

Medacs Healthcare PLC

# Medacs Healthcare - Croydon

## Inspection report

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### Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service effective?	Inadequate ●
Is the service caring?	Requires Improvement ●
Is the service responsive?	Inadequate ●
Is the service well-led?	Inadequate ●

# Summary of findings

## Overall summary

This inspection took place on 17, 18 and 24 October 2018 and was announced. Our last inspection was in March 2018 where we rated the service 'Requires Improvement' and identified one breach of the legal requirements in relation to staffing.

This inspection found a continued breach of the legal requirements in relation to staff training as well as further breaches in relation to the safety of care, staff deployment, person centred care, complaints, governance and statutory notifications.

This service 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 adults, younger disabled adults, and children.

Not everyone using Medacs Healthcare - Croydon receives regulated activity; 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. At the time of our visit 648 people were receiving personal care from Medacs Healthcare – Croydon.

There was a registered manager in post. 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.

The care people received was not safe. Records relating to risks people faced were inconsistent and inaccurate. People's medicines records were not kept up to date and we identified instances where medicines records showed a potential overdose. The majority of people's care calls were not delivered at the time they were expected and people gave us examples of where this had impacted significantly upon them and the safety of the care that they received.

Improvements to staff training had not been implemented and we found gaps to staff training records. One to one supervision meetings and spot checks were not taking place as planned. People's consent was not sought in line with legislation and there was a lack of information about people's nutritional needs. Assessments of people's care were not always carried out and lacked information. Where people received 'reablement' support, the provider did not identify and plan for them to achieve their goals. Records showed a lack of communication with health and social care professionals.

The service was not always caring. People did not always receive support from a consistent staff team. Records contained no evidence of people having been involved in their care planning and there was a lack of information about how to promote people's independence. The service did not consider the impact people's religious beliefs, cultural background, sexual and gender identity had on their care preferences. We have made a recommendation about this.

Care was not planned in a personalised way. Care plans lacked information about how to provide support to people in a way that responded appropriately to their needs. Care plans did not identify what was important to people. The provider's systems for monitoring care delivery and reviews was not robust enough to identify and respond to changes in needs. People's wishes regarding end of life care were missing from records, despite them having conditions that would require this information to be in place. People and relatives told us their complaints were not responded to and we saw that numerous concerns about staff punctuality and care delivery had not been picked up through monitoring.

There was a lack of governance at the service. The provider's systems had not adequately identified and addressed the numerous concerns identified at this inspection and improvements following our last inspection had not been implemented. Record keeping was not up to date and there was no robust system for management to check care records. The systems to involve people, relatives and staff in the running of the service were not working. The provider had failed to notify CQC of important events that they had a statutory duty to do so.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

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

If not enough improvement is made within this timeframe so that there is still a rating of 'Inadequate' for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of 'Inadequate' for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe.

Staff were often very late or early and did not always attend visits as scheduled.

People were exposed to the risk of harm as there were no clear guidelines for staff about how to mitigate risk or administer medicines safely.

It was not clear that incidents were being appropriately identified and escalated.

Where safeguarding concerns were identified by other organisations the provider completed investigations as instructed.

Staff were provided with personal protective equipment to ensure people were protected by the prevention and control of infection.

**Inadequate** ●

### Is the service effective?

The service was not effective.

People's needs had not been appropriately assessed and care plans did not contain enough information to ensure staff provided the support people needed.

Staff had not always received the training and support they needed to perform their roles.

People were not always supported to eat and drink a balanced and nutritious diet.

Information about the support people needed in relation to healthcare was not clear.

It was not clear the service was following the principles of the Mental Capacity Act 2005.

The service was not working with other agencies involved in

**Inadequate** ●

providing care to people.

### Is the service caring?

The service was not always caring.

People and relatives said their relationships with care workers were affected by the lack of continuity in the staff who supported them.

People's communication needs were not consistently assessed or supported.

The service did not explore the impact people's religious beliefs, cultural background, sexual or gender identity had on their care preferences.

**Requires Improvement** ●

### Is the service responsive?

The service was not responsive.

Care was not planned in a person-centred way. Care plans lacked information about people's needs or what was important to them.

The systems to identify changes in people's needs were not robust enough to ensure changes were actioned swiftly.

Information about people's preferences and wishes relating to end of life care was lacking.

The provider had failed to respond to complaints and there was no system to track and monitor these.

**Inadequate** ●

### Is the service well-led?

The service was not well-led.

Shortfalls in governance meant that the provider's audits had not identified the numerous concerns identified at this inspection.

Records were not up to date and the systems in place to monitor and check records was not robust.

The provider had failed to respond to feedback from people, relatives and staff.

The provider had failed to notify CQC of events that they had a statutory duty to do so.

**Inadequate** ●

# Medacs Healthcare - Croydon

## **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 was prompted in part by concerns shared with CQC by commissioning authorities about call punctuality and shortfalls in care delivery. This comprehensive inspection followed up on those concerns.

This inspection took place on 17, 18 and 24 October 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because the service is large and co-ordinators are often out of the office supporting staff or conducting reviews. We needed to be sure that they would be in.

Inspection site visit activity started on 17 October 2018 and ended on 24 October 2018. It included telephone calls to people, relatives and staff. We visited the office location on 17 and 18 October 2018 to see the registered manager and office staff; and to review care records and policies and procedures. We returned on 24 October 2018 to consider the provider's response to our initial feedback.

During the inspection we spoke with 15 members of staff including the registered manager, the care manager, the quality manager, the quality officer, two electronic call monitoring administrators, two coordinators, a service quality assessor, the head of operations, the managing director and five care workers. We spoke with eight people and ten relatives of people who received a service. We reviewed the care files for 31 people and the medicines administration records for 32 people. We looked at eight staff files. We also reviewed the call monitoring information for 21 members of staff. We read various policies and procedures, as well as records of incidents, complaints and other documents relevant to the management of the service.

The inspection team consisted of two inspectors, two assistant inspectors, an evidence review officer and an administrator. We also had advice from a medicines inspector after the inspection.

Prior to the inspection we reviewed information shared with CQC by commissioning authorities such as clinical commissioning groups (CCGs) and local authorities.

# Is the service safe?

## Our findings

When we inspected the service in March 2018 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not have enough staff to meet people's needs. We issued a requirement notice and the provider sent us an action plan which detailed their plans for recruiting office based staff and care workers.

The provider had recruited additional coordinators, team leaders and service quality assessors (SQAs) since our last inspection. However, other staff had since tendered their resignations and so vacancies remained.

Before the inspection we received feedback from people who used the service and commissioning local authorities that there were issues with the timing and punctuality of visits. During the inspection we reviewed the electronic call monitoring information for 21 staff and 15 people for the two weeks prior to our site visit. We found people were not receiving care on time. Overall only 45% of visits took place within 15 minutes of their scheduled time. One member of staff attended visits outside of the schedule 77% of the time, another 75% of the time and a third 62% of the time. Records showed there were occasions when only one care worker attended when two were required to deliver safe care.

Staff working on weekends received schedules where the first visit of care was scheduled to take place at 3am. We saw some people receiving their morning visits of care as early as 5:30am, while on other days they did not receive their first visit of care until 10am. This meant people did not know what time to expect their care workers. The records showed staff were not adhering to their schedules. Staff gave us mixed feedback about their rotas. Some told us they were suitable and manageable, but others said they were not well structured. One care worker said, "If I go on holiday there is no one to cover my jobs." Another care worker said, "It depends on your coordinator. My coordinator is not good. They do not listen. They give me too many jobs."

A relative told us the timekeeping of care workers was so poor they chose to go without a service. They explained, "They are meant to come at 9am. They come at 10, or maybe even 11. [Relative] cannot wait that long so I have usually helped them by then. I am going to cancel it because of the timekeeping issues." A person told us, "There is no set time that they come." Another relative told us their family member had missed out on their education due to the service being unable to arrange cover when their regular care worker was away from work.

The above issues are a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our concerns about scheduling and timekeeping by making some changes to their scheduling system preventing staff from scheduling visits before 6am. They committed to providing training to staff completing the scheduling and to seeking and using feedback from care workers about their schedules.

We reviewed the recruitment records for eight staff and these showed the provider followed robust processes to ensure staff were suitable to work in a care setting. The provider checked applicants' references and employment history and completed checks on their criminal histories to ensure they were suitable to work in a care setting. The provider had identified they were facing difficulties covering the demand for their services and was completing targeted recruitment in specific areas.

We reviewed the care plans for 18 people who required support from staff to safely take their medicines. None of these care plans contained sufficient information to ensure medicines were managed in a safe way. Care files did not contain information about which medicines people had been prescribed, the support they needed to take them, or any side effects staff needed to be aware of. The systems in place for ensuring accurate and up to date information about people's medicines was held by the service were ineffective. The service relied on individual care workers reporting issues with medicines to the office or to an SQA who would then complete the medicines risk assessment. However, the assessments viewed were poorly completed and did not include suitable information about the risks associated with medicines. We saw identical risk assessments in files regarding over dose, under dose and mis-dose. These all stated the mitigation was to "double check and administer the medication." This was not a specific instruction or information about this risks of over/under or mis-dosing specific named medicines. This meant there was a risk that people would not receive the support they need with their medicines as staff did not have guidance in place.

We reviewed the medicines administration records (MAR) for 32 people and found these did not demonstrate staff had supported people to take medicines safely. They contained gaps, and where staff had handwritten information about medicines they did not contain sufficient information about them to ensure they were administered safely. For example, medicine names were misspelled, or the dosage and timing were not indicated. This meant staff did not have accurate information about what medicines people were taking, and may have shared incorrect information with health services in an emergency.

Some medicines are prescribed on an 'as needed' basis, for example, pain relief medicines. There was no guidance in place to inform staff when to offer or administer such medicines. Some 'as needed' medicines should not be given together as they pose a risk of overdose or toxicity. For example, co-codamol is a medicine containing both paracetamol and codeine. It should not be administered together with paracetamol as there is a risk of liver damage if too much paracetamol is taken. Staff had recorded administering both paracetamol and co-codamol to one person on 17 occasions. The care manager investigated this and told us this was a recording error and the staff member had not actually administered medicines in an unsafe way.

Other risks to people were identified by referring agencies and through the initial needs assessment. However, the measures in place to mitigate risks were not clear and care workers were not provided with sufficient information to mitigate risk. For example, four people were identified as being at risk due to diabetes, but there were no diabetes risk assessments within their files. Thirteen of the care files reviewed showed people needed support with moving and handling or mobility. None of these files contained sufficient instruction to mitigate the risks associated with their mobility. Two people whose files were reviewed were identified as being at risk of developing pressure wounds. There was no guidance in place regarding their repositioning needs or how to mitigate the risks of them developing pressure wounds. Another two people were identified as being at risk of self-neglect but there were no risk assessments in place to address this.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to our significant concerns about medicines and risk management the provider audited all the care files and prioritised people for re-assessment and re-writing care plans and risk assessments.

The provider had safeguarding policies in place for safeguarding children and adults. This was appropriate as they supported both children and adults with personal care. However, the policies did not contain the local contact details for each relevant safeguarding team. This meant this information was not easily accessible to staff. Staff told us they had received training about safeguarding and were able to identify the different types of abuse people may be vulnerable to.

The quality manager had been in post for less than two months at the time of our inspection. They had started the process of coordinating and analysing safeguarding alerts and investigations. The files showed they were completing investigations as directed by the local authority safeguarding teams. However, prior to their appointment it was not clearly captured when safeguarding concerns were raised and what investigations had taken place.

The provider relied on care workers reporting incidents to the office. However, reviewing daily records of care showed that not all incidents had been reported and recorded appropriately. For example, we saw a care worker had recorded a person had suffered an injury during their visit in the daily logs, but this was not captured in the incident recording systems in place. Care workers told us they reported issues to the office, but did not always get a response from office based staff. It was not clear that information about incidents was being appropriately recorded. The management team at the provider recognised this. During the inspection they sent out a newsletter for care workers reminding them of the type of incidents that they should report and how to report them. They were in the process of introducing more robust systems to capture and monitor incidents within the service.

The provider provided staff with gloves and other personal protective equipment to ensure people were protected by the prevention and control of infection. A relative confirmed care workers wore gloves when supporting their family member with care tasks, "Oh yes, they wear their gloves when supporting him." Where it was commissioned by the funding authority the service supported people with domestic tasks to ensure their home environment was kept clean and hygienic.

## Is the service effective?

### Our findings

In March 2018 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not up to date with core training required for them to perform their roles.

The provider submitted their training matrix to us. This showed fewer staff were out of date with their basic life support, and moving and handling training than had been in March 2018. However, more staff were now out of date in their safeguarding adults, health and safety and food hygiene training. The matrix did not include safeguarding children training despite the provision of care and support to children. After we made further enquiries about this the provider sent us an update matrix which showed the safeguarding adults training and safeguarding children training were completed together. The provider submitted a plan to ensure staff had received updated training.

New care workers who joined the service completed an induction programme which included training in areas covered by the Care Certificate. The Care Certificate is a nationally recognised qualification that provides staff with the fundamental knowledge and skills required to work in a health and social care setting. Staff gave us mixed feedback about the level of support and supervision they received. Some staff told us they received regular supervision meetings and spot checks, while other staff told us they had not received any supervision. This was supported by the staff files we reviewed: half of the staff files contained regular supervisions in line with the provider's policy, but the remainder didn't contain any supervisions, or none since our last inspection.

The above issues with training and supervision are a continued breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an assessment template in place which formed the basis of their care planning process. However, this was poorly completed in most cases, and in some geographic areas the provider relied on the commissioning borough's paperwork and did not complete their own assessments of people's needs. The provider confirmed to us that none of their contracts were Trusted Assessor contracts where it is appropriate to rely on the commissioning authority's documentation. The Trusted Assessor approach is a national NHS initiative designed to reduce delays in discharges by allowing adult social care providers to adopt assessments carried out by suitably qualified trusted assessors while the person is still in hospital.

Where needs assessments had been completed they did not lead to support plans which had clear goals or outcomes. For example, one person required support to improve their confidence mobilising within their home but their support plan only instructed staff, "Carers to practice with [person] twice a day." There was no further guidance in the file to inform staff how to do this. Another person's care plan stated, "I would like you to support me to get ready for bed." There was no further information or guidance to describe this support. Some care plans simply listed "key tasks" to be completed with no guidance regarding people's preferences for how these tasks should be completed. For people receiving a 'reablement' service, this showed a lack of planning for rehabilitation goals through the provider's assessment process.

Where specific needs were identified at assessments, there was no care planning around how to meet them. For example, we identified four people whose assessments documented mental health conditions with no care plan created to inform staff about how to support people. This showed a lack of consideration for how these conditions impacted on people and there was a lack of information about how to support people in a way that promoted their mental wellbeing. One person's care plan recorded that they had schizophrenia but there was no information about how it affected the person and how staff could support them if they experienced delusions or psychotic episodes. This showed a lack of consideration of people's individual needs and wellbeing when planning care.

People receiving a service lived with a range of complex healthcare conditions. However, staff were not provided with clear information about the support people needed to manage their health conditions. For example, staff supporting people living with diabetes were given no guidance about how to identify high or low blood sugar levels or the actions to take in response. One person's care file stated, "No known medical history." The person was described as being alert and able to communicate their needs but their medical history had not been explored. There was no information about their GP within the file which meant there was a risk staff would not have access to information needed to respond to medical concerns. Several of the people whose files we reviewed were diagnosed with dementia or a dementia type illness. None of the files contained any information about what this meant for the person, or how staff should communicate with and support these people in relation to their diagnoses.

People told us care workers helped them prepare meals. One person said, "They'll help if I need it." Staff confirmed they supported people to prepare meals where this was part of their care package. One care worker explained, "I help people with their meals. I'll see what's in the fridge and what they want from what they have in."

However, care files did not include information about people's dietary needs and preferences. For example, one person's care plan stated, "Ensure he has eaten and has food in the fridge" but did not include any information about what he might like to eat. Another person's plan said, "Ensure [person] has eaten her breakfast, assist with meal preparation." There was no information about what meals they might like support to prepare. A third person's record of care showed they were supported to eat "blue cheese on toast" for 17 out of 20 days in August 2018. The other three days recorded either goats cheese or butter on toast. This person's care plan showed they relied on staff to both complete their shopping and prepare their meals. The records showed they were not being supported to prepare nutritious or balanced meals as all they ate was toast.

The above issues with the quality of assessments and resulting care plans are a breach of Regulation 9(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

It was not clear that the service was applying the principles of the MCA Code of Practice. While most people had signed forms to indicate their consent to their care, we found several examples where staff had recorded that the person was unable to sign their consent due to visual impairment. Staff had not recorded how they were assured that people were consenting to their care. Information had not been provided in any alternative formats to facilitate their understanding or ability to provide consent. We also found several files

where relatives had signed to indicate consent on their family member's behalf. Family members may only consent on a relative's behalf if they have appropriate legal authority through a power of attorney authorised by the Court of Protection, or if they have been appointed as a deputy by the court. The provider had no records to demonstrate that relatives providing consent were lawfully authorised to do so.

Care workers told us they offered people various choices during their care. Care workers told us they offered people a choice of meals and the order in which they wished to receive their care. Despite the lack of detail about people's communication methods within the care plans, staff told us they could interpret people's non-verbal communication to ensure they were offered choices and were involved in making decisions about their care. One care worker said, "I can understand him. The family will suggest things but he always has the final say on whether or not he does something."

The provider held several contracts for reablement services. Reablement support is usually short term support provided to people to support them to regain their independence after a temporary change in their needs. The terms of one of the reablement contracts required the service to work closely with social services, physiotherapists, occupational therapists and other healthcare services. This was to ensure people received a coordinated package of care designed to ensure they regained skills and independence. Despite the terms of their contract it was not captured within the care files that staff were working with other services as required. This meant it was not clear that staff were working well across organisations to achieve effective outcomes for people.

## Is the service caring?

### Our findings

At our last inspection in March 2018 we noted that some people felt the quality of their relationships with care staff were affected by changing care workers. At this inspection we found this had continued. While people had developed strong relationships with staff who visited them regularly, they found this more challenging when their care workers changed frequently. Several people told us they preferred to go without care when their regular worker was not available. One relative said, "We don't get no one else, we don't want it, we'll wait for the carer to return."

Care workers described the steps they took to maintain people's dignity. They described ensuring doors were closed and people remained covered during personal care. People we spoke with told us they felt staff respected them and their homes. However, some relatives whose family members had communication difficulties told us not all care workers made the effort to communicate effectively with their family member. One relative explained, "[My relative] trying to vocalise a bit. New people might not understand her. But after a while you would gather what she is trying to say. They're not understating her and then she gets frustrated which they call challenging behaviour but I call frustration."

People's needs assessments captured where people had sensory impairments that affects their communication. For example, we saw several people were hard of hearing and others had a visual impairment. We saw another person did not speak English. Despite identifying that people had needs in relations to communication, there was no further guidance for staff about how to communicate effectively with people. For example, one care plan detailed the person did not speak English and relied on their family members to interpret for them. However, there was no information about what language the person spoke. This meant the service could not identify if they had care workers who shared a common language with the person and match them to work together.

The assessment template and care plan contained places where staff could record details of people's personal history, significant relationship and religious beliefs. However, this section was often blank, or contained very limited information. For example, we saw people's religious beliefs were captured but there was no further information about what this meant in terms of their care preferences. For example, staff were not advised whether a person's religious beliefs affected the timing of their care, or how they should behave in people's homes.

Although some care plans made reference to people's partners, this was inconsistent and it was not clear whether staff explored people's sexual and gender identity with them. This was not captured with the provider's paperwork. This meant staff were not exploring what, if any, impact people's relationships, sexual and gender identity had not their care preferences. As it was not clear that people were asked about this information, the service cannot be assured they are providing an environment where people feel safe and confident to disclose their sexual and gender identity and the impact this may have on their care preferences.

We recommend the service seeks and follows best practice guidance from a reputable source about

ensuring that information about people's religious beliefs, cultural background, sexual and gender identity, and the impact these have on their care preferences, are considered as part of a comprehensive assessment and care planning system.

## Is the service responsive?

### Our findings

Care was not planned in a person-centred way. People's care plans lacked detail and the information for staff was not sufficient to provide person-centred care. For example, one person's care plan stated, 'support with personal care' with no information about what elements of personal care this person required support with. This level of record keeping was consistent in the majority of care plans seen and did not provide staff with enough detail to provide personalised care. The impact of this was heightened because people did not receive support from a regular and consistent staff team that had got to know them. A relative told us it was very frustrating as they had to explain their family member's needs to each care worker who attended. They said, "I've got to tell them. I was fed up every other week it was someone else new I have to tell them what needs doing and whatever." A care worker said, "The care plan is very basic. A new carer would struggle."

Care plans did not record what was important to people, such as times they liked to receive care or have their meals. Shortfalls in the scheduling and monitoring of calls meant people received their care at different times every day which people told us impacted significantly on their daily routines.

Where specific needs were identified at assessments, there was no care planning around how to meet them. For example, we identified four people whose assessments documented mental health conditions with no care plan created to inform staff about how to support people. This showed a lack of consideration for how these conditions impacted on people and there was a lack of information about how to support people in a way that promoted their mental wellbeing. One person's care plan recorded that they had schizophrenia but there was no information about how it affected the person and how staff could support them if they experienced delusions or psychotic episodes. This showed a lack of consideration of people's individual needs and wellbeing when planning care.

End of life care was not appropriately planned for. We looked at three care plans for people who were discharged from hospital with conditions that meant they were likely to receive end of life care at home. These care plans lacked information about people's wishes and what was important to them at this stage of their lives. One person's records contained a detailed moving and handling plan from the clinical commissioning group, but no paperwork from the provider and no record of what was important to the person and any spiritual needs to be considered when they passed away.

Reviewing and monitoring of changes to people's care need was not robust. The regularity of reviews of people's care was not consistent and where people had raised issues, these had not been followed through. We identified regular instances where people had said they had concerns with staff or punctuality and the review outcome was that they were satisfied with their care. In some cases, people had not received a review for over six months and there was not a robust system in place to flag this up. We also found people who had no records of any daily notes within their records which meant office staff could not proactively check care delivery to identify when a review might be required. This showed there was a lack of robust system in place to identify and respond to any change in people's needs.

The shortfalls in relation to care planning and the lack of monitoring and reviews of people's needs was a

breach of Regulation 9(1)(b)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's complaints were not responded to in an open manner. A relative said, "Yes, we did make a complaint, but it fell on deaf ears. This was regarding timekeeping." Another relative said, "Complaints take a long time from Medacs. They don't communicate by phone or email." People told us that complaints had not been responded to or addressed. Records of complaints showed frequent concerns raised by people about staff punctuality and missed calls. Records did not always show what was done in response to complaints and there was no system to track and monitor issues raised by people and relatives. Issues relating to punctuality and call times were still unresolved by the time of our visit, which showed that the provider was not monitoring and responding to patterns and trends within their complaints.

The failure to respond to and act upon complaints was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

# Is the service well-led?

## Our findings

People raised numerous concerns with us about the governance of the service. Relatives gave examples of when they had late or missed calls and a lack of communication from staff and the provider.

There was a lack of governance at the service that impacted significantly on the safety and quality of the care that people received. The provider's systems to check and audit care had not identified or addressed the significant concerns that we raised during this inspection. Audits related to care planning and medicines had not found the regular and repeated issues we found in these areas. There were no systems to robustly monitor incidents and call schedules, with data being held in different places which meant staff could not adequately analyse it. Following our inspection in March 2018, the provider sent us an action plan to say that they would implement improvements to staff training and support by 31 July 2018. At this inspection, we found that the provider had not made the improvements as outlined in the action plan. There was not a robust system in place to log and track staff training and it took over two weeks after this inspection to access the data regarding staff training.

People's feedback was not acted upon. Where calls were repeatedly attended outside of the scheduled time or missed, the provider's systems were not sufficient to address this. Audits of call monitoring systems had not prompted any changes or action to address this widespread and significant issue. Staff use of the monitoring system was inconsistent and there was no record of any robust action being taken to improve people's experience, despite punctuality and call times being raised repeatedly by people at reviews and within complaints. Records showed that the majority of visits took place outside of the expected call time with no evidence of any action being taken to improve people's experiences.

There were insufficient systems to ensure records were up to date. People were asked to regularly post their daily notes and medicines records back to the provider to be checked. There was no tracker for this and we identified multiple instances where people's daily notes and medicines records were not available. This meant staff could not regularly audit records in a timely manner. Where medicines records had been checked, they all contained gaps which staff had sometimes noted in their audit. However, gaps in medicines records were widespread which showed that the action to address them was not robust enough to prevent it from happening again.

There was a lack of opportunities to involve staff in the running of the service. Records showed that staff meetings did not happen regularly and staff had raised concerns with their rotas and scheduling through surveys. Despite this significant issue having also been raised by staff, there was a failure to address it which the survey showed was impacting on the wellbeing of staff. Records also showed that concerns raised about call attendance regularly involved a lack of communication resulting in staff having incorrect information about where they needed to be.

The failures relating to governance at the service were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had not carried out all the requirements of their registration. Providers are required by law to notify CQC of important events such as deaths, serious injuries and allegations of abuse. During the inspection, we identified events that should have been notified to CQC in an open and transparent manner. For example, records showed that recent safeguarding concerns raised by the local authority had been shared with the provider. Records showed CQC had not been notified of these allegations of abuse.

The failure to submit statutory notifications to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw evidence of ongoing work with stakeholders in response to concerns. Due to the recent concerns, the provider was meeting regularly with local authorities to address the numerous concerns being raised by people and relatives. Local authorities and clinical commissioning groups (CCGs) told us they had seen some improvements prior to our inspection, but our findings showed there is significant work to be undertaken to improve the governance at the service. We will maintain contact with stakeholders whilst monitoring action plans from the provider to ensure improvements are implemented as planned.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints  The provider was not appropriately identifying or responding to complaints.

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents  The provider had not submitted notifications as required. Regulation 18

### The enforcement action we took:

We investigated this criminal offence.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  People's needs had not been appropriately assessed, and their care plans did not contain sufficient information for staff to be able to meet their needs. Records did not demonstrate people were having their needs met. Regulation 9(1)(b)(c)(3)(a)(b)

### The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Risks faced by people in the receipt of care including medicines had not been appropriately identified, assessed or mitigated. Regulation 12(1)(2)(a)(b)(g)

### The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The systems in place for monitoring and improving the quality and safety of the service were ineffective. Regulation 17(1)(2)(a)(b)

**The enforcement action we took:**

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  Staff were not deployed effectively to meet people's needs and had not received the training they needed to perform their roles. Regulation 18(1)(2)(a)

**The enforcement action we took:**

We imposed a condition on the provider's registration.