Monarch Care Services UK Ltd

# Monarch Care Services UK Ltd

## Inspection report

Regis House
223 Halesowen Road
Cradley Heath
West Midlands
B64 6JE

Tel: 01384410829
Website: www.monarchcareuk.com

Date of inspection visit:
06 July 2021
07 July 2021

Date of publication:
10 August 2021

## 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
Monarch Care Services UK Ltd is a care at home service providing personal care to 150 people at the time of our inspection. The service supports people living in their own homes. The majority of support provided to people was re-enablement packages. This is when people require support for a short period of up to 12 weeks. However, some people received support on a long term basis.

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.

People's experience of using this service and what we found
Staff were recruited safely, but recruitment records did not always evidence how risks had been addressed or gaps in information had been explored. Systems to learn lessons when things went wrong were not always effective and there were missed opportunities to use learning from incidents to drive improvements.

The provider had not informed us of incidents that should have been legally notified to CQC. This meant we were unaware of significant events that occurred at the service.

People and staff did not always feel there was good communication with the service. However, staff enjoyed their role and found the manager approachable if they had a concern.

There were systems in place to audit and monitor the service but these did not always identify the issues we found during the inspection. The provider was in the process of formulating an action plan to address any shortfalls and updated technology was to be implemented to drive improvements.

People told us they received safe care that met their needs. Those who were supported with medication said it was administered safely. Care plans and risk assessments were in place to guide staff about people's needs. However, records were not always robust when people had specific requirements.

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

Rating at last inspection
The last rating for this service was good (published 16 March 2019).

Why we inspected
The inspection was prompted in part due to concerns received about recruitment practices, medication errors and poor moving and handling practices. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. The provider took immediate action to address the issues found through their improvement action plan. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Monarch Care 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 statutory notifications and the governance of the service 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 for 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.

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

# Monarch Care 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
The inspection team consisted of two inspectors and two assistant inspectors.

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. At the time of our inspection there was also a new manager in post who was planning to take over the role of registered manager for the service in the near future.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 06 July 2021 and ended on 08 July 2021. We visited the office location on 06 July 2021.

What we did before the inspection

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 sought feedback from Local Authorities, the Clinical Commissioning Group (CCG) and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and five relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, manager, compliance officer and seven care workers.

We reviewed a range of records. This included nine people's care records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, care hours provided and quality assurance records. The provider took immediate steps to address the issues found during the inspection.

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 good. At this inspection this key question has now 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.

Learning lessons when things go wrong

- Records identified a discrepancy with a controlled drug had been raised with a staff member. However, no investigation or outcome was evidenced and the registered manager was not able to provide further details. This meant is was unclear whether any risk to people had been managed.
- Lessons were not always learned when things went wrong. Safeguarding matters were not analysed to identify any potential trends, learning for the service or to reduce the risk of further incidents.
- Where staff spot checks identified shortfalls, there was no record of what action was taken to address the issues.

Staffing and recruitment

- The inspection was prompted in part by concerns about recruitment processes. During the inspection we found systems were in place to recruit new staff members safely, however they were not always robust.
- We examined recruitment records for five staff members. We found risk assessments in place for staff with criminal disclosures lacked detail about how risks to people had been considered and mitigated. Gaps in employment history had not always been explored.
- People did not always receive the length of care calls detailed in their care plan. Some staff told us it was difficult to manage the volume of visits they were allocated. However, people told us the care met their needs. One person said, "They do stay for the time I need. Sometimes they overrun, sometimes it's quicker. They always ask if there is anything else they can do."

Assessing risk, safety monitoring and management

- Records were not always amended to reflect emerging risks. For example, plans and risk assessments had not been updated for a person following a recent incident that had put staff at risk. The service had identified that reviews of people's records were required and this was underway.
- Care plans and risk assessments were in place to guide staff and monitor people's assessed risks. However, information about people's specific health needs was not always detailed. The provider planned to address this as soon as possible.

Using medicines safely

- Protocols were not in place for medication which was prescribed to be taken as needed. Care plans for medicines with specific administration instructions, such as mixing with a drink, lacked detail. This meant that staff did not have clear guidance for when and how people who couldn't communicate should be given such treatments.

● People who received support with medication told us they received their prescribed medicine correctly. One person said, "I am happy with the way it's done. The (medication) has to be counted and put in a book. They watch me take it."
● Staff were trained in administering medication and were confident to support people with their medicines.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse and records showed that concerns raised with the service were investigated.
● People and relatives told us the support they received was safe. One person told us, "I think they are wonderful. I have no complaints." Another person said, "I haven't been unhappy with them, they all seem nice and caring."
● Staff received safeguarding training and understood the signs of abuse. Staff members knew what steps to take if they needed to report any concerns.

Preventing and controlling infection
● People told us care staff took precautions to manage the risk of spreading infection whilst visiting their homes. Staff were knowledgeable about what Personal Protective Equipment (PPE) was required for their role.
● The provider had policies and procedures in place to address infection control. An additional policy had been developed to consider the specific risk of COVID-19 and how the service should function considering the unique pressures of the pandemic.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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

- Audit systems and processes had not identified the shortfalls we identified in recruitment processes and staff records. For example, systems were not always effective to identify how discrepancies had been responded to to prevent further reoccurrence.
- The registered manager dealt with safeguarding issues on a case by case basis. This meant there was not a formal system for highlighting themes and trends or to identify learning for the service.
- Systems to monitor and review people's support plans had not always been completed when new risks emerged. Medication audits had not identified medication protocols were not in place. The provider was in the process of reviewing people's care plans at the time of the inspection.
- Staff had not received specific training to support people's individual health needs, such as diabetes or Parkinson's disease. Following the inspection, the provider highlighted this issue in the improvement plan for the service.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems and processes had not identified matters which required a statutory notification to CQC. The provider had been informed by the Local Authority about a number of safeguarding issues since the last inspection. The registered manager had investigated the concerns but had not notified CQC in line with their legal responsibilities. The service took immediate steps to review this.
- Whilst notifications had not been received, the registered manager understood their responsibility in relation to duty of candour and was able to describe when they were obliged to inform CQC of an incident.
- Staff understood the provider's whistleblowing policy and knew how they could use this to raise concerns.

This was a breach of regulation 18 of the Care Quality Commission Registration Regulations 2009 notification of other incidents. This is being followed up and we will report on any action once it is complete.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received mixed feedback from people, staff and relatives about how effective communication was with the provider. Whilst many spoke positively, some felt communication could be improved. One person said, "One thing is communication. If they're late, they should let me know. You're in the dark at home waiting. If they called it would put me at ease."

● People and relatives said the service was well-led and they were happy with the care they received. Staff spoke positively about enjoying their role and supporting the people that used the service.

● The manager gave examples of when the team had gone beyond what was expected to support people and their families in times of crisis. This meant people achieved good outcomes when there had been shortfalls in the service from other agencies.

● Staff felt supported by the new manager and were confident to raise any issues with them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Systems were in place to gather feedback from people using the service. At the time of our inspection a feedback survey was in progress. Results from the previous survey had been analysed and were being considered as part of the improvement plan for the provider.

● Supervisions were held regularly with staff members and staff meetings took place when practicable during the pandemic. Information was also shared throughout the team using emails, messages and phone calls. One carer said, "They (the manager) are brilliant and can't do enough for you. I can't fault them, I'm never left to feel on my own."

Continuous learning and improving care; Working in partnership with others

● A compliance officer had recently been recruited at the time of our inspection. The registered manager, manager and compliance officer had a clear vision on how to move the service forward and an improvement plan was being formulated.

● New technology was due to be implemented to assist the monitoring of the service. This meant the registered manager would have greater oversight of any missed or late calls. It would also allow for records to be updated by staff electronically which would support the auditing process.

● Systems were in place to ensure people could access external services as needed. We saw records showing people had been referred to health services due to their needs.

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 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |