Mears Care Limited

Mears Care - Richmond

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced inspection of Mears Care – Richmond on 6 and 7 August 2018. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

Mears Care – Richmond is a domiciliary care agency providing personal care and support to people living in their own homes within the London Borough of Richmond upon Thames. The majority of people had their care funded and organised by the local authority. They also provided short term care and support alongside the treatment and support provided by the health authority to people moving back home after an accident, hospital admission or operation. This type of support is known as reablement and is designed to help people to regain skills and confidence so that they can return as far as possible to the lifestyle they had previously. The number of people who used the service changed regularly because the agency was one of the main providers used by the local authority

Until just before the inspection this service also provided care and support for people living within two extra care schemes in the borough as part of their contract with the local authority. These two extra care schemes have been registered as a separate location from 10 August 2018 so the care provided was no longer managed by Mears Care - Richmond. At the time of the inspection the agency was delivering an average of 6500 visits per week of around 2600 hours of support for approximately 469 people. Not everyone using Mears Care - Richmond receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. Mears Care Limited is a national organisation and has branches in different counties and London boroughs. The Mears Care - Richmond branch was based in an office with a number of other branches.

We previously inspected the service on 18 July 2017 where we rated it requires improvement in the key questions of 'is the service safe? 'is the service responsive?' and 'is the service well-led?' as well as overall. The key questions of Effective and Caring were rated good.

At the time of the inspection the registered manager had left the service four weeks earlier and a new manager had started at the service the week before the inspection. The new manager was in the process of applying to become registered with the CQC when the inspection was undertaken. 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.

People were not receiving care which met their assessed needs because the provider was not deploying care workers to ensure that visits took place at the stated times and care workers stayed for the agreed length of time.

The provider had a policy for the management of medicines but care workers were not always provided with guidance on how to administer people's medicines and records were not always completed clearly.

Risk management plans were not in place where specific issues had been identified to provide care workers with the information to enable them to mitigate these risks when providing care.

We have made a recommendation in relation to the recruitment process which not robust as information had not been recorded and appropriate references were not always in place before assessing applicants' suitability for the role.

The provider had a procedure to assess a person's mental capacity to consent and make decisions about their care but this was not always completed in a way that ensured people's care was provided in line with the principles of the Mental Capacity Act 2005.

People's care plans did not include the person's wishes about how they wanted their care provided as they were focused on care tasks. Records did not provide up to date information relating to people's care needs.

The provider had a range of audits in place but some of them were not effective and did not provide appropriate information to enable them to identify any issues with the service and take action to make improvements.

People using the service told us they felt safe when they received support from care workers in their own home.

Care workers completed training the provider had identified as mandatory and where this was overdue the manager had arranged for the relevant training to be provided. Care workers told us they felt supported by their manager.

People felt the care workers were kind, caring and treated them with respect when providing care.

People told us they knew how to raise a complaint but these were not always responded to in line with the provider's policy but this was being reviewed by the manager.

People were able to provide feedback on the quality of the care and support they received which was acted on by the provider.

We found six breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person centred care (Regulation 9), need for consent (Regulation 11), safe care and treatment of people using the service (Regulation 12), good governance of the service (Regulation 17) and staffing (Regulation 18). You can see what action we told the provider to take at the back 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?

Requires Improvement

Some aspects of the service were not safe.

People were not receiving care which met their assessed needs because the provider was not deploying care workers to ensure that visits took place at the stated times and care workers stayed for the agreed length of time.

The provider did not ensure medicines were managed safely.

Risk management plans were not in place for specific issues to provide care workers with the necessary information to enable them to mitigate these risks when providing care.

The recruitment process was not robust as information had not been recorded and appropriate references were not always in place before assessing applicants' suitability for the role.

People felt safe when they received support from care workers.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider did not have arrangements to ensure people had maximum choice and control of their lives and that staff support was not restrictive.

Care workers had completed the Care Certificate and the training identified as mandatory by the provider.

People's nutritional needs, if they required support from care workers and any food preferences were identified in the care plan.

An assessment of the person's care needs was completed before support visits were started.

Care plans included the contact details of healthcare professionals involved in supporting the person to have healthy life.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not ensure visits were always carried out at the agreed time or for the agreed length of time which could have an impact of the person's quality of life so therefore this did not care for people.

People felt the care workers were kind, caring and treated them with dignity and respect when providing care.

Care plans included information on the person's religious and cultural beliefs.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans did not identify their wishes as to how they wanted their care provided and the records were task focused and not person centred.

Information in care plans was not always up to date or accurate in relation to the person's care needs.

People told us they knew how to raise a complaint but these were not always responded to in line with the provider's policy but this was being reviewed by the manager.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had audits and other checks in place but these were not effective as they did not identify areas where improvement was required so the provider could address these

People were supported to provide feedback on the quality of the care they received and this was acted on.

The manager said they met regularly with the local authority to review their performance and discuss any issues identified in relation to how the care was being provided.

Mears Care - Richmond

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 the 6 and 7 August 2018 and was announced. The provider was given two days' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

Two inspectors undertook the inspection and an expert-by-experience carried out telephone interviews of people who used the service and relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for older people.

Prior to the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports. Registered providers need to send notifications to the CQC about certain changes, events and incidents that affect the service or the people who use it.

During the inspection we spoke with the manager, regional director, field coordinators, one care worker and reablement coordinator. We reviewed the care records for five people receiving reablement support, care plans for 10 people receiving the home care service, the visit summary records, the employment folders for nine care workers, training records for all staff, the visit rotas for one day and records relating to the management of the service. The expert by experience contacted five people who used the service and one relative by telephone. We sent emails for feedback to 97 care workers and received comments from 12.

Requires Improvement

Is the service safe?

Our findings

People were not receiving care which met their assessed needs because the provider was not appropriately deploying care workers to ensure that visits took place at the stated times and care workers stayed for the agreed length of time.

People we spoke with said they had experienced issues with care workers not arriving when planned. Their comments included "They arrive mostly on time; sometimes they're an hour late and they don't let me know if they're running late", "The regulars are on time and let me know if they're running late. The new ones aren't so good at timekeeping" and "No they don't. It's the worst of all the problems. There's no communication between the carers and the office; I'm forever ringing to see when they're coming. They only get five minutes travel in between each job. They have no chance of keeping to any time scale. When you call to ask when they will be here, they give a time, but never keep to it. It's all over the shop. You agree the time when you set up the care package, but it doesn't happen. It affects my day; you don't know what time to get up; I'm playing the waiting game; it's a major problem and needs to be addressed. They have been one and a half hours late." Two people we spoke with told us the care workers arrived when planned and they were contacted when the visit was going to be late.

We also spoke with a relative and they explained their family member had commitments in the morning which meant they required their visit at the agreed time. They said care workers frequently arrived later than scheduled and they do not always receive a call to let them know in advance, "Their timekeeping is not ideal. Timekeeping is now consistently late. 50% of the time they let us know they're running late from the office; other times we get no call at all." The relative also commented "We have said to Mears we are very happy to have a trainee care worker [recently recruited care worker] as a double up with an experienced care worker; we're not happy to have two trainees. My family member's needs are quite complex, so if a trainee comes, it must be with a carer who is very experienced about my [relative's] care requirements. My family member can give detailed instructions. "

We also asked people if the care workers stayed for the full length of the agreed visit and we received mixed feedback with some people confirming the visits were for the full time or longer while other people felt the visits were shorter than planned. The comments included "Yes, they stay the full allocated time; in fact, quite often, they stay over their time" and "They don't stay the full time. Sometimes it does have an impact on me."

Care workers told us they usually had enough time but this could vary. They said that if they felt there was not enough time to complete all the care activities required during a visit they would contact the office so the visit time could be reviewed. One care worker told us "I have enough time to complete all the tasks during a visit. If I have a new service user it will take more time. Sometimes is not enough time to finish the task. Some service users expecting more from us. Now most of the personal care reduced from one hour to 45 minutes. It's very difficult personal care, food preparation, feeding, medication. Not enough time for me. If I visit the same service users daily no problem. New calls are difficult to finish in time."

Care workers we spoke with told us usually they have enough travel time but it can vary as sometimes it takes longer to travel between visits than the time allocated or there are issues with traffic. The comments included "I have car. I will manage. I have enough time to visit. If any new coordinators book the rota, they don't know the places,'' and "I have, but sometimes I don't have enough time, transport problems, traffic, next visit is too far destination."

The electronic call monitoring system (ECMS) was used by care workers who used the telephone to record the time they arrived and left the person's home for each visit. During the inspection we reviewed the ECMS records for all the visits carried out on 25 July 2018.

We saw the records for four people which indicated they required two care workers to attend each visit to provide support to meet their needs. The records showed the care workers arrived at different times and were not in the person's home at the same time. For example, one person had a 30-minute visit scheduled on the rota between 4.10pm to 4.40pm with two care workers which included support with personal care. The record showed one care worker had logged a visit between 4pm and 4.22pm with the second care worker logging in between 4.22pm and 4.36pm. The records for another person showed a 45-minute visit was scheduled between 11.35am and 12.10pm but one care worker logged the visit between 10.35am and 10.54am and the second care worker logged their visit between 11.21am and 11.36am.

This meant the two care workers were not available at the same time to provide safe and appropriate support to meet the person's care needs. In addition, the care workers did not stay for the agreed length of time for the scheduled visit.

The ECMS records also identified many visits had occurred more than 45 minutes earlier or later than indicated on the rota. For example, we saw one person was living with a medical condition which required medicines to be administered within 30 minutes of a specific time. We saw visits were not occurring within the specified time period to enable the medicines to be administered as prescribed. Records indicated a complaint had been raised in relation to this as, the care workers were arriving outside of the time period, which meant the person was not receiving their medicines as planned.

The ECMS records showed the total time each person should have per day for planned visits and we saw a large number of people were not receiving the full amount of time. This included incidents where calls lasted only 11 minutes of a planned 30-minute visit. We saw the total visiting time for 16 people on the 25 July 2018 was less than 50% of what was scheduled. This was due to care workers not completing the full visit time for example, the records for one person showed they were scheduled to have visits totalling five hours 30 minutes on 25 July 2018 but the record showed care workers only recorded a total of two hours and 30 minutes of logged visits that day. The record for another person indicated they should be visited for a total of five hours but care workers logged two hours 39 minutes.

We discussed this with the manager who explained that due to the requirement for the provider to accept all new care package referral from the local authority there were issues with deploying enough care workers. The manager told us the focus was ensuring people received the agreed number of visit per day but this did result in visits occurring either earlier or later than agreed or being shorter then scheduled.

This meant the provider was unable to deploy care workers in such a way as to meet the care needs and wishes of the people using the service in relation to how they wanted their care provided.

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

The provider did not ensure the safe and proper management of medicines. Medicine administration record (MAR) charts were not always completed clearly and the audits of the charts did not always identify issues with how medicines were recorded. We saw recent MAR charts had not been audited as they had not been collected from people's homes to ensure medicines had been administered as prescribed and safely.

MAR charts were often difficult to read with information being written over and crossed out. This meant that the details of administration were not clear. The MAR charts for two people, which we viewed, included gaps where no administration had been recorded.

The local authority referral for one person indicated that some of their medicines were time specific for administration which meant they had to be administered at strict timescales during the day. This information was not included in the medicines administration authorisation, the risk assessment, care plan or the MAR charts so care workers were made aware of the importance of visiting the person at the agreed time.

Where a medicine or cream had been prescribed to be given as and when required (PRN) there was no guidance for the care workers in relation to how and when it should be administered. For example, one person was prescribed a cream to be applied when required but there was no guidance in the care plan or medicines authorisation to identify when it should be applied and to which parts of the body.

The provider had a general risk assessment in place which included moving and handling, medicines management and the home environment. Where an issue had been identified during the initial assessment process a risk management plan had not been developed and guidance was not provided for care workers as to how to reduce the risk. We saw people were living with a range of issues which included diabetes, asthma, use of a catheter, increased risk of skin breakdown due to incontinence and a degenerative disease, but there was limited information on the possible risks associated with their medical condition and how care workers could reduce those risks.

The above shows that risks to people's health and wellbeing were not always identified and appropriately managed or planned for.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had a recruitment policy and procedure in place but this was not always followed. The policy stated a minimum of two references should be requested, one of which must be from the applicant's most recent employer. If the applicant was previously employed in social care a reference should be obtained from that provider. During the inspection we looked at the recruitment records for care workers who had recently started work for Mears Care Richmond.

A form was used to record the interview process and assess the applicants current experience and knowledge by asking competency based questions but these were not always completed in full. For example, the employment history records for one care worker indicated they had a two-year gap in their employment but the section related this in the interview notes had not been completed so there was no record that this was discussed and the reason was not noted.

The recruitment records for another care worker included an application form which had not been completed in full as section relating to employment history and education record had been left blank. The

competency questions used as part of the interview had not been completed in the interview record document. We saw three references had been requested for this applicant but two were character references from former colleagues. The third reference indicated it had been completed by a previous employer but the name of this employer had not been recorded and what role the applicant had undertaken. This means the recruitment process did not follow the provider's process to ensure they had appropriate information to assess the suitability and knowledge of the applicant to carry out the care worker role in a safe manner.

We recommend the provider review their recruitment processes in line with national guidance on the safe recruitment of care staff.

There was an active recruitment campaign underway and the manager confirmed staff visited local job centres regularly as well as working with other home care agencies to have enough care workers available.

During the inspection we looked at the records for incidents and accidents that had occurred when care was being provided. The folder containing the forms included a clear description of the process the provider had put in place. This included the manager to complete the incident and accident form, add the information to the computer database within 48 hours of the report being made followed by a detailed investigation as necessary and record on the care communication log.

We saw eight completed forms in file from February 2018 and June 2018. We saw the forms had been completed to include a description of the accident/incident and dated but no evidence of investigation or follow up actions. We looked at one form referred to as a medicines error where a person had received medicines which should be administered at different times of the day at the same time. The manager explained that when this had been investigated it was found that the medicines had not been administered at the same time but the person had chosen to have their medicines prepared in advance for them to take later. The records indicated the person had the capacity to make decisions about their medicines. The incident and accident record did not include the investigation or the outcome to show this was not an incident and accident. We discussed this with the manager who explained the computer records had been updated but these had not been included on the original form but this would be reviewed.

People we spoke with told us they felt safe when they received care in their home. Their comments included "I feel safe definitely. They always make sure the doors are locked and shut; just generally I feel safe with them", "I feel very safe. They're very good quality people. They're caring and helpful", "I feel very safe; they know what they're doing", "I feel very safe. They're very good to me and they look after me. I can trust them. They've never done anything to upset me" and "I do. They're caring people; I've never felt threatened in anyway." A relative we spoke with told us they felt their relative was safe when they received care. The provider had a procedure in place to investigate and respond to concerns regarding the care provided. During the inspection we looked at the records for five incidents which had been raised as safeguarding concerns with the local authority. Information in relation to any investigation, the outcome and any actions to reduce the risk of reoccurrence were recorded appropriately.

Care workers were provided with personal protective equipment for example gloves and aprons to be used when providing care. Infection control training was also part of the mandatory training identified by the provider and records showed this had been completed by carer workers.

Requires Improvement

Is the service effective?

Our findings

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 checked whether the service was working within the principles of the MCA.

The provider had a procedure in place to assess a person's capacity to consent and make decisions about their care but it was not always completed in line with the principles of the Act.

We saw a mental capacity assessment had been completed for one person who was living with a degenerative condition. The staff member completing the assessment felt they were unable to access the person's capacity as the person could not communicate verbally. The form stated that the person did appear happy to accept and receive the care to be provided. There was a question on the from relating to the person being able to retain information relevant to the decision but the staff member had recorded that as the person could not communicate verbally and was unable to write as they could not hold a pen they could not establish the person's capacity. The use of a pen or being able to communicate verbally does not indicate a person's capacity to consent to care. The MCA code of practice does ask if the person could communicate their decision but does not specify this as needing to be verbally or in writing. The person should be supported to communicate their consent to care in the most suitable method.

In addition, we saw a best interests form had been completed for this person and it indicated a friend had consented to the person's care plan and risk assessments to enable the care to be provided. As the staff member was unable to establish if the person could consent to care but had identified the person had indicated they were happy with the care to be provided non-verbally there was no indication that a best interests decision was required.

The assessment for another person indicated the person was able to understand, retain and use the information provided in relation to the planned care, and that they, therefore, had the capacity to consent to their care. We saw a best interests form had also been completed on behalf of this person in which their relative had been asked to agree that the care plan was in the person's best interests. As the person had been assessed as having the capacity to consent to the care plan there was no need for a best interests decision to be made on behalf of the person.

The mental capacity assessments for some people which had been carried out by the provider did not include information about specific decisions and were recorded as 'consent to care via the completion of an individual support plan and risk assessment'. This has not accounted that a person's capacity to consent

can vary depending on the complexity of the information and decision for example a person could make decisions in relation to personal care and food but not in relation to the administration of medicines. The assessments did not indicate if the person was able to consent to specific aspects of the care being provided. The care plans and other documents did not indicate how care workers should support people in making decisions related to specific areas of care.

This meant people were not supported to consent to their care whenever possible in line with the principles of the MCA.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people if they felt the care workers who supported them had received enough training to provide the care they needed. We received a range of comments but most people felt the long-term care workers had the training required but raised concerns relating to new care workers. Their comments included "On the whole I would say yes. When I needed a hoist, they know how to use it safely", "Difficult to say. They don't have to do much for me. For what they do, they seem to know what they're doing", "Not that I know of. On the whole, the long-term carers are good, but the ones that arrive out of the blue, not so much" and "Yes, I do; they know what they're doing. The come and do what is necessary. The new ones aren't as skilled."

Care workers we spoke with told us they felt they understood their role and had received enough training to enable them to carry the role. Comments included "Yes, I feel confident and I believe to be able to handle any situation might occur. I have been working in the field for more than two years" and "Yes, I get a lot of supports from the office and I think I 'm working well."

Care workers completed annual refresher training courses which included moving and handling, safeguarding, medicines management and health and safety. There was also training every two years which included mental health, dementia, infection control and nutrition. The manager explained they had reviewed the current training records and had identified all the care workers who had training courses which were overdue. They had scheduled these care workers to complete all the outstanding courses as soon as possible and we saw the records showing the planned training.

New care workers also completed the Care Certificate during their 12-week probation period. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

The manager explained new care workers would complete a number of shifts shadowing an experienced care worker and then having their competency assessed but there were no records of these assessments. The manager provided records to show the care workers had been paid for completing their shadowing shifts but there were no records to show they had been assessed as having the knowledge and required skills for the care worker role. This was discussed with the manager who confirmed they would review how the competency of new care workers was recorded.

During the inspection we reviewed the staff records for four care workers who had been employed for more than a year and we saw records did not always indicate they had completed regular supervision with their line manager. A range of supervisions were in place which included face to face meetings and observed practice. The records for one care worker showed there had been an observed practice visit in April 2018 but their most recent supervision and appraisal was in March 2017. Care workers we spoke with confirmed they had regular supervisions with their line manager and they felt supported. Their comments included "Yes, my

manager always helps me" and "We have got a new manager right now. I was feeling supported and considered by my previous manager who left the company." We discussed this with the manager who confirmed supervisions and appraisal were undertaken but may not always be recorded and they would now ensure records were taken of these meetings.

The local authority provided a referral document which included information regarding the person's support needs, medical history and personal history. The field coordinator would then visit the person to review and assess the person's needs and complete the care plan and risk assessment with the original left in the person's home and a copy taken to the office. If there were any issues identified with the meant the planned care package did not meet the person's support needs or of the provider could not meet the person's support needs the local authority would be contacted to review the referral.

The care plans identified if the person required support from care workers to prepare and/or eat their meals. We saw the care plans indicated the care workers should provide the person with a meal and drink of their choice, but no information was available in the care records on people's specific preferences. Care workers confirmed they had completed food hygiene training which included food preparation, preventing cross contamination between raw and cooked food and infection control to ensure they could engage in meals preparation safely.

We saw the care plan included the contact details for the person's GP and any other healthcare professional involved in their care. The local authority referral provided an overview of the person's medical history and there was a section for information on medical conditions in the assessment which was completed.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care received and they felt care workers were kind and caring. One person stated they were happy with the care workers but not the way the service was managed. The comments we received included "Yes, I do. As mentioned before, I just feel safe with them; I'm happy", "On the whole, yes; they know what they're doing", "Yes, I am. They're very good to me and they look after me. I can trust them. They've never done anything to upset me" and "I'm a lot more pleased with the carers when they come; not so pleased with the way it is managed." A relative commented "Currently, we are blessed with experienced carers who come, who are great, fine and absolutely charming" but they told us they were not happy with how the care workers were allocated with problems relating to having visits cancelled if only one of the two care workers scheduled to visit was available instead of sending one care worker with the relative providing additional assistance.

Notwithstanding the feedback we received from people using the service that the care workers who provided their care treated them in a kind and caring manner there were aspects of the care that were not caring and which did not demonstrate respect for people's needs, choices and rights. We saw that people were not always supported to make decisions about their care and support in that appropriate methods were not explored to communicate with people who could not communicate verbally or in writing to ascertain their views. we saw the provider had also not always ensured that visits were carried out at the agreed time or for the agreed length of time. This could have an impact of the person's quality of life and plans for the day, particularly where the visits might have been time sensitive.

We asked people if they were visited by regular care workers or if there were regular changes in who provided care. Some people confirmed they were not always allocated the same care workers so they could build and maintain a caring relationship with their care workers. Their comments included "They change very often and I'm not very happy about that along with the timing issues" and "They change, not often, but they do change. I would rather have the same ones; you get used to each other; when they change carers, it's not too much of a problem, but I would prefer the same carers each time." Other people accepted that care workers changed. Their comments included "Carers change about once a month; I'm quite happy with that", "Sometimes I get different carers". "At the moment I have regular carers. Only time I get different carers is to cover holidays and sickness",

People we spoke with told us the care workers treated them with dignity and respect when they provided care. A relative commented "Yes they do. Understandably, we think the carers often are overworked and (I stress), on occasion, they can be stressed, but most days they are absolutely fine and professional." We asked care workers how they provided care for people which maintained their dignity and respect. Care workers told us they ensured people received personal care in such a way that reduced the time they were uncovered, ask how they wanted the care provided and if they were happy for them to continue as well as closing doors and curtains when necessary. One care worker told us "To maintain, assure people dignity during a strip-wash, bed-wash or assisting to shower a service user I use bath towels to cover them, it does avoid feeling too expose. Regarding their privacy I am careful not to invade their space, I am also careful with the handling of the information given or written records."

People we spoke with told us care workers helped them maintain their independence by the way the care was provided. Their comments included "Yes they do. They ask if I want to go for walks, and generally encourage me to be more active", "They help me to do what I can; depends on how I am feeling" and "Yes it does; there's certain things I can't do and they do it for me." A relative also commented "Completely, my family member is quite severely disabled and would spend the whole daytime in bed if there were no carers."

Care workers were provided with a range of information relating to the background of the people they were supporting. The care plans identified if the person had any cultural and religious requirements that may impact on the way their care should be provided. The care plans also identified if the person was involved in any social organisations and details about their family and friends who were important to them. Information on their personal history, links to the local area and any hobbies was also included in the care plans. □

Requires Improvement

Is the service responsive?

Our findings

The care plans for people who received care in their homes from Mears Care Richmond were sometimes focused on the care tasks to be completed and not the wishes of each person as to how they wanted their care provided. For example, the care plan for one person identified the support care workers should provide for an afternoon visit was "Support worker to supervise toileting, change pads. Please get ready meal from freezer and put into microwave." The guidance for care workers did not identify how the person preferred their care to be provided but was a list of the care activities to be completed during each visit.

We looked at the records for five people who were receiving reablement support and we saw all the files contained the Richmond Reablement Response Team (RRRT) initial support and rehabilitation plan. All stated preliminary package of only a week and there was no indication of if or how long this would be extended as no reviews were documented. The folders also contained the care plan documents used for people receiving home care and these were also task focused. There were no records in the folders we looked at relating to a review of the person's progress during the reablement process. The daily records of each visit were used to identify any improvements or areas where the person required additional support but a reablement coordinator confirmed that this documentation along with a weekly progress report was in the person's homes. There had been no review of this information and no documentation had been brought to the office. All communication with the reablement coordinator had been verbal for example we saw one person had been transferred from the reablement service to home care but their records had not been updated to reflect this.

The care plan records we looked at did not provide accurate information in relation to people's care needs. The needs assessment form for one person identified they were living with a degenerative medical condition which could impact on how their care was provided but this information had not been recorded in the care plan. Therefore, information on how care workers should provide care to meet the possible changing care needs was not provided.

The information provided by the local authority for another person receiving care indicated that care workers needed to use a thickener powder when providing drinks and other fluids. We reviewed the needs assessment and care plans and we saw this was not mentioned in the guidance provided for care workers. We checked this with a field supervisor who explained that during the assessment of the person's care needs they were not made aware of any need to thicken fluids for the person. Before the end of the inspection the field supervisor confirmed they had checked with the person's relative and thickening powder was not required. This information had not been noted from the initial local authority referral and checked as part of the needs assessment. This meant the person could have been at risk of receiving inappropriate care because information about their care had not been fully considered and addressed. The provider later wrote to us to tell us that this was an error in the recording document and that the person was not at risk of choking.

The care plan and medicines administration authorisation form for one person indicated the care worker should assist with medicines but it also stated the care worker was responsible for the administration of all

the medicines. The care needs and risk assessment document as well as the care plan also indicated the care worker should administer all medicines. The daily records of visits completed by care workers indicated the person either had their medicines administered or prompted by a care worker, administered by a family member or self-administered but there was no consistency in how the medicines were administered. This meant the care workers were not provided with clear information in relation to how the person should be supported with their medicines to ensure they were taken as prescribed.

Mears Care had a policy on people's end of life care. The manager also confirmed that people would be supported by the care workers should they develop end of life care needs and wanted to stay in their homes. The care plans of people did not include any information to identify the person's wishes in relation to their end of life care needs.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with confirmed they knew how to raise a complaint in relation to the care provided. People told us they would contact the provider or the local authority if they had any concerns and where a person had raised a complaint it had been resolved. Their comments included "I would call head office. I've made a complaint about one person. It was resolved to my satisfaction" and "I would call the agency. So far, never had to make a complaint." A relative told us they had not made a formal complaint yet but they had raised concerns verbally. They explained that when they raised questions in relation to visits being made on time by the two care workers allocated to the double-up visit, they felt the provider had "had negative answers to our questions."

The provider had a procedure in place to respond to complaints and a flow chart identified this process. The complaints made to the local authority against the provider, were passed to the service and the process required an acknowledgement to be sent within 24 hours of receipt of the complaint. Then, following an investigation, the final response would be sent to the local authority with the outcome of the findings. We looked at complaints records and we saw they were not always investigated and information on the outcome sent to the complainant. We raised this with the manager who confirmed they would be reviewing the management of complaints to ensure the provider's procedure was followed.

People were given copies of their care plans, assessments and information about the agency, which they kept at their homes. We asked people if they had been involved in decisions about the care they received. Two people told us they had been involved in a review and they said, "They come to see me once a year for a review" and "I was at the beginning; they come and do a review every so often." Three other people told us they had not been involved and their comments included "Since the care has taken place, I've not had any further consultation on the care provided nor have I been asked for input" and "No, I'm not." A relative confirmed they had been involved in decisions. The manager confirmed people were visited as part of the development of the care plan and the person and/or their relatives were involved in making decisions about their care.

People, overall, told us the care workers completed the care activities which were indicated as part of the care package. Their comments included "Yes they do. Sometimes they go above and beyond" and "Yes, they do. Sometimes I have to ask them to do it, but if I ask they do it". One person did comment "Not always, no; sometimes they're not here long enough. I think they should stay their full time."

The regional manager and the manager explained they were in the process of implementing a new computer system. This would provide care workers with access to people's care plans, risk assessment and

be able to record details of each visit in real time by using a portable device. This would enable the office to monitor each visit and identify any changes in a person's support needs or any issues almost immediately so these could be addressed promptly.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have effective systems and processes to identify, monitor and improve the quality of the service provided or to assess, monitor and mitigate risks that people might face. During the inspection we found audits were in place but these did not provide appropriate information to assist in the identification of areas which required improvement so that these could be addressed.

An audit had been carried out to review the care plans and other records for people using the service. We saw forms had been completed identifying if the care plan had been completed in the previous year, if the care plan was person centred and had been signed by the person. These audits did not identify if the information recorded in the care plans and risk assessments was accurate and consistent to ensure care workers had up to date guidance on people's care needs.

The MAR chart audits did not always identify when the records had not been completed accurately and clearly. We saw MAR chart audits had not identified errors in the recording of medicines. For example, the MAR chart audit for May 2018 for one person stated there were no issues about the MAR chart. However, there were some days where there was no record to show where medicines had been administered. The April 2018 MAR audit for the same person stated there were no issues with recording but the MAR chart had been completed in pencil on some days. Also, records had shown the GP had administered the medicines on 17 April but the care worker had signed the MAR chart stating they had administered the person's medicines. We saw copies of letters which had been sent to care workers where issues with completing a MAR chart had been identified during an audit but there was no record of any checks after this to ensure the MAR charts were now being completed accurately. This meant the provider could not ensure medicines were being administered and recorded correctly.

People were supported to provide feedback on the quality of the care they received from care workers. The engagement officer explained each person using the service was contacted every six months either by visiting then or by telephone to ask their comments on the care they received. If the care records indicated the person was unable to respond a relative would be contacted instead. A form was completed with their feedback and the engagement officer explained if any concerns or issues were identified the information would be discussed with the field coordinator. A service concern record would also be completed and information about any actions taken would be recorded on the computer system. We identified that no record was made on the feedback form to indicate an issue had been identified and responded to in line with the process. This meant it was not clear if the concern or issues had been dealt with. We discussed this with the engagement officer who confirmed they would review how it was recorded on the feedback form to indicate any issues had been responded to.

The provider's systems for mitigating risks and improving the quality of the service were not always effective. For example, the provider had received contact from a person's landlord to say that their living environment was not safe and that they may benefit from a cleaning service. The provider had not taken any action to refer the person to the local authority so they could assess this need and had responded that the care package for this person did not include domestic support. This meant that they had not effectively mitigated

risks which they had been made aware of. In another example, a person's morning visit had not taken place until 11am and the person had been found in soiled bedding. This was bought to the attention of the provider by the local authority as a service concern. There was no evidence the provider had acted to prevent the reoccurrence of this.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people if they felt the service was well-led. Two people told us they felt it was well run and the care workers were good while three other people identified issues with the way the service was run. Their comments included "I think the carers are very good", "Very well run", "Yes I do. I've no complaints so far, apart from the changing of carers" and "No I don't. The Office are not up to scratch. It's all about sending different carers and them not staying the full time". A relative told us "The front-line carers are generally speaking all fine; it's the administration that is the concern. We know our team of carers and we think that Mears now has got the whole of the local authority's business, we understand they have to do all of them which means more and more work, and the carers are struggling."

When we asked care workers if they felt the service was well led they told us there had been improvements but they identified the current requirement from the local authority to accept all care package referrals as an area of concern. Some of their comments included "[The service is well led] but I think needs improvement", "It is sensible that Mears should not have the obligation to take new clients if they do not have the capacity to deliver the services with enough number of carers", "To me being a carer is something I do for love and not for the wages. I feel the pressure working until late and weekends because the high demand of work and there is never going to be enough carers if it is no limit to new clients coming" and "Yes [the service is well led] and it has improved. Key point I have noticed, lots of care workers have been allocated to specific area rather than being constantly send from one area to another. It generates efficiency. They are patient to support any issues, all this is only one phone call away."

We also asked care workers what they felt about the culture of the organisation and if it was fair and open. They told us "I see it as an office team doing their best to cover people needs with the care workers availabilities and all the responsibilities it carries to everyone", "Very friendly place to work. I am very happy and very proud to work with the organisation. Nearly 10 years I am working with this organisation. It is fair and open."

People told us they knew who to contact at the office if they had a question about the care provided. In general, we were also told by people using the service that the information they received from the provider was generally clear but two people did tell us they did not receive any information from the care provider. The service user guide was given to all people when they started to receive care from the service. The guide included information on the aims and objectives of the organisation, how care was planned and provided, how to get documents translated and the complaints process.

The manager had scheduled regular meetings with care workers, visiting officers and care coordinators. A monthly newsletter was also sent to staff which included ECMS compliance and opportunities for training. The provider had a care worker of the month scheme to identify and reward good practice. Existing care workers could also receive an incentive payment if they introduce new care workers to the service to help build the staff pool.

The manager told us they met regularly with the local authority to review their performance and discuss the care being provided and to identify any areas which needed to be improved.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met their needs, reflected their preferences and was designed to meet people's needs by following healthcare professional advice. Regulation 9 (1) (a) (b) (c),(3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 for service users who were 16 or over and were unable to give consent because they lacked the mental capacity to do so. Regulation 11 (4)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users. The registered person did not ensure the proper and safe management of medicines. Regulation 12(1) (2) (g)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have an effective system to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The registered person did not have an effective process to assess the specific risks to the health and safety of services users and do all that was reasonably practicable to mitigate any such risks. The registered person did not maintain accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (1)(2) (a)(b)(c)

The enforcement action we took:

We issued a Warning Notice requiring the provider to comply with the Regulation by 2 December 2018.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the identified needs of services according to their care plans. Regulation 18 (1)

The enforcement action we took:

We issued a Warning Notice requiring the provider to comply with the regulation by 2 December 2018.