Mears Care Limited

Mears Care - Ealing

Inspection report

Desk 2, 114B Power Road
Chiswick
W4 5PY
Tel: 020 8987 232
Website: www.mears.co.uk

Date of inspection visit: 17 March 2015
Date of publication: 30/03/2015

Ratings

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

Overall summary

The inspection took place on 17 March 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The previous inspection of the service took place on 27 June 2013 when we found no breaches of the Regulations.

Mears Care-Ealing is an agency providing personal care and support to people who live in their own homes in the London Borough of Ealing. This location is a branch of a national organisation, Mears Care Limited. The Ealing branch provided a service to 179 people at the time of the inspection. The majority of people were older adults, some had dementia. There were also a small number of younger adults with a physical disability, acquired brain injury, learning disability or mental health needs and one child who had a learning disability.

There was a manager in post who was employed in November 2014. She had applied to be registered with CQC and was waiting for this to be processed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Most people were happy with the service they received and felt the agency met their needs. Some people raised concerns about care workers arriving late, being rude or the agency not communicating changes, such as a different care worker.

The provider had not always visited people to carry out care and treatment as planned and they had not always investigated why this had happened or taken action to prevent it from happening again.

Not everyone using the service felt safe and the provider had not taken any action to address these concerns.

The provider did not always supervise or appraise staff and had not always taken action to address poor performance.

People's complaints had not always been investigated, responded to and acted upon. The provider was not able to demonstrate how they had learnt from complaints or taken action to prevent reoccurrence.

The provider did not have an effective system to monitor the quality of the service and to make improvements based on these assessments. Risks to people's health and wellbeing had not always been identified, assessed or managed.

The provider carried out appropriate checks on staff suitability to work and employed the staff in sufficient numbers to meet people's needs.

People received their medicines in a safe and appropriate way.

People's capacity to consent had been assessed and they had consented to their care and support. The provider had acted in accordance with their legal responsibilities under the Mental Capacity Act 2005.

People had good relationships with their regular care workers. They felt they were treated with respect. People were not always happy with alternative carers and sometimes felt communication with the agency was poor. The manager had acknowledged this and was introducing systems to improve communication and customer care.

People were involved in assessing their needs and planning their own care. They were happy with the care they received and said they were involved in reviewing this.

People felt there was a positive and inclusive culture at the agency and were able to speak with the manager about their views. The manager had identified areas where improvements were needed and had plans to address these.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had not always visited people to carry out care and treatment as planned and they had not always investigated why this had happened or taken action to prevent it from happening again.

Not everyone using the service felt safe and the provider had not taken any action to address these concerns.

There were procedures for safeguarding people and these were followed.

The provider carried out appropriate checks on staff suitability to work and employed the staff in sufficient numbers to meet people's needs.

People received their medicines in a safe and appropriate way.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always supervise or appraise staff and had not always taken action to address poor performance.

People's capacity to consent had been assessed and they had consented to their care and treatment. The provider had acted in accordance with their legal responsibilities under the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People had good relationships with their regular care workers. They felt they were treated with respect. People were not always happy with alternative carers and sometimes felt communication with the agency was poor. The manager had acknowledged this and was introducing systems to improve communication and customer care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's complaints had not always been investigated, responded to and acted upon. The provider was not able to demonstrate how they had learnt from complaints or taken action to prevent reoccurrence.

People were involved in assessing their needs and planning their own care. They were happy with the care they received and said they were involved in reviewing this.

Summary of findings

Is the service well-led?

The service was not always well-led.

The provider did not have an effective system to monitor the quality of the service and to make improvements based on these assessments. Risks to people's health and wellbeing had not always been identified, assessed or managed.

People felt there was a positive and inclusive culture at the agency and were able to speak with the manager about their views. The manager had identified areas where improvements were needed and had plans to address these.

Requires Improvement

Mears Care - Ealing

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 on 17 March 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert who supported this inspection had worked with older people and had undertaken related charity work.

Before the inspection visit we spoke with 12 people who used the service and the relatives of seven other people who used the service over the telephone to ask them about their experiences. During the inspection visit we spoke with seven members of staff, the manager, three care-coordinators, a visiting officer (member of senior staff who carried out assessments of people) and two care workers. We looked at the care records for nine people who used the service. We also looked at the recruitment, training and supervision records for eleven members of staff and staff meeting minutes. We looked at records of complaints, missed calls, compliments and the results from the organisation's quality surveys.

Following the inspection visit we spoke with the local authority Contracts Officer who commissioned and monitored the service for about 90% of the people who used the service.

Requires Improvement

Is the service safe?

Our findings

The provider's records showed that there had been ten occasions in 2015 when people who used the service had not received their care visit from the agency as planned. Three of these incidents had not been investigated. Only four of the incidents which had been investigated had resulted in action to improve staff performance. The records indicated that only three people using the service received feedback as to why their visit had been missed. We spoke with the manager and she told us the provider did not have arrangements in place for continually reviewing this type of incident to make sure action was taken to prevent reoccurrence. People using the service were placed at risk of harm because they had not received the care and treatment which had been planned for them. Some of these missed calls meant that people had gone without meals or had not had their continence needs met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Ten of the 12 people we spoke with told us they felt safe with the agency. Some of the things they said were, ''I very much feel safe, always kind carers, the same carers for five years'', ''I definitely feel safe'', ''I feel very safe with them'' and ''they look after me I am safe.'' However, two people told us they did not always feel safe and one person said, ''I am not very happy with them, they keep changing my carer and do not let me know. A person appears and says they are my carer and this worries me.'' The staff told us that the agency did not always tell people who used the service if there was a change in their regular care worker or if the care worker was arriving late. They said that some people were anxious or annoyed about this because they did not know who the care worker was or when they would be arriving.

The provider asked people who used the service to complete a quality satisfaction survey in May 2014 and 67 people had responded. 46% of the people who responded said they did not always feel safe. There was no record to state what the organisation had done about this. We asked the manager and she told us that no action had been taken to investigate why such a high number of people reported feeling unsafe. She said there had been no specific action to help people feel safer or to alleviate their worries and anxieties following these survey results.

We recommend that the provider seeks guidance and advice from a reputable source about how to support people to feel safer.

The agency had procedures regarding safeguarding vulnerable adults and children and whistle blowing. The staff had been trained in these and were able to tell us what they would do if they suspected someone was being abused. The staff who worked with children told us they had received additional training regarding safeguarding children. The provider had responded appropriately to safeguarding alerts by reporting these to the local authority and CQC. They had undertaken investigations into concerns with the local authority.

Each person had the risks associated with their care, including moving around, and the risks within their environment, assessed. The visiting officer told us this was part of their role and they undertook risk assessments before the person started using the service and once a year, or more often if their needs changed. There was evidence of comprehensive risk assessments in all the care records we viewed. These had been reviewed and updated at least annually. The person using the service had signed their agreement with the assessments. Assessments included information on the action needed to reduce risks and minimise the likelihood of harm to the person.

Six of the people we spoke with told us they received support to take their medicines. They said they were happy with this support. One person said, ''They give it to me and watch me take it.'' Another person told us, ''They give (my relative) medicines three times a day and make sure she takes them.''

The agency had a procedure for administering medicines. People's medicines, including doses were recorded on their care plan, and this was reviewed every six months. The manager told us that all medicines administered by staff were supplied in dosset boxes from the pharmacist. At the time of our inspection the staff recorded administration of medicines in a general communication book which included all the information about their visit. Therefore it was not always clear whether or not medicines had been administered as prescribed. The manager told us the agency was introducing individual medication administration records and the staff would be trained to use these.

Requires Improvement

Is the service safe?

All the staff had been trained to administer medicines and their competency in this area had been assessed when they started work and then annually. We saw records of this in individual staff files. The staff told us they knew how to administer medicines safely and what they would do if someone refused their medicines. They told us they would record this, report it to the main office and the next of kin would be informed. Therefore people using the service could be confident they would receive the support they needed to take their medicines.

People who used the service told us they thought there were enough staff. At the time of our inspection 102 care workers were employed by Mears Care Ealing. They were supported by four care coordinators, three visiting officers and the manager. The care coordinators told us there were enough staff to meet people's needs. They said that they covered staff absences with existing staff members and they felt there were enough staff employed. Some staff told us they were not always given enough time to travel between people they supported and therefore they were sometimes late for these visits.

People could be confident the agency was checking the suitability of the staff they employed.

We looked at the recruitment checks for eleven members of staff. These included references, criminal record checks, proof of identity, details about their previous employment, an interview and a literacy and numeracy test.

Requires Improvement

Is the service effective?

Our findings

The staff had not always received formal support or supervision to make sure they were carrying out their roles and responsibilities. Four of the 11 staff files we looked at had no recorded formal supervision meetings between the manager and member of staff during 2014 or 2015. Four of the other members of staff had only had one formal supervision meeting in this time. None of the staff had taken part in a formal appraisal of their work since 2013. Three members of staff had not been observed in the work place by a senior member of staff in the previous six months. There had been identified concerns about the performance of one of these members of staff.

We looked at the files for four members of staff where concerns had been identified with their performance, either through complaints, missing visits to people who used the service or another reason. Two of these staff had formal improvement plans. There was evidence that managers had monitored the staff performance and followed up concerns for one member of staff. There was no evidence the other member of staff's improvement plan had been monitored. There was no record of the concerns about staff performance or action taken to improve this for two of the members of staff. The formal supervision record for one member of staff identified concerns about the attitude and conduct of another member of staff. There was no evidence that this had been investigated or acted upon. Therefore people who used the service could not be confident that staff were properly supervised or supported or that performance concerns were acted upon. This put people at risk of inappropriate care and treatment.

The above evidence demonstrates that there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they thought most of the care workers had the skills and abilities to care for them. The staff received an induction when they started work. This included training in safeguarding, moving and handling, health and safety and medicines. New staff worked alongside experienced staff to learn about their role. Their competencies were assessed at the end of their induction and before they were able to work alone. We saw records of staff training and inductions. The staff received refresher training in some areas. The agency monitored this to make sure all staff received regular training updates. At the time of our inspection some staff needed to update training in safeguarding adults, medicines management and moving and handling as they had not had training in these areas for more than two years. However, the agency had arranged for them to attend refresher training. The staff told us they were given regular training opportunities. One member of staff told us about special training they had been given when they started supporting a young person. The manager said that she was arranging additional training for all staff in customer care and learning disabilities. Some staff were being supported by the organisation to undertake professional qualifications in care.

People told us they had been consulted about their care and treatment and they had consented to this. They told us the staff generally asked them for consent for and checked they were happy with the care they were providing. People's care plans and risk assessments had been signed by the person or there was a record of their verbal consent and a signature of their representative to confirm this.

The manager told us the agency was introducing a new capacity to consent form which they had been trained to use. She told us where people lacked capacity to consent the form outlined checks to ensure care was being provided in the person's best interest, including discussions with the person's next of kin, GP and other representatives. People's capacity to consent had been assessed by the local authority and was recorded in their care records.

The manager was aware of the agency's responsibilities under the Mental Capacity Act 2005. She told us all staff had been trained in this. She told us she was planning to refresh staff knowledge through a team discussion about capacity and consent. The staff were able to explain about consent and told us people were able to refuse care and treatment and they had to respect this.

People's nutritional needs were assessed and if they needed support with food this was recorded in their care plan. Most of the people we spoke with told us they did not require support with meals or they just needed staff to heat up meals. Some people said the staff did not have enough time or did not arrive on time to support them with cooked meals. One person told us, ''I asked them if I could sometimes have an egg and the carer said, 'I haven't got time to cook an egg'.'' Another person said, ''In my plan they are supposed to help with the cooking but they don't come when I cook.''

Requires Improvement

Is the service effective?

People's health care needs were recorded in their care plans. They told us they had the support they needed to meet these needs and see the health care professionals who cared for them. However, they said the agency was not involved in supporting them to meet these needs.

Good

Is the service caring?

Our findings

The majority of people told us they thought the staff were kind and caring. They said the staff respected their choices and allowed them freedom. They said their regular care workers were flexible. One person said, ''If I need to go to the doctor, they come earlier or later, they fit me in.'' Another person told us, ''The carers are very flexible, we agree changes of timings from both points of view.'' Another person said, ''They are quite flexible if I want any little extras doing.''

People liked their regular care workers. Some of the things they said were, ''They are very attentive, we totally rely on them'', ''She is a smasher, just like a sister'' and ''He likes his carer, when he had a fall the carer stayed with him.''

Most people told us the care workers were polite and friendly, that they listened to what they asked them to do. One person said, ''The carer just asks me what do I want her to do.'' Another person told us, ''They have respect for (the cared for person).'' And another person said, ''They do things I ask which is good.''

People told us their privacy and dignity was respected. Some of the things they said were, ''They always put a towel around her to protect her privacy'', ''they wait outside whilst I use the bathroom'', ''they close all the doors they are good at keeping things private'', ''they always knock before going into the bathroom and they encourage her to do as much for herself as she can'', ''my carer is very polite and thoughtful, she always closes the toilet door and waits'' and ''they always ask if it is ok to help me''.

Most people told us the care workers treated them with respect. Some of the things they said were, ''They are nice to her'', ''if they finish early they stay and have a chat'', ''good rapport'', ''always kind and very respectful'', ''they are nice and respectful to me'' and ''very caring''. However, some people were not always happy with the support they received. One person said, ''sometimes they talk to me like a child, it upsets me.'' Another person said, ''(the care worker) just sits there and reads the newspaper whilst I have my breakfast, we don't have a conversation and when he leaves he just walks out without saying goodbye.'' A third person told us, ''some are kind but others are not very nice, it's the way they talk to you, they bully.''

Some of the complaints the agency had received were about staff being rude or unkind. We spoke with the manager about this and the comments we had received. She told us that she had identified this as a problem with some of the staff. She said that she was arranging customer care training for all staff. She also told us she had asked the care coordinators to discuss this with all staff in their formal supervision meetings and she had discussed it at the recent team meeting. The care coordinators told us that concerns about some staff attitude had been identified and they were working with the staff to improve the way they communicated with people. One care coordinator told us she asked all her care workers to ''arrive at people's home with a smile, listen to them and apologise if they are late.'' Another care coordinator told us they were improving communication with people who used the service, asking them for regular feedback about the care workers.

Requires Improvement

Is the service responsive?

Our findings

People could not always be confident that their complaints were appropriately investigated and acted upon. The provider could not demonstrate they had learnt from complaints or taken action to prevent them from reoccurring.

We looked at the agency's record of six complaints for December 2014 and 2015. With the exception of one record, these did not include information about how the complaint had been investigated, what the outcome was and whether the complainant had been responded to. There was no evidence of written responses or apologies to any of the six complainants. One complaint related to a person being unhappy with their care worker. Although their care worker had been replaced there was no evidence of an investigation into why the person was unhappy or if the care worker had done something wrong. Therefore the agency was not able to demonstrate that they had learnt from this complaint and put in place measures to prevent this happening again.

We looked at the care files and staff records relating to two of the recorded complaints. There was no record of the complaint or what had happened in the care files for either of the people who had complained or the staff who were complained about. For example, one person had complained that their regular care worker arrived two hours late every week. The record of this complaint stated that the care worker said they were unable to visit before this time for personal reasons. The only recorded outcome of this complaint was to ''remind carer to arrive on time''. There was no information on what action had been taken, for example whether the person now received their visit at the correct time and whether any action was taken to discipline the staff. There was no record in the staff member's file to indicate whether the complaint had been discussed with them.

Another complaint had been made about an inappropriate way in which a care worker had spoken to a person. Apart from the initial statement from the person there was no other information about what action had been taken in the complaint record, the person's file or the staff member's file.

The above evidence demonstrates that there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

However, most of the people we spoke with told us they knew what to do if they had a concern and that these had been listened to and acted upon. People were happy with the response they had received to complaints and concerns. Some of the things people said were, ''they take my comments seriously'', ''I had a concern, they sorted it very quickly'', ''I had a problem with a carer, I reported it. The manager and supervisor visited and I was happy with the way they dealt with it'' and ''my brother complained and they apologised to us.''

People told us they have been involved in planning their own care and this met their needs. One person said, ''they are very efficient and caring.'' Another person said, ''I get a good service, they work hard.'' People told us they had a copy of their care plan. One person said, ''We did the care plan together and agreed to it.'' Another person told us, ''I have a copy and I have signed this.''

People told us their care was regularly reviewed and they were involved in this. Some of the things people said were, ''I was involved in planning my care originally, they review this every six months, I have a copy of my plan'', ''my daughter was involved and they have reviewed my care but they did not change anything, I have a copy of my care plan but it's hard to read'', ''they review my care every six months, we sit down and talk about it and they record any changes'', ''they visit me every six months and they put everything in the book''.

The care plans we viewed included assessments of people's needs including their health, personal care and social needs. Care plans gave staff instructions on how to meet people's individual needs. They included information on people's likes, preferences and dislikes. People had signed copies of their care plans. They had been reviewed every six months and people had signed these reviews.

The staff recorded the care they had provided in communication books. These indicated that staff had followed the care plans. However the records referred to ''the client'' or ''the service user'' and did not record the person's name. The records were a list of tasks and did not include any information about how the person felt,

Requires Improvement

Is the service responsive?

whether they were happy with the care provided or if they had any concerns. This meant it was hard to judge whether people had their social and emotional needs met as well as their physical and personal care needs.

Most people told us the staff arrived on time, stayed for the agreed length of time and did everything they were supposed to each visit. Some of the things they said were, ''overall they are pretty good, do everything as they should, they are very good at telling me if they are running late'', ''they may be a few minutes late but she rings me, she always stays the full half hour and does everything she should, I have a very good carer'', ''the regular ones are usually on time and they do everything they are supposed to'', ''they stay the time, they do everything, they don't rush'' and ''they arrive on time, do everything they should and a bit extra''. Some people said the staff were often late and they were not always told when this was the case. For example one person said, ''a lot of times they don't turn up, they warn us sometimes but not always.'' Another person told us, ''some carers are good, others are late its very inconsistent.''

Some people told us the agency always contacted them if there was a change in care worker or someone was running late. They said, ''they ring us if they are late, it doesn't happen often'' and ''the agency always advises me''. However, seven of the people we spoke with said that the agency did not tell them about changes of care workers or if someone was running late. Some of the things they said were, ''they don't ring me to say they are late, I don't know who is coming or what time, I have three different carers, its very unfair on an old lady'', ''they never tell me when they are late, it can be up to an hour late, and they don't advice of change of carers, I have taken this up with them but nothing has happened'', ''the care worker tells the office they will be late but the office don't tell me, they never tell me when the carer is changing'' and ''my regular carer rings me but none of the others do.''

We discussed some of these concerns with the manager and care coordinators. They told us they recognised that poor communication when care workers were late or when there was a change in care worker had been a problem. They said they were trying to improve the way they communicated changes and make sure they always contacted the person when there was a change. They told us they were monitoring this.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have an effective system to assess and monitor the quality of the service. Some of the incidents which had occurred, such as staff not attending visits, had not been properly investigated. There was no overall analysis of such incidents to determine what had gone wrong, to look at themes and trends and make improvements to the way in which care and treatment were provided as a result of reflecting on these. Not all complaints had been investigated and there was no evidence of learning from these to improve the way in which the service was run. Therefore the provider had not identified or managed the risks for people using the service.

The provider had asked people who used the service to complete a satisfaction survey in May 2014. Whilst the results of these were largely positive, 43% of respondents were not satisfied with the service and 46% of people said they did not feel safe. However, there was no analysis of these results or evidence that any action had been taken to address the concerns which had been identified.

The above evidence demonstrates that there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Most people told us they thought the agency provided a good service. One person told us, ''I think its brilliant.''

Another person said, ''it's a good service, they do well and work hard.'' The staff told us they felt supported and there was a positive and open culture. The staff told us they were happy with the way the service was managed. They said the manager was approachable.

The manager had been in post since November 2014. She had applied to be registered with CQC. Before taking up the post she had previously worked for other care agencies and had worked for some time in the quality monitoring department of Mears Care Limited. She knew the service well and had worked alongside the care coordinators in her previous role. The manager told us she had plans to develop the service. She had identified customer care and communication needed to be improved and had plans to support staff to better understand the importance of this. She also told us she planned to look at ways of supporting people to combat isolation and loneliness by making sure people who used the service had information, and if necessary arranging escorts and transport, to community facilities. She also wanted to improve communication with the staff by introducing a monthly newsletter and more regular team meetings.

The local authority contract monitoring officer told us the agency worked well with them, identifying concerns, investigating safeguarding alerts and responding to their requests. They told us they felt the agency was a good provider.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure each service user was protected against the risks of receiving care and treatment that was inappropriate or unsafe because they had not always planned and delivered care to ensure the welfare and safety of each service user. Regulation 9(1)(b)(ii)

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person had not made suitable arrangements to ensure persons employed were supported to enable them to deliver care and treatment to service users safely and to an appropriate standard because they had not provided appropriate supervision and appraisal. Regulation 23(1)(b)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have an effective system in place for identifying, receiving, handling and responding to complaints because they had not fully investigated or resolved the complaints they had received. Regulation 19(1)(c)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not protect service users against the risks of inappropriate and unsafe care and treatment because they did not have an effective system to assess and monitor the quality of the service or to identify, assess and manage the risks relating to health, welfare and safety of service users. Regulation 10(1)(a) and (b), (2)(b) and (c)