Monarch Care Services UK Ltd

Monarch Care Services Coventry

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 January 2017 and 31 January 2017 and was announced. We also visited the service on 23 February 2018 in response to staffing concerns.

This was the first inspection of the service trading as Monarch Care Services UK Ltd. The service took over the provision of care calls which had previously been provided by another care agency which closed.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. The service is registered to provide care to older people, people living with dementia, people with autism and learning disabilities, and younger adults. At the time of our inspection visit, the agency provided support to 33 people.

The registered manager worked part time in the Coventry office and part time in another of the provider's locations. 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.

Since taking over the provision of the previous care provider, Monarch Care Services Coventry accepted a local authority contract to provide care to people in a designated area of Coventry. This meant the service grew quickly to provide care to a much larger group of people than they originally anticipated. The registered manager informed us they had struggled to meet the needs of the larger volume of people their contract required them to support.

The management team acknowledged they had been 'fire-fighting' to keep pace with the number of people who required care and support. They had not had the time to undertake some of the management functions such as assuring themselves of the quality of service provided by carrying out the appropriate checks on service delivery. This meant there was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations; Good governance.

There were not enough staff to meet people's needs. The provider had not been able to recruit enough staff to meet the higher demand of people who used the service. Because the existing staff team were stretched, this led to people often not receiving their care calls at the expected time, and care undertaken by staff they were not familiar with. Whilst pre-employment checks had been started, we found prospective staff had gone into people's homes with other staff before initial clearances had been confirmed. This might have put people at risk as the provider did not know whether the prospective staff member had a criminal record. This meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations; Staffing.

Medicines were not managed safely, and health and social risk assessments of people did not always

support staff to know what actions they should take to reduce the risks from occurring. This meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations; Safe care and treatment.

Care records did not always provide enough detail to help staff know about the person they supported and how to meet their needs. At times, staff visited people without having any prior knowledge of their needs. Reviews were not always undertaken in a timely way. This meant the provider was in breach of Regulation 9, Person-centred care.

Staff knew how to reduce the risks of infection from spreading by using hand gels, gloves and aprons.

Staff had received training which the provider considered essential to meet people's health and safety requirements. Some had undertaken Care Certificate training. Most people and relatives thought staff had the skills and experience to meet their or their relatives care needs.

Staff supported some people with eating and drinking. Concerns were raised that some staff did not offer people choices when making their drinks or meals.

People and relatives told us staff asked permission before they carried out any care tasks. Staff understood the importance of gaining people's consent.

Staff mostly supported people with kindness and consideration and treated people with dignity and respect. However we were told of occasions where this had not been the case.

The provider had recognised the service required more support and had started to make changes in the management structure to provider this.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe.

There were not enough staff to meet people's needs. The staff team struggled to attend calls at the expected times, and people did not always receive care from staff they knew and trusted. People's risks were not always managed well, and medicines were not always administered or managed safely. People did not always feel safe. Staff recruitment checks mostly gave the provider assurance staff were suitable to work at the service. Staff understood how to prevent infection from spreading with the appropriate use of gels, gloves and aprons.

Is the service effective?

Requires Improvement

The service is not always effective.

Staff mostly had the skills, knowledge and experience to meet people's needs. People were asked their consent before care tasks were carried out. Where people received food and drink from staff, they were not always offered choices. The provider and staff understood the Mental Capacity Act. Where necessary, staff contacted health care professionals to meet people's needs.

Is the service caring?

Requires Improvement

The service is mostly caring.

People did not always know who was going to support them with care. Not all staff knew people's needs and preferences and sometimes the office staff did not take this into account when planning rotas. People and relatives mostly thought staff were kind, and treated people with respect and dignity, although we were informed of occasions where this was not the case.

Is the service responsive?

Requires Improvement

The service is not always responsive.

People's care needs were assessed prior to them using the service, but care plans did not provide enough information for staff to know people's preferences, likes and dislikes. Daily

records did not always provide accurate information about the care tasks undertaken by staff. Reviews of care had not always taken place as planned. Complaints had been addressed but not always in line with the provider's complaint policy.

Is the service well-led?

Inadequate

The service is not well-led.

The provider had struggled to meet the demands of the contract they had accepted. They did not have enough staff to provide care to people or to support the office function in ensuring records were up to date and to check the care provided by staff was safe, caring, effective and responsive. The provider had started to consider how to rectify this.

Monarch Care Services Coventry

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.

This service is a domiciliary care agency. It provides personal care to people living in their own homes. At the time of our inspection, 33 people were provided with personal care and support.

Before the inspection visit we reviewed information we held about the service to inform and plan our inspection. This included information that we had received about the service as well as statutory notifications the provider had sent to us. A statutory notification contains important information about certain events that they must notify us of. We contacted the local commissioners who funded the care and support people received. They had concerns that people were not receiving their care calls at the expected time.

The inspection was informed by feedback from questionnaires completed by a number of people using the service. We had also received information of concern from three people who shared their experience of the service with us.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection site visit took place on Thursday 25 January 2018 and was announced. The provider was given 48 hours' notice of our visit. This was because we wanted to be sure staff would be available to meet with us as part of the inspection visit. The service was inspected by one inspector.

When we visited the office location we spoke with one member staff, the registered manager and the care manager. We also looked at the records of the three people who used the service, and records related to quality and safety. We spoke to two more staff by phone on 30 January 2018.

We spoke by phone with two people, and five relatives of people who used the service on Wednesday 31 January 2018.

Following our inspection we sent the provider a letter expressing our concern about their service and asked them to report to us actions they were taking to improve the service. They responded to our letter of concern, but we did not feel the response was sufficient to reduce immediate risks.

Therefore on 23 February 2018 we visited the service again after being informed there were not enough staff to provide care for people the week-end of 24 and 25 February 2018. By the end of the day we received confirmation that agency staff had been contacted and all care calls were covered, the majority by staff from different care staff agencies.

Inadequate

Is the service safe?

Our findings

Eighty per cent of people and 67 per cent of relatives surveyed by the CQC told us their care workers did not arrive on time. Relatives we spoke with by phone told us their family members did not always feel safe because they could not trust staff to arrive at the expected time, or arrive at all. This was because sometimes they waited so long they did not think the care call was going to be made. For example, one relative told us that on one recent Saturday the care worker did not arrive for the breakfast call until 12.40pm. Another told us their family member's breakfast call was 8am but the care worker did not arrive until 9.30am. This was then closely followed by the lunch call at 11am. They told us it was fortunate they were at their relation's home because they were able to send the care worker away and give their relation lunch at a later time when they would be hungry.

One relative told us of occasions where staff had not turned up and they had to make office staff aware of this. They said their family member lived on their own and had a diagnosis of dementia, and it was only because they had visited the person they found staff had not been to the home to provide the expected care.

The registered manager acknowledged there were not enough staff to meet people's needs. They told us following the implementation of a new local authority contract; there had been a significant increase in number of people they provided support to. This increase had not been matched with staff availability in the area. They told us they struggled to recruit staff of the right calibre to meet the level of demand. They explained they were continually looking to recruit new staff, but people were not applying or didn't always turn up for an interview.

Following our first inspection visit we received information of concern that there was not enough staff available to cover people's care calls for the week-end of 24 and 25 February 2018. Therefore on 23 February 2018 we visited the service again to find out more. We found that most of the staff who worked for Monarch were absent due to sickness, and the majority of care calls were being contracted out to staff from other agencies to ensure people's needs were met. One of the agencies had previously been used by the service so people would have been familiar with their staff, but the other agency had not been used. This meant staff would not know people's care needs and people would again have staff they were unfamiliar with.

This meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations; Staffing .

Relatives told us when staff were late they had to phone the office to find out why, and to check that a member of staff was going to be attending the call. They felt frustrated that the onus was on them to check whether the care worker was going to attend the call, and not the office staff informing them if their staff were going to be late.

We were told that as part of the contract with the local authority, the provider was required to install a telephone monitoring system in each of the homes of people they supported. This was so when staff

attended a call, they could phone to confirm their arrival and departure from the person's home. However, the care manager told us there was no system to check care calls had been made. This meant there was no monitoring to ensure people received their calls at the required times to meet their care and support needs and ensure they were safe. We asked the local authority to provide us with figures of staff punctuality. They informed us for the period 1 January 2018 to 18 February 2018, there were 38% of calls which were late (this was excluding the fifteen minute leeway given for calls either side of the expected time). After our inspection visit the registered manager confirmed to us they would track punctuality of visits and if staff were going to be late they would inform the person there would be a delay.

We looked at three staff recruitment records. We found that, for two staff members, checks had been carried out to ensure people were safe to work with people who used the service. For example criminal record checks had been sent from the Disclosure and barring service (DBS) and references had been received from previous employers.

However, for one person, we found prior to the references and DBS checks being received; they had worked alongside another staff member in people's homes. We were told this was to help the new staff become familiar with what care work entailed. We informed the registered manager we were concerned this could potentially put people at risk because they did not know whether the person was safe to work with people in their own homes. The registered manager acknowledged this and said they would stop this practice.

We asked to look at the care plans and risk assessments of four people we planned to contact by phone. This was so we could gain a full understanding of the care and support they required and how their needs were met. The three we looked at provided us with varying levels of information about how risks were identified and managed.

One risk assessment provided detailed information about the person and how staff should support that person's needs. Another gave limited information about the risks associated with the person's care. For example, the person's care needs put them at increased risk of skin damage. The risk assessment for skin said, "Skin good at the minute." There was nothing about why staff should check the person's skin and what they should do if they found any changes to the person's skin such as red areas.

The third was a care record and risk assessments for a person who lived with dementia. This person could leave their house via the back door and use the garden but not get out of the front door. The provider's policy was that if the person was not in the house, the staff had to contact them to let them know. Staff had written in the person's notes that they were not in the house. There was no indication they had looked to see if the person was out in the garden, their notes simply stated they were not there. The person's risk assessment in relation to confusion/disorientation stated there were 'no issues' despite the fact they had been assessed as being too confused to leave their home on their own.

Staff were required to record the actions they undertook during each care call to provide evidence of the care given to people. We found care records did not always tell us what staff were doing and the time they spent at the person's home. Where times were recorded, we found a couple of instances where a half hour call was completed in a lot less time. Given the complexity of the call in relation to the person's care and support needs, we were concerned that staff took less time to complete it as this might have meant staff were rushing.

In contrast, another person's notes told us the person staff were to provide care for was not in the house when they called. Staff recorded they stayed at the home for the 30 minutes they were expected to be there.

There was nothing in the notes to say the staff had looked for the person who would have been vulnerable if they had left their home. The care manager told us staff should have informed them if the person was not in the home but this had not happened. They were not aware that this had occurred because they had not had the opportunity to check the notes written by staff.

The majority of family members we spoke with did not believe the records always provided a true account of the care people received. One relation told us they had seen records which said staff had washed up their relation's dishes, but the person's bowl and plate were still unwashed. They also said, the care notes completed by care workers sometimes said the person had been supported to change their clothes, but there was no evidence of dirty clothes ready for washing. They went on to tell us, "If there isn't time to do something then write that, be honest." Another told us of an incident involving a care worker which had been investigated by the provider and the local authority commissioning team. They said the care notes did not reflect what they had witnessed.

We looked at how medicines were managed. People and their relatives told us they were not always assured that people received their medicines as prescribed and at the time required. One relative, whose family member had diabetes and required medicines for this said a care worker should have arrived to give the person their lunch at 1.30pm but they received information from the person at 2.30pm to say no one had arrived. The office was contacted who said they would get someone to support the person after 3pm. But, nobody turned up to deliver care. Another told us that whilst they thought medicine administration had started to improve, they had experienced confusion as to whether their relation had received their medicines because of poor and inconsistent recording by staff on the medication administration records.

The registered manager and care manager told us medicine administration records (MARs) should be returned to the office each month for office staff to check they had been completed properly. This was to assure management that people's medicines were being managed safely. We asked to look at the MARs of people whose care records we had looked at. The care manager was unable to find all the MARs for each person. Most of those which had been returned to the office had not been checked because the management team told us they had not had the time to do so.

The sample of MARs we looked at showed people might not have received their prescribed medicines including the application of topical creams as required. One person's local authority support plan informed staff the person should have creams applied, and staff should monitor any breakdown in skin. This information had not been transferred to the person's care plan. The daily records completed by staff also did not show that creams had been applied by staff.

Another person who lived with dementia should have been supported to have medicines each day. The MARs available showed the person had not had their medicines on a number of occasions. The care records showed staff had attended the home of the person on the days where the MAR had not been completed and there was no reference in the person's care records about medicines being administered.

This meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations; Safe care and treatment.

We checked staff understood the importance of hand washing and used gloves and aprons when providing personal care. This was to reduce the risk of infection spreading from one person to another. All the people we spoke with by phone told us care workers did all they could to prevent and control the spread of infection through using hand gels and gloves and aprons when providing personal care.

The registered manager told us that prior to our inspection the provider had recognised the service needed more management support to ensure the service was safe. They said a new position of regional manager had been created, and this role would provide more over sight and guidance to the registered managers in both the provider's locations.

Requires Improvement

Is the service effective?

Our findings

We asked people if staff had the skills, knowledge and training to support them with their care. Just over half the people who completed the questionnaire, strongly agreed that staff had the skills and knowledge to support them; where-as the same proportion of relatives who completed the survey strongly disagreed that staff had suitable skills and experience.

People and their relatives also had mixed experiences of using the service. One relative said, "You can tell if they (care workers) care and have compassion … if they don't rush dad … he has poor mobility … if they offer him a chair if he isn't able to walk … if they talk to him … then I know they know what they're doing. However, others do the reverse." They went on to tell us not all of the others were 'Monarch' staff, some had been staff from an agency which was used to provide care on behalf of Monarch. Another relative told us they felt at times staff did not know how to support people with dementia. They said staff asked whether their family member was hungry, and if they said no, they would not support them with making a meal. They said staff should know it was better to show the person two meals to remind them of the food, and this would help encourage them to choose a meal they liked and to eat it.

Staff told us they had received training considered essential by the provider to meet people's health and safety needs. This included training to safeguard people from harm, the Mental Capacity Act, infection control, and moving people safely. The provider had a 'workers compliance report' which tracked whether staff completed their training. We found the majority of staff had received updated training, and all staff who supported people with medicines, had undertaken medicine administration training.

We asked staff various questions linked to their training and their answers suggested they understood the training provided to them. For example, one care worker told us how important it was to always ask people what they wanted staff to support them with, and to find out from them how they wanted the support delivered. They told us the importance of people having a choice. Another care worker was able to tell us how they would safeguard a person from harm by reporting to senior management information they had come across which suggested the person might be at risk.

The Care Certificate was introduced in April 2015 and sets the standard for the fundamental skills, knowledge, values and behaviours expected from staff within a care environment. The Provider Information Return informed us that some staff at the agency had completed the training necessary to achieve this certificate.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Prior to using the service, the local authority social workers had assessed whether people had capacity to

make their own decisions. Where people lacked capacity, the recorded care plans had not identified which decisions the person continued to have capacity to make. For example, when people could continue to make decisions about choices of clothes, or choices of food and drink, and how staff could encourage and support people to make such choices.

One person who lacked capacity to make decisions had been assessed as too vulnerable to go out on their own. To reduce the risk of this happening, the person's front door was locked so they would not be able to go out the front of the house, but they could get out of the back door into the secure garden. Staff were asked not to allow the person to go out on the street on their own. We were concerned this meant staff were supporting the person to be unlawfully deprived of their liberty but we could not see an application had been made for a deprivation of liberty safeguard to the court of protection. The care manager approached the social worker involved in this person's care and it was confirmed after our inspection visit that an application was being made.

All the people and relatives we spoke with told us they had been asked by staff if they had their permission to carry out a task before starting the task. For example, one relative said, "They do check. Mum likes to wash herself but can't manage her bottom half, so the carers always make sure she's alright with them doing it."

Some of the people who used Monarch Care required staff to prepare or cook food for them and to provide them with drinks. However because of staffing issues sometimes people told us they did not get their meals and drinks at the time they expected them. One person told us because of cultural and language differences, they sometimes did not get what they wanted. For example, they asked for marmalade on toast and received just that. The care worker did not realise that a person would normally have butter or margarine with their marmalade.

One person told us that staff who were expected to support people with their meals had sometimes gone straight to the fridge or freezer and prepared a meal for the person without asking them first what they wanted.

Care staff and office staff understood the importance of contacting health care professionals if a person's needs changed. During the morning of our first visit, care staff contacted the office by phone to say they were going to be delayed as they had called an ambulance for one of the people they cared for because of concerns about the person's health.

Requires Improvement

Is the service caring?

Our findings

Most people and their relatives told us that because of staff changes, the staff who supported them did not always know their personal preferences. We also found there was not enough information in the person's care records to support staff knowledge of these preferences to ensure people received support in accordance with these.

All people and relatives we spoke with told us they were not told when different or new staff would be attending their care call. One relative told us a male care worker arrived unexpectedly on one occasion. They said their family member went into a "panic" because they did not want a male care worker to provide them with this support. They told us it was sorted out and had not happened since. However, we were concerned this had not been identified when the staff rota for care calls was initially planned.

Another relative told us of occasions where confidentiality had been breached by staff. They said there had been three occasions where a member of staff had left a list of names with the codes to their key safes in their relation's bedroom.

A third relative told us of a very poor experience their family member had with one of the care staff from the service. They told us the member of staff had refused to support the person with a personal care task when needed, and this resulted in the person's dignity being compromised. They told us the person was 'scared' of the care worker. We found this had been investigated by the manager and the care staff member no longer worked for the service. Other people and relatives told us most care staff treated them and their relation with dignity and respect. For example, people told us, "They are never rude." And, "They are more than willing to help." Family members told us care staff, "Are courteous and never rude" and "They listen to her."

Overall people and their families felt most staff treated them well. One person who had consistent care workers told us, "It's more than just earning a wage to them." Another told us, "We have a chat, a bit of a laugh." A relative told us that whilst it could be "Hit and miss" if the provider used agency workers, there was one care worker who consistently worked with their relation who was, "Definitely caring, lovely." Another told us, "They are very caring. For example, they make her a cup of tea, and they sit and chat to her."

All respondents to our survey told us they strongly agreed that staff treated them with dignity and respect. All respondents also told us they strongly agreed that staff were caring and kind, and helped them to be as independent as possible.

All people and family members told us staff made sure personal care was delivered so that people's privacy was respected.

Requires Improvement

Is the service responsive?

Our findings

Before people started to use the service, their needs had been assessed by a social worker from the local authority to determine what care they required and how many hours of care the service should provide to meet those needs. However, the detailed information in these assessments had not been transferred into the care plans for people who used the service. This meant care plans did not contain enough information for staff to help ensure the care they provided was centred on people's individual needs and preferences. For example, one person needed support with eating and drinking. The care plans gave staff no indication about the person's likes and dislikes for meals or the types of drinks. This meant each time a different care worker attended the person; they would have needed to ask the person these questions. The care manager told us they were aware the care plans were not as detailed as they would like them to be.

The registered manager told us they had so many 'care packages' coming through they struggled to keep up with the demand. They stated the previous Thursday and Friday they had 10 new care packages which they needed to set up, and with limited staffing available, the care records were not a priority.

As well as care plans not providing sufficient information, some people and relatives also told us staff did not read the care plans available. One relative told us, "New carers don't check it before they start, it would be useful if they did." Another said they didn't believe staff read the care plan because, "They don't always know what they're meant to be doing." A member of staff told us when they provided care to a new person; sometimes they only received the address of that person, and had to ask the person when they got to their home what their needs were.

We looked at whether people's care needs were reviewed. We were told there was a tracking system to determine when people were due to have their care plans reviewed. The provider had a system of reviewing people's care after they had used the service for 12 weeks. We found by looking at their 'client compliance' report that many of their 12 week reviews were overdue. Once the 12 week review period was completed, other reviews were yearly unless there were identified changes to people's needs.

We received mixed responses from people and their relatives about the review process and their involvement. A relative told us their relation's care needs were reviewed yearly, but it had been over a year since the last review and no review had been arranged. One person told us the office staff came out and discussed their care needs with them, but this was not a regular occurrence. They told us they thought this would be useful, "To make sure everything was alright." One relative told us the planned review meeting they had attended ended up being a discussion about a complaint they had made about the care, and the review of their relation's care needs did not take place.

This meant the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person-centred care.

The provider information return told us the service had received six complaints since it was registered in 2017. We looked at how these had been managed. The records did not contain clear information about how

the concerns had been investigated. There was no letter to the complainant outlining what the issues were and the steps the provider had taken to resolve them. For most, the complaint record was a recording of the resolution as opposed to the steps taken towards the resolution.

One complaint was about the care provided by an individual care worker. The notes of this investigation showed a discussion had taken place with the care worker as another person using the service had also raised concerns about them. However, there was nothing in the complaint record to identify who the second person was. When we asked the care manager, she was not able to remember who had raised the concerns. This meant we could not check whether the person was satisfied with the way their complaint was managed.

All the people and relatives we spoke with had complained about the service. One person was pleased with the outcome of their complaint, others felt their complaint had been managed in the short term but were not confident their concerns would not arise again in the longer term. One person was not satisfied with the way their complaint had been managed.

Each person had information about how to make a complaint in the Service User Guide which they were given when they started to use the service. This guide provided them with details of how to complain to the CQC as well as how to complain to Monarch Care UK. We reminded the registered manager that whilst we wanted to hear about people's individual experiences we did not have the legal right to carry out complaint investigations. The registered manager said she would amend the guide.

The responses to the questionnaire we sent to people showed that 80% of respondents strongly agreed they knew how to make a complaint. Sixty per cent of people who used the service strongly agreed staff responded well to any concerns they raised. However, 100% of relative's strongly disagreed that staff responded well to any complaints or concerns raised.

Inadequate

Is the service well-led?

Our findings

This was the first inspection of the service since Monarch Care Services UK Ltd took over the provision of the service from a registered provided which was closing its service.

The provider had another service in the West Midlands and the registered manager was registered to manage both the Coventry service and a location in Dudley. The registered manager told us the provider had recognised both services required a full time registered manager in each location. They told us of plans for them to become an operational manager who would oversee both services. The current care manager at the Coventry service planned to apply to the CQC to become the registered manager. Most people and their relatives knew who the care manager was and had been in contact with them.

Soon after the provider registered with the CQC, they agreed to contract with the local authority to provide care to people in a designated 'cluster' area of Coventry. This meant the relatively small service grew quickly. The registered manager told us they felt it had grown too quickly and had left them and the office team 'fire-fighting' (dealing with immediate problems rather than planning for the future). They told us they had a high demand of 'care packages' and had not been able to recruit to the levels of staff they wanted and needed to provide continuity of care to people. Instead, they had used existing staff and this meant they had to change staff rotas frequently to make sure calls were covered.

The care manager told us because office staff were managing the day to day demands of the service, the quality monitoring aspect of their work had not been carried out. This meant the provider could not assure themselves people's needs were being met safely and effectively. The care manager and registered manager had not checked care or medicine records to make sure staff were carrying out their duties safely and in line with the care plan. The care plans were not sufficiently detailed to support person-centred care; and there were not enough checks on the daily records completed by care workers to make sure staff were undertaking care as required. Complaints and concerns were not always managed appropriately.

After our first inspection visit, we sent a letter to the provider outlining our concerns and asking for information about action they were taking to address these concerns. The provider promptly replied to our letter, however we did not feel their response was sufficient to reduce the risks in the short term. During our second visit we found the service was faced with further challenges, and had not yet acted on any of the concerns raised during our first visit.

We found that the safeguarding authorities had been involved when one person had not received their medicines when they should. We had not received a statutory notification to inform us of this as required. The registered manager told us this had not happened because it was a medicine error and we did not have a notification they could complete for medicine errors. We explained that the circumstances were neglect and an act of omission because the care staff had not administered the medicines to the person and as such a safeguarding notification should have been sent to the CQC. The registered manager acknowledged this and said they were now clearer about when to notify the CQC.

The provider had a 'worker compliance' report. This informed the registered manager when staff supervision meetings were due, what training staff required, and when unannounced visits to check staff competence and safety should be completed. We found that staff had received supervisions and unannounced checks, but more recently some staff had not had these because of competing management demands. Some training was also identified as overdue.

During our inspection visit we saw that team meetings had been held with staff to discuss the service and to look at staff practice. We also saw that an action plan had been devised to identify the concerns the management team had, and the action which had, or needed to be taken. For example, staff discussions had taken place to explain the importance of them using the call monitoring system; and the provider had increased their advertising for staff, to include using recruitment websites as well as using local services. The action plan also acknowledged the need to increase staff supervision and observations. However the action plan had no date to inform when the required actions had been identified, and when they hoped the actions would achieve improved outcomes for people.

We asked people and their relatives what they thought of the 'out of hours' service (evening and week-ends). People told us this was mostly okay during the evenings, but it was more difficult getting a response at the week-ends. Some said this may be because the calls went through to the provider's Birmingham office.

The provider sent us the Provider Information Return (PIR) as requested. This had been completed by the provider just before we visited the service. The PIR should provide the CQC with an accurate account of the service provided and any issues impacting on service provision. The PIR did not reflect what we saw and were told during our inspection visit. We discussed this with the registered manager who acknowledged it did not inform of the issues they had faced, but said they would make sure any concerns would be reflected in any future PIRs.

The provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Good Governance.

The provider sent quality assurance questionnaires every six months to people who used the service. These were last sent out in October 2017. We looked at the responses provided. The registered manager told us they had not had time to collate the responses to look to see whether there were themes, trends or learning points from the questionnaires. However, from looking at the questionnaires we could see that most people felt the office staff were responsive to calls made to the office during office hours. Some of the respondents' spoke of issues with the timing of care calls and continuity of staff, and some were concerned about staff's understanding of English, and about staff not speaking English well.

This concurred with what people told us. People and their relatives mostly said the Coventry office staff were helpful when they called. For example, people said, "They're very nice in the office. They always get back to you, they're very helpful." And, "I've always found them attentive and empathetic." A relative said they "Try to come up with solutions." Family members also spoke to us about not knowing when staff changes had been made, and some staff's understanding of English.

We asked people if they would recommend this service to others. Only one person categorically said yes they would. Others said they would recommend certain care workers, or were waiting to see if some recent improvements continued before they would recommend it to others.

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 9 HSCA RA Regulations 2014 Person-centred care The care plans did not provide staff with enough information to help them understand people's needs, wants and preferences. People experienced staff having to ask them what they needed because they did not know in advance of the care call what people's needs were.