Mercury Care Services Limited

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Inspection report

2.13-2.15 Astra House
23-25 Arklow Road
London
SE14 6EB

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14 February 2017
16 February 2017

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 14 and 16 February 2017 and was announced.

Mercury Care Services Limited is a domiciliary care agency delivering care to older people in their homes. At the time of the inspection the service was providing support to 31 people.

The service had a registered manager in place. 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.

Staff knew how to recognise signs of abuse and knew what actions to take to protect people if they suspected abuse. Risk assessments identified avoidable harm and plans were implemented to mitigate risks. The provider used a robust recruitment process to ensure that staff were suitable and safe to work with people. Staff supported people to take their medicines in line with prescriber's instructions and they used appropriate hygiene practices to reduce people's risk of infection.

The staff delivering care and support to people were trained and supervised. Staff and the registered manager were understood their responsibility to provide support to people in line with the principles of the Mental Capacity Act 2005 [MCA] People consented to the care they received and were provided with the level of support they required to eat and drink safely and sufficiently. People were supported to use healthcare services whenever they needed to.

People and their relatives told us that staff were respectful, polite and kind. The provider ensured a continuity of staff delivering care and support to promote positive relationships. People had their privacy protected and their independence promoted.

The service was responsive to people's individual needs. People had care plans in place which directed staff as to how people's assessed needs should be met. People knew how to make a complaint and were regularly invited to share their views about the service they were in receipt of.

Good governance was in evidence at the service. The roles and responsibilities of the leadership team, office staff and care staff were understood by all staff. Quality assurance monitoring was effective and on-going. The provider worked in partnership with other agencies to achieve best outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were trained to detect and report abuse.

Risks to people were assessed and plans developed to manage identified risks.

There were sufficient numbers of staff available to ensure people received their care visits as planned.

Staff were recruited safely and in sufficient numbers to ensure people received their agreed care and support.

People received the support they required to take their medicines safely.

The infection control practices of staff reduced people's risk of cross contamination during personal care.

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Is the service effective?

Good

The service was effective. Staff were inducted and received on-going training, supervision and appraisals.

People's care was provided in line with the principles of the Mental Capacity Act 2005.

Staff met people's nutritional needs and ensured they had sufficient amounts to drink.

People were supported to access to health and social care services.

Is the service caring?

Good

The service was caring. People and their relatives told us staff were kind and caring.

People received care and support from regular staff who were familiar with their needs.

Staff treated people with dignity and respect.

People were encouraged to maintain their independence and staff respected their privacy.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans were in place which gave staff guidance on meeting people's needs.

People's needs were reassessed when their needs changed

The provider actively sought people's views about how their care was delivered.

Is the service well-led?

Good

The service was well led. Staff felt supported by the registered manager.

The registered manager ensured effectively communication between office staff and care staff.

Robust quality assurance processes were in place.

The provider worked with external agencies to ensure positive outcomes for people.

Mercury Care Services Limited

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 announced inspection took place on 14 and 16 February 2017. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager and staff were available. The inspection was undertaken by 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.

Prior to the inspection we reviewed the information we held about Mercury Care Services Limited including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with 15 people and three relatives. We also spoke with three staff, the quality assurance manager and the registered manager. We reviewed 11 people's care records, risk assessments and medicines administration records. We reviewed 10 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted four health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

People received support that was safe. When asked if they felt safe with the staff who were delivering their care people told us, "Yes definitely" and "Very much so. I would be lost without them". Relatives shared similar views. One relative told us, "Yes [relative] feels safe. [They] would show me if they didn't."

People received support from staff who were trained to keep them safe. Staff received regular training in safeguarding adults and children from abuse. Staff we spoke with were able to tell us about the signs that may indicate a person was being abused or was at risk of abuse. Staff were clear about the actions they would take. One member of staff told us, "I would reassure the person and contact the registered manager." Another member of staff said, "I would phone the office straight away and make a written statement as soon as I could. The registered manager would make sure that social workers knew straight away."

People were further protected by staff member's understanding of the provider's whistle-blowing policy. Staff explained to us that whistleblowing was the practice of bringing concerns to external agencies if they felt that managers were not adequately addressing them. One member of staff said, "Of course if I was worried about people's safety and the manager didn't do anything with what I told them I would go on and tell the local authority or CQC".

The provider reduced people's risks of avoidable harm. The registered manager assessed people's risks including their health and mobility. Risks assessments of people's homes covered tripping hazards, radiator temperatures, toilet heights, smoke alarms and the condition of external paths and steps. Where risks were identified we found that the provider took action. For example, when people presented as unsteady on their feet, the registered manager made referrals to health and social care professionals for an assessment.

People were made safer by the provider's no response protocols. Staff told us what they would do if they arrived to deliver care and support and the person did not answer the door as planned. One member of staff said, "I would phone the office and they would phone [the person] and their next of kin. In all probability they have just gone out and I wasn't told the call was cancelled. But I have to wait for the office to phone me back." Another member of staff said, "The risk is that they [the person] has fallen and can't get to the door. The office would tell me what to do after they speak to [relatives] and social services. It maybe that the police will have to be called."

There were sufficient numbers of staff to meet people's needs. People told us they had not experienced missed care calls. One person told us, "They [staff] always turn up." Another person said, "We have no missed calls." A member of staff told us, "The office plan in enough time for me to get from one call to another. It means I'm on time and people aren't left waiting." On occasions when staff were running late they reported the delay to the office who informed people. In some circumstances the registered manager had redirected other staff team members to attend the care visit to reduce the time people had to wait for their support to be delivered.

People were protected by the provider's safe recruitment processes. The registered manager had taken the

necessary steps to ensure staff were suitably skilled and of good character. Staff submitted applications, were interviewed and provided references that covered the five years prior to their employment with Mercury Care Service Limited. The provider obtained proof of identity, reviewed checks made against barring and criminal records lists and ensured staff were eligible to work in the UK.

People told us staff provided them with the support they needed to take their medicines. One person told us, "They remind me and record [in medicines records]". Care records guided staff as to the support people required to take their medicines. Where people managed their medicines independently or were supported by relatives this was stated in care records. Staff attended medicines training during their induction and refresher courses were provided regularly. The registered manager reviewed people's medicines administration record [MAR] sheets when they were returned to the office each month. Whilst the field supervisor audited MAR sheets whilst conducting spot checks in people's homes.

People were protected from infection by the staff's use of personal protective equipment (PPE). A relative told us, "They always use latex gloves before helping my [relative]. It was a surprise to me until it was explained that it was to prevent cross infection between clients. They test the temperature of the hot water before using it and they ask for clean clothes if I have forgotten to put out a new change of clothes." Staff received training in infection prevention and control and managers observed the hygiene practices of staff during spot check visits to people's homes.

The provider took action to ensure people's living environments were safe. A member of staff told us, "Some people we support have come straight out of hospital. When you go to them you find out their home is unsafe. You have to contact the office immediately. They need to contact social services to get the go ahead for us or someone else to do a deep clean."

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the skills to deliver care and support effectively. One relative told us, "All of the staff from Mercury Care Services have been conscientious, clean, polite, helpful and caring to my [relative] and appear to be experienced in providing care."

People received care from staff who were trained and supported to maintain their knowledge and skills. We saw records of training undertaken and planned and found the training programme to be comprehensive. Staff told us that the provider's office was appropriately equipped to meet their training needs. One member of staff told us, "I do my online training in the training room. There are half a dozen computer stations there." Another member of staff said, "The office facilities are good for training. We have a bed, hoists and a dummy to practice lifting people safely."

New staff completed induction training. This included training in the use of hoists and slings, hand washing and pressure area relief. New staff were supported to complete the 15 areas of the care certificate. This meant staff received information and were assessed as being able to demonstrate knowledge in areas including safeguarding children and adults, equality and diversity, communication, and supporting people in a person centred way. As part of their induction new staff read the provider's procedures, people's care records and shadowed experienced staff as they delivered care. This ensured that new staff were competent and confident when they began to support people.

People were supported by supervised staff. The manager and field supervisor arranged one to one meetings with staff four times each year. These were used to discuss people's needs and staff development. In addition, staff were regularly observed by the field supervisor as they delivered care to people and appraised by the registered manager annually.

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. We found that people consented to the care and support they received. People signed their care records to agree to their support plans.

People received the support they required to eat and drink healthily. People's nutritional needs were assessed before they received a service and were regularly reviewed. Where people did not require assistance with eating or drinking and in circumstances where relatives met these needs, it was stated in care records. Where people required support from staff to eat this was stated too. For example, one person required their food to be cut into small sizes and moistened.

Staff supported people to access health services as and when they were required. Care records contained the details of the health and social care professionals involved in supporting people's wellbeing. These included GPs, community nurses and social workers. Staff recorded the outcome of people's appointments

to enable the tacking of their health needs by the provider and professionals.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were caring. One person told us, "[Staff] are very polite and nice." Another person said, "They [staff] seem to be quite good people." One relative told us, "Overall we have been pleasantly surprised by how good the service from Mercury Care Services is and how pleasant the staff are."

Staff knew people well. People told us they received their care visits from staff they were familiar with. One person said, "Nice crowd. I have got to know them." Another person told us, "It's mostly the same [staff]", Whilst a third person said, "I would be lost without them." The information staff shared with us about the people they provided support to reflected the information contained within care records. They told us that by ensuring the same staff supported the same people positive and trusting relationships had developed.

The provider identified and documented people's support networks as part of the initial assessment of needs. Care records contained social histories. These included details about people's lives and highlighted those who were important to people. For example, records noted who people's children, grandchildren and great-grandchildren were. This enabled staff to meaningfully converse with people about their lives when they chose and to support people to maintain contact.

People were supported to make decisions about their care and support. One person told us, "They [staff] always ask me what I want. They treat me very well." People contributed to their assessments and care plans which stated when and what care people would receive. On a day to day basis people's choices included how personal care was delivered and what they chose to wear.

People and their relatives told us that staff respected their privacy and treated them with dignity. One person told us, "They [staff] keep the doors closed and knock before they come in if I am in the bathroom." Another person said, "They close the doors when I'm having a shower." A third person said, "I am never rushed. They are very nice." A relative told us, "[Staff] speak to [relative] nicely when we have observed them." Where people had continence needs staff had guidance in care records on how to deliver personal care in a way that promoted people's dignity. For example, care records detailed how people preferred to be washed and whether additional health care aids were required.

People were supported to maintain their independence. Care records noted people's abilities. For example, where people walked without assistance this was stated so that staff did not undermine people's independent mobility. Where people required support to meet their needs this was stated too. For example, one person's care recorded stated "Support required to wash and dress their lower half due to [health condition]." Another person's records noted, "[Person's name] can only wash their hands and face on a good day." This meant staff had guidance on the support to be delivered and the independence to be promoted.

Good

Is the service responsive?

Our findings

People received care and support that met their individually assessed needs. The registered manager undertook assessments with people prior to a service being offered. This was to ensure that the service was able to meet people's needs.

People told us that their care visits were arranged for times of their choosing. One person told us, "[Staff] come at a time that suits me." Another person said, "[Staff] will fit in with my hospital appointments". Whilst a relative told us, "The Christmas and New Year holiday rota was organised in good time by [the service] and worked perfectly for us." This meant the provider was responsive to people's preferences.

People's care records provided staff with guidance on meeting people's needs and care plans stated the purpose of the support being delivered. For example, one person's records stated that the objective of their support was, "To live independently in their home for as long as possible." The outcome stated in another person's care plan was, "To promote independence at home because [person's name] does not want to go into a care home." A third person's care records stated that the goal for their care and support was to, "Good hygiene and a healthy life."

The support to be provided to people during each care visit was stated in care records. For example, the care to be provided for one person during their morning care visit was stated as, "Support personal care, make the bed, make breakfast, support continence management and prompt with medicines." In another example, a person's evening care visit was scheduled to, "Support mobility upstairs safely, support with personal care, change into night wear and settle into bed for the night." This meant staff had clarity regarding the support to be delivered to people.

People were supported with reassessments of their needs when their needs changed. For example, when one person began to experience difficulties transferring staff made a referral to healthcare professionals. As a result of their reassessment the person's care records were updated to reflect their new level of support. Additionally, people were supported with reassessments when their circumstances changed. A member of staff told us, "Reassessments don't just get organised when people's needs change but when their relative's needs change too. Like, when a relative who is the main carer is unwell, can't cope or feels depressed the amount of support that is needed increases. I let my manager know and they contact social services."

People and their relatives were invited to share their views about the service. The registered manager, quality assurance manager and field supervisor made telephone monitoring calls to people and spoke to them during spot check visits. They also reviewed the results of surveys in which people and their relatives shared their views about their experiences of the provider's delivery of care and support.

People told us they knew how to raise a complaint or a concern. People were provided with a copy of the provider's complaints procedure when their service started. We found that the provider had acted promptly in response to issues raised and in line with its procedures. Complaints were investigated and responded to in writing.

Good

Is the service well-led?

Our findings

The service had a registered manager in post who was supported by an office based staff team which included a quality assurance manager and field supervisor. We found that care staff and office staff understood their roles and those of their colleagues.

Staff told us they felt supported by the registered manager and the provider's leadership team. One member of staff told us, "The registered manager is always fair and always available to talk to." Another member of staff said, "I like the encouragement and praise. If you do well or if the people you care for say something nice [the office staff] lets you know straight away and it really makes you want to do even better."

There was effective communication from the registered manager to staff delivering care to people. The registered manager organised bi-monthly team meetings for staff. These meetings were used to discuss people's changing needs. Minutes were kept of team meetings for staff who could not attend to read later. Minutes showed the registered manager regularly explained the provider's procedures. For example, the records of one meeting showed the registered manager reminding staff that they should never use their mobile phones in people's homes. The minutes of another team meeting recorded the manager saying, All the duties carried out in [people's] homes need to be well documented. Reports should be clear to read and understand." The registered manager used a mobile phone application as a forum for group discussions with staff and for providing information to the staff team when they were not in the office.

The provider monitored the quality of care people received. The field supervisor and quality assurance manager undertook quality monitoring activity. This included fortnightly telephone monitoring calls and spot checks. During spot checks the managers arranged to go to people's homes prior to staff arriving. They discussed people's experience of care and observed staff practice including punctuality and their adherence to the provider's infection control procedures. Notes and observations from spot checks were retained and reviewed by the registered manager.

The care and support people received was recorded and monitored. Staff maintained daily notes which provided an account of the care and support provided at each care visit. For example, one person's care records stated, "Medicines given, supported to shower, dry, apply creams and get dressed. Dishes washed." Whilst another person's daily records said, "Helped into night clothes, to use the toilet and helped into bed." This meant information was available to the manager to ensure that care and support were being delivered as planned. The registered manager conducted a rolling programme of auditing care records in people's homes. Care records were checked every three months to ensure they remained accurate, up to date and met people's needs.

The provider worked in partnership with others to ensure people's needs were effectively met. The registered manager regularly sought advice from health and social care professionals. For example, referrals were made to physiotherapists and social workers who staff worked alongside during assessments and reviews. The registered manager understood the legal responsibilities of their registration with CQC and the requirement to keep us informed of important events through notifications when required.