Mears Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Mears Care Limited provides care and support to mostly older people, who live in their own homes. The services provided include personal care and domestic work in Torbay, Newton Abbot, Teignmouth, Dawlish and surrounding areas. In January 2015, Torbay and Southern Devon NHS Trust awarded Mears Care Limited the contract for provision of domiciliary care in Torbay. The contract started on 1st April 2015 and resulted in the merger of three existing domiciliary care agencies to create the new agency.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We visited the office on 6 and 8 June 2016. We carried out visits to people's homes on 10 June and 15 June 2016. We made phone calls to people during the week commencing 13 June 2016. At the time of this announced inspection 404 people were receiving personal care from the service. The service was registered in April 2015 and this was the first inspection.

We carried out this focused inspection as we had received some concerns about the quality of care and the management of medicines. The purpose of this inspection was to check people were receiving safe care.

Risk assessments were not always carried out to ensure people received care in a safe way. We found risks had not been assessed in relation to people who were at risk of harming themselves and others. Some care plans contained a good level of detail for staff to follow. Others were more basic and contained a list of tasks. For example, wash, dry, dress. We found one person did not have a care plan in their home. This meant staff who visited this person had no information to follow in order to meet this person's complex needs. This placed them at risk of inappropriate care. Following our visit to this person's home, the registered manager arranged for a care plan to be delivered back to their home. The registered manager was aware care plans and risk assessments needed to be reviewed. They had allocated four senior staff to carry out a review of all care plans. Work on this had commenced and was being done on a priority basis, starting with people with the highest dependency levels.

People told us they received a list of their planned visits each week. People were happy with their regular staff members and told us everything worked well when they visited. However, when the regular staff members were on holiday or off sick, they said there could be a number of different staff. Some of these staff did not have such a good awareness of their needs. We saw lists that contained visits with no staff name against them. People told us someone always came but they didn't know who was coming. Some people told us they were told about changes, others told us they weren't contacted. The registered manager told us they planned to move the service to smaller area hubs. This meant people should know the staff who visited them and provide them with the continuity they wanted.

Some people told us staff were often late. There was an alert system in place to ensure people's visits took place at the right time, and lasted for the allocated time. Further to the phone calls we made, we asked the branch manager about late calls. They were able to provide a report and reason for these. Where issues had been identified about timings of visits, the staff had locked in specific times on the computer system to prevent a re-occurrence. The service's plan to move staff to working in smaller geographical areas should reduce the travel distance between visits.

People were supported safely with their medicines and told us they were happy with the support they received. Staff completed medication administration record (MAR) sheets after they gave people their medicines. This showed people had received their medicines as prescribed to promote good health. Where there was a gap in one MAR sheet, we checked with the person who told us they had received their medicines. The senior lead told us they would follow this up with the staff member concerned.

People told us they felt safe when staff were in their home and when they received care. Staff had received training in safeguarding vulnerable adults and knew how to recognise signs of potential abuse. They confirmed they would report any concerns in line with the service's safeguarding policy.

Risk assessments had been completed for each person's home environment. Where risks were identified, action had been taken to minimise the risk of potential harm. For example, staff noticed one person did not have smoke detectors in their home. They discussed this with the person and arranged for the fire prevention officer to fit smoke alarms the following day. The service had a partnership agreement with the Devon & Somerset Fire and Rescue Service.

Recruitment practices were safe. Staff files showed the relevant checks had been completed. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable adults.

There was an 'on call' telephone number for people to ring in the event of an emergency out of office hours. The service had a plan in place to deal with foreseeable emergencies. There was a system in place to ensure visits to vulnerable people were prioritised.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

A further comprehensive inspection will take place to check improvements have been made. We will inspect all five questions relating to this service. These questions ask if a service is safe, effective, caring, responsive and well-led. This will result in the service receiving an overall rating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were not always carried out to ensure people received care in a safe way.

People told us they felt safe when staff were in their home and when they received care.

People were supported safely with their medicines and told us they were happy with the support they received.

Staff recruitment practices were safe and staff knew how to report concerns to protect people.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 and 18 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure staff were available to speak with us. We made telephone calls to people during the week commencing 13 June 2016. We carried out home visits on the third and fourth days of the inspection.

One social care inspector carried out the inspection visit to the office. They were supported by another inspector on the first day of the inspection. A team of inspectors made calls to people.

On the first day of our visit, 404 people were using the service. We used a range of different methods to help us understand people's experience. We spoke with 25 people and 9 relatives. We spoke with six staff, two senior leads, the quality and safety manager, the medication compliance officer, the branch manager and the registered manager.

We reviewed information we held about the service. This included analysing information relating to the concerns that had been raised with us. We looked at 12 care plans, medication records, three staff files, audits, policies and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We carried out this inspection as we had received some concerns about the quality of care and the management of medicines. The purpose of this inspection was to check people were receiving safe care.

Risk assessments were not always carried out to ensure people received care in a safe way. We found risks had not been assessed in relation to people who were at risk of harming themselves and others. One person who was living with dementia could show some aggression. A staff member told us this person needed to have familiar staff they knew as the person could be aggressive. Daily records showed the person had tried to hit out at staff and there had been difficulty in gaining their co-operation. The care plan had not been reviewed to include information which would help staff to support this person in a safe way if they were in a distressed state. Another person was at risk of harming themselves. Although this person had a regular staff team who knew them well, their care plan had not been updated following an incident. Records showed staff had stayed on to ensure the person was kept safe and appropriate healthcare professionals were contacted. The care plan did not contain any detailed information on how staff should respond to this person.

Some care plans contained a good level of detail for staff to follow. Others were more basic and contained a list of tasks. For example, wash, dry, dress. We found one person did not have a care plan in their home. A relative told us staff had taken it away some time ago. This meant staff who visited this person had no information to follow in order to meet this person's complex needs. This placed them at risk of inappropriate care.

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

Following our visit to this person's home, the registered manager arranged for a care plan to be delivered back to their home. The registered manager was aware care plans and risk assessments needed to be reviewed. They had already allocated four senior staff to carry out a review of all care plans. Work on this had commenced and was being done on a priority basis, starting with people with the highest dependency levels.

People told us they received a list of their planned visits each week. There were enough staff to carry out all of the planned visits. Over half of the people told us they always had the same care staff and were happy with them. This was confirmed by staff who knew people well and could explain their needs in detail. Other people were happy with their regular staff members and told us everything worked well when they visited. However, when these staff members were on holiday or off sick, they said there could be a number of different staff. Some of these staff did not have such a good awareness of their needs. We saw lists that contained visits with no staff name against them. People told us someone always came but they didn't know who was coming. Some people told us they were told about changes, others told us they weren't contacted. The registered manager told us they planned to move staff to work in smaller geographical areas. This meant people should know the staff who visited them and provide them with the continuity they

wanted.

Most people told us their staff usually arrived within the allocated time for their visit, with several people saying staff were never late. Some people told us staff were often late. Staff told us they could be late as some visits were on the other side of town. Comments included "We have very little travel time, if you overrun you are half an hour late" and "Sometimes we have enough time to get to visits, sometimes it's the other end of town so we're late". There was an alert system in place to ensure people's visits took place at the right time, and lasted for the allocated time. Further to the phone calls we made, we asked the branch manager about late calls. They were able to provide a report and reason for these. Where issues had been identified about timings of visits, the staff had locked in specific times on the computer system to prevent a re-occurrence. The service's plan to move staff to work in smaller geographical areas should reduce the travel distance between visits. There had been some recorded missed visits. The manager told us this had resulted in staff receiving formal supervision to reduce the risk of this happening again.

People were supported safely with their medicines and told us they were happy with the support they received. Staff completed medication administration record (MAR) sheets after they gave people their medicines. This showed people had received their medicines as prescribed to promote good health. Where there was a gap in one MAR sheet, we checked with the person who told us they had received their medicines. The senior lead told us they would follow this up with the staff member concerned. People also had the opportunity to manage their own medicines if they wanted to and if they had been assessed as safe to do so. Staff told us about a person who was supported with medicines; staff administered their medicines. However, the person wished to take their pain killers independently. Staff assessed the person and found the person was able to do this. However, the service monitored the situation and when they identified this had become unsafe, they discussed this with the person and agreed that staff would administer all medicines. The service employed a medication compliance officer. Their role was to plan training, visit people's homes, deal with staff queries, and work with the Trust and other stakeholders. MAR sheets were audited. An audit form was completed and when shortfalls were identified action was taken. This included additional staff training and a follow up check to ensure the improvements were maintained. Where medication errors had occurred, staff had contacted healthcare professionals for advice and monitored the person concerned. An investigation was carried out and any required follow up action was taken.

People and relatives told us they felt safe when staff were in their home and care was delivered. Comments included "I feel very safe and confident" and "I wouldn't be able to leave my mother with them if I didn't feel she would be safe" People told us when they felt uncomfortable with a member of staff, they had rung the office. The service had carried out investigations to explore why people felt uncomfortable. People confirmed their wishes were respected and the staff member didn't visit again.

Care plans contained information so staff knew how to access people's homes. Some people had key safes installed outside of their homes. This meant staff were able to access people's homes when people were unable to open their doors. We saw staff announce their arrival at people's homes and ensure their homes were secured on leaving.

Staff had received training in safeguarding vulnerable adults and knew how to recognise signs of potential abuse. They confirmed they would report any concerns in line with the service's safeguarding policy. We saw the manager attended the 'safeguarding adults board meeting'. This is a multi-agency meeting where good practice and keeping people safe is discussed.

Recruitment practices were safe. Staff files showed the relevant checks had been completed. The staff files

included evidence that pre-employment checks had been made including written references, satisfactory police checks [Disclosure and Barring Service clearance (DBS)], health screening and evidence of their identity had also been obtained. New staff told us references and a DBS check had been completed before they started to work in the community. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable adults.

Risk assessments had been completed for each person's home environment. Where risks were identified, action had been taken to minimise the risk of potential harm. The service had a partnership agreement with the Devon & Somerset Fire and Rescue Service. When staff noticed one person did not have smoke detectors in their home. They discussed this with the person and arranged for the fire prevention officer to fit smoke alarms the following day.
Incidents and accidents were recorded on incident report forms. The forms contained details of what had happened, why it had happened, and any witness statements. These were monitored and discussed at the monthly operational meeting with the Trust. The quality and safety manager was working with the local authority and the ambulance service to discuss falls in the community and how the handling of these could be improved.

There was an 'on call' telephone number for people to ring in the event of an emergency out of office hours. We saw a letter from one person thanking the out of hours team for their prompt action in contacting 111 to ensure their safety. The service had a plan in place to deal with foreseeable emergencies . This gave information on the action to be taken in events such as fire, flood, severe weather conditions, and loss of power. We saw the service had carried out a practice where they had to activate their business continuity plan due to a computer system failure. This lasted for four days and at the end of this time, there was a review of what worked well and what needed to be improved. Following the practice, a secure email was introduced so the manager could access essential information and a list of contacts were added to the plan. There was a system in place to ensure visits to vulnerable people were prioritised.

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 Risks to people's health and safety had not always been assessed. The provider had not done all that is reasonably practicable to mitigate risks. 12(1)(2)(a)(b)