Mears Homecare Limited

Truscott House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 July 2017 and was announced. We gave the registered manager 48 hours to make sure someone was available in the office to meet with us. This was the first inspection of the service following registration with CQC in February 2016.

Truscott House provides personal care for up to 37 people living in one bedroom flats in a supported living scheme of the same name. People had a range of needs including mental health and physical disabilities as well as dementia. There were 23 people using the service at the time of this inspection.

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

There were not always enough staff deployed to meet people's needs. In addition, the provider did not adequately always assess risks to people and ensure actions were taken to mitigate risks. This included risks relating to people's medical and health needs. The provider did not always have care plans in place to inform staff about some people's individual needs and how staff should care for people in relation to these. The provider did not always review people's care plans when their needs changed to ensure care provided to them continued to meet their needs.

Medicines management was not always safe as we were unable to confirm people received medicines as prescribed. This was because the provider did not have systems in place to keep track of the quantities of medicines in stock. We were also unable to confirm medicines were disposed of safely as the provider did not keep disposal records.

Care was not always provided to people in line with the Mental Capacity Act (MCA) 2005. The provider had not always carried out mental capacity assessments regarding decisions relating to people's care, such as those relating to medicines administration. In addition the provider had not taken action to assess whether people required constant supervision as part of keeping them safe, and had not arranged deprivation of liberty authorisations where these may have been required. The provider told us they would carry out mental capacity assessments, arrange best interests meetings to decide the best ways to care for people where necessary and also review whether people required deprivations of liberty authorisations to keep them safe.

The service was not always well-led. Although the provider had audits in place to monitor and assess the quality of service, these had not identified the issues we identified relating to staffing, risk assessments, care plans, medicines management and supporting people in line with the MCA.

People were cared for by staff who were recruited following robust checks of their suitability. Staff were well

supported by the provider. A suitable programme of training and one to one supervision was in place to help staff understand people's needs and carry out their roles. Staff felt well supported and the provider communicated with staff and had systems in place to gather their feedback on the service.

People felt safe and staff understood how to respond if they suspected anyone was being abused to keep them safe as they received training in relation to this from the provider.

People received the support they needed in relation to eating and drinking. The provider supported people to access the healthcare services where this was part of their care package.

People were supported by staff who were kind and caring and treated them with dignity and respect. People spoke positively about the staff who supported them. Staff knew the people they were supporting, including their preferences, health needs and backgrounds. People were supported to maintain their independence as far as possible.

The provider gathered feedback from people on the quality of service in various ways and people felt confident if they complained the registered manager would take this seriously and respond appropriately.

We found breaches of the regulations relating to staffing, safe care and treatment, consent and good governance. You can see what action we have asked the provider to take to address these breaches at the back 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

The service was not always safe. There were not always enough staff deployed to meet people's needs. The provider had not always ensured risks to people were assessed and managed appropriately as part of keeping people safe. Medicines management was not always safe.

Staff knew how to recognise abuse and how to respond to it to protect people.

Is the service effective?

Requires Improvement

The service was not always effective. The provider had not always assessed people's mental capacity to make decisions, ensuring decisions were made in people's best interests where they lacked capacity. The provider had not assessed whether people required deprivation of liberty authorisations to keep them safe.

Staff received one to one supervision and a training programme which was suitable.

Staff provided people with the right support in relation to eating and drinking. Staff supported people to access healthcare professionals when this was part of their care package.

Is the service caring?

Good

The service was caring. Staff treated people with kindness, dignity and respect and staff knew the people they were caring for.

People were involved in decisions about their care and were supported maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care was not always planned in relation to people's needs and care was not always reviewed in response to people's changing needs.

People were involved in assessing and planning their care.

An activity programme was in place to occupy people and help reduce social isolation.

A suitable complaints policy was in place and the provider had arrangements in place to encourage feedback from people.

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Is the service well-led?

Requires Improvement

The service was not always well-led. Although systems were in place to assess the quality of the service people received these had not identified the issues we found.

The registered manager had inclusive ways of communicating with people, relatives and staff and gathered feedback as part of monitoring the quality of service.

Truscott House

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 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 was a comprehensive inspection. The inspection took place on 20 July 2017 and was announced. We gave the provider 48 hours' notice of the inspection to make sure someone was available in the office to meet with us. The inspection was carried out by one inspector.

Before our inspection we reviewed information we held about the service. This included statutory notifications received from the provider and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

During the inspection we spoke with four people using the service, one relative, the registered manager, seven care workers and the regional operations manager. We looked at a range of records including three staff files, five people's care plans, records relating to medicines management and other records relating to the management of the service.

After the inspection we contacted a social worker who had recently audited the service who shared their report with us.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff deployed to meet people's needs. A person told us, "Sometimes staff are run off their feet, we could do with more staff." Although only one person we spoke with told us there were not enough staff, all seven care workers we spoke with expressed concerns they were not able to meet people's needs well due to staff shortages. Staff told us staff numbers were often short on weekends and sometimes during the week if staff were off sick or on annual leave. One staff member said that when staff were short, "It's stressful. It's really, really hectic. As soon as you finish [providing person care to one person] you go on to another." We checked rotas for four weeks and these confirmed that not all shifts were covered as there were staff shortages over each weekend and also on some weekdays. The registered manager told us they assigned staff to people according to the number of hours agreed in their care package by their social worker and so there was no dependency tool in use to calculate staff needs across the service as a whole. When we raised our concerns about staffing levels with the registered manager they told us they tried to cover shifts with overtime but this was not always possible. The registered manager also told us the staff on shift each day would increase as people with high needs were scheduled to be admitted to the service in the next few weeks, and records confirmed the provider was recruiting additional staff. However, we were remained concerned that there were not enough staff deployed at the service to meet people's needs.

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

Although people told us the provider managed their medicines well, we found people's medicines were not always managed safely. One person said, "Staff give me my medicines at the right time and I know what they are for." Staff received training in medicines management with annual competency assessments to check they administered medicines to people safely. However, we were not always able to confirm people received their medicines as prescribed because the provider kept insufficient records. We were unable to carry out stock checks of people's medicines to check medicines were administered as prescribed, which meant there was a risk people's medicines were not managed safely by staff. This was because the provider did have systems to know the quantities of each medicine they should have in stock. For example, although the provider recorded the quantities of medicines received each month, they did not always record quantities of medicines carried over each month to keep track of medicines stocks. In addition the provider did not have a system in place to ensure staff recorded the number of paracetamol they administered to a person who received this 'when required'. The prescribers' instructions were to take one or two tablets. This meant there was a risk that staff did not always administer paracetamol to this person safely. The provider also did not keep records of medicines they disposed of for people with the pharmacy, where they were responsible for this. This meant there was a risk people's medicines may not be disposed of safely. The provider told us they would review their medicines practices in light of our feedback.

For most people the provider managed risks to their safety well. The provider identified and assessed the risks to individuals and put suitable management plans in place to reduce the risks. This meant staff had reliable information to follow in reducing risks to people while providing care and support to them. However, for one person the provider had not reviewed their risk assessments since they were discharged

from hospital even though risks to them increased. A relative told us, "It's not safe. [My family member] is at risk from everything including falling…It's been wonderful but [my family member] needs the next level". The registered manager told us Truscott House was no longer suitable for this person and arrangements were being made to transfer them to nursing care. However, the provider had not appropriately reassessed risks to the person to ensure they were taking sufficient action to mitigate risks while they remained with the service. This meant the provider may not have been supporting the person to mitigate risks to them appropriately. The registered manager told us they would review the person's risk assessments as soon as possible.

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

The provider kept people safe by responding appropriately to accidents and incidents. Staff recorded accidents and incidents and the registered manager analysed reports to ensure people and staff received the necessary support. The registered manager also checked that sufficient action was taken to reduce the risk of reoccurrences.

The provider recruited staff following robust recruitment practices. The provider checked staff's previous employment history, identification, proof of address, any health related issues which may affect staff's ability to carry out the role and also undertook criminal record checks. The provider checked the suitability of staff to work with people using the service during an initial interview and monitored their suitability during their probationary period.

People were safeguarded from abuse and neglect by staff. People told us they felt safe when they received care from staff. One person told us, "I feel safe. I always feel safe. I look after myself." Another person said, "I feel safe. I would tell [the registered manager] any issues if I wasn't safe." Staff we spoke with knew different types of abuse as well as signs people may be being abused. Staff knew how to respond to suspected abuse to keep people safe and the provider trained staff in safeguarding people at risk each year to keep their knowledge current.

Requires Improvement

Is the service effective?

Our findings

People were not always cared for by the provider in line with the MCA. Staff received mandatory training on the MCA. Our discussions with staff showed they understood the principles of the MCA and their responsibilities to provide day to day care in line with the MCA. However, people's care plans did not include an assessment of people's capacity to consent to the actions covered by their care plan with confirmation that those actions are agreed to be in the person's best interests. Staff told us they believed some people lacked capacity to make some decisions relating to their care but records showed these had not been assessed. For example the provider had not carried out a mental capacity assessment to determine people's mental capacity in relation to staff administering medicines to them and to ensure decisions to administer medicines were made in line with the MCA and in their best interests. The provider told us they would review their procedures in relation to this when we feedback our concerns.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider did not have processes in place to assess whether people required deprivations of liberty as part of keeping them safe. The registered manager told us about a person using the service who was disorientated to space and time who required staff support in the community to remain safe. However, the person remained free to leave the service via the front door at any time, even though they may have come to harm in doing so without staff support. Staff told us if they happened to see the person leave via the front door they would try to persuade him to return or they would stay with him while he waked outside. However, staff would not always be aware when the person left the service and in some circumstances it would not be safe for staff to leave the service to support the person due to the needs of others. When we raised our concerns with the provider the registered manager contacted the person's social worker to request they assess whether a deprivation of liberty was required to prevent the person from being free to leave and to implement more rigorous monitoring in order to keep them safe.

The registered manager also told us about two other people who used the service in the past year who were not always kept safe and who may have required deprivation of liberty authorisations as part of keeping them safe. However, the provider had not made arrangements to assess whether these people required deprivation of liberty authorisations in place. A safeguarding alert resulted in the past year due to an incident when one of these people was found in a distressed state as they had left the scheme without staff being aware, inappropriately dressed during a cold winters night. The person was disorientated to space and time and required staff assistance in the community yet the provider had not considered whether they

required constant supervision and restrictions on leaving the scheme alone to keep them safe.

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

People were supported by staff who were provided with sufficient induction and training supervision and appraisal to understand and meet their needs by the provider. Staff were provided with a suitable programme of training which included annual mandatory training in moving and handling, mental capacity act (2005), safeguarding adults at risk and fire safety. Staff were also provided with training to meet peoples specific needs including mental health awareness, dementia awareness and diabetes management. Staff told us the training was good quality and was appropriate for their role. The provider inducted new staff to their role with mandatory training along with a period of shadowing more experienced staff until staff felt confident to care for people alone.

New staff completed the 'Skills for Care' Care Certificate. The Care Certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support. This meant the provider supported staff to reach the national standards expected of care workers during their induction period.

A programme of staff supervision was in place and records showed staff were able to receive guidance on the best ways to care for people and also to review their development. Staff also received annual appraisal from the provider during which they received feedback on their performance and set goals for the following year.

People received appropriate support in relation to eating and drinking from the provider. When we asked people about their food comments we received included, "It's very nice" and, "It's fine". Many people chose to receive meals in the communal dining area. We observed a mealtime in this area and saw staff were present throughout the meal and promptly responded to people's requests for assistance. People received choice of meals and we observed people being supported to choose their meals for the coming week from a range of choices. The service catered for people's ethnic, cultural, religious and other food related needs and preferences. One person told us, "There is ackee and saltfish [a popular Jamaican dish] on the menu." People's care plans set out any support they required from staff in relation to eating and drinking and staff had a good knowledge of this.

People were supported by staff to access the healthcare services they needed when this was part of their care package. People's physical and mental health diagnoses were recorded in their care plans for staff to be aware of. Staff had access to the contact details of the healthcare professionals involved in people's care to use if people required their support, such as GPs, district nurses and tissue viability nurses. Where people required assistance from staff to maintain their health, such as attendance at health appointments, sufficient guidance was recorded in their care plans in relation to this.

Good

Is the service caring?

Our findings

People were supported by care workers who were kind and caring and people liked the staff who supported them. One person said, "Staff are kind. They have a good laugh with us". A second person said, "Staff are quite good. They are kind." A third person said, "I get on very well with [staff]". Another person who had limited speech nodded and smiled when we asked how they found staff. We observed people and staff had developed positive relationships and spoke fondly of each other. Staff spoke to people in a respectful manner and maintained people's privacy and dignity while providing personal care. For example, staff told us they covering parts of people's bodies while washing other parts.

People were encouraged to be involved in decisions about their care. The registered manager met with people and their family members where possible, before their care package began. This was so the registered manager could find out more about them and how they wanted their care to be delivered, such as how they preferred staff to support them with personal care. In addition people were involved in choices about the support the received on a day to day basis. Staff supported people to choose the clothes they wore each day and also how and where they spent their day. Staff supported people to be as independent as they wanted and people's care plans contained information for staff to follow in supporting people to maintain their independence. For example a person's care plan detailed how staff should provide personal care in a way which encouraged the person to carry out some tasks themselves.

People were supported by staff who understood their needs and cared for them in the ways they preferred. One person told us, "Staff know me". Our discussions with staff also showed they understood people's needs, preferences and backgrounds well, including previous hobbies and employment. Staff also understood the best ways to communicate with people. We observed staff adapt their communication style depending on the person they were speaking with, for example using shorter sentences and repetition for a person who was living with dementia. However, the provider had not always recorded information about the best ways to communicate with people in their care plans for staff to refer to. For example, a person had limited verbal communication and used some gestures to communicate. Staff supported the person to attend a 'Talk Back' group which was focused on teaching the person to regain their speech. Although we observed staff understood how to encourage the person to express themselves, the provider had not recorded information about this in their care plan to guide staff who may be unsure. The registered manager told us they would review there care plan when we fed back our concerns.

People were provided with information when they needed it, for example to enable them to understand the service provided by Truscott House as people were given written details when they began using the service. This included information about service provision and options available to people.

Requires Improvement

Is the service responsive?

Our findings

People were provided with a service that was responsive to their core needs, such as personal care, medicines administration, support with eating and drinking and domestic tasks. However, sometimes the provider did not plan people's care in relation to their additional needs. For example, two people had a history of suicidal feelings or behaviours and yet their care plans did not guide staff on how to care for people in relation to this. One person was blind yet their care plan did not set out accommodations staff should make in relation to this to respond to their sensory needs. In addition, another person was diabetic although they managed their medicines and medical appointments in relation to this themselves. Staff told us of a recent time when they had to support the person when they experienced an episode of low blood sugar which required medical treatment. Although staff received training in diabetes awareness the person's care plan did not contain information for staff about symptoms of diabetes for them to refer to, as well as guidance on how to respond if the person experienced episodes of low or high blood sugar. The provider told us they would review their assessment and care planning process to take account of needs people had in addition to their core needs to ensure all their care needs were met.

People's core needs were assessed by the provider who developed care plans around these. People's care plans were based on the care the local authority commissioned for individuals as well as information gathered about people's views in relation to this from meetings the provider had with them and their relatives. People's care plans also contained information about people's preferences, backgrounds, the people who were important to them and religious beliefs for staff to refer to in helping them to better understand people's needs.

Staff did not always respond to people's changing needs as the provider did not always update people's care plans when their needs changed. For example, when a person was discharged from hospital and required more assistance from staff in relation to eating and drinking and falls management the provider did not reassess their needs and review their care plan. However, the provider reviewed other people's care plans in response to their changing needs and preferences. The registered manager made referrals to social services to increase the time people were allocated for care when necessary, and also made referrals for people to be transferred to residential care services when their needs became too high for this service.

People were provided with a range of activities at the scheme which helped stimulate them and reduce social isolation. One person told us, "I like singing and games [provided by the service]". Group activities were provided in the communal lounge including exercise classes, watching movies, bingo and arts and crafts. Staff consulted with people when reviewing the activities programme which meant it was based on activities they were interested in. A person told us how the provider supported them to meet their religious needs, "We have a lovely service every second Sunday [where a local church visits the scheme]. When there are big events at the church they invite us [and staff support us to attend]."

People were encouraged to feedback about the service including complaints. One person told us, "I'd tell [the registered manager] if there were any issues or complaints." The provider invited people to complete an annual satisfaction survey. At the time of our inspection people had recently completed the survey but the

findings had not yet been analysed. The provider had a suitable complaints process in place. People we spoke with knew who to complain to and were confident the registered manager would take any complaints they made seriously. Records showed complaints were recorded appropriately along with the action taken to provide resolution and the outcome.

Requires Improvement

Is the service well-led?

Our findings

People received a service that was not always well-led. This was because the provider did not have sufficient systems in place to assess and monitor some key aspects of the service. In particular systems were not in place to ensure there were enough staff deployed to care for people, that medicines management was sufficiently audited, that risks to people were assessed and mitigated and that people were cared for in line with the Mental Capacity Act (2005). Although some audits were in place, these had not identified the issues we found during our inspection, which meant they were ineffective.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings, people and staff told us the service was well-led and knew who the registered manager was. One person told us, "The service is well led, [the registered manager] is very nice… we have a chat when she's free" Another person told us the way the service was managed was "quite good." All staff we spoke with told us the registered manager was a good manager who was approachable, supportive and took the right action when any concerns were raised.

The audits in place for the provider to monitor and improve the quality of care provided to people included monthly submissions to senior managers, by the registered manager, of quality information which included complaints, safeguarding allegations and accidents and incidents. The provider also carried out regular audits of the service in line with CQC inspections. We viewed an action plan from the most recent audit and the registered manager confirmed the plan was on schedule. A recent audit carried out by the local authority found the service was well managed with no areas identified for improvement.

The provider gathered feedback from people as part of their quality checks of the service. A person told us, "We discuss different things that might be occurring and whether we're settled in here." The provider held regular meetings with people using the service to gather their feedback. These meetings were usually attended by the local councillor who was keen to hear how they could improve their quality of life. The provider frequently carried out spot checks to confirm care workers were caring for people appropriately and according to their care plans. During these spot checks people were given the opportunity to feed back on the quality of care they received, such as whether staff were caring and treated them with dignity and respect. A senior member of staff worked with staff to make improvements to their practice if needed following an observation or spot check. The provider sent questionnaires to people and staff to gather their views on the service and to make improvements from these. Questionnaires had recently been sent out to people and we saw feedback was mainly positive although one person recorded the service required improvements in relation to a few areas. The registered manager told us the results would be analysed and used to make improvements to the service where possible.

The registered manager encouraged staff to become involved and improve the service. The registered manager held regular meetings with staff during which their feedback on the service and suggestions for improving care provided to people were discussed. The registered manager also used these meetings as an

opportunity to communicate any developments within the service or the wider organisation, as well as to review beset practice in particular areas of their work. The provider also sent questionnaires to staff to gather their feedback on the service.

The service was meeting their registration requirement to send notifications to the CQC of incidents such as allegations of abuse.

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 11 HSCA RA Regulations 2014 Need for consent The registered person did not have suitable arrangements to ensure the service acted in accordance with the Mental Capacity Act 2005 when people lacked capacity to consent. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for people by assessing the risks to the health and safety of people of receiving the care and doing all that is reasonably practicable to mitigate any such risks. Regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not operating effectively to ensure the registered person was able to assess, monitor and improve the quality and safety of the services provided by the service. Regulation 17(1)(2)(a).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure there were sufficient numbers of staff deployed to

meet people's needs. Regulation 18(1).