Mears Care Limited

Mears Care - Lincoln

Inspection report

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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?	**Good**

Overall summary

This inspection took place 11 November 2015 and was announced. Mears Care Lincoln provides personal care in people's homes to adults of all ages with a range of health care needs. When we undertook our inspection there were approximately 270 people using the service and the service was providing approximately 2500 hours of care a week.

At the time of our inspection 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.

Most people said they felt safe with the care they received from their regular carers but expressed concern that they did not have as much confidence in the relief carers. Staff had completed safeguarding training and had access to guidance. They were able to recognise if people were at risk and knew what action they should take.

Summary of findings

Where risks had been identified there were plans to manage them. effectively. Staff understood risks to people and followed guidance. Staff were alert to changes in people's usual presentation. They recorded incidents and reported them.

There was usually sufficient staff to provide people's care. Recruitment checks ensured that people were protected from the risk of being cared for by unsuitable staff. People's care was provided by staff who were sufficiently trained and supported.

People didn't always get their medicines on time. Staff undertook medicines training and were observed by senior staff when delivering care. Staff had received an induction when they started employment with the provider and completed further training relevant to people's needs and were supported to undertake professional qualifications. Systems were in place to support staff and monitor their work.

The provider mostly acted in accordance with the Mental Capacity Act 2005 (MCA), however it was not always clear where people lacked the capacity to consent to their care and what care was being provided in their best interests. People told us staff treated them with dignity and respect.

Care plans were updated regularly. People's needs in relation to nutrition and hydration were documented. Care plans were personalised and people were supported to maintain their choices.

Staff felt supported and the manager ensured people had information and support to make complaints. Where complaints were made they were investigated and actions taken in response. The majority of people told us there were good communications from the office and issues were usually resolved. People's feedback on the service was sought through a range of reviews. Staff were encouraged to speak with the office about any concerns they had about people's care.

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?
The service was not consistently safe.

Medicines were not consistently recorded. People did not always get their medicines on time.

There were sufficient staff.

Staff were aware of how to keep people safe. Risk assessments were completed and action plans were in place to manage the risk.

Requires improvement

Is the service effective?
The service was not consistently effective.

The provider the provider understood the requirements of the MCA however this was not always followed in practice.

People's health needs were not consistently recorded to enable staff to be able to respond to them.

Staff received regular supervision and training.

People had their nutritional needs met.

Requires improvement

Is the service caring?
The service was caring

Staff responded to people in a kind and sensitive manner.

People were involved in planning their care and able to make choices about how care was delivered.

People's privacy was respected and their dignity maintained by staff.

Good

Is the service responsive?
The service was not consistently responsive.

Care was not always provided at the time people requested.

Care plans were personalised but people were not always aware of their care plans.

The complaints procedure was available and people knew how to make a complaint.

Requires improvement

Is the service well-led?
The service was well led.

There were effective systems and processes in place to check the quality of care and improve the service.

Good

Summary of findings

Staff felt able to raise concerns.	

Mears Care - Lincoln

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 was planned to check 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 inspection took place on 11 November 2015 and was announced. Forty-eight hours' notice of the inspection was given to ensure that the people we needed to speak with were available. In particular we wanted to ensure that we were able to speak to staff who would otherwise be out providing care. The inspection team comprised 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 by experience had personal experience of community services.

During the inspection the inspector spoke with two care staff, the regional manager and the registered manager. We reviewed records which included 20 people's care plans, two staff recruitment files and records relating to the management of the service. Following the inspection we spoke with 15 people who used the service by telephone and three family members.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us that they felt safe with the care they received from their regular carers but that often they didn't have their regular carers. They told us that they didn't feel that the carers who were not their regular carers knew how to care for them. One person told us about an incident when the carers had not put a shower mat down before showering the person. The person had mobility problems and nearly fell as a consequence. On this occasion staff had not recognised the risk to the person. Risks to people had been assessed and identified in relation to areas such as safety, medicines, mobility and environment. We saw where people required specialist equipment to support them with their care, for example a specialist bed, this was detailed and any risk regarding the use of the equipment was highlighted. Where risks were noted there were plans in place to manage them and maintain people's safety. For example, a person was at risk of falls and this was recorded.

Two people we spoke with told us that they often got their medicines late because the carers were late. One person told us, "Most of the carers are wonderful but some are not. When they are late in the morning my medication is late and I have to have it before meals and don't think they are trained in well-being at all." Another person said, "I am very happy I rely on them for my Insulin and they are regular carers, a relief didn't turn up a few weeks ago."

We saw in the care records one person required their medicines to be given at a specific time in order for it to be effective and the medicine administration records (MARS) did not identify this. The person was at risk of not benefiting from the medicine. We reviewed people's MARS and saw staff had signed to say what medicine had been administered. If a medicine was not administered, the reason and any action taken as result was usually recorded.

However we saw in one record a code was being used and it was not clear from the documentation what the code meant. It was therefore not clear from the record whether or not a person had received their medicines. The provider's records medicine management policy did not include tis code which meant that staff were not consistently following this policy. Where people required support with their medicines we saw that they had agreed to this support and how it was to be provided for example, 'given from a blister pack'. Staff had completed medicines training which records confirmed and staff had access to the provider's medicines policy however despite this medicine's were not always managed effectively and records were not consistently clear.

Staff were able to demonstrate an understanding of their safeguarding responsibilities. People were kept safe as staff understood their role in relation to safeguarding procedures. The provider had identified potential safeguarding situations and reported them to the local authority, which records confirmed.

Staff said that there was usually enough time to provide care appropriately. Staff worked in teams and within each team there were senior staff to provide support and supervision to staff. Where people required two care staff to support them with their care this had been factored into the rotas. A staff member said there were office staff who managed staff rosters and there were sufficient staff to provide people's care.

Records demonstrated the provider had a robust staff recruitment process. Staff had undergone relevant recruitment checks as part of their application and these were documented. These included the provision of suitable references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires improvement

Is the service effective?

Our findings

Where people did not have the capacity to consent, the provider acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests. However it was not clear in three of the records which we looked at whether or not people had capacity to make decisions. We found that information about their ability to consent to care was conflicting and people were at risk of receiving care that was not in their best interests. We spoke with the registered manager about this who said that they would review their arrangements for assessing and recording mental capacity issues. Records detailed what care people had agreed to and what time people had requested their calls for. Documentation included consent to care and access to people's records if required. When we spoke with staff they were able to tell us what they would do if people did not consent to their care and were considered at risk.

People told us that they thought staff were well trained. One person said, "I couldn't wish for better care, the office are good the carers are well trained they manage the hoisting well, I have regular carers in the morning and sometimes they get sent elsewhere." A member of staff said, "The training is really good." A comment in a review record said, "Carers are very good."

People were cared for by staff who received an appropriate induction to their role. All the staff we spoke with told us they had received an induction and they had found this useful. A training plan was in place. The registered manager told us that staff who had transferred from other providers as part of the contract change were receiving update training to ensure that they had the skills to care for people. The training included first aid, food safety and medicines.

The registered manager told us they provided regular supervision for staff and also carried out spot checks on their practice. Staff we spoke with also told us that they had regular supervision and support. We saw records of regular supervision and spot checks which included discussions about people's performance and training needs. A system was in place for appraisal and the registered manager was in the process of planning appraisals for staff to ensure that the process included all new staff. Appraisals are important because they allow staff to review their progress and plan training to ensure that they have the skills to care for people.

Care records detailed what, if any support people required with their meals and contained clear information about their likes, dislikes and allergies. For example one person was allergic to potatoes and potato starch and this was clearly documented. Where people required specific support such as additional fluids to prevent urinary tract infections this was recorded and staff were aware. One person required additional snacks during the day and the record detailed this.

Staff liaised with other professionals regarding people's health needs, for example, the GP and district nurse. Care records included contact details of other professionals who were important to people. Where people had specific health issues the information was detailed however records did not include guidance for staff about how to monitor the issues and what to do if they were concerned about the person's wellbeing. For example one person was recorded as suffering from asthma but the record did not detail how to support them in the event of an asthma attack.

Good

Is the service caring?

Our findings

When we asked if staff were caring we received mixed responses from the people we spoke with. One person told us, “On the whole the carers are not bad, a lot have left as they don’t like the job or people. I prefer regular carers but sometimes just have to have various ones” and another said, “I am very happy my carers are brilliant and fantastic.” A telephone review record commented about the care, ‘could not get better.’

Staff told us that they tried to treat people as they would a family member and ensure that their choices were respected. They told us they were aware of the need for confidentiality and ensuring that the care records are maintained and regarded as people’s property.

One care record we looked at detailed how to support a person when they were anxious. The record said, “If I get upset or anxious I like my hand being held and reassurance.” People’s preferences about their care were recorded, for example a record said, ‘I would like the carer to assist me to dry thoroughly’ and ‘I would like my carer to bring to me a breakfast of my choice, usually toast. Please bring up to me in bed on a tray.’ Another record detailed how to support someone with their medicines and stated, ‘carer holds cup’.

Staff told us how they provided care to people who required more than one member of staff to support their needs for example where people required a hoist to assist them with their care. Care records explained clearly what support people required.

The registered manager told us that during the changes in the contract arrangements their priority was to ensure that people received their care. They said that they had also tried to ensure that people received the same staff to provide their care and that continuity for people was a priority.

Requires improvement

Is the service responsive?

Our findings

People's care records demonstrated their needs had been assessed prior to them being offered a service. The registered manager told us that people who had transferred to the service or were new to the service had their needs assessed. Some assessments were in the process of being completed. When we spoke with people they were not always aware of their care plan. Care plans when fully completed were detailed and personalised to support the person's care and treatment. For example, they documented people's life experiences so that staff had an understanding of people's interests and could chat with them about these. One record said, "I enjoy my art and used to enjoy travelling."

Where people were unable to communicate verbally records detailed how they preferred to communicate. For example one record said, "I am deaf but I can read lips if you speak clearly and face me."

We saw when the provider undertook reviews with people they recorded who people liked and wanted to provide their care and if they had a preference for a male or female carer. When we asked staff how they knew how to care for people they told us that they read the communication log which was kept in people's homes before providing care. They said that this was always updated and they found it a useful way to ensure that people received the appropriate care. They also told us that they were alerted to new people via their electronic system which would remind them to ensure that they were aware of people's care needs.

Staff told us that they felt there was usually sufficient time to provide care. They said that if they found people needed more time on a regular basis this would be discussed with managers and additional support negotiated. Staff also told us that if a person required more time immediately because they were unwell or upset they would provide this and inform the office of any delay to their next call.

However we saw in a quality review that people had raised issues about the time of calls. Three people we spoke with told us that they were unhappy with the times of their calls. One person told us that the calls were too early which meant that they had to go to bed before they were ready to do so.The registered manager told us that as part of the implementation of the revised contract they were reviewing everyone's care package and the times that their care was delivered to ensure that it met people's needs.

People were provided with information about the compliments and complaints procedure, in written format. Records showed all written complaints had been logged, investigated and where required action had been taken, for example, discussions with the person and their family and changes made to care. Complaints were reviewed on a monthly basis to identify any trends or patterns to ensure that these were addressed. People we spoke with gave us examples of when they had complained and changes had been made. For example one person told us that they had not got on with a member of staff and the provider had changed their arrangements to address this.

Good

Is the service well-led?

Our findings

The manager told us that the service had recently been awarded a new contract with the local authority and this had resulted in an increase in demand and in order to ensure that they met this the provider had appointed a member of staff who was responsible for recruitment within the region. The registered manager told us that this had increased recruitment. We saw from records that new staff had been successfully recruited and were in the process of being trained. The provider had an action plan in place to ensure that issues were addressed to facilitate a smooth transition. A member of staff told us that they thought that the changes had been introduced well.

In addition the registered manager had allocated two members of staff to carry out assessments on the new people who had been referred to the service following the award of the new contract. This meant that staff would be informed about people's care needs.

Systems and processes were in place to ensure that a quality service was provided. For example, there was an electronic system in place for training which monitored what training staff had received and flagged up when people were out of date with their training. Quality monitoring included telephone checks with people using the service and quality visits to ensure that people were happy with the service. The registered manager told us that they also checked all reviews in order to ensure issues were addressed and learnt from. The provider also had an electronic system in place for monitoring visits. They told us that they system flagged up if staff were late or had missed visits so that they could respond in a timely manner.

Five people we spoke with told us that they did not receive a rota and would like to have one so that they knew who was due to visit. An electronic system was in place to provide rotas on a weekly basis so that staff were aware of their workload the week beforehand however this was not being fully utilised at the time of our inspection. The registered manager told us that they would usually send out weekly rotas out to people so that they were aware of who would be providing their care. However they said that initially during the transition period this had not always been achieved.

Where staff worked alone they were provided with equipment and support mechanisms to keep them safe. The manager told us that they were keen to provide support to staff in their role. A system was also in place for staff when they were working at evenings and weekends so that they could get assistance and advice.

Staff told us that they felt able to raise concerns and were confident that these would be listened and responded to appropriately. One member of staff said, "I can always come in, always someone to speak to." Team meetings had been held in order to discuss the progress with the new contract. The registered manager told us that they were aiming to have monthly team meetings where they could discuss operational and training issues. Details of the whistleblowing policy were available to staff. People were supported by staff who were encouraged to raise issues.

People had been asked about their views of the service on a regular basis as part of their care reviews they told us that they knew how to raise a concern or make a complaint. People said they would contact the office and one person told us, "My regular carer is fine I did have problems but phoned the office and they replaced them."