Mears Care Limited

Links View Extra Housing Scheme

Inspection report

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Date of inspection visit:
11 August 2016

Date of publication:
03 October 2016

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

This inspection was carried out on 11 August 2016. We were unable to give notice of our inspection as the agency had not updated us when they changed their contact details.

Links View Extra Housing Scheme is a branch of Mears Care Limited (the provider), they are a domiciliary care agency providing personal care support to people living in their own home. This branch is registered with the Care Quality Commission as a separate location and is known as Links View Extra Housing Scheme.

Links View is based in an extra care living facility in the Woolton area of Liverpool. The facility is a block of flats providing extra care support for people. At the time of our inspection there were 41 people living in the flats 38 of whom received support from the agency. Links View did not provide support to anybody living outside of this facility.

The agency did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 previous registered manager had left in June 2016. Staff told us that there had been four managers since January 2015; two of whom had been registered with CQC.

During the inspection we spoke with seven of the people receiving a service from Links View. We also spoke with four members of staff including the team leader who was in charge of the service on the day of our inspection. We looked at a range of records including care records, staff records and records relating to quality assurance of the service.

At this inspection we found two breaches of regulations. This was because medicines were not always properly and safely managed and systems were ineffective at assessing, monitoring and improving the quality of the service .

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

People's medication was not always managed safely. No system was in place for checking stocks of people's medication and for supporting people to return unused medications. This increased the risk of medication errors occurring.

The service did not have a registered manager and had had a number of managers within the past two years. Staff felt demoralised by the number of changes to the senior management team within a short time and did not always feel supported to undertake training relevant to their role.

Systems for checking the quality of the service were not always effective at identifying areas of improvement

and planning how to improve the service people received.

The way in which information about the day to day running of the agency was shared with people was not always suitable for the people they supported.

People supported by the agency and staff were not aware of how flexible or otherwise the agency could be in meeting people's care needs at times other than those listed within their care plan.
Systems for supporting people to complain or raise a concern were not always effective at capturing peoples' concerns and pro-actively dealing with them.

People were supported by staff who they liked and were familiar with and sufficient staff worked at the agency to provide the support people needed in a timely manner. Safe recruitment procedures were in place and followed to ensure staff were suitable to work with people who may be vulnerable.

People said they felt safe with the support provided to them by the agency. Staff had received training in recognising and reporting potential and actual abuse and polices were in place to guide them on the actions to take if they had any concerns.

Care plans contained up-to-date information on the support people needed and this had been discussed and agreed with the person. People received the support they needed with their personal and health care, preparing meals and making decisions.

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.

People's medication was not always managed safely.

Sufficient staff worked at the agency to provide the support people needed in a timely manner.

Systems were in place for training staff to recognise and report potential abuse.

Recruitment procedures were in place and followed to ensure staff were suitable to work with people who may be vulnerable.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always feel supported to undertake training relevant to their role.

People received the support they needed with making decisions, their health and meals.

A Lack of signage made it difficult to locate the agency's office.

Is the service caring?

Requires Improvement

The service was not always caring.

The way in which people were given information about the day to day running of the agency was not suitable for everybody they supported.

People liked and trusted the staff team who supported them. Staff knew people well and were respectful when providing support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Systems for obtaining and acting upon concerns or complaints people had, were not always effective.

Staff and people working at the agency were unsure as to how flexible the service could be.

Care plans were up to date and provided sufficient guidance for staff to follow, in order to meet the person's needs and choices.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a registered manager.

Staff felt demoralised by a number of changes to the senior management team within a short time.

Systems for checking the quality of the service were not always effective.

Links View Extra Housing Scheme

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 was carried out on 11 August 2016 by one adult social care inspector. We were unable to give notice of our inspection as the agency had not updated us when they changed their contact details.

Prior to our visit we looked at any information we had received about the agency including any contact from people using the service or their relatives and any information sent to us by the agency.

During the inspection we spoke with seven of the people receiving a service from Links View. This included speaking individually with two people and holding a meeting with a further five people. We also spoke with four members of staff including the team leader who was in charge of the service on the day of our inspection.

We looked at five care plans and medication records relating to people supported by the agency; we looked at recruitment records for four members of staff and at a sample of records relating to staff training and recruitment. We also looked at records relating to complaints and quality assurance and other records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People supported by the agency told us they felt safe with the staff who supported them. A lifeline call system was available and everyone living at the extra care facility had access to this. We saw that people used a lifeline call bell they could wear and they also had call points in their flat that they could use. People told us that whenever they had used these day or night, they had received a quick response from agency staff.

Some of the people using the agency received support to take their medication. One person told us, "They make sure I have my tablets." Another person explained that their family helped with ordering stocks of medication and checking them but staff provided them with help to make sure they took their medication on time.

Some people required support to remember to take their medication whilst others required some support to order and manage their medications. Two people supported with their medication agreed to us looking at how it was stored and managed by staff.

One person's care plan said that staff re-ordered their medication when it was low. We found that the person had high stocks of used or part used medication in their cupboard. This included five part used blister packs and three open inhalers. We also saw that the foil packets for use in the inhalers were loose in this cupboard. As staff supported the person with their medication this amount of used medication could lead to errors occurring. No method for checking the amount of stock the person had was in use. A senior member of staff explained that they had tried working with local pharmacies who had been reluctant to take back people's stocks of medication. However the agency's policy clearly stated that people could be supported to return medications they did not need.

A second person had a pot of loose tablets in their cupboard. The reason for this was known to staff and the person who told us they were to be returned to the pharmacy. The tablets had been put into the pot by agency staff, however no record of the amount of tablets had been recorded by agency staff. This meant there was a potential for them to be misused.

These examples are breaches of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This is because the provider had failed to ensure medicines were properly and safely managed.

We saw that medication administration record sheets (MAR) were used by staff to sign when the person had taken their medications. These had been audited regularly by the agency and where staff signatures were missing this had been noted and action taken to address the issue. The support the person needed with their medication had been assessed within their care plan and was clearly recorded.

A policy was in place to provide guidance for staff in supporting people with their medication and records showed staff had received training in supporting people with their medication.

Polices were available to provide guidance for staff on safeguarding adults and whistle blowing. Whistle blowing protects staff who report things they believe are wrong in the workplace and which are in the public interest.

Information about both of these polices was available in the staff handbook and staff told us they had received a copy of this document. However the information regarding whistle blowing was brief and did not include contact details. Full copies of the policies were available in the office and we saw that the whistle blowing policy included details of the name, phone and email address of who staff could contact. A copy of the local authority's safeguarding policy was also available to provide guidance for staff. Although available in the office this meant polices were only available via senior staff and not freely available in the staff room for staff to access.

In discussions with staff, they displayed an awareness of how to recognise and report abuse and they told us they would not hesitate to report any concerns that they had. No safeguarding referrals had been made by the agency within the past year.

Some of the people using the agency had a key safe fitted so that staff could access their front door. We discussed this with staff who were aware of the need to keep the number confidential. We saw that records of the numbers for key safes were kept securely.

Accidents or incidents that occurred had been clearly recorded. Information on these was sent each month to the agency's head office so that they could be analysed for any emerging patterns.

Requires Improvement

Is the service effective?

Our findings

People told us that staff had supported them when they had been unwell. One person commented, "They call the doctor," and several people confirmed staff had always offered to get them medical help if they felt unwell.

People said they liked the staff who supported them and said that they thought staff were knowledgeable about the support they provided. One person said, "They are good," and another person commented "They are a good team." The office for Links View was based within the extra care building. On arrival we found it difficult to find where the office was based as no clear signage was available within the foyer. A doorbell outside of the building was available but could be easily overlooked. Once in the building a pass was needed to access the area of the building where the office was located. Although this meant added security it also made it more difficult to find staff from the agency to talk with. A reception area was closed and we were advised that this was staffed twice a week for anybody wishing to talk to agency staff. Clearer signage within the building would make it easier for visitors to find staff working for the agency to talk with.

Mears Care Limited have a training department who arrange training for staff working at Links View. We were advised that all staff received training in health and safety, mental capacity, food hygiene, infection control, medication, moving and handling, safeguarding and fire. Records showed that staff had undertaken this training and a list of staff whose training was due to expire had been sent to the team leader so that refresher training could be arranged. A member of staff told us that they had attended a refresher training day and found it beneficial. We were told that all staff either held or were working towards a National Vocational Qualification (NVQ) in care.
Staff told us that they had been given the above training from Mears Care Limited but had not received any training in more specialist areas. One member of staff commented, "We have learnt ourselves." A second member of staff said, "I just had basic training. I learnt a lot doing my NVQ. I learnt myself about dementia."

No overall training plan was in place for staff at Links View and we saw no evidence that staff had received training to help them meet any additional needs of the people they supported. For example, we saw that one person the agency supported, had diabetes and that information was available within their care file. However, we saw no evidence that staff had received training on this subject. The team leader advised us that additional training could be requested. We saw a request had been made for training in epilepsy. We were told that this was being arranged but saw no information as to when it would take place. The lack of more specialist training along with the lack of a planned training programme meant that staff may lack the knowledge they need to support people safely and well.

Staff meetings had been held in March and May 2016 and a variety of areas had been covered including care plans, security, inspection, medication and staff issues. In addition individual staff files showed that staff had received a yearly appraisal and some one-to-one supervision sessions had also taken place. These meetings provided staff with the opportunity to discuss their work and any support they may require. Observations of staff practice had also been undertaken by senior staff and their findings recorded and discussed with the staff member.

Staff had received training in understanding the Mental Capacity Act 2005 and demonstrated an understanding of people's right to make their own decisions. People told us that staff provided their care in a way they preferred and listened to them. They also told us that they had been involved in putting together and reviewing, their care plan. We saw that care plans had been signed by the person wherever possible to agree the contents. Information about how the person made decisions and their ability to do so was recorded within their care plan.

Information about any health conditions the person had was also recorded within their care plan along with guidance for staff to follow to support the person with their health.

People told us that staff provided them with support including shopping for meals or preparing meals as detailed within their plan. People also told us and we observed throughout our visit that staff were always willing to make them a drink. Guidance on the support people required with their meals or drinks was recorded within their care plan.

Requires Improvement

Is the service caring?

Our findings

Comments we received from people about staff who supported them included: "They have been good", "They are lovely", "They are very good," and "Some of the staff are marvellous." People told us that they liked the staff team and had found staff to be polite and respectful towards them. People knew how to use their lifeline to call for help from staff at any time of the day or night and were confident they would receive a response.

A survey carried out by the agency in June 2016 had received positive comments about staff and included the comments, 'They respect my privacy' and 'Every carer goes the extra mile.'
A tannoy system was used by the agency to communicate with people living in the flats who they supported. This was used to provide information to people on upcoming events such as activities. It was also used to inform people of our inspection should they wish to speak to us. People supported by the agency and staff had conflicting views as to how well this system worked.

Some people told us that they found this system worked well, however other people said that they could not always hear the messages clearly and sometimes missed them. Staff expressed similar views. A senior member of staff told us that the system had recently been replaced and tested. However the fact that a number of people said they often missed the information indicates the agency should look at alternative or additional ways to communicate important information to people.

One person told us, "New people are not always introduced." They explained and other people agreed, that it would be nice if new people coming to live at the flats and supported by the agency were introduced to them, as sometimes new people attended activities run by the agency but did not get formally introduced. They said they thought this would help people settle in and build more of a community feeling to the support they received.

We found that staff knew the people who they supported well and we observed that they had built positive relationships with people. Staff were respectful of the fact they were entering somebody's home and waited for permission before entering. We observed that staff altered their communication style to interact with people in a way that the person preferred.

People had been given information about the agency and how it worked via a 'service user guide.' This was a generic guide for Mears Care Limited and contained information about some of their policies and procedures.

Requires Improvement

Is the service responsive?

Our findings

People told us that when they had used their lifeline call bells staff had always responded quickly. They also told us that staff usually arrived to provide their support on time.

People said that if they wished to change the time of their support by pre-arrangement such as when they had an appointment then staff had always accommodated this.

Two people we spoke with told us of occasions when had been in bed feeling unwell when staff arrived to provide their morning support. They told us, "They can't come back so if you are in bed at 8am you may be better by lunchtime and can get up but there's no carer to help you," and "They say once they go out they can't come back." One person explained this had happened to them over a year ago whilst another person said it had occurred recently.

A member of staff explained that they had been told they were only insured to help people at the times set in their care plan. Conversely a senior member of staff said that if possible staff would return to help the person later. Another member of staff said, "I think we are flexible. I read notes yesterday that said the person asked could we come back in half an hour and we did."

This conflicting information meant that staff and the people they supported were not fully aware of how responsive and flexible the agency could be in providing the support people were contracted to receive.

People using the agency told us that if they were unhappy with something then they would feel confident to raise it with a senior member of staff. A complaints procedure was in place for staff to follow and information about this was recorded within the 'service user guide.' This provided information about the timescales within which a response to the complaint would be made. However it also said that if the complainant was unhappy with the local investigation then people could contact the regional operational manager and stated, 'the address is at the front of this guide.' The service user guide which we were given did not contain these contact details.

The complaint file held in the agency's office contained details of one complaint made by several people receiving support in May 2015. We were told by the team leader that this had been investigated and responded to by staff from Mears Care Limited head office. However no details of the investigation process, outcome and whether this was feedback to the complainants were available. This meant that we were unable to check whether the agency had followed their own procedures and responded appropriately to the complaint. It also meant that people in charge of the day to day running of the agency had no information to refer to so that they could ensure any actions rising from the complaint had been addressed.

Some of the people using the service told us that they had raised concerns in the past regarding the tannoy system used and the flexibility of the service. We were told by a senior member of staff that the tannoy system had been replaced, however we found some people remained unhappy with this. The fact that these on-going concerns had not been noted and therefore addressed by the agency showed us that the

complaints system was not always effective.

Individual care plans were in place for all of the people the agency supported. Copies of these were located within the agencies office and within the person's home. Information about the person, their support needs and how they liked this support had been assessed and where needed a care plan to provide guidance for staff was in place. Information was detailed and included the person's health, mobility, medication, decision making, safety, and personal care. Care plans had been regularly reviewed to check they were up to date and reflected any changes to the persons care needs. People knew about their care plans and said they had discussed the contents with a member of staff.

A member staff told us they found the care plans useful and explained that they referred to them when need as, "They give a background" of the support people needed.

Where identified within their plan of care people received support from the agency with activities such as carrying out their shopping. Within the extra care scheme the agency provided communal activities each afternoon for people to participate in. On the afternoon of our visit a group of people were playing, 'Play your cards right.' Other activities had included quizzes and bingo. Within the wider building an attached community hub provided a number of activities that people could take part in if they chose.

Requires Improvement

Is the service well-led?

Our findings

The agency did not have a registered manager in post. The last registered manager had left in July 2016. Staff told us that they had had a number of managers whilst working for the agency. They explained that since January 2015 there had been four successive managers working there, two of whom had registered with the Care Quality Commission.

At the time of our inspection the management team consisted of two senior carers and a team leader. The team leader worked Monday to Friday and was viewed by staff and people using the agency as the person currently managing the service on a day to day basis. We were told that an operational manager for Mears Care Limited had overall management responsibility for the service provided at Links View. However they were not locally based and also had wider management responsibilities.

One member of staff told us that they had felt supported by the agency when they had changed their job role. However other staff said that they had not felt supported. Their comments included, "There's no support from the company. Managers come and go," and "We are kind of left to it."
It is our view that the lack of a stable management structure at Links View had impacted on the morale of the staff team.

The views of people supported at Links View had been obtained via surveys carried out in November 2015 and June 2016. We looked at the 13 responses received from the June 2016 survey and found these were generally positive. 100 percent of people said that staff were caring, respected their independence and treated them with dignity. 85 percent of people said that staff had met their needs in a timely manner. Comments included, 'They go the extra mile' and 'A friendly great service responsive to my needs.' The result of the survey had been analysed into categories and we were told that an action plan was in the process of being put together to address the areas where improvements could be made.

Some quality assurance systems were in place at the agency. For example we saw that staff files had been audited to ensure all the relevant information had been obtained. An audit of medication records had been carried out which had identified some missing signatures. However we found concerns with the management of medication stocks for people who required support. No overall audit of the support provided to people with their medication was in use.

Throughout our inspection we found parts of the service provided at Links View required improvement. This included the management of people's medication, ineffective systems for listening to people's views and acting on them and staff who felt unsupported by the agency. We also found that information relevant to the running of the service such as complaints records and a training plan were not available. We are concerned that quality assurance systems in place from the agency had failed to note and address these issues.

We were told that Mears Care Limited had undertaken an overall audit of the service provided at Links View in July 2016. The results of this had not yet been sent to Links View and we were therefore unable to verify whether this had resulted in any areas for improvement being noted and therefore if any action had been

taken or was planned.

Prior to our inspection we tried to contact the agency but were unable to do so. This was because they had not updated us when the phone number and email contact they had given to us had changed.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations because the provider had failed to assess, monitor and improve the quality of the service and seek and act on feedback from relevant persons in order to evaluate and continually improve the service.

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 The provider had failed to ensure medicines were properly and safely managed.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality of the service and seek and act on feedback from relevant persons in order to evaluate and continually improve the service.