workers. One person said, "I feel extremely safe; they are like family to me now." Another person told us, "I do feel safe and [staff] will point out things I do not know about with regards to caring for myself. In recent months, I have had issues with pressure sores and the carers were helpful with getting me what I needed [for the pressure ulcer]." A third person said, "I asked few of them if they knew how to use the new hoist and they knew how to use it. I asked them to show me and they did it all right. I feel safe with them."

● Risk assessments had been carried out to identify and mitigate any risks involved in people's care. Where risks were identified, guidance had been developed for staff about how to provide the person's care safely.

● The agency's management team took action if staff had concerns about people's healthcare needs. We saw evidence that the management team had contacted healthcare professionals, including GPs and district nurses, if staff reported a deterioration in people's wellbeing. In some cases, the action taken by the management team had resulted in referrals to an occupational therapist who had prescribed equipment to meet people's needs.

● People told us staff wore appropriate PPE when they visited their homes and provided their care. One person said of their care worker, "She wears an apron and a mask and puts her gloves on. I put a mask on too, just to be extra sure." A relative told us, "They explained about COVID and they have all the PPE." Another relative said, "They wear masks and gloves and aprons; they are very careful."

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question 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; Continuous learning and improving care

At our last inspection, the provider had not notified CQC of significant events at the service, such as allegations of abuse. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Since our last inspection, statutory notifications had been submitted when necessary.
● The provider's quality monitoring systems were not effective in ensuring people received a consistent and well-planned service.
● Some people and relatives said staff usually arrived on time for their calls. One person told us, "In general, they are good at their timekeeping", and a relative said, "Usually they arrive pretty much on time."
● However, other people were dissatisfied with this aspect of the service. One person told us, "They are often late. Sometimes they are more than half an hour late." Another person said, "They come for lunch and teatime visits. Last night they came for lunch at twelve and the tea call was delayed until seven thirty. It was long time to wait [between meals]."
● This also applied to the consistency of care people received. Some people told us they saw the same care workers regularly, which they said was important to them. One person said, "Sometimes I get different people but most of the time it's the same person." A relative told us, "We do get the same people mainly. We ask for that and they try to train enough people so that it can stay consistent."
● People who saw the same staff regularly were happy with their allocated care workers. One person told us, "I could not wish for any better. They are always happy, cheerful and helpful. They are very considerate when I am having problems." A relative said their family member had established a positive relationship with their regular care workers, describing one of the care workers as, "A breath of fresh air" and saying, "They have little jokes with [family member]. They have nicknames for her, and they get her to smile and she waves goodbye to them." Another relative said of their family member's regular care worker, "He is very kind

and caring. We like him a lot. I hope he stays."
● People who did not receive consistent care expressed their dissatisfaction with this aspect of the service. One person told us, "They keep changing them. There were two [regular] carers but they put the other one somewhere else." A relative said, "We have had loads of different ones. They don't really know [family member] well. I get fed up when they change all the time."
● People who were visited by many different care workers told us the quality of staff was variable. A relative told us that one care worker, "Was very nice, he was very caring", but said of other care workers, "They don't speak to [family member]. We have had some that have come in and not even taken their coats off."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People's experience of communication from the agency was inconsistent. Some people told us the agency communicated effectively with them, for example about which staff would be visiting them and if staff were running late. Other people said they were not informed if staff would be late for their call or if a different care worker would be visiting them.
● One person told us, "I am not very happy when people are late and about the communication. The office know what is going on but never let me know. [Staff] are not too late but when it does happen it is a nuisance. I don't know what is going on and can't plan the rest of my day." Another person said, "Sometimes a carer says they will be back the next day but then it changes and someone else turns up."
● The provider had systems in place to gather people's feedback, including visits (when COVID-19 restrictions allowed), and telephone monitoring calls. However, improvements were not always made in response to feedback.
● Some people had raised the issues they reported to us at this inspection with the provider during previous quality monitoring checks. This included concerns such as poor timekeeping, not being told if a care worker was running late and not being advised when a different care worker would be visiting.

Failure to effectively assess, monitor and improve the quality of the service was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they received good support from the agency's management team, including when working out-of-hours. One member of staff said, "The managers are good, they are very supportive." Another member of staff told us, "Support is there all the time if I need help and the on-call team picks calls up anytime out of hours. I have been working with Morecare for a few years and the [management] team are very helpful."
● Staff told us they received one-to-one supervision, which had taken place remotely since the outbreak of the COVID-19 pandemic. One member of staff said, "I had a one-to-one supervision around November last year and another one few week ago on Zoom." Another member of staff told they had supervision, "At least once in three months before COVID, now we talk over the phone and video calls."
● Team meetings were also held remotely. Staff told us these were used by the provider to keep them up to date about working practices and people's needs. One member of staff said, "We do have online meetings about government guidance on this COVID-19 pandemic and to remind us about PPE." Another member of staff told us, "Team meetings are arranged to give us updates and also to give us training."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to operate effective systems to prevent abuse of service users or to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to operate systems to effectively assess, monitor and improve the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had failed to operate effective recruitment procedures.