Medacs Healthcare PLC

Medacs Homecare - Bristol

Inspection report

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Date of inspection visit:
02 August 2016
03 August 2016

Date of publication:
06 October 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook an inspection on 2 and 3 August 2016. The inspection was announced, which meant the provider knew we would be visiting. This is because we wanted to make sure the provider, or someone who could act on their behalf, would be available to support the inspection. The last full inspection took place on 17 and 18 June 2015. We found one breach of the regulations of the Health and Social Care Act 2008 relating to consent. We also found one breach of the CQC (Registration) Regulations 2009 relating to their statutory duty to notify CQC of incidents. These breaches were followed up as part of our inspection.

Medacs provides personal care to people living in their own homes in the Bristol and North Somerset area. At the time of our inspection the service was providing personal care and support to approximately 250 people.

A registered manager was not in post at the time of inspection. 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 2008 and associated Regulations about how the service is run. A manager has been appointed and they have sent their registered manager's application to CQC for consideration.

In June 2015 we found that people's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions for themselves. We found insufficient improvements had been made.

In June 2015 the provider did not notify CQC of all relevant incidents that affect the health, safety and welfare of people who use the service, as required. We found sufficient improvements had been made.

The service used the CM2000 system which is a database that allows the service to electronically monitor calls. Between the period of 4 July and 31 July 2016 the service made 9864 calls which represented 100% of their planned calls. 92.92% of calls were made within 30 minutes of the planned time. This meant the service were covering their expected calls and people were in the main receiving their calls at the correct time.

The provider operated safe recruitment procedures and ensured all pre-employment requirements were completed. Staff had received appropriate training to identify and respond to suspected abuse.

Staff received training to enable them to carry out their roles. An induction process was completed by staff newly employed at the service. Staff received supervision, in some cases they needed to be up-dated in line with their supervision policy.

People in the main felt they received good care from staff and that staff were confident and knowledgeable when providing their care. Some concerns were expressed regarding the timeliness of calls and the lack of communication from the office staff.

Records showed that staff liaised with other healthcare professionals when it was appropriate to do so. This helped to ensure that there was good communication and sharing of information about the person's care needs.

People generally spoke positively about the staff and told us they were caring.

People told us the service was in the main responsive to their needs. Before people commenced a care package with the agency, a full assessment of their needs was carried out by a Service Quality Assessor. This included gathering full information about the person's needs and their views on the kind of support they wished to receive.

There were systems in place to respond to complaints and this was set out in a written policy. We saw that the concerns outlined in the complaints had been responded to comprehensively and with openness and transparency, with apologies made where appropriate when the service had not performed as expected.

There were systems in place to monitor the quality of the service provided by the agency. This included a system to check that calls to people were being made as scheduled; and having a system of spot checks in place to monitor the quality of the service provided by staff.

Although some staff raised concerns regarding travelling times and their rotas being changed with limited notice they felt well supported by their managers.

People were given the opportunity to feedback their experience of the service through care planning reviews and surveys.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Some people felt that the office staff did not relay messages from carers if they were going to be delayed. They also felt that office staff did not in all cases return their calls. This is an area where the service is aiming to make improvements.

Medicines were managed safely.

Staff had training in safeguarding adults and felt confident in identifying and reporting signs of suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not upheld in accordance with the Mental Capacity Act 2005.

Staff were supported through a training programme. Staff received supervision, in some cases they needed to be up-dated in line with their supervision policy.

Staff worked with other healthcare professionals when required to.

Is the service caring?

Good

The service was caring.

The majority of people spoke positively about the staff and told us they were caring.

People mentioned qualities in the staff they particularly liked, such as being respectful and making them feel at ease.

Staff understood people's needs and demonstrated they knew how people preferred to be cared for.

Is the service responsive?

Good

The service was responsive.

Before people commenced a care package with the agency, a full assessment of their needs was carried out by a Service Quality Assessor

People said they had been involved in deciding their care packages.

There was a complaints procedure in place. Formal complaints were responded to with openness and transparency.

Is the service well-led?

Good

The service was well-led.

Systems were operated to assess and monitor the quality and safety of the service provided.

Staff generally felt well-supported by their managers.

People were given the opportunity to pass on their feedback regarding their experience of the service through care planning reviews and surveys.

Medacs Homecare - Bristol

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.

The inspection took place on 2 and 3 August 2016 and was announced. The provider was given short notice because the location provides a domiciliary care service and we needed to be sure senior staff would be available in the office to assist with the inspection. The last inspection of this service was in June 2015 and we had identified two breaches of the legal requirements at that time. The service was rated as 'Requires Improvement.'

This inspection was carried out by one inspector 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.

Before the inspection we sent a questionnaire to: staff members; people who used the service; relatives and friends; and community professionals. We received a response rated of 48% from people who used the service. The response rate from the other groups was 13.2% or less. The sample sizes are considered too small in isolation to make decisions on the quality of care but were used to inform our lines of enquiry on the inspection.

On the day of the inspection and the following day we spoke with five people and the relatives of five other people who received care from the service. We also spoke with five members of staff, the manager and the regional manager. The local authority also provided feedback on the service.

We looked at four people's care and support records. We also looked at records relating to the management of the service such as the daily records, policies, complaints, surveys, recruitment and training records.

Good

Is the service safe?

Our findings

Medicines were generally managed safely. All staff who administered medication received the appropriate training and refresher training, when due. Each service user's medication needs was assessed by a Senior Quality Assessor (SQA) before care was provided. Risk assessments relating to medicine management were undertaken. These detailed the support people required with regard to taking medicines. A checklist was completed for each person requiring assistance with their medication and the individual's specific needs were written into their personal support plan.

The medicine administration records demonstrated that people in the main received their medicines when required. There was a system in place where medication logs were returned to the office monthly and were audited by office staff. Records demonstrated that medicine errors were recorded and appropriate action had been taken where required, such as additional staff training.

Staff told us they reported to the office if they were going to be more than 30 minutes late for a call, and the person was informed. Where permission had been granted staff told us they used people's telephones to log their visit times. When people did not give permission for their telephones to be used, staff completed time sheets. Staff told us they were generally given enough time to complete the care people needed. On- call arrangements were in place so a designated senior member of staff could be contacted during out- of-office hours.

We received mixed feedback from people regarding the timeliness of calls. Some people felt that the office staff did not relay messages from carers if they were going to be delayed. They also felt that office staff did not in all cases return their calls. Comments included; "They always turn up, they can be late but it is understandable if they have been held up by the previous call"; "I like my regular carer who knows from working with me over a long period of time exactly what my needs are and he is reliable. If he is late, which is rare I can always phone and ask why. Usually it's a reasonable explanation, such as an emergency"; "On occasions carers have been late. This can vary from 10 minutes to more than an hour. You do not usually get a call and it is left to you to contact the office"; "If there is a change of rota because of sickness or late arrival, telephone contact is pretty well non-existent." The manager was aware of this issue and told us they are continually addressing this issue with staff members through team meetings.

The service used the CM2000 system which is a database which allows the service to electronically monitor calls. Between the period of 4 July and 31 July 2016 the service made 9864 calls which represented 100% of their planned calls. 92.92% of calls were made within 30 minutes of the planned time. 4.34% of their overall calls were 15 minutes or less than the planned time. The service was covering their expected calls and people were in the main receiving their calls at the correct time and length of time. The manager reviewed calls on a weekly basis and analysed call compliance rates alongside their capacity of whether they could take on new clients. In exceptional circumstances where calls were missed the manager conducted an investigation and implemented an action plan to mitigate future risks of the event re-occurring. A member of staff who had responsibility over coordinating care and rostering calls told us that they were working over the weekend to review their planning. Their aim was to improve their rostering process and planning of calls

over their respective areas.

People felt safe and most of the comments we received were positive. They generally spoke positively about their relationships with the staff. Comments included, "All carers are excellent" and "I feel safe I have pleasant girls who come in with a smile on their face"; and "they're all lovely and I'm quite happy with them." There were some other comments; "My loved one does not always feel safe. It depends on who comes. They like the regular carers, they know what to do."

The provider operated safe recruitment procedures and ensured all pre-employment requirements were completed. Staff files had completed initial application forms together with the staff member's previous employment history and employment or character references. Photographic proof of the staff member's identity and address had been obtained. An enhanced Disclosure and Barring Service (DBS) check that ensured the applicant was not barred from working with certain groups such as vulnerable adults had been completed.

The provider had ensured staff had received appropriate training to identify and respond to suspected abuse. Staff understood safeguarding procedures and explained the process they would undertake to report concerns. Staff recognised the different types of abuse or harm people could experience and said concerns would be reported to senior staff.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way. The provider had appropriate policies for safeguarding and whistleblowing.

There were sufficient numbers of suitably qualified staff to ensure that people's needs were met. We spoke with staff who were responsible for rotas. We were told that at the present time, staffing levels were balanced with the care hours provided so that all visits were able to be covered. They would not take new clients if staffing levels were not sufficient to provide adequate cover. At times of unexpectedly high levels of staff absence, they would call existing staff to provide care. Failing this, we were told that senior staff would be available to cover visits. Staff we spoke with felt staffing levels were generally adequate to meet people's needs. Comments included; "There have been a lot of staff changes but things are working well. There is a good level of communication between the carers and the office. Travelling time is always an issue but they're (care coordinators) sorting out the timetables which will help. It will be nice to have regular rotas"; and "Sick absences are covered by existing staff. I've not missed a call but have been late because of public transport."

An assessment of people's needs and risks had been completed and identified risks were managed through detailed guidance for staff to follow. For example, moving and handling assessments detailed the mobility equipment needed to keep the person safe. The assessments included staff guidance on how to use the equipment and position the person.

Environmental risks had been assessed and risk management guidance produced where required. This assessment highlighted the external and internal areas of a person's home that staff would visit. It ensured that staff were working in a safe environment and any risks to people or the staff member were identified. For example, the assessment ensured that access to the home was clear and safe and free of potential risks, such as trip hazards. This demonstrated the provider had ensured that staff were working in safe conditions.

The provider monitored incidents and accidents reported by staff. Incidents or accidents were reported by staff and relevant information was recorded on a designated form. This was then reviewed by senior

members of staff. The incident reports showed that the cause of the incident together with any contributory facts were highlighted, together with any measures that could be put in place to prevent a repetition of the incident.

Staff told us they were supplied with the right equipment to be able to support people safely, such as gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

In June 2015 we found that people's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005. This provides a legal framework to protect people who are unable to make certain decisions themselves. The provider sent us an action plan telling us how they intended to meet the requirements of the regulation. We found the provider had not made sufficient improvements.

There was a lack of documentation related to a service user's capacity to make decisions and how to support a service user when there was evidence that they lacked, or had variable capacity to make informed decisions. Mental capacity assessments were not conducted on specific issues such as the provision of personal care; assisting with medicines; nutrition and hydration. Where people were unable to make decisions the person's representative and health professionals were not consistently involved in best interest meetings. Involving the person's representative would enable the service to take into account the person's wishes, feelings, beliefs and values. One person held the Lasting Power of Attorney (LPA) over their relative's health and welfare. They had not signed the consent agreement relating to their relative's care. Their relative who had been diagnosed with a condition which affected their capacity to make decisions had signed their consent agreement. Their LPA commented on the document; 'My father states that he didn't hear a word what was said.'

The Head of Homecare told us that the current practice is an organisational issue and it is currently being addressed. We were advised that the Head of Clinical Services and the Training Manager for Homecare have been working on developing a robust process that supports the care needs assessment, alongside the consent to care provision document. They intend to introduce a process that answers questions such as; Do we need an advocate? Why is the family consenting to care? Do we need a social worker? What is the reason the service user does not have capacity? What support do we need to put in place? They have developed a training session relating to this process and this will be cascaded to the service in October. The service continues to act in breach of Regulation 11 of the Health of Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training to enable them to carry out their roles. Staff spoke positively about the training they received and felt they were able to provide good care as a result of the training. Records showed staff had received regular training in a variety of relevant topics such as moving and handling, health and safety, safeguarding adults and infection control. One member of staff felt they would benefit from more intensive training on dementia and the Mental Capacity Act.

An induction process was completed by staff newly employed at the service. New induction training in line with the Care Certificate guidelines had been implemented. These are recognised training and care standards expected of care staff. The induction ensured new staff received training in key areas such as medicines, first aid, moving and handling and safeguarding adults. New staff members also completed a period of shadowing an experienced member of care staff. We spoke with one member of staff who had recently been inducted and felt sufficiently trained and supported to undertake their role.

Staff told us that in the main they felt well supported and received regular performance supervision. Supervision is where staff meet one to one with their line manager. Staff records demonstrated that staff received supervision, in some cases they needed to be up-dated in line with their supervision policy. Staff would discuss their overall performance, people's care needs, if they felt sufficiently supported and a plan was created for any areas of improvement or development identified.

People in the main felt they received good care from staff and that staff were confident and knowledgeable when providing their care. Some concerns were expressed regarding lack of knowledge about specific medical conditions. One person told us; "I would like to always have the same carers. The ones that I am used to know what to do. I have to teach all the news ones, they know nothing about my medical condition."

Staff provided assistance to some people in the preparation of their meals and drinks. People told us they were supported by staff with their meals, and care records reflected the level of support people received. Snacks were left for people when required during the day. Specific dietary requirements such as diabetes were catered for by the carers

Records showed that staff liaised with other healthcare professionals when it was appropriate to do so. This helped to ensure that there was good communication and sharing of information about the person's care needs. On one file it was noted that one person's GP was very impressed with the carer for their observation and recording details which related to the person's broken arm. The carer called the GP and they noted the 'carer's efficiency and dedication to duty.'

Good

Is the service caring?

Our findings

The majority of people spoke positively about the staff and told us they were caring. Comments included; "They are very good and kind"; "My loved one likes them. They are kind and have a chat. No-one has ever been nasty"; "It is like having a friend coming in to see me"; "Care varies. It depends on who it is. Some carers are excellent and treat my loved one well. Others do not understand their needs."

Good relationships had been established between staff and the people they provided care for. People mentioned qualities in the staff they particularly liked, such as staff members being respectful and making them feel at ease. We were also told the staff understood the need to respect people's privacy and dignity. Comments included; "I am quite comfortable with personal care. We have a laugh and a joke"; and "It took a long time for my loved one to settle with the carers but now it is alright. They have a joke and my loved one even teases them." A recent compliment received by the service stated; [person's name] said that [carer's name] was a perfect gentleman especially when he has to escort her to the bathroom. He was very caring and considerate."

Assessments ensured staff promoted people's independence when supporting them. Within one person's record it documented that they did not want staff to make decisions and choices on their behalf. The person was content with staff making suggestions but they wanted to choose. Staff understood people's needs and demonstrated they knew how people preferred to be cared for. Staff we spoke with told us the service aimed, where possible to ensure that the same care staff supported people. Staff said this ensured they were able to know people well, learn their preferences and understand what was important to them in relation to their care.

One staff member told us about one of the people they cared for, "[person's name] has dementia and lives with their family. I talk in a calm manner and using distracting techniques works quite well. She generally responds positively. If she refuses personal care I suggest something like having their hair washed. If she refuses I respect that decision. I do not push beyond her boundaries. I do not want to take their independence" Another member of staff told us; "I always refer to the care plan. If people need more time I give them more space. I always involve them in decisions and treat them as individuals."

People were given important information about the service. People were given a 'service user guide' when they commenced a care package. The guide contained information about the service, the aim of the service and how they would achieve their aim. People had the main contact number and the out of hours emergency number so they could contact the service at any time. People told us that in the main they received other information such as their scheduled care appointment times and information on who would was scheduled to provide their care. We were told by people that the person scheduled to provide care may differ at times.

Good

Is the service responsive?

Our findings

People told us the service was in the main responsive to their needs. One person raised concerns that they though that some staff did not understand their needs and they intended to leave the service. People said they generally saw the same staff. Staff also confirmed that they tended to care for the same people, where possible. We saw that there were systems in place to ensure that staff were matched to the needs of the person they supported. One care plan states; [person's name] is a very private person. She prefers female carers and would not accept two male carers.' One person told us they had asked for one carer not to return and this request was respected.

Before people commenced a care package with the agency, a full assessment of their needs was carried out by a Service Quality Assessor. This included gathering full information about the person's needs and their views on the kind of support they wished to receive. This included details about their medication, an environmental risk assessment, moving and handling requirements, daily routine and various other risk assessments.

People said they had been involved in deciding their care packages. We found that care plans were reviewed annually or when circumstances had changed. People's records contained personalised care information within them, for example how somebody liked their personal care given, what drinks and snacks they preferred or tasks they required the staff to complete prior to them leaving. The care plans were detailed. An example of this included the wording; '[person's name] does not like having the hoist used on her. She therefore does not want a running commentary on what is about to happen. She wants staff to just get on with it.' People told us that in the main care was delivered that met their needs and in line with their care preferences.

Following this initial assessment, support plans were created to guide staff in providing the right support. People spoke about the flexibility of the service and how staff took account of their changing circumstances. One person told us about how extra hours had been requested because of a serious family problem and this had been arranged for them. Care plans were reviewed regularly to ensure that they were current and updated when people's needs changed. People gave examples of when their changing circumstances had changed and the service accommodated their changing needs, such as when increased help was required due to hospital appointments.

Plans had been produced which detailed the support to be provided by staff on each visit. Staff said the plans gave them the information they needed about people's care needs and their individual preferences. This enhanced staff understanding of the person and provided guidance on their personal interests in addition to their care preferences. They were person centred and included people's personal history, employment history and particular interests, such as travelling.

There were systems in place to respond to formal complaints and this was set out in a written policy. A record of complaints was kept. We saw that the concerns outlined in the complaints had been responded to comprehensively and with openness and transparency, with apologies made where appropriate when the

service had not performed as expected.

People we spoke with told us they would feel able to raise complaints when necessary. Examples of issues raised included punctuality and people's preferences not being adhered to. As a result of the complaints made, packages were amended to ensure time critical calls and people's preferences were adhered to. A consistent theme from people was timeliness and a lack of communication from the office. The manager was aware of this concern and was addressing them as they arose. The care coordinators were also in the process of reviewing their areas and rostering, with the view that this should improve timeliness. There was also an expectation that communication levels between office staff and people would improve. The manager told us that it was an issue that was regularly raised with staff.

Good

Is the service well-led?

Our findings

In June 2015 we found that the provider did not notify CQC of all relevant incidents that affect the health, safety and welfare of people who use the service as required. The provider sent us an action plan telling us how they intended to meet the requirements of the regulation. We found the provider had made sufficient improvements. The service now refers the appropriate notifications when incidents have occurred.

There were systems in place to monitor the quality of the service provided by the agency. This included a system to check that calls to people were being made as scheduled. This allowed reports to be created, to see what percentage of calls had been completed within the allocated time. In the exceptional circumstance where a call had been missed, it was clear from the data what the impact of this missed call was and whether it represented a risk to the person concerned. Although missed calls rarely occurred assessing them in detail better informed the service and ensured that the required improvements were made. Evidence of poor practice such as poor time-keeping concerns and persistent short term absences were effectively processed through the provider's disciplinary procedure.

The provider had a system of spot checks in place to monitor the quality of the service provided by staff. A senior staff member attended unannounced to observe and check the delivery of care. The records showed that all areas of practice were monitored, for example, the appearance and attitude of the staff, communication, adherence to the care plan and record keeping. We saw that when an observation had identified that standards were not being met feedback and supervision were provided.

Although some staff raised concerns regarding travelling times they felt well supported by their manager. The manager communicated with staff about the service. They had recently sent a letter to all care staff with areas that required attention. These included issues such as; wearing personal protective equipment at the appropriate times; communicated the improvements of the use of CM2000 and the need to continue improvements; timesheet and rota requirements. Regular team meetings were also held which communicated similar issues to the staff.

People were given the opportunity to pass on their feedback regarding their experience of the service through care planning reviews and surveys. This year 206 surveys were sent and the service received 90 responses. The key findings from the survey were that people were generally happy with the service they receive. There had been an important improvement in people receiving the same regular carer. The main area for improvement identified was the breakdown in communication regarding letting people know when a carer was going to be late and also for the office staff getting back to people regarding issues received. Comments from the survey included; "I am very satisfied with the carers I have at present and would appreciate very much if I remain with them"; My regular care worker treats me with the upmost respect and is extremely caring"; "Rare indeed to be contacted by the company of any change or delay; and "No feedback on the requested changes to care package."

Following the survey the manager told us that their current priorities were to: Look into the lack of communication and introduce a process to ensure managers respond to concerns raised; Keep service

users informed regarding changes in care worker; Ensure rotas are sent out at the same time each week for consistency; Ensure continuity of service over the weekends; and feedback would be provided to people on what they're going to do to improve.

The manager in post at the time of our inspection has since been registered with the Commission as the Registered Manager.

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 11 HSCA RA Regulations 2014 Need for consent People's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions for themselves.