Care Quality Commission

Mcare24 Limited

# Mcare24 Limited

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

MCare24 Limited is a domiciliary care and supported living service, providing the regulated activity of personal care. The service provides support to people living with dementia, people with a learning disability, autistic people, older people, people with a physical disability and people with mental health needs. At the time of our inspection there were 3 people using the service who were in receipt of personal care in supported living settings.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People told us they felt safe when supported by care staff and were happy with and complimentary about their care. Staff were aware of the risks to people, but care records were not up to date and did not always reflect people's current needs. People were supported by safely recruited staff who knew them well.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care:
People were supported by staff who were aware of their responsibilities to protect them from harm. However, there had been a number of incidents where the provider had failed to recognise people were at potential risk of harm. The provider worked alongside other agencies in order to support people to meet their health care needs. People were supported by a consistent group of staff who knew them well.

Right Culture: We found some areas of the service that required improvement that the provider's own systems and processes had not identified. These were in relation to ensuring information held in people's care records was up to date and correctly risk assessed. People told us they had no issues getting hold of management and relatives were kept informed of events that affected their loved ones.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection The last rating for this service was good (published 4 December 2017).

Why we inspected
We inspected this service due to the length of time since the previous inspection. This inspection was also prompted by a review of the information we held about this service. We completed a focussed inspection of the key questions safe, effective and well led. For those key questions not inspected, we used the rating awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for MCare 24 Limited on our website www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?**<br>the service was not always safe. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not always well led. | **Requires Improvement** |

Care Quality Commission

# Mcare24 Limited

## 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
The service was inspected by 1 inspector.

Service and service type
This service is a domiciliary care agency providing personal care to people living in their own houses and flats and specialist housing. This service provides care and support to people living in 3 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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

Inspection activity started on 4 January 2024 and ended on 23 January 2024. We visited the location's office

on 4 January 2024.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from 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.

During the inspection
We spoke with 6 members of staff including the registered manager [who is also the provider], a nurse and 3 care staff. We spoke with 1 service user, 1 relative and 2 healthcare professionals. We also received feedback from a local commissioner. We looked at the care plans and medication records of 2 people, policies, and procedures and 2 staff files.

Requires Improvement

# Is the service safe?

## Our findings

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

At 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.

Assessing risk, safety monitoring and management
● The information recorded in people's care records and risk assessments was not always accurate, up to date and complete. For example, one person's care plan and risk assessment did not contain an accurate picture of their needs, including their healthcare needs and their associated risks.
● A pre-assessment care plan was in place for 1 person, but the provider did not conduct an individualised risk assessment in association with person's care and support needs until after the inspection. However, staff spoken with were knowledgeable regarding these needs and how to support people safely. One member of staff told us, "Everyone is confident on what to do."
● Staff confirmed they were kept up to date regarding people's care needs and any changes in care needs were passed onto them in a timely manner. Staff confirmed that following any incidents that occurred where a person may display distressed behaviours in response to the circumstances they found themselves in, a debrief took place to ensure all staff responded consistently and in line with the person's care plan and risk assessment.
● Regular meetings took place with other healthcare professionals in order to, obtain guidance and support in how to meet a person's ongoing care needs.

Using medicines safely
● There was no effective oversight of the management of 'as required' (PRN) medication. One person had received their 'as required' medicines daily, without clear rationale as to why this was the case. This was not picked up in audits and no action had been taken to review this arrangement.
● The provider had not always produced clear written guidance for staff on the use of people's PRN medicines, and their audits had failed to identify this. This meant there was a risk of these medicines being administered inconsistently. This was rectified immediately following the inspection and 'as required' protocols were put in place.
● Staff had received training in how to administer medicines but had failed to consistently follow the provider's policies and procedures regarding this. For example, staff had failed to consistently record the reasons for administration of 'as required' medicines. Further, the provider confirmed when 'as required' medicines were administered this should be recorded on handover sheets and daily notes. We found 2 instances of 'as required' medicines administered but no recording in the daily notes or the incident form acknowledging the medicine had been administered in response to the incident.
● A relative told us they had no concerns regarding their loved one's medicine management by the service.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems and procedures in place designed to protect people from abuse and neglect;

however, these were in need of improvement.
● The provider had not always notified the relevant external agencies of potential abuse concerns or made these notifications in the correct manner. For example, they had not always informed CQC of abuse concerns by completing the relevant statutory notification without delay.
● However, where the provider had identified abuse concerns, they had taken steps to keep people safe.

● People were supported by staff who had received training in safeguarding. Staff understood their responsibilities to report and record any concerns that came to their attention.
● One person told us they felt safe when supported by staff and a relative reported they felt their loved one was safe.

Staffing and recruitment
● People were supported by a consistent group of staff. Staff were able to describe people's needs and knew them well.
● Staff told us they felt well supported in their role and the registered manager was always available, day and night. One member of staff told us, "If something happens and we need to call the manager they will help. There is a team there always available to help."
● Recruitment checks were in place to ensure people were supported by staff who had been safely recruited. This included checks with the Disclosure and Barring Service (DBS) which provide information including details about convictions and cautions held on the Police National Computer. The information gathered helps employers make safe recruitment decisions.

Preventing and controlling infection
● The provider had taken steps to protect people and staff from the risk of infections.
● Staff were provided with appropriate personal protective equipment (PPE) and made consistent use of this.

Learning lessons when things go wrong
● Systems were in place to ensure accidents and incidents were reported appropriately and reviewed by the registered manager. However, the provider had not conducted overall analysis of these events to identify themes and trends and reduce the risk of reoccurrence.
● Following a recent incident, a review of practices had taken place and changes implemented. Staff spoken with were aware of the changes and the reasons for them.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- A pre-assessment process was in place, to assess people's individual needs and preferences before their care started, and a relative confirmed they were involved in this process. However, the initial information gathered had failed to identify and gather enough information to establish the complexities of some people's needs and the potential risks to them.
- Staff spoken with were aware of people's needs and how they wished to be supported.

Staff support: induction, training, skills and experience
- The provider did not have effective oversight of staff training needs. The information recorded on their staff training matrix was not accurate, up to date and complete. For example, the training overview showed staff had completed all of their mandatory online training, including moving and handling training, on a single day. When this was raised with the provider, they advised the training took place 'over several days'. The training matrix also failed to record the specialist training and workshops that were attended by staff and provided by healthcare professionals. A healthcare professional told us, "A lot of resources have been poured into the service."
- The provider's staff training matrix indicated Mental Capacity Act training had only been completed by a third of their staff. The provider advised they would arrange for the remaining staff to receive this training following the inspection.
- People were supported by staff who were provided with an induction prior to them commencing in post. The induction included shadowing opportunities and staff spoke positively about the induction process. One member of staff told us, "I felt confident because the shadowing really helped. I was watching how things were done and staff really helped and gave me lots of information". Feedback from staff was obtained following their induction to ensure it met their training needs.
- Staff benefitted from an annual appraisal and told us they could speak to the provider at any time if they had any concerns. Formal supervisions had not taken place as per the provider's own protocol [every 3 months]. However, staff spoken with told us they saw the provider on a regular basis and could approach them with any concerns. The provider advised they would ensure staff received more consistent supervision, in line with their protocol, following the inspection.
- The registered manager visited people in their homes on a weekly basis, to obtain feedback and carry out informal spot checks on staff practice. Staff spoken with confirmed these visits took place and advised the registered manager was supportive and approachable during these visits.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff spoken with were aware of people's dietary needs and preferences.

Staff working with other agencies to provide consistent, effective, timely care, Supporting people to live healthier lives, access healthcare services and support
● We saw a number of examples of the provider working closely with other agencies in order to ensure people had access to a variety of healthcare services and professionals to meet their needs. One healthcare professional told us, "I came across the service when it was recommended to me. I was impressed with [provider's name], their professionalism and how they understood patients and the complexity of their needs."
● Staff were aware of people's healthcare needs and a hospital passport was in place for one person, but health care plans documenting those needs were not put in place until after the inspection.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People were supported by a group of staff who were aware of the need to obtain their consent prior to supporting them. Staff were also aware of the need to respect people's privacy and confidentiality.
● Care records failed to demonstrate people's capacity to make decisions for themselves and the provider had failed to obtain copy of Court of Protection documents in respect of one service user. They followed this up following the inspection.

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Systems in place to monitor the quality of care people received were not robust and had not identified areas of potential risk which were found on this inspection.
● There was a number of documents that were not available for viewing during the inspection. Many of these documents were forwarded or created and forwarded to the inspector following the inspection. For example, 'as required' protocols, records of supervision meetings, staff meetings, training matrix, debrief meetings, updated care plans and risk assessments and service user feedback forms.
● Care plans and risk assessments did not consistently provide an accurate and up to date picture of people's needs. For example, one person's care plan advised staff to 'use strategies that had worked in the past' when supporting a person, but no information had been provided to staff to advise what those strategies were. This was addressed following the inspection.
● The provider had a poor understanding of their regulatory responsibilities. For example, they had failed to adequately assess the risks associated with people's individual care and support needs or to recognise when they were in receipt of a regulated activity. The provider had also failed to correctly notify CQC of 2 notifiable incidents concerning another service user.
● The provider had failed to follow their own policies and procedures. For example, 'as required' protocols were not in place for all 'as required' medicines, in line with the provider's medicine procedures, placing people at potential risk of harm.
● Medication audits had not enable the provider to identify and act on the risks associated with the daily administration of people's 'as required' medicines.
● The provider's staff training matrix was not robust and failed to provide a complete and accurate picture of the training staff had received and training that was required.
● The provider's systems and procedures to identify potential abuse and then take preventative action, where appropriate, were not robust.
● Systems were not in place to robustly analyse accidents and incidents taking place. There was a heavy reliance on community healthcare professionals to review this information. The provider had no system in place to consolidate their own learning from these events in order to reduce the risks to a person.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's quality assurance systems and processes were not sufficiently robust or effective.

● The provider responded immediately during and after the inspection to the concerns raised. We found no

impact on people's care because staff knew people well. However, in the event of an unfamiliar member of staff supporting people, there increased risk of people receiving unsafe and inconsistent care and support.

● Staff said they felt listened to by management and told us the registered manager was approachable. However, the provider had not ensured staff supervision was taking place on a consistent basis.

Continuous learning and improving care

● The provider did not have robust systems in place to provide effective oversight of the service, including the effectiveness of risk management processes and the standards of people's care and support.

● Whilst the provider knew the people they supported well, the shortcomings of their governance systems hampered their ability to learn and make improvements in people's care. The provider had purchased an electronic recording system for all records, and this was not yet fully utilised.

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

● One person told us they were happy with their care and staff knew how to support them the way they liked. They described all their staff group as their 'favourites'. A relative told us, "I would recommend the service."

● People were complimentary about the service and the kindness and respectfulness of staff. A community professional was highly complimentary about the service and the staff group as a whole. They told us, "I was very impressed with [provider's name] as they understand the person using the service and the complexities of their needs. They [care staff] are very realistic and caring."

● Staff told us they felt supported by management and spoke highly of the provider and the service which they said they would recommend. They told us communication with the provider and their colleagues was good and they were able to access support from the provider at any time of day. One member of staff told us, "[Provider's name] is really approachable and knowledgeable and will answer any questions you have. If you need them in the middle of the night, they are someone who is very accessible. We call and they are there to support us."

● Staff told us they felt listened to and were able to raise any concerns they may have. However, the last staff meeting was recorded as having taken place in August 2023. Staff told us the provider visited where they worked on a regular basis providing them with the opportunity to raise any concerns they may have. A member of staff told us, "We are like family as part of a team."

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

● The provider was aware of their duty of candour responsibilities but had not consistently informed the Commission, where appropriate, when incidents had taken place.

● A relative confirmed they were kept informed of any incidents involving their loved one. They told us, "If there is a problem, they will call and let me know. I feel [person] is safe and the manager knows them, and they are content at the moment."

Working in partnership with others

● The service worked in partnership with other healthcare professionals and services to ensure people received the care and support they needed.

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

● The providerf sought people's feedback on the service, but there was no formal system in place to record

feedback received and how they had actedon this. The provider told us they would be exploring alternative ways of obtaining feedback from service users who may experience difficulties in communicating their needs and feelings.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems in place to monitor the quality of care people received were not robust. |