Medacs Healthcare PLC

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Inspection report

12 Fusion Court
Aberford Road, Garforth
Leeds
West Yorkshire
LS25 2GH

Tel: 01132874612
Website: www.medacs.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Medacs Healthcare PLC is a domiciliary care agency providing personal care. At the time of our inspection there were 93 people using the service. Everyone who used the service, at the time of our inspection, received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Risks to people's health and safety were assessed but related documentation had not always been completed. Some care records needed to be updated and better organised to make sure staff were using up to date information about people's needs. The registered manager had identified this issue and was addressing it. Staff were recruited safely and the registered manager took immediate action to address an issue we identified in making sure staff, new to the service, followed an effective induction process. Some improvements were needed to make sure required documentation in relation to managing medicines was in place.

Staff knew what to do to make sure people were safe and the service managed safeguarding issues well. Staff felt there were enough of them to meet people's needs safely. People told us they felt safe with staff and were complimentary of the care they received. One person was concerned that not all staff stayed for the correct amount of time.

Systems to audit quality and safety within the service at branch and provider level were in place but needed some improvement to make sure they covered all aspects of the service. Where auditing had identified issues, action had been taken to find the cause and address the issue. The provider used this process to learn lessons for future improvement of the service.

Whilst some people and their relatives told us they had been involved in their care planning, others were not aware of their current care plan or how to access the App used to view their or, where appropriate, their relatives care plan and care records.

Some people told us their opinions of the service were sought but others said not. People and staff felt they were listened to by the management team and some felt communication from them was good. All of the

people we spoke with felt the service was well managed and many said they would recommend it.

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 good (published 01/01/2019). The rating has now changed to requires improvement.

Why we inspected
This inspection was prompted by a review of the information we held about this service. This report only covers our findings in relation to the Key Questions Safe and Well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Medacs Healthcare PLC on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Details are in our well-led findings below.

Medacs Healthcare PLC

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by three inspectors 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.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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

Inspection activity started on 16 January 2023 and ended on 26 January 2023. We visited the location's

office on 18 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We also used information gathered as part of monitoring activity that took place on 17/11/2022 to help plan the inspection and inform our judgements.

During the inspection
We spoke with 9 people who used the service, 6 family members and 11 staff including the registered manager, the lead trainer and 1 care co-ordinator and 1 quality officer. We reviewed a range of records. This included 9 people's care records and medication records. We looked at 5 staff recruitment files and a variety of records relating to the management of the service.

Requires Improvement

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Staff were recruited safely but introduction to the role through shadowing more experienced colleagues was not always managed well. For example, one new member had shadowed calls with two more experienced staff, one of which was their relative.

● Periods of shadowing for staff new to care were often short and records did not always evidence any follow up with the member of staff to make sure they felt confident in their role. A care worker checklist and manager sign off form was completed for new workers. However, this did not include confirmation of a satisfactory period of shadowing.

● The registered manager acted immediately following the inspection to address issues with shadowing. This included going out with some staff.

● Staff felt there were enough of them to make sure calls were made and people's needs were met. However, one member of staff told us there had been occasion, when staff had been asked to attend calls that required 2 staff to be in attendance, on their own.

● One person we spoke with said there had been a missed call. Some people commented calls were not always on time and this has meant calls had been very close together. However, one person said, "The carers arrive pretty much on time and definitely stay to do the job they are employed for."

● Another relative expressed some concern about the length of some calls. They told us, "Some carers are very diligent and go above and beyond to make sure (person) is comfortable and has everything (person) needs while, unfortunately, some are in and out in minutes."

● People were mostly complimentary of the staff. One person said, "I wouldn't change them. They are consistent and support us well during a difficult time."

Assessing risk, safety monitoring and management

●Risks to people's health and safety were not always fully assessed. Risk assessments using the providers own comprehensive systems were not always fully completed. One person confirmed they had been involved in their risk assessment. They said, "I had the full risk assessment before they (Medacs) started coming".

●The registered manager told us care plans were reviewed on an annual basis, however, records we reviewed showed this was not always the case. Care records showed some care plans had not been updated or reviewed for more than one year. This meant there was not always evidence to demonstrate risks to people's health and safety were being effectively assessed, monitored and mitigated.
● Care files held in the office were not always easy to navigate with archived records mixed with current records. Whilst the provider had an electronic care record system, the system did not contain care plans or risk assessments. These two factors meant we could not be sure that staff were following up to date information about people's needs.
● Daily records were in place, with notes and observations recorded on most occasions. However, where a scheduled call had not been made, there was no indication why this happened and what the outcome was.
●The registered manager was in the process of introducing new audit documentation for care files.

Using medicines safely
● Systems in place to manage medicines required improvement.
● Protocols for administering as needed medicines were not always in place.
● Some care records on the providers electronic care records system did not always record people's GP and/or pharmacist.

Systems and processes to safeguard people from the risk of abuse
● Staff knew what to do if they thought someone was at risk. On the day of the inspection visit, the senior training was updating safeguarding information for staff to include contact numbers of local safeguarding teams.
● A member of care staff had identified an issue with one person's medicines which meant the person was at risk. This was managed well and appropriate action taken to ensure the person's safety.
● Referrals to safeguarding had been made as needed and the local authority safeguarding team told us the service worked well with them.
● Safeguarding incidents had been investigated appropriately and followed up. However, documentation in relation to these incidents had not always been signed by the registered manager.
● People felt safe when receiving care. One person said, "They know what they are doing, and they are always respectful and caring." A relative said, "They (carers) know they have to announce themselves when they arrive so (person) doesn't worry. (Person) says (they) feel safe with them." Two relatives told us staff also checked they were alright when they delivered care to their family member.

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 MCA 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.

● We found the service was working within the principles of the MCA.
● People were asked for their consent for care, however, one care plan we reviewed had been signed by the person's spouse. The registered manager told us the person had capacity and would ask staff to revisit this section of the person's care records and update it.

Preventing and controlling infection
● Staff had received training in use of personal protective equipment (PPE)
● People said staff wore masks and used other PPE such as gloves and aprons as needed.

Learning lessons when things go wrong

●Where the provider had identified issues within the service including call timekeeping, consistency of care staff and recruitment and retention of staff. A route cause analysis of each issue had been completed and a report detailing an overview of the action taken to address the issue. Lessons had been learned to prevent a re-occurrence.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- One relative told us they had been involved in their family member's care plan review, but other people didn't always feel fully involved. One person said they did not know if their care plan had changed when their needs changed. Another said, "About 2 years ago an admin person visited and left a care plan which was supposed to have been updated but I heard she left, and I don't think it ever got updated?"
- One relative said they had access to their family member's notes on the App but said, "I have to say, the completion by some carers is sketchy to say the least and tells you absolutely nothing." Another person said, "I had no idea that I could have access to my notes on the App." Another relative told us they had not yet been given access to the App.
- We saw satisfaction surveys were sent to people, but received a mixed response when we asked people if they had been asked about their opinion of the service. One person said, "The office has regularly phoned to check I am happy with everything, but nobody has ever visited to do a spot check." Another person told us "They don't ask about the service. I don't ever remember getting sent a (feedback) form either."
- People and their relatives told us the service was well managed and management responded well to any concerns they might have. One person said, "If I ring the office, they do listen and then sort me out."
- Staff felt listened to by the management team and felt well supported. One staff member said, "I don't have any trouble whatsoever, if I need anything, I would get them. Whenever I do need them, they are more than happy to help, I've never felt disappointed. When I put my opinion across (registered manager) takes them onboard".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems to audit quality and safety within the service at branch and provider level were in place but

needed some improvement to make sure they covered all aspects of the service. The registered manager told us they were aware that the quality audit of care records was a little inconsistent but said this was being worked on.

● People and their relatives told us the management team worked well together and said they would recommend the service. One person said, "It seems well run and they have certainly done everything by the book. Very professional."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Systems were in place to ensure that relevant people, for example the local authority safeguarding team, were appropriately informed about issues affecting people using the service.

● Notifications about significant events were submitted to the CQC.

● People felt communication was usually good. One told us, I don't speak to the office very often, but I have their number and they call me if there is anything I need to know or there are any changes. It works for me."