Meadowvale Homecare Ltd

Meadowvale Homecare Ltd

Inspection report

Beehive Business Centre, Skelton Industrial Estate
Skelton In Cleveland
Saltburn By The Sea
Cleveland
TS12 2LQ

Tel: 01287653063

Date of inspection visit:
31 March 2020
01 April 2020
02 April 2020
06 April 2020

Date of publication:
01 May 2020

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Meadowvale homecare is a domiciliary care agency which provides personal care and support to people who live in Redcar and Cleveland. The service supported adults and older adults living with physical and mental health conditions, including dementia. At the time of inspection 121 people were using the service. 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. At the time of inspection 53 people received personal care.

People's experience of using this service and what we found

People said staff supported them to feel safe and had managed any potential risk of harm. Care records needed continued development to ensure they were accurate and up to date. Systems to support a lesson's learned approach had been embedded. Staff were proactive in raising concerns.

Quality assurance measures needed further development to increase their scope of review. The level of information within audits was limited in places. Feedback was used to drive development at the service and communication at all levels had improved. People were happy with their care and staff were committed to the service.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 November 2019) and there were multiple breaches of regulation. At that inspection we identified breaches in relation to the care which people received, staffing levels, support for staff and the quality of the service. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The service had remained within a serious concerns protocol with Redcar and Cleveland local authority. As part of this process, the provider shared an action plan each month and met with stakeholders (including the Care Quality Commission) to demonstrate the improvements they had been making.

At this inspection we found continued improvements had been made in areas around the care and support which people received. Continued improvements were needed in record keeping and quality assurance processes. This meant the provider was still in breach of one regulation.

Why we inspected
We undertook a targeted inspection to review the progress made by the service to become compliant with the multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This

report only covers findings in relation to safe care and treatment and quality assurance. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement
We have identified a breach in relation to the governance of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will continue to work with Redcar & Cleveland local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated. Details are in our safe findings below.	**Inspected but not rated**
Is the service well-led? Inspected but not rated. Details are in our well-led findings below.	**Inspected but not rated**

Meadowvale Homecare Ltd

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the breaches in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In line with the current restrictions in place for managing the risks of COVID-19, we carried out a desk-based inspection.

Inspection team
Three inspectors and one Expert by Experience carried out this inspection. 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.

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 provider 24 hours' notice of the inspection. This allowed the provider time to let people know we would be contacting them for feedback and provide us with records for review as part of the inspection.

Inspection activity started on 31 March 2020 and ended on 6 April 2020. We carried out telephone interviews with people and staff on 1 April 2020 and 2 April 2020. We reviewed information provided for inspection on 31 March 2020, 2 April 2020 and 6 April 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information shared with us as part of our attendance at serious concerns protocol meetings. We also

contacted stakeholders with the Redcar and Cleveland serious concerns protocol forum to provide feedback. This included the chair, safeguarding team, commissioning and contracts team and South Tees CCG. We used all of this information to plan our 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.

During the inspection
We spoke with five people and six relatives via telephone. We spoke with 18 members of staff by telephone including the provider, registered manager, deputy manager and 15 care workers.

We reviewed a range of records which were shared via email. This included six people's care records. We also looked at the training matrix for all staff and a variety of records relating to the management of the service, including policies and procedures were reviewed.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to review the progress which the service was making to become compliant with the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in relation to the management of risk and quality assurance processes to manage the safety of people using the service in relation to the safe domain.

Assessing risk, safety monitoring and management

At our last four inspections of the service the provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Care records did not support the management of risk. The quality of risk assessments had improved, however, continued gaps remained. This led to a reduced oversight of risk because quality assurance measures had not identified these gaps.
- Gaps in information did not support new staff to deliver safe care to people. Risk assessments omitted some key risks or did not provide clear information about current risks. There were some gaps in staff knowledge about specialist risks which people displayed.
- Where incidents occurred, staff worked quickly to provide people with the support needed. Care records were not routinely updated following incidents.
- The overall risk of harm was mitigated by the knowledge of staff. One comment included, "I feel safe going into calls and know what to expect." Staff were proactive in their support and consistency with staff involved in people's care supported the management of risk. Comments included, "Staff recognise any little changes in [person]. They are spot on." And, "[Care staff] are absolutely brilliant. They noticed straight away [person was unwell] and alerted me. This early detection meant I could get [person] antibiotics quickly."

Staff supported people with the care they needed, however incomplete records did not safely support the oversight of risk. Therefore there is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to record keeping.

Learning lessons when things go wrong

At our last four inspections of the service the provider did not have robust systems in place to ensure lessons were learned when things went wrong. At this inspection we found enough improvement in this area had been made.

● A system to support a lessons learned approach was in place. The number of incidents occurring at the service had reduced. Consistent reporting of incidents had led to increased oversight and analysis of incidents. Staff said, "If I thought something was happening that shouldn't, I'd report it. We act on safeguarding [concerns] pretty quickly now."
● Staff worked together to improve the delivery of care to people. Staff were more proactive in following the provider's policies and procedures. People and relatives were very positive about the care provided, comments included, "[Care staff] are absolutely wonderful." And, "[Care staff] are always polite. They go over the top to help."

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to review the progress which the service was making to become compliant with the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in relation to quality assurance processes to deliver a good service to people using the service in relation to the well-led domain.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last four inspections of the service, quality assurance processes did not support the delivery of good care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 in relation to monitoring the quality of the service.

● The scope of quality assurance measures needed further development. These measures had not identified gaps in care records. They had not reduced all aspects of risk at the service.
● Information in records to monitor the quality of the service was limited. There was a lack of clarity when judgements were made. This meant it was difficult to determine how risk was safely managed. The current action plan to drive improvement needed review as it was not effective in it's purpose.
● Staff were committed to the service and enjoyed their roles. They felt supported. Comments included, "The management team is very approachable and very helpful." And, "It is good working here. I enjoy it." And, "The communication is good. We received a 'thank you' for our work. It was nice to be appreciated."

Further development of quality assurance processes was needed. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At our last four inspections of the service, the procedures in place to continually improve the service for people needed to be further developed. At this inspection we found enough improvement in this area had been made.

● Feedback was regularly sought and used to make improvements. People and relatives said they were listened to when they raised concerns, and these were dealt with quickly. Communication had improved and everyone felt better informed about the service. Comments included, "They [management team] act

when we suggest things." And, "The office [staff] deserve a pat on the back. They are very good."

● Information from incidents was used to make improvements. Common themes were discussed in meetings with staff to increase their knowledge. This had resulted in improved practices.

● People and staff said the overall quality of the service had improved. Comments included, "The carers are part of the family now too. I would struggle without them." And, "[Care staff] are fantastic."

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 (1) Quality assurance measures were not effective. The quality of record keeping in some areas was not sufficient.