Mears Care Limited

Mears Care Colchester

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Mears Care Colchester was registered in April 2017 and subsequently took over the personal care delivered by another care agency. This new legal entity has not yet had a comprehensive rating inspection. This inspection was undertaken in response to concerns about medicine administration and we focused on whether the service was Safe and Well Led. This report therefore only provides information on our findings in relation to these areas. A further comprehensive inspection will be undertaken at a later date.

This inspection was unannounced and the registered manager was not available on the day of the inspection as they were on annual leave. We subsequently asked them to provide information to us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager of this service was also registered as manager of another of the provider's services.

We had been advised that there had been medicine errors which had resulted in an individual being admitted to hospital and staff suspended from administering medicines to people. The errors had the potential to result in serious harm to people's wellbeing.

We found that the systems that were in place to manage medicines were not working effectively. The agency were not always following their own policy and procedures. Risks were not being identified and managed.

Audits were undertaken but were not robust and did not drive improvement.

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

Inadequate

The service was not safe

Medicines were not managed in a safe way

Risks were not always identified and effectively managed

There were systems in place to check on staff suitability prior to appointment

Is the service well-led?

Requires Improvement

The service was not always well led

There was a registered manager in post

Management oversight systems were not working effectively as risks were not being identified and managed.

Mears Care Colchester

Detailed findings

Background to this inspection

The inspection was prompted by notification of an incident which raised potential concerns about the administration of people's medicines. The inspection took place on 21 September 2017 and was unannounced.

The inspection team consisted of two inspectors and during the inspection we looked at the systems for managing medicines, spoke to staff involved and examined medicine administration records and auditing arrangements. We looked at one support plan, three staff recruitment files and training records. We visited one individual who was in receipt of support at home and spoke with them and their relatives and reviewed the onsite arrangements in place for the support they received and medicine administration. Following the inspection we spoke with the registered manager as they were on annual leave at the time of our site visit. At our request they provided details of the auditing arrangements in place.

Inadequate

Is the service safe?

Our findings

We found that the systems in place for the administration and oversight of medicines were not safe and did not protect people. An incident had occurred which could have resulted in serious consequences for an individual. They had been given another individuals medicines and this error was not immediately identified. A further error occurred the following day which resulted in the same individual being admitted to hospital. A similar medicine error had occurred some six weeks earlier and we could not see that learning had been undertaken by the organisation to prevent a reoccurrence.

Medicine Administration (MAR) charts were provided by the Agency for staff to follow but did not provide clear guidance to staff on the medicines they should be administering. For example they stated, 'follow instructions on the blister pack' and did not provide details to staff on what was in the blister pack so they could be clear about what they were administering. Other medication had specific guidance for staff to follow, such as giving before food, but this was not transcribed on to the medication administration chart.

Staff were not always checking the administration chart before administering. We checked a sample of medication administration charts and found that there were regular gaps where staff were not always signing to evidence that they had given medicines and we could not be assured that people were receiving their medicines as prescribed.

Responsibilities were not clear, for example for ordering and disposal of people's medicines. Support plans identified the agency as being responsible but there was no clear plan in place which was contrary to the agencies medicines policy. We found occasions where medicines were not available as well as excessive amounts of other medicines. The risks regarding this had not been considered. The policy stated that all medicines should be stored in a place of safety but we found that arrangements were not documented in individuals support plan. Medicines were not being securely or consistently stored. This meant that people were at significant risk and the agency was not keeping people safe. We found that this had contributed to one of the errors which had occurred.

Medicine audits were being undertaken but not always consistently or in line with procedure as the MAR charts were not always promptly returned to the office when complete to be checked. Audits were largely a review of signatures and did not check that people were being given medicines as prescribed. The audits we reviewed as part of the inspection did not always identify issues, for example that specific medicines such as paracetamol should be given at least four hours apart. The first error which had occurred had not been identified or considered as part of the auditing systems.

These shortfalls in medicine management were a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008. (Regulated Activities 2014.

Risks to the service and to individuals were not adequately managed. When people started using the service a senior member of staff visited them to assess their needs and the risks. These assessments were recorded and included assessments of the environment, and individual risks. The management plans and risk

reduction measures were not adequate and did not provide sufficient guidance to staff on the issues and how the risks should be managed to reduce the likelihood of harm. Management plans simply stated, 'report any concerns'. We saw that the risk assessments were reviewed but the review did not take in account changes in people's wellbeing and issues which had occurred such as falls. There was no clear guidance provided to staff on moving and handling and how equipment should be used to prevent injury.

These shortfalls in the management of risk were a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008. (Regulated Activities 2014.

The provider's recruitment procedures offered adequate protection to people using the service. We saw that the provider undertook checks with the Disclosure and Barring service (DBS) which helps prevent unsuitable people from working with people who use care services. References were obtained from individuals last employers before they started to work with people. Training was provided on a range of areas including infection control and medication however we were not assured that the training and competency checks met the needs of all new staff because of the nature of the recent medication errors.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who managed this service and another of the provider's services located approximately 25 miles apart. The registered manager oversaw the support to 170 people at this service and 110 at the other service. The registered manager told us that they attended the service on two or three days each week and was assisted in the day to day management of the service by a care manager who was based in the service.

Staff morale was not high, they told us that some care packages were due to move to another provider and they were unclear about their future. The registered manager confirmed that they were due to meet with individual members of staff to discuss the proposed changes to the packages of care

As part of our inspection we reviewed only a small proportion of the overall support provided by this agency. This was because two incidents had occurred in quick succession and we wanted to focus on medicines and check that the arrangements in place were safe. From our analysis of these incidents and the level of risk, we concluded that the agency was not operating in a safe way. The management of agency was not fulfilling its responsibilities and acting in a proactive way to identify and address shortfalls.

Following the incidents we found that the agency had suspended staff but not taken any actions to review their processes. They were unaware until it was pointed out, that a similar medicines error had occurred some weeks previously. Following our inspection they sent a memo to staff to remind them to complete records but had not identified some of the wider issues we found regarding the management of risk, medicine storage and ordering. The registered manager told us that they were planning to review the matter when they returned from annual leave.

The registered manager told us that they used number of different methods to assess the service and check quality. This included staff supervision, reviews and spot checks. We found that some of these processes were not working effectively, reviews for example had not identified that people's needs had changed. Staff were using equipment to assist with moving and handling which was not documented in the care plan. Checks had been undertaken on staff competency on managing medicines and found them safe but staff were not consistently following procedures.

The registered provider's audits were not effective. We asked the registered manager to provide us details of the provider audits. They showed us details of health and safety checks that were undertaken on the office premises and told us that data was collected on supervisions and training. Where incidents and accidents had occurred in people's own homes, these had been recorded and investigated; however there had been no oversight to identify recurring trends, such as falls or where a serious incident of self-harm had occurred. There were no recent registered provider audits on the quality of care.

The shortfalls in oversight were a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed in safe way. Risks were not being managed effectively.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not identifying shortfalls