MidCo Care Limited

MidCo Care

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

MidCo Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people, people living with dementia and people with mental health needs. Not everyone using MidCo Care received a regulated activity; Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

This announced inspection was carried out on 22 and 26 February 2018. At our inspection in December 2016 the service was rated as Requires Improvement. At this inspection in February 2018 it had improved to Good. At the time of our inspection there were 10 people using the service.

There was a registered manager who had been in post since the service was registered in March 2015. 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.

Staff understood how to recognise and report any suspicions of poor care and harm. Staff were only offered employment at the service, once all necessary checks had been found to be satisfactory. There was a sufficient number of suitably trained staff to provide people with safe care and support.

Staff cared for people in a kind and considerate way and people's care was undertaken in an unhurried and patient manner. Staff listened to people and assisted them in a caring way. Staff encouraged people to make their own choices and live as independently as possible. People's privacy and dignity was promoted by staff.

People helped determine what their care arrangements were and the provider took account of people's wishes and choices and any future goals. People's care and support plans were an individual record about each person's needs and any assistance they required from staff. Risks to people were identified, and plans were put into place to promote people's safety without limiting people's right to choose what they wanted.

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

Staff benefitted from the support, training and mentoring they were provided and this helped to promote people's safety and wellbeing. Staff understood their roles and responsibilities in meeting people's needs. Systems, including regular spot checks and training were in place to help staff to maintain their skills and the standard of work expected from them by the registered manager.

People were supported to maintain their health by staff that had been deemed competent to safely administer people their prescribed medicines. Staff assisted people to maintain the correct level of nutritional intake of food and fluids. Staff enabled or supported people to access community health care services.

People received a service that helped them to have their needs met in a person centred way. People were encouraged to maintain contact with their relatives and friends when they wished to do so. There was a process in place to manage any concerns, suggestions and complaints. Complaints were resolved to the complainant's satisfaction.

Staff had various opportunities including meetings to feedback their experiences and receive updates about the service. Any suggestions or concerns that staff had could be raised at one to one supervision meetings or at other occasions staff contacted the office. Staff were supported by the registered manager who listened and acted upon any opportunity for improvement.

Arrangements were in place to ensure the quality of the service provided for people was regularly monitored. People who used the service and their relatives were encouraged to share their views and feedback about the quality of the care and support provided and felt listened to. As a result of feedback, actions were taken to drive forward any improvements that were required.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to keep people safe from harm as well as to whom they could report any concerns of harm to. Risk assessments were in place to help staff promote people's safety.

Sufficient staff were in post and these staff had been recruited in a safe way.

People's medicines were administered safely by trained and competent staff.

Is the service effective?

Good

The service was effective.

People's needs were met by staff who knew them well.

Staff provided people with nutritional support and this promoted people's wellbeing.

People's preferences were respected by staff who understood how to increase people's independence by offering choices.

Is the service caring?

Good

The service was caring.

Staff listened to what people said and acted with compassion.

People were supported to access or use advocacy support when required.

Staff respected people's privacy, dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People had a say in how their care was provided.

People's concerns were acted upon.

Systems were in place to support people with their end of life care needs should this be required.

Is the service well-led?

Good

The service was well-led.

The registered manager understood their responsibilities.

People contributed, and had a say, in how the service was run.

The registered manager had fostered an open and honest staff culture. Staff were supported in their role to work as a team.

MidCo Care

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 checked 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.

The inspection took place between 22 February 2018 and 26 February 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was undertaken by one inspector. The inspection site visit started on 22 February 2018 and ended on 26 February 2018. It included visiting the office location on 22 February 2018 to see the registered manager and office staff. We also shadowed staff as part of our inspection to help us understand how people's needs were met.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our inspection, we looked at this and other information we hold about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Before the inspection, we asked for information from representatives of the local authority contracts monitoring team and the local authority safeguarding team. This was to help us plan our inspection.

During the inspection, we spoke with three people who used the service and four people's relatives. We also spoke with the registered manager, a care coordinator and five care staff on the 22 and 26 February 2018. We looked at three people's care records and records in relation to the management of the service. These included quality monitoring records; management of staff; management of people's medicines; compliments and complaints; and two staff recruitment files. We also observed the care and support people received to assist us in our understanding of the quality of care provided to people.

Good

Is the service safe?

Our findings

At our previous inspection in December 2016 the provider and registered manager were not always supporting people as safely as they could have. At this inspection we found that improvements had been made to help people to be as safe as practicable.

One person told us they felt safe as, "They [staff] move me in my sling carefully and I always feel safe as there are two staff." People were given information in a 'service user guide' about what being safe meant and how to report any concerns.

Staff demonstrated to us their knowledge about how to raise concerns about any suspicions of poor care and/or incidents of harm. This was by describing to us what the signs or symptoms of this could be, as well as the action they would take in reporting such incidents. For example, by contacting the registered manager or other external agencies such as the local safeguarding authority to report any concerns. One staff member explained, "I would see any bruises, but any non-visible signs such as a person being nervous in certain situations or not being as happy would need to be reported." A relative told us, "I have never had any concerns as they [staff] take great care. If I ever was worried I would soon call the [registered] manager." We saw that safeguarding incidents had been referred to the appropriate authorities and measures were in place to safeguard people from harm. This demonstrated to us that staff knew the processes in place to reduce the risk of poor care and harm occurring.

To assist and promote people's safety a range of risk assessments were in place. These included assessments for people at risk of falls, malnutrition or pressure sore areas. One person told us that they were kept safe as, "Staff make sure I am positioned in a comfortable position in bed and they keep me dry and clean." To mitigate and manage any risk to people, staff had guidance on how to keep people safe such as making sure the person's home environment was tidy. The registered manager kept records of when people's lifting hoists and slings were due to be serviced. One relative told us that in order for their family member to be cared for safely, they needed two staff and equipment including a hospital type bed and specialist hoist. We saw that two staff always provided their care and used the equipment in the correct and safe way. Formal arrangements were in place where information about people's care needed to be shared with other care providers, including with community health care services. This demonstrated to us that risks to people's safety were well managed.

Prior to working for the service, staff were subject to pre-employment checks on their suitability. These checks including those for establishing their good character. At a local authority contracts' monitoring visit in January 2018 not all these checks were in place. At our inspection we found that the provider had obtained additional evidence of staff's good character. The registered manager told us they had introduced a monitoring form with a list of all the required checks staff needed before they provided people's care. Only when this was completed would they be able to start.

Other recruitment checks included references from previous employers; employment history checks; photographic identity checks and criminal records checks (Disclosure and Barring Service). One staff

member told us, "I had to disclose any health conditions to make sure I didn't put people or myself at risk." Another staff member told us, "When we recruit new staff we are looking to make sure they have the right attitude and ability to communicate well. It is at this time you can determine their suitability and not just [through] paper records." This demonstrated to us that there was an effective process in place to make sure that staff were suitable to work with the people they supported.

Sufficient, skilled staff were in place to meet people's assessed needs. This was evidenced to us through our observations and what people, relatives and staff told us. Two relatives both told us that "Staff were always on time." The system the provider used to record people's care calls showed us that between January 2018 and our inspection on 22 February 2018 there had been two care calls over one hour late. This had been due to staff being delayed in traffic or having to attend to people's urgent care needs. Although this reason had been explained to people, this was not always the case. This increased people's anxieties at waiting for their care staff to arrive.

A staff member told us that a new staff role to monitor the care call system would enable immediate action to be taken. For example, any late calls would trigger an alert to the care coordinator. A relative told us, "The staff are generally spot on time. [My family member] needs a lot of help these days but they [staff] have never been late or missed any care at all." One staff told us, "If I am running late I call the office [staff] and they get someone out as soon as they can." Another staff member said, "I do get time for traveling between each person and I stay for the time the person needs." Our shadowing of staff showed us they had the time to travel between each care call as well as providing people's care safely.

People were administered their medicines by staff who had been trained to do this in a safe way. Staff, once deemed competent to administer medicines, were then authorised to do this. Staff completed medicines administration records accurately and the reasons for any refusals or missed medicines were explained, such as when people did not want their medicines. Sufficient information was in place including that for staff to administer people's medicines prescribed to be administered 'as and when required' and any topical creams and eye drops. One person said, "I take all my own medicines but staff sometimes prompt me if I have forgotten." This showed us that people were safely supported with their prescribed medicines.

Staff were trained in infection prevention and control procedures. We saw that staff adhered to safe hygiene process including hand washing, wearing protective clothing and changing their gloves in between care tasks. A relative said, "They [staff] never do any care without their aprons and gloves on." One staff told us, "It is important to not cross contaminate anything. I always have, and wear, the protective clothing we are provided with."

Staff were aware of when to report any situation that could have the potential to cause harm including a person refusing their medicines. In addition, where allegations of harm had been reported, the registered manager and staff were cooperating with the local authority and other stakeholders. The registered manager told us that they were being transparent in proving records and evidence that had been requested as part of an on-going investigation. They told us that, "Should any lessons need to be learned then any necessary actions will be implemented."

Good

Is the service effective?

Our findings

At our previous inspection in December 2016 the provider had not always supported staff with regular supervision. At this inspection, we found that improvements had been made to the support staff received.

People's needs were assessed by staff that had the skills to determine how these were to be met. Examples of the needs people were assessed for included their health needs, mobility and levels of independence and nutrition. Staff had the necessary skills to meet people's needs. The provider's mandatory training included subjects such as equality and diversity and human rights, moving and handling, health and safety and the Mental Capacity Act 2005 (MCA). Staff also had more specialist training to cover people's needs including, catheter care and the safe use of oxygen. Staff's training was based upon current guidance such as that from the National Institute for Health and Care Excellence (NICE). This was for example, for medicines that were administered to people living in the community. Staff treated people in an equal way no matter what their needs were.

Staff completed a programme of training that was in place and this included completion of the Care Certificate. The Care Certificate is a nationally recognised induction programme that applies across health and social care and was designed to develop staff's knowledge and skills. All staff apart from the three newest staff members, who were going to complete this, had completed this training. Additional support for staff also included a bi-monthly supervision for field-based staff and six-monthly for office staff. A relative told us that staff knew what they were doing and that they got on well with their family member. One staff member told us, "My supervision is a good chance for me to raise issues such as any increase in people's care needs which needed more care time." Additional training about risk assessments had been booked for staff. This and other training such as percutaneous endoscopic tracheostomy (PEG) feeding, for people fed through a tube into their stomachs, gave staff the skills they needed for their role.

People were supported to eat a healthy balanced diet including any person who needed to have a reduced sugar diet. People's care plans documented who was responsible for maintaining people's adequate nutritional intake such as a relative or staff member. People's nutritional wellbeing was promoted including for those people who needed specialist support such as that for their PEG feeding. One relative told us, "They [staff] help prepare meals. I get everything ready and they help my [family member] to eat." A staff member said, "We record how much people eat and drink. This allows the office staff to check that the person is eating enough." Care calls to people were timed upon their needs regarding food and drink intake. The spacing between each care call was flexible enough so that people had time to eat their food at their pace or be assisted with this by staff.

The registered manager told us that when a person returned home from hospital or was new to the service gathered all relevant information about the person. This helped ensure that people's care was a seamless as practicable. One relative said, "Now [family member] is back home they are being assisted to get out of bed which they are much happier with." Another relative told us about the physiotherapy their family member was having and how this was benefitting them.

People were given the support they needed to access community health services. Care plans recorded the external health care support that people were using. This was as well as which aspects of this were undertaken by care staff such as emptying catheter bags. One person told us, "I have a district nurse come to sort out my [health condition]. They [staff] do everything else and they do it well." People were supported to access health care services and if required staff enabled this to happen such as contacting a GP or paramedic. In conjunction with external stakeholders, regular reviews of people's care were undertaken to make sure and the service promoted the person's wellbeing and met their needs.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures to deprive people of their liberty for community are applied for through the Court of Protection. The registered manager told us that no person using the service lacked the mental capacity to make decisions.

We checked whether the service was working within the principles of the MCA. Staff were able to describe the key principles of the MCA. A relative told us, "They [staff] always make sure my [family member] agrees with it [their care]. They always wait for an answer as my [family member] is not as quick to respond as they used to be." One staff member said, "We always assume people can make a decision or choice. It's up to them what they want. If people make an unwise decision we just make sure the person is safe. We prompt people with medicines but any refusal is documented on our [records] system." People were assisted to make decisions about their care. They were supported to have maximum control of their lives and staff supported them in the least restrictive way possible.

Good

Is the service caring?

Our findings

People were well cared for by staff who knew each person and how they wished to be cared for, and how to promote their independence. We saw how staff asked people for permission before providing care. For example, one staff member asked, "Would you mind if I helped you to get dressed" and, "Is it alright to put your [hoist] sling on?" Staff spoke with people clearly and in a respectful manner. One person told us, "They [staff] are amazing. They make a massive difference to me doing all the intimate care with such dignity." A relative told us that staff were, "Definitely very caring. I used to help but I have to rely on them. I can't fault how kind they are." One written compliment to the provider stated, "Thanks to [staff] who became a friend to my [family member]."

Staff provided people's care in line with their care plans. These care plans included information about the person and what their likes, dislikes and other preferences were, such as only female staff for personal care. One person said, "I get on very well with them [staff]. They have almost become a family member." We observed how staff engaged in polite conversation as well as being able to share a joke and a laugh. People were made to feel they mattered. Staff knew the people they cared for well and how to make the person as relaxed about their care as possible. Staff achieved this by explaining the care they were providing to the person whilst being sensitive to the person's needs.

People, when required, were enabled to access advocacy or they had chosen a valid lasting power of attorney in place. This was for people had made advanced decisions included those about their finances and health. Information about advocacy was included in a service user booklet which people were given when they started to use MidCo Care. People, and their relatives, when people wanted them to be, were involved in the care and support they needed from the staff. One person said, "My [family member] has done all the work in my [care plan]. I just read it today and it seems okay." Each person had a keyworker who was responsible for making sure that people had the care and support they needed. Having a consistent keyworker helped people develop a better rapport.

Arrangements were in place that gave staff time for training. This was to allow staff the time they needed to keep and update their skills to meet people's care needs in a person centred way. Staff rosters had been developed to allow staff to have the right amount of time with each person they cared for.

Staff respected people's privacy and dignity and they cared for them in a compassionate way. One person told us that the staff always kept them covered as much as practicable when providing personal care. Staff described to us how they ensured that people's privacy was respected. One staff member said, "I do all the bits the person can't reach but I let them have time on their own to wash where this is safe." Care plans described what level of independence each person had and how staff promoted this. One relative told us, "It is really good to see my [family member] up and about. The staff do all the hard work with lifting and moving. Just being able to stand has made a big difference to my [family member]."

Good

Is the service responsive?

Our findings

Staff completed an assessment that determined the care and support that people needed. This allowed people, or those acting on their behalf, to have a say in how and when their care was provided. For example, the time that people received a care call that enabled people to do other pastimes during the day such as watching a sports program on TV. One person told us, "I am getting stronger each day and hope to walk again soon." A relative said, "Now that there is a physio program in place the staff are assisting [my family member] at each care call with the exercises to be more independent." People's individual care needs were met by staff who understood what person centred care was. As a result, staff assisted people to be as independent as possible. People could choose the amount of support that they preferred.

We saw that care plans were up-to-date and an accurate reflection of people's needs including information about the person's life history. We did find that some information was limited for people's moving and handling. Staff were however, able to tell what people's needs were. The office manager told us they would add further clarity and detail to guide staff if required. People were supported with their social stimulation as much as possible during care calls as well as visits by relatives and friends. This enabled staff to engage in conversations that the person could take an active part in. This was as well as staff who had been matched as far as practicable to the person's interests. For example, similar age groups, interests in pets and different countries cultures.

The provider used an electronic care call recording system to assist management to monitor the care that staff had or had not provided. Any aspects of care that were not recorded were investigated. In situations where an internet phone signal was not available the information uploaded the next time staff obtained such a signal. In addition, other safety systems were in place including for those people who wished to have a pendant life-line call system for emergency situations. One person told us, "They [staff] always fill in the care records on their phones [provider's electronic recording software] when they come to see me." In addition, staff had mobile phones which they could use to contact the registered manager.

We found that the provider had followed their complaints' procedure. We saw that where complaints had been submitted that these had been resolved to the complainants satisfaction. One relative told us, "I have complained about care calls being over an hour late several weeks ago. They [staff] have given me their [work] mobile phone number if this happens again." The relative added that sometimes when they had called the office that their calls were not always responded to. They also added that lately care calls had been on time. The registered manager told us that they had investigated these incidents and that staff had provided satisfactory explanations such as their car breaking down or being stuck in traffic. Staff had been reminded at staff meetings to report any late call issues straight away. One staff member told us, "We do rely on staff reporting incidents which affect their timekeeping. As soon as we are informed we can use office based staff to cover urgent care calls."

At the time of our inspection nobody was receiving end of life care. The registered manager told us that the provider did not have an end of life care policy. However, this was sent to us before we published our report. People could decide when they wished to make any advanced decisions about their end of life care and

discuss these with relatives if required. We saw that where people had chosen whether or not to be resuscitated that their records about this decision were included in the person's care plans. One written compliment from a relative whose family member had died stated, "They [staff] cared for [family member] with great respect and empathy towards them." Arrangements and systems were in place to provide relatives, friends and staff with emotional support should someone die.

Good

Is the service well-led?

Our findings

At our previous inspection in December 2016 the provider had not always ensured that the governance of the service was effective. At this inspection we found that improvements had been made to quality assurance, audit and governance.

There was a registered manager who had been in post since the service was registered in March 2015. 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.

We found that the registered manager had not always notified us about incidents they are supposed to without delay. This was due to them waiting for the local safeguarding authority to decide if a safeguarding incident had occurred. The registered manager submitted this notification with 24 hours of us requesting it. However, from notifications we had already received, we found that this was not what normally happened. They told us that in future they would always notify us as soon as they became aware of any incident. They had also taken steps to inform the staff team, in their absence, when to notify the Care Quality Commission about incidents that, by law, they are required to tell us about.

The registered manager had made staff aware of their responsibilities at staff meetings, supervisions and during day to day contact. Staff were encouraged to be as open and honest as possible in reporting incidents which we found they had been. One staff member told us, "I get a lot of support and also when I need it, advice and guidance. I have a one to one supervision with [Name] in the office and they are very supportive." The registered manager told us that other management staff also provided assistance to care staff including with training.

One relative told us, "They [office staff] have been better lately getting back to me although they haven't in the past. The registered manager told us that they were recruiting additional resource in the office to respond more quickly to any concerns. Another relative told us, "I have never had any concerns. We have used the [provider's] service for a few months and everything seems to be working as we want."

Staff told us that they could raise any concerns if ever they had these about any poor quality care. One staff said, "If I ever saw or became aware of any staff not adhering to the values expected of us I would ring the [registered] manager or office staff [representatives of the provider]. Staff told us that they were confident that they would be supported should concerns be raised. Compliments showed us what the service did well. One example of these was, "Thank you for the wonderful attention and support your team of care staff provided."

Staff told us that they were motivated in a positive way. The office management team supported staff in a variety of ways including spot checks to observe their care practice. We found that staff were held accountable for any decisions they made, such as not reporting late care calls. A relative told us, "[Office]

staff came out a few weeks ago to check on their staff. There wasn't any concerns from us or the staff." We saw that staff meetings were used to remind staff of good practice. For example, to report late care calls, to undertake training and to not speak in their own language at care calls. This was as well as a daily review of people's care and any changes that staff needed to be aware of such as newly started medicines or new equipment. A staff member said, "If I need support I just need to call the office [staff]. I have the co-ordinator's and directors' number and I can call the out of hours number as well in case of an emergency."

The registered manager kept up-to-date with current information and guidance about developments in social care. This was through various social care organisations and information from the CQC and NICE. Their main challenge was in recruiting staff with the right skills. They had recognised where they were not able to meet people's needs and handed back people's care packages to a local authority. They were, under new local authority contractual arrangements, gradually increasing their staff and the number of people being cared for.

People received a consistently good quality of service. One relative told us, "We get the same staff all the time which is important for my [family member] and they are very good at what they do and I can only compliment them for what they have done so far."

The provider's quality assurance and governance procedures were effective in identifying where improvements were needed. This was as well as the actions to make sure the quality of service including staff recruitment, incident reporting and risk assessment training were implemented. Audits for medicines administration records and incidents showed us where actions had been taken and that these had been effective in driving improvements.

People, their relatives and staff member's views about the service were sought in various ways including a quality assurance survey. Views were also sought by visits to people in their home to make sure their care needs were being met in a way they wanted. One person said, "I know the [management staff] as I spoke with them when I first started and they were very helpful." A relative said after a late call, "[Name] from the office came to see me in person and offer an apology. I haven't had a need to contact them since but I know I can if I need to." Where people had a relative or legal representative, they could also provide information to help make any improvements if these were needed. Other management staff also spent time caring for people.

Staff told us that they could raise any concerns if ever they had these about any poor quality care. One staff said, "I know I would be supported by [registered manager]." Another staff member told us, "If you make a mistake you are supported to learn."

Compliments we looked at showed us what the service did well. One example of these was, "Thank you for everything you and your staff did for [family member]." All staff we spoke with described their love of their work and seeing the difference they made to people's lives. One staff told us, "Seeing people either getting better or having the care that best meets their needs and developing a working relationship with them is what I come to work for."

Staff were made aware of their care call rosters by mobile phone as well as regular contact with the office staff. The registered manager told us they were in the process of introducing an additional level of governance using an automated staff rostering system. This was planned to improve the performance of their current electronic care call system.

Records, and people we spoke with, confirmed that the service and its staff team worked well with other

stakeholders. In addition, work was in progress to help ensure that the care people received was fully co-ordinated. For example, to make sure that where care was shared, such as with the community nursing team, that each organisation met the needs of the person in a unified approach. One person told us, "I have a district nurse for my dressings but the staff make sure I get out of bed." A relative said, "I am happier now that the occupational therapist has given MidCo care staff all the necessary exercises for my [family member]."