Mears Care Limited

Mears Care Limited Leeds

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17, 18 and 25 July 2017 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care services and we needed to be sure that someone would be in the office. We contacted people who used the service and staff by telephone on 18 July 2017 to ask for their views. On the 17 and 25 July we spent time at the office site, speaking to staff and reviewing relevant documentation.

Mears Care is a domiciliary care service that provides personal care to people in their own homes within the Leeds area. Mears Care was registered with CQC in July 2016 and this was the first inspection of the service. The service provides care for older people and people living with dementia, mental health, physical disabilities and sensory impairment, learning disabilities or autistic spectrum disorder, older people, people who misuse drugs and alcohol, people with an eating disorder and younger adults. At the time of our inspection there were 272 people using this service.

The service had a manager although they were not the registered manager. The manager told us they are in the process of applying to the CQC for registration purposes. We checked this and saw the manager had recently had an interview with the CQC as part of this process. 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 medicines were administered but that administration was not always documented correctly. Staff signatures to confirm they had supported people to take their medicines and other information written on the Medicines Administration Record Sheets (MARs) were not always clearly written. Not all MARs charts were audited monthly and the audits we did see were completed several months after they had been completed.

Governance structures were in place but these were not being followed in accordance with the provider's procedures and policies. For example, audits for medicines were not being followed up with actions taken and not all supervisions had been completed within the provider's policy timeframe.

The manager was compliant in notifying the CQC of all medication errors and some incidents. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'.

Some people using the service did not have capacity. We found people's care records did not include information to reflect that assessments had taken place where people lacked capacity, and there was no evidence that best interest's decisions had taken place, where relevant. No systems were in place to monitor if a person's capacity had been reviewed.

Staffing levels were adequate to meet people's needs and there was consistency with the same staff attending care calls whenever possible. Staff were recruited in line with the providers policy, inductions took place and staff received appropriate training.

Risk assessments were completed and reviewed to support people with specific needs to avoid any harm.

People told us they felt safe when being supported by staff. People using the service felt confident to raise any safeguarding alerts and staff had a clear understanding of the relevant policies and procedures.

Where people required assistance, they were supported to eat, drink and maintain a balanced diet. People were also supported with their health needs and this was evidenced in care records. Staff told us they also supported people to attend hospital appointments if needed.

People using the service and staff had positive relationships and people told us they felt well cared for. People were encouraged to be independent and make choices regarding their care. Staff respected people's privacy and dignity when in their home.

Care plans were detailed and included relevant information such as initial assessments and instructions for staff to follow. People received personalised care which responded to their specific needs and preferences.

Complaints were responded to with letters and appropriate outcomes had been recorded. Incident and accidents were managed via an online system and people using the service told us they felt confident to discuss any concerns with the provider.

All of the people we spoke with said the manager was approachable, supportive and listened to others. People using the service were happy with the care provided and with management.

Staff meetings took place and staff were encouraged to discuss proposed improvements for the service. Surveys were provided to people using the service to monitor the quality of the care provided.

We identified one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014; you can see what action we told the provider to take at the end of the full version of this report.

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 not always safe.

The management of people's medicines was not always robust.

People told us they felt safe. Staff received training in how to protect people from abuse and how to respond if they suspected abuse was taking, or had taken place.

Risk assessments were in place for people who needed them and were specific to people's needs and their home environment.

Staffing numbers were sufficient to meet people's needs and recruitment was on going.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions, care plans did not evidence compliance with the Mental Capacity Act 2005.

Not all staff had received supervision in line with the providers policy.

There was an induction and training programme in place for staff.

People were supported to meet their nutritional needs.

People were supported to maintain their health and supported to access professionals, when needed.

Is the service caring?

Good

The service was caring.

People told us staff were caring. Positive relationships had been built between people using the service and staff.

Staff treated people with dignity and respect and they were supported to be independent.

Staff involved people in their care planning.

Is the service responsive?

Good

The service was responsive.

People were supported to pursue activities in their home although this was limited.

People received personalised care and support. They and the people that mattered to them, had been involved in identifying their needs, choices and preferences and how these should be met.

A complaints procedure was in place which had been followed. People using the service felt confident to complain if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits were being completed on medicine administration records, but actions or outcomes had not been completed.

People using the service and staff spoke positively about the manager and felt supported.

Staff meetings were held and surveys asking people about a range of elements of the service delivered had been completed by people who used the service.

Mears Care Limited Leeds

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.

This was a comprehensive inspection. The inspection took place on 17, 18 and 25 July 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service providing support to people in their own homes. We needed to be sure that someone would be available at the office to assist us with our enquiries.

This inspection was carried out by one adult social care inspector and one expert by experience. The expert by experience had experience of caring for a person with dementia and completed telephone interviews on 18 July 2017.

Before this inspection we reviewed information we held about the service. This included reviewing statutory notifications that we had received from the provider. Statutory notifications are notifications of certain events and incidents that the provider has to inform the CQC by law. We used this information to help plan the inspection. We also contacted the local authority, local safeguarding team and Health watch to gather their feedback about the service.

During the inspection we spoke with 13 people who used the service, the manager, one co ordinator and six care workers. We looked at a range of records including 10 staff files relating to recruitment, supervision, appraisal and training. We also looked at 14 people's care records which included care planning documentation, risk assessments and daily records. We viewed records relating to the management of the service, surveys, audits and a wide variety of policies and procedures.

Good

Is the service safe?

Our findings

The service used Medicine Administration Records (MARs) to document the medicines people had been prescribed and record when medications were administered to them. We found there were some minor shortfalls in recording on MARs and gaps existed about medicines administrations, where staff had omitted to sign these records. However, when we looked at people's daily notes, we found that where we had identified gaps in recording on people's MARs, staff had made entries in their corresponding daily notes. These confirmed that medicines had been administered, or alternatively where they had not been taken, a specific reason for non-administration was documented. We discussed these minor records shortfalls with the manager who told us the matter would be addressed with staff.

Medications were ordered by people's general practitioners and delivered by local pharmacies. These were usually delivered in blister packs but individual prescriptions were also provided in separate boxes. Blister packs contain designated sealed compartments, or spaces for medicines to be taken at particular times of the day. They can help people to keep track of their medicines.

People told us, continuity in staff attending their homes to assist them, helped them to have confidence and feel safe with staff. One person said, "I feel very safe that they come and see me" and another person told us, "Staff are lovely and meet all my needs." One staff member said, "I've worked with the same three people for the past 11 years." This showed us staff were able to build relationships with people using the service and they knew their specific needs and how to meet them well.

Safeguarding and whistleblowing procedures were robust and policies had clear guidance for staff to follow. There was a good understanding from staff of the process. One person told us, "We have to protect vulnerable adults and children. If we suspect anything we would report it to the office immediately, I feel confident to do so."

Risk assessments were completed to ensure people could make their own lifestyle choices without these impacting on their safety and wellbeing. The assessments included details about how staff should support people safely with medicines, nutrition, mobility, finance and mental health to name a few. Some people had equipment in place to assist with care tasks for example, a 'banana board' to be used for all transfers. Another person had an assessment which included steps about safely supporting a person to take their medication due to memory loss.

Risk assessments were regularly reviewed by staff, with the involvement of other professionals where required, and incorporated into people's care plans. One person required a telecom wrist band to alert a care line for additional support if a fall occurred. The care plan gave clear instructions for staff to ensure the person was safe, for example it stated 'on leaving ensure [Name] has her care line wrist band on, ensure she has her telephone on the table and glasses to hand.'

The provider investigated accidents and incidents via an online system. Forms included clear details of the event and actions taken to keep people safe. People told us they would report any concerns to the provider.

One person using the service told us, "I've had no complaints but if I did I am confident the office would help me."

We looked at staff recruitment records which showed that appropriate processes and vetting checks were undertaken before staff began work. This included staff submitting application forms, being interviewed, their identity being confirmed and two references and a Disclosure and Barring Service (DBS) check being obtained. These checks identify if prospective staff have a criminal record or are barred from working with vulnerable children or adults. We looked at 10 staff files and found all processes followed the provider's policy.

Staffing levels were adequate and flexible to meet people's needs; however staff told us more office staff were needed. The manager told us they were currently recruiting office staff and had recently appointed two new coordinators to join the service.

At the time of our inspection staff had the choice of contracts or zero hour contracts, with only 15 staff on contracts. If visits were not covered by regular staff, the manager told us they contacted other staff members to do the visits and did not currently use any agency staff to ensure consistency.

There was an on call system in place from 6am till 9am and 5pm – 11pm. The manager told us, should a person require support in the night, emergency services were contacted by relatives or the individual. Some people also had access to telecare (a system that alerts the emergency service should a fall occur).

Staffing rotas we looked at showed consistency where possible and people received the same care workers for their care calls. People we spoke with said they were contacted if visiting times changed, one person commented, "If the carers are late, the office will call me." Rotas were completed in advance; however, people we spoke with all said they did not receive rotas confirming visits. We discussed this with the manager who agreed to send rotas to people using the service.

Requires Improvement

Is the service effective?

Our findings

Not all of the people who used the service had the mental capacity to make informed choices and decisions about all aspects of their lives. 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. We discussed whether anyone in receipt of care from the service had a granted authorisation in place from the Court of Protection, to lawfully deprive them of their liberty in a community setting. The manager told us that to their knowledge none of the people they supported had such authorisations in place but should such authorisations be necessary in the future, they would pursue this with the relevant parties.

We checked whether the provider was working within the principles of the MCA and found that staff and management understood their responsibilities under the Act. However, care plans did not always document when a person lacked capacity. Staff understood the MCA framework from their training and one staff member told us, "If a person has not got capacity and can't make decisions it would be in the care plan. We would see if it's in the person's best interest. If we suspected someone didn't have capacity we would report it to the office and ring the doctor."

At the time of our inspection the manager told us, no one was subject to a best interest meeting and these were usually completed by social services or other health care professionals. One staff member told us they had attended a best interest meeting although there was no evidence of this within the persons care records.

We recommend the provider reviews their application of the MCA to ensure that best practice guidance is followed and that appropriate documentation is retained about capacity assessments and best interest decision making that are undertaken.

We looked at the support staff received from management. We found staff were provided with an annual appraisal but records of supervisions that had taken place were not well maintained. The manager and staff told us supervisions were every three months and that some were informal however, this was not always documented. Staff told us regular supervisions took place and they felt supported by the manager. We discussed this with the manager and promoted that records to evidence supervisions had taken place should be introduced.

Training records showed staff received training on a range of subjects, some of which included safeguarding, MCA, medication, health and safety, food hygiene and infection control. All staff completed training sessions annually and staff told us, "The training is helpful; I have refresher courses to remind me of

the policies and training." People we spoke with told us staff were well trained and met their care needs.

Newly recruited staff completed a 12 week induction programme which included completing annual training courses and shadowing experienced staff members. Before a staff member could work independently they were observed and assessed by senior care workers using a competency tool, to ensure they are providing safe care. The induction training programme was in line with the Care Certificate that was introduced on 1st April 2015.

People who used the service felt communication was effective. One person told us, "Staff and office staff always listen to me and try and help me." The manager told us staff had informal morning hand overs to discuss people's care and any concerns. We observed staff in the office contacting people to inform them care workers were going to be late and confirmation of the person's staff visits for the week.

Where people required assistance, they were supported to eat, drink and maintain a balanced diet. People confirmed this and told us nutritional support was provided in line with their preferences. People told us, "I'm always asked what I would like to eat or drink" and one care plan stated, 'provide any snack or drinks, [Name] may have a Horlicks or cup of strong coffee with three sweeteners.'

People using the service were supported with their health needs; this was evident in care plans and daily notes we looked at. District nurses supported people who required assistance with peg feeding and catheter changes. One person's care records reflected that they were supported with their healthcare needs by a nurse who specialised in Alzheimer's care, and dietician input was evident in care records for those people who required support with weight monitoring. Staff told us they also supported people to their hospital appointments if needed.

Good

Is the service caring?

Our findings

People we spoke with told us staff were caring and respectful in every way. Some of the comments included, "Very caring staff, can't do enough for me", "Staff respect me and my home", "All staff are very caring and understanding" and "They really do care."

Staff told us they had positive relationships with people using the service and knew them well. One staff member had been working with the same person for the past nine years and told us they had a great bond. The manager also commented, "Building trust with customers is so important to us especially when we provide intermit support, you don't just want anyone." They ensured that where possible there was consistency of staff visits so people felt comfortable with their care worker. One person told us, "I'm really happy with my carers" and another stated, "Excellent carers."

Staff were respectful of people's privacy and dignity. One staff member told us, "It's part of our daily job; if a person was showering I would make sure to close the door. If I was helping someone I would make sure I put a towel around them if we were moving from the bathroom to the bedroom. If they had friends over I would keep myself out of the way and make sure all information was kept confidential." One care plan stated, 'carers to bring the rise and recline chair up and transfer person onto the wheeled commode using a stand aid. Wheel into the bedroom and then give person some privacy to use commode.'

People using the service were supported to be independent and were involved in their care. One person told us, "Staff encourage me to make decisions, staff listen to my needs." One staff member explained, "We let people do as much as they can but do offer assistance, for example if we are helping to bath someone we would offer to wash their back and ask if they want to wash their front if they can." One care plan stated 'Sometimes I get dressed quite quickly and other days I will take my time. If it gets to 07:50 please step in and assist me to get dressed. Starting from the bottom, please let me do my shirt buttons even if I find it difficult as this is good for me to do myself.'

People's diverse needs were taken into account during the care planning stages. We saw one person did not speak English and therefore a care worker who spoke their first language Punjabi was allocated to work with the person. The manager also told us in the past they have used interpreters when required to support a person's needs.

At the time of our inspection no-one using the service had an advocate. Advocates help to ensure that people's views and preferences are heard. Staff we spoke with and the manager had a good understanding of what an advocate's role was and how they could support people. They also had systems in place to refer people for advocacy through social services should they wish to access this support.

Information about people was kept securely in the office and locked in a cupboard at all times. Staff told us they were aware of keeping personal information confidential and knew how to access this information. The manager told us information was also kept in people's homes.

Good

Is the service responsive?

Our findings

People received personalised care which responded to their specific needs and preferences. For example, one care plan documented – 'I enjoy a bacon sandwich in the morning.' Another care plan stated, 'Carer to assist to bathroom. [Person] can mobilise independently using his three wheeled walker. [Person] will sit on his shower chair, carers to assist with undressing. [Person] can manage to wash his hands and front, will need assistance washing back and lower half.' A compliment the manager had received about a staff member, from a person using the service stated, '[Name] gave the best bath I have had in years. [Name] applied cream to my body and face which no one has done before. [Name] made me feel like the only lady in the world.' This showed us staff were aware of peoples individual needs and wishes.

Care plans identified people's historical information, likes and dislikes. Staff told us this helped them to build relationships with people they cared for. One care plan stated, '[Name] enjoys having soup in her soup mug, usually in winter. The soup can be warmed up in the microwave.' Another plan documented where the person was born and their previous job as a nurse. We also saw care plans asked questions such as, 'What is your preferred name?' and 'How I feel about my support?' This showed people had the opportunity to convey their preferences about the support they received.

People using the service told us they were provided with a choice and this was clearly documented in care plans. One person told us, "The staff encourage me to make choices" and, "Staff always ask me if I need anything." Staff told us they always offered people a choice. Some examples included offering a variety of food and choices of clothing.

We looked at 14 care plans and found each one included an initial assessment, referral information, planning records and reviews. We saw evidence of people being included in their reviews and care plans were signed by people or their relatives. One person told us, "All my needs are met." Another person we spoke with said, "My care plan was very good; I was involved in all the planning."

People with spoke with did not comment on any social activity support they received. Staff told us they would do activities with people in their homes but only if this was part of their agreed care package and it was documented in their care plan, for example, playing card games. Care plans identified people's hobbies and activities they enjoyed. Staff explained, people were often referred to respite care or to day centres where activities were provided if they wished to expand their social interaction and the number and types of activities they pursued. Staff said that activities provision was not generally part of the majority of agreed care packages.

Systems were in place to manage complaints. We saw complaints were acknowledged, apology letters provided, documentation of investigations retained and appropriate actions taken to resolve complaints. People using the service and staff told us they felt confident to complain if needed. From March 2017 there had been four minor complaints that had all been resolved; people told us, "I would call the office to complain."

The manager received compliments from people using the service and their relatives. We saw from December 2016 to July 2017 there had been 25 compliments received. One person stated, "We are very satisfied with [Name], she [staff member] really shows great understanding to [Name's] needs. [Name's] needs are adequately met by [staff member] and the care plan is very effective."

Requires Improvement

Is the service well-led?

Our findings

We found shortfalls in a number of areas relating to the lack of record keeping in the service. In addition, throughout the inspection it took several hours for staff and the manager to find information in records relating to MCA information.

We discussed with the manager about the lack of records to demonstrate when a person lacked capacity in the service. The manager could not inform us which people in the service did not have capacity without checking individual files for documentation. We were provided with two assessments which had been completed by other services; however, this had not been documented in the person's care plan. The manager told us they were not aware of the current documentation processes regarding the MCA and best interest decisions but planned to revise this and follow guidance provided by the MCA.

The providers policy stated 'senior staff/visiting officers will complete Mears Mental Capacity Assessment form' to determine if a person lacks capacity, however, the manager confirmed staff had not received any training in how to complete assessments of peoples capacity. This meant that the provider had not followed processes within their own policy to ensure the service delivered was effective.

We also identified shortfalls in record keeping with regards to staff supervisions and medicine administration. Staff told us supervisions took place regularly but the provider could not evidence this with documentation, as records about these were not always maintained.

Supervisions were not being completed in line with the provider's own policy. We looked at 10 staff files; one staff member had received a supervision meeting in 2017 and all others were completed in 2016. The policy stated a minimum of four supervisions should be completed which could include 'an appraisal', at least one observed practice and an office based supervision. Supervision may also form as part of team meetings which should be held at least quarterly.'

In relation to records shortfalls linked to the administration of medicines, we found MARs were not always complete where staff had omitted to sign when they had supported people to take their medicines. Best practice guidance about the recording of medicines administration was not embedded within the service and records needed to be improved.

We found audits were carried out approximately two months after MARs had been completed. We saw 10 MARs from April 2017 and nine from May 2017 which were audited in June 2017. June and July MARs had not yet been audited when we inspected. The majority of MARs had missing signatures which were identified on the audits with actions to contact the office; they called this 'Red Ring'. The manager told us, the 'Red Ring' allowed staff to be honest and open about any mistakes they may have identified.

The provider carried out a number of audits and had systems and procedures in place to support the delivery of a good service, but these were not always effective. In practice, the provider's own quality assurance policy was not always followed. For example, not all medication audits were completed and the

audits that were completed did not reflect what we found on corresponding MAR's. In addition, errors identified on the audits were not always followed up. This meant that learning from auditing and the review of shortfalls, accidents and incidents, was not used to drive improvements within the service.

The manager told us medications audits were kept in people's files and they did not retain this information communally together. This meant it would be difficult for the provider to determine if there were any trends that may need to be addressed to ensure the safe administration of medicines.

The manager told us, care files were to be audited every 12 months, however, we found five people had not had their files audited in the preceding 12 month period. The manager also told us that telephone quality checks were to be done every quarter to each customer. Out of 14 care plans, nine people had not received a quality telephone check for a period of 12 months. The manager was aware of this and had an action plan in place to address these concerns. This plan had been completed prior to our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 entitled Good governance.

The manager was compliant in notifying the CQC of incidents which had occurred. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. This allows the CQC to check that appropriate action had been taken at the time of the event.

All of the people we spoke with felt the service was well led. Comments included, "[Name] is the best manager we have ever had, he listens and involves the carers" and "[Manager] has the right attitude and we can approach him." Staff spoke positively about the culture of the service and how this has changed since the new manager started a few months ago. One person told us, "We are working together as a good team and pulling together, we are all there for each other and very open." Other comments included, "It's been excellent, and I don't have any problems."

People using the service said the following about the provider, "I like the manager, [Name] is understanding", "[Name] is the best manager we have had" and, "They are absolutely fabulous."

At the time of our inspection the manager had applied to become the registered manager of the service and had been in post for three months prior to our inspection. The manager spoke of their vision to improve the service and had started to implement some changes. There had been a recent 'Carer's Forum' to build on relationships between the office staff and care workers. Staff told us, "We get to discuss what the clients want to see, discuss problems in the community and getting the communication better." Some staff had informed us communication between the office staff and care workers could be improved. The manager told us, "We want to engage with the carers, we want their ideas and opinions. We want them to feel valued."

Staff meetings took place every month, the last meeting was held in June 2017. The meeting focused on the importance of record keeping, medications, daily notes, staff respect for each other, following procedures for improvement and answering telephones. Previous meetings were held in April and May. The manager told us, if staff can't attend their meetings, they ensured everyone received a copy of the minutes.

The manager told us they had a social value calendar, where four events are held every year for staff. One example included a walk for dementia which helped to raise money for charity. The manager stated that in the future they plan to support people who use the service to participate in these events should they wish to.

Surveys were sent to customers annually and other methods of capturing service user feedback at various periods throughout the year including telephone reviews, individual home reviews and on site observations were completed to obtain feedback on service delivery. We looked at the annual customer review satisfaction analysis completed in June 2017 and found 37% of people felt the service was very good, 21% felt it was outstanding and 2% unsatisfactory. The survey included questions about maintaining independence, establishing if people's needs were being met, communication with staff, level of respect from staff and managing complaints.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not established and effective systems or processes in place to assess, monitor and improve the quality and safety of the service being provided. In addition records throughout the service were not always well maintained.