Maidstone Home Care Limited

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Inspection report

Home Care House
61-63 Rochester Road
Aylesford
Kent
ME20 7BS

Tel: 01622719988

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Maidstone Home Care Limited is a domiciliary care agency. It provides personal care for people living in their own homes. At the time of inspection, the service was supporting 20 people. 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
People were not always protected from harm. The provider had not always understood their responsibilities to report concerns through safeguarding processes. Appropriate professionals (Kent County Council who consider safeguarding concerns) were not made aware of a concern and this resulted in a potential delay to actions to support a person. The registered manager and staff had not ensured they had safeguarding training which would have supported them to understand their responsibility to share concerns appropriately in a timely manner.

Care plans did not always contain detailed information about people's health conditions and this increased the potential risk of harm. Where risks had been identified, these had not always been considered within care or risk planning processes. We did not find evidence that people had experienced harm. Incidents had not always been managed in accordance with safeguarding practice and CQC had not always been notified of concerns. Following the inspection, the provider notified CQC retrospectively of concerns.

People and relatives spoke highly of the support managers and staff provided. One person said, "They are excellent, marvellous, they can't do enough for you". A relative told us how the registered manager had contacted them to discuss providing additional support to manage a health concern. They said, "[The registered manager] rang to say [person] was confused due to an infection and suggested they do an extra call at lunch time to make sure [person] takes their antibiotics until [they] get better".

Staff were consistently positive about the registered manager and how they received support through working alongside managers, telephone calls and messages. Staff did not always receive sufficient training and supervision was generally informal. Following our inspection, the provider told us they had implemented a new training programme to ensure staff received sufficient training.

Systems and processes did not effectively identify or manage concerns found with care planning, safeguarding or staff training and this is an area in need of improvement. The service did not always have robust arrangements for managing confidential information to ensure it was secure and shared appropriately in line with data security standards. Following the inspection, the provider responded promptly to review their systems to ensure they were able to demonstrate improvements were being made. People, relatives and staff spoke positively about the registered manager.

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 08 March 2019)

Why we inspected
The inspection was prompted in part due to concerns received in relation to safeguarding people from abuse. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well led sections of this full report.

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 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 Maidstone Home Care Limited on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding and governance of the service at this inspection.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Maidstone Home Care 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 inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience of caring for older people.

Service and service type
Maidstone Home Care is a domiciliary care agency which provides care and support for people in their own homes. Care is provided for a range of people including older people and people at the end of their lives. The service operates in areas of West Kent.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

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

Notice of inspection
We gave a short period 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 14 April 2022 and ended on 26 April 2022. We visited the location's office/service on 21 April 2022.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided and five relatives. We spoke with five members of staff including the registered manager who was also the nominated individual, the operations manager and three care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted two social care professionals who were involved with the service.

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.

Systems and processes to safeguard people from the risk of abuse

- People were at risk of harm. The provider did not have a suitably robust procedures to ensure people were protected from abuse. For example, the providers safeguarding processes failed to ensure professionals were made aware of an issue to enable them to ensure one person's safety. This left them exposed to risk.
- Within safeguarding guidance (The Care Act 2014) defines, a vulnerable person as someone, "Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". The provider and staff had assessed the person as vulnerable, however had also made an assessment a relative was acting in the person's best interests. This had not been considered as part of a multi-professional approach and resulted in staff failing to raise concerns through safeguarding processes which potentially impacted on professionals' ability to make timely intervention to support the person and their family.
- Managers and staff had provided regular support to one person with complex health needs. They had identified concerns regarding some behaviours they had witnessed in the home. Records confirmed staff had witnessed potentially abusive behaviours and potentially unauthorised care practices which had not been reported in line with safeguarding requirements. As a result, the person remained at risk of harm and the provider did not make sure people were protected from abuse.
- Health professionals told us, "The agency [Maidstone Home Care] felt there may be some safeguarding concerns regarding a mutual patient following some behaviours their staff had witnessed whilst in the property". They went on to say if the agency had safeguarding concerns, they had a responsibility to raise them.
- A staff member told us how they reported concerns, "Anything I feel uncomfortable with goes back to the office." It was apparent managers and staff had been discussing concerns, however had not raised these through the appropriate safeguarding channels. This put people at risk.
- The provider had not ensured they or staff had received updated safeguarding training to keep up to date with changes to legislation and best practice. Staff told us they had received safeguarding training but could not recall how recently. Records relating to staff training had not included safeguarding.

The provider did not ensure that systems and processes operated effectively to prevent abuse.
This is a breach of Regulation 13:(1) (2) (3) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and operations manager acknowledged their safeguarding systems had not operated effectively and told us how they and staff had failed to recognise or report concerns. The registered

manager informed us they were taking immediate action to ensure they and staff received updated training which would ensure they acted in accordance with safeguarding principles to report and share concerns appropriately with the local authority for consideration under safeguarding processes.
● People and relatives told us they felt safe.
● A health professional spoke positively about Maidstone Home Care Limited, and said, "We have not identified any concerns specifically in terms of the care they provide to patients where we know of their involvement, and we also haven't received any complaints from patients/family members regarding the service they provide".
● Safeguarding policies informed staff of what they should do if they had concerns about people's safety.
● The registered manager had not informed CQC of allegations of abuse or potential abuse. We reviewed safeguarding records and found one recent example of an incident that they had not reported in line with regulation.

The provider had failed to notify CQC in accordance with their statutory obligations. The lack of a robust reporting process has resulted in a breach of Regulation 18 (Notification of other incidents) of the CQC (Registration) Regulations 2009.

We fed this back during this inspection and the provider acknowledged this failing in their processes and provided assurance that immediate action would be taken to address this. Following the inspection, the provider notified us retrospectively of events.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risk to some people's safety had not always been identified or managed effectively. One person was living with specific health conditions which required staff to pay particular regard to the condition of their skin to maintain good health. Specific guidance for staff had not been detailed within the person's care plan. We have not identified evidence of harm and the risk was partially mitigated by the knowledge of staff who were knowledgeable about how they supported people.
● Another person's care plan had noted they were living with a mental health condition. Records did not contain details of how this condition affected the person or actions to take in the event of a crisis. Staff spoke of techniques they deployed to support the person; however, these had not been documented effectively. This increased risks the person would not always receive consistent support from staff.
● Risks were partially mitigated by people being supported by staff who knew people well.
● The registered manager could not be assured incidents affecting the health and welfare of people had been safely managed. At the time of inspection, there had been no recent incidents or accidents recorded as a result the registered manager was unable to evidence learning from incidents. We have reported further on shortfalls within the well led section of this report.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate risks to people's health, safety and welfare were effectively managed. This was an area in need of improvement.

The provider responded immediately during and after the inspection. They provided assurance of the actions they have taken to review their systems in line with best practice and improve.

● People told us how the registered manager and staff had supported them to share information with health professionals about specific health risks. One told us, "Staff report things to [the registered manager] even if I am not aware of it. They reported they found me crying in bed. [the registered manager] contacted the doctor". A relative shared another example, "[the registered manager] has organised for an occupational

therapist assessment to look at the possibility of a hoist and reclining chair as (person's) mobility has deteriorated".

● Environmental risk assessments and checks were completed for people's homes. This was to ensure people's safety and that of staff when care was being delivered.

● Staff demonstrated their understanding of reporting incidents and told us how they had managed incidents previously. One spoke of when they had found a person who had fallen in their home. They described how emergency support was accessed and how they had stayed to support the person until help arrived.

Staffing and recruitment

● There were enough staff to support people safely. A person told us, "They come round in pairs and the senior experienced one trains the newer one until they are confident and know what they are doing". One relative, referring to the skills and knowledge of staff, told us staff were, "A lovely bunch of girls, very caring".

● Staffing levels were calculated by the number of people using the service and their needs. Our observations were there were enough staff to safely support people, this was reflected in the staff rota. The registered manager and operations manager were available to provide assistance for people when needed.

● Staff were recruited safely. Employment histories and any gaps of employment had been discussed at interview and documented. Pre-employment checks such as references and Disclosure and Barring Service (criminal record checks) were obtained prior to employment. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions. The information helps employers make safer recruitment decisions.

Using medicines safely

● Medicines were managed safely. Staff were trained to administer medicines.

● A person confirmed staff assisted them with medicines and they were given on time. They told us, "All medications are done on an app. If medication is not recorded properly, they can't sign out."

● People received their 'when required' (PRN) medicines such as pain relief.

● The registered manager undertook audits to ensure administration and medication administration records (MARs) were completed appropriately.

Preventing and controlling infection

● The registered manager and operations manager carried out informal checks on staff to ensure they were wearing appropriate personal protective equipment (PPE) whilst accompanying them on support calls to ensure people were kept safe from the transmission of infections.

● Staff had received training in infection prevention and control (IPC). This included the use of PPE. Staff told us there were ample stocks of PPE and this was readily available to them. We were assured staff were tested for infection in line with government guidance.

● We were assured that the provider's infection prevention and control policy was up to date. Staff had completed the relevant training.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were treated well, however, the provider had not always ensured safeguarding systems supported people's wellbeing or responded to their needs quickly enough. We reported on this in the safe and well led sections of this report.
- The service had a person-centred culture. People and their relatives confirmed how the registered manager and staff supported them. One told us, "I am totally happy with their care".
- Staff treated people with kindness and compassion. A relative described how the service had worked with the family and ensured they expressed their views, were involved in decisions and received reassurance from the staff.
- Professionals were consistently positive about how caring and supportive the staff had been. They told us, "We have found the service to be adaptable and caring when supporting our complex patients, communicate well with other professionals and patient", and, "We have found the management and staff have gone above and beyond to support our complex patients, they have shown understanding and compassion as well as a flexible approach".
- The registered manager and staff consistently demonstrated genuine regard for the people they supported. People were supported by a consistent team of staff who knew people and their needs well.
- The registered manager had effective systems to ensure people and their relatives could express their views of the service. They worked directly with people and as a result recognised when people and their relatives wanted support from staff. Rotas were scheduled with the needs of the people in mind.
- A professional told us how the service supported people to be involved in their support, "They communicate very effectively with the patient and involve them at all times with their care".

Respecting and promoting people's privacy, dignity and independence

- People's independence was encouraged and respected.
- Relatives spoke highly of the staff and how they respected their loved one's dignity and independence. Records confirmed how staff responded in a timely, compassionate manner to the needs of people.
- Confidential information relating to people was handled appropriately by staff. There was a policy and procedure on confidentiality.

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; Continuous learning and improving care

●The registered manager could not always be assured systems in operation effectively monitored the quality performance of the service and protected people from abuse. For example, managers and staff had voiced concerns about behaviours they had witnessed in a person's home, however, they had failed to recognise, report or manage this through safeguarding processes. Managers had not ensured they or staff had kept their knowledge up to date with training which would have highlighted the need to raise and share safeguarding concerns with the local authority.

● The provider did not always continually monitor risks to people's health, safety and wellbeing and as a result did not effectively consider potential measures to minimise the impact of risks. For example, care and support plans had not included specific guidance for staff to support health conditions and incidents were not always recorded or managed.

● The provider did not have effective oversight systems in place. The provider told us they had not completed audits recently to review the quality of the service as since the pandemic the management team had been required to provide support directly with people. A staff member told us, "The managers have had to work as well, they must be working 24 hours a day". This had resulted in shortfalls in management oversight processes. For example, existing oversight systems had not identified concerns when staff had recorded potential abusive practice they witnessed in a person's home.

● Quality performance processes were not always in place or were managed informally; records were not always available. For example, the registered manager spoke of working alongside staff members and monitoring their practice informally. Staff were not aware they were subject to spot checks of practice. This increased the risk managers were not always effectively monitoring staff practices or picking up concerns or themes. This was a shortfall that increased the potential risk to people.

● The registered manager did not always demonstrate their knowledge of regulatory requirements. They had not always understood their duty to notify CQC of events within the service.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us how the global pandemic had affected the service. They were in the process of recruiting additional staff and told us this would enable them to focus time in managing the quality of the service. Following the inspection, the provider told us they had reviewed the quality of the

service which had involved completion of a number of audits. They told us how this identified the need for managers to allocate time to maintaining their oversight of the service and this resulted in them recruiting further staff in order for this to be completed effectively. They had recognised the need to identify and report concerns appropriately and told us, "We have truly learned a valuable lesson here and at the slightest concern we will raise a safeguarding immediately".

● People spoke highly of the registered manager and staff and comments included, "The manager is always there I can always phone or text", and "They are the best I ever had, I had a different care agency which wasn't nearly as good".
● Relatives were consistently positive, and one said, "They are excellent, marvellous, they can't do enough for you". One told us how managers had ensured they had received updated information regarding their loved one, and said, "The staff put information into the report which gets passed on to [registered manager] and they ring me about any changes".
● Staff told us the registered manager and operations manager were always available to talk to and provided support when needed. One staff member told us how managers had showed genuine concern about their welfare. Another described how managers had supported staff through the pandemic, and said, "Managers have been really good, working their socks off".

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; 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
● There was a positive and inclusive culture for people. The registered manager and staff demonstrated shared values which placed people at the centre of their support and ensured people were as comfortable as possible including supporting people to the end of life. Staff described this, and one said, "We support people by giving them the small things that make a difference "and, "Making the last few months the best they can be". The registered manager and operations manager told us how they had deliberately remained a smaller service to ensure they maintained personal contact with people.
● The provider encouraged people to give feedback about the service they had provided to support the development of their reputation in the area. One person told us, "The district nurse said to me 'if you've got Maidstone [Home Care] you've got one of the best ones'".
● Staff told us they had not been asked to provide feedback about the service and had not taken part in a survey. Those who chose to provide feedback to the inspection told us they felt supported by managers.
● The registered manager understood their duty to be transparent and truthful if something were to go wrong.

Working in partnership with others
● The service worked in partnership with external agencies and other care providers to ensure continuity of care for people. Health professionals including district nurses and GPs were involved to provide advice for staff to support people's needs.
● A health professional told us, "Our relationship with the agency is such that they will often contact us directly if they are mutually involved with a patient and they have concerns that we may be able to support them with – patient general condition / symptom management / end of life care / sudden changes in status. I would say we have more contact from this agency than most other care agencies, and from our perspective we welcome this means of collaborative working."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to operate effective safeguarding systems and processes. This placed people at risk of harm

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm.