Merit Healthcare Ltd

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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

Merit Healthcare Ltd provides care to people living in Gloucestershire. This service provides care at home. It provides personal care to 20 people living in their own houses and flats in the community. It provides a service to older adults, younger people, people who misuse drugs and alcohol and people with mental health problems. It can also support people with a physical disability, sensory impairment and people living with dementia. Not everyone using Merit Healthcare Ltd receives a regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

This inspection took place on 2, 3 and 14 November 2017. The service had not previously been inspected. The service was first registered with CQC on 17 November 2016 and began providing personal care to people in March 2017. This is the first time the service has been rated Requires Improvement.

There was a registered manager in place. A registered manager is a person who has registered with the 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.

People were not being kept safe from the risks of potential harm. Risk assessments had not been completed describing the strategies in place to keep people safe from the risk of choking and how any tissue viability concerns were managed. Staff had not always followed people's moving and handling and medicines care plans putting them at potential risk of harm. Medicines administration charts had not always been completed. People did not always get their medicines at times to suit them. People did not always receive their care to reflect their personal wishes or preferences. Staff had not reported missed visits or near misses. The registered manager was unable to respond to these and to make the appropriate changes or improvements to the service. Their quality assurance processes had not identified these issues. People's capacity to consent to their care had not been considered in line with the Mental Capacity Act 2005.

Merit Healthcare provided care to people by staff they knew well. People liked the consistency of having a named person to deliver their care. Arrangements were in place to provide cover for absences. People said their visits were usually on time and staff stayed for the correct length of time to meet their needs. People's dietary needs had been discussed with them and staff ensured they provided snacks and access to fluids when needed. People's health and well-being was monitored. Staff reported any changes to the registered manager who liaised with the family and health care professionals. Staff understood how to recognise and report suspected abuse and how to ensure people stayed safe in their homes.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were treated with respect and dignity and their independence was encouraged. Staff knew people well and had

positive relationships with people. People's needs had been assessed to make sure the service could meet their needs. People and their relatives had been involved in the planning of the care and support. People's care plans were available to staff electronically and technology was being introduced which would monitor visit times. People's diversity and human rights were respected and adjustments made to their care and support if needed. Information could be provided in alternative formats if needed. People knew how to make a complaint. Complaints had been investigated and action taken to improve people's experience of their care.

The registered manager had a vision for the service to provide personalised care to people by staff they knew well. They recognised the need for improvements to achieve this. Quality assurance systems sought feedback from people and their families to find out their experience of their care. She recognised the need to value staff and to maintain a stable staff team. The registered manager kept up to date with best practice and current guidance through links with other agencies.

We have made one recommendation to ensure new staff complete a robust induction programme. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version 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. People were not protected against the risk of harm or injury. Risk assessments had not been put in place describing strategies to keep them safe from the risk of choking or tissue viability concerns. Staff did not always follow risk assessment guidance. Lessons had not always been learnt when things went wrong.

People's medicines were not administered and managed safely and given at the times they needed them.

People were supported by staff who had been through a recruitment process to check their suitability to provide their care.

Staff understood how to recognise and report suspected abuse. People were protected against the risk of infections.

Is the service effective?

Requires Improvement

The service was not as effective as it could be. People's capacity to consent to their care and support had not been considered in line with the Mental Capacity Act.
People did not always have their needs met by staff who had all the skills and knowledge they needed. The induction process for new staff was not robust.

People's needs were assessed and technology was used to improve the delivery of their care and support.

People were supported to stay healthy and well through help to maintain their diet and fluid intake. Staff monitored people's health and well-being and liaised with other organisations and health care professionals to co-ordinate their care.

Is the service caring?

Good

The service was caring. People were treated with kindness, respect and understanding. Their independence was encouraged and their communication needs had been explored with them.

People and those important to them were involved in the planning and review of their care and support.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care did not always reflect their individual preferences and needs.

People had accessible information about how to raise a complaint. Complaints were investigated and responded to, with action being taken to address any issues raised.

Is the service well-led?

Requires Improvement

The service was not always well-led. Clear and transparent processes were not in place for staff to report and take account for their actions and performance. As a result the service was unable to respond and drive through quality improvements.

The registered manager had a clear vision for the direction of the service and wished to improve the quality of service provided to people. They liaised closely with other agencies to share information openly and transparently.

People's views were sought to make improvements to their experience of their care and support.

Merit Healthcare Ltd

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 took place on 2, 3 and 14 November and was announced. We gave the service notice of the inspection because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure they were in. Inspection site visit activity started on 2 November 2017 and ended on 14 November 2017. It included a visit to the office, visits to people in their homes, telephone calls to people and emails to staff and social care professionals. We visited the office location on 2 November 2017 to see the registered manager; and to review care records, staff records, quality assurance systems and policies and procedures.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We contacted the commissioners of the service obtain their views about the care provided to people.

During our inspection we spoke with two people and two relatives over the telephone and two people and one relative in person. We spoke with the registered manager and one member of staff. We contacted two members of staff asking for their feedback. A community nurse, two social workers and commissioners of the service provided feedback. We looked at the care records for four people, including their medicines records. We looked at the recruitment records for six new members of staff, training records and quality assurance systems. We asked the registered manager for additional information after the inspection, which was provided.

Requires Improvement

Is the service safe?

Our findings

Risks to people's wellbeing and safety had not always been effectively managed or mitigated. We saw people's risk of falls, developing pressure ulcers and nutritional risks including the risk of choking had been discussed with them and identified in their care plans. Care plans clearly stated when people needed a soft diet or thickened fluids to minimise their risk of choking or if their skin condition needed to be checked and monitored to prevent pressure ulcers. Staff accessed people's care records through electronic systems. These electronic records did not include information relating to the management of people's risks of choking or tissue viability concerns that were available in their paper records, copies of which were kept in their homes and in the office. This meant when staff relied on people's electronic care records to deliver care these did not always guide staff about the actions required to protect people. There were times when staff, who had not worked previously with people, were asked to provide their care but had not followed strategies to minimise risks. For example, moving them inappropriately or administering their medicines when this was done by their family. They did not have access to sufficient information about the risks to people to provide their care safely. This increased the risk of people receiving unsafe and inappropriate care and support.

People's equipment was not always being used safely. For example, one person's urinary catheter care was not being managed correctly which placed them at risk of infections. A relative stated at times staff would put the night bag on during the day and at other times they would not fix the clip correctly to the day bag leading to leaks and discomfort for the person. Another person's moving and handling risk assessment clearly stated they were unable to mobilise independently and needed the support of one member of staff with the assistance of a family member. A standing aid had been provided to ensure the person was transferred safely from their bed to a wheelchair. A relative told us a new member of staff had prompted the person to stand and attempted to transfer them without the equipment or the help of a second person. The relative was able to prevent an accident occurring. There were no records in the office of this near miss. The registered manager was informed of this, by us, during the inspection.

People were potentially put at risk of harm or injury because the provider had not done all that was reasonably practicable to minimise risks. This was a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks, such as those linked to the premises, were risk assessed and agreed actions to minimise those risks were in place. People had been involved in assessments of their environment to identify and lessen any possible risks both to them and to care staffing visiting them. Environmental risk assessments recognised hazards with the layout of people's homes such as moving equipment in narrow spaces or identifying obstructions. Staff were directed to make sure people were left safely with access to lifelines (mobile alarm systems) and their home was secure. Staff had raised concerns about a lifeline which was not working and the organisation responsible had been called to replace it.

People's medicines had not always been managed or administered safely. Each person had a medicines care plan which agreed the medicine support staff were to provide and described how people were to

receive their medicines from staff. A relative stated a new member of staff had given medicines to one person, despite the care plan stating the family took responsibility for medicines. This put the person at risk of receiving the wrong medicines. Another person was observed being given their medicines by staff but staff had not always recorded the medicine support given to this person for each individual medicine on every occasion. Staff had occasionally entered this in the daily records but this was not done each day. This increased the risks of the person being given their medicines incorrectly. The person's care plan stated staff would give the person their medicines twice daily. One person described how they were unable to take their medicines as prescribed because their early morning visit had been changed to mid-morning. They needed to take their medicines with food and had to wait until staff arrived later in the day. This meant they had not received the support they required to maintain their blood sugar levels. The registered manager had raised this issue with the local authority because they were having difficulty meeting this person's needs. People's medicines were not always being safely administered.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had consented to have their medicines administered by staff. Staff completed training in the safe handling of medicines and were observed administering medicines before being assessed as competent. A medicines error had been highlighted with the local authority which was raised because a person would not take their medicines. The local authority and health care professionals were informed and were taking action to address this. Staff continued to offer the person their medicines. Systems were in place so that staff could electronically inform the registered manager about any changes to people's medicines so that care plans and medicines records could be kept up to date.

Lessons were not always learnt when things went wrong. As a result of a safeguarding concern the registered manager had recognised the need to be more robust in her recording of conversations with health care professionals and the logging of incidents. The registered manager had liaised with other organisations and health care professionals to review incidents and issues when things had gone wrong. However records had not been maintained providing a thorough overview of any investigations which had taken place and the action taken to address these. The registered manager said they would take action to improve safety. Staff had not always reported missed visits or raised near misses internally. There were not effective processes in place to monitor missed visits or near misses and to evidence any lessons learnt and action taken in response to ensure people were safe.

This was a breach of regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager monitored accident and incidents to assess if any action needed to be taken to prevent them reoccurring. There had been two incidents logged and action had been taken to make a referral to an occupational therapist in response to increased risks for one person.

People were safeguarded from abuse. People were supported by staff who had access to safeguarding training and information to equip them with the knowledge to recognise and report suspected abuse. Staff described what they would do in response to suspected abuse and were confident any issues they raised with the manager would be responded too appropriately. Safeguarding policies described how people's protected characteristics under the Equality Act would be positively promoted to prevent discrimination and harassment. People were given information about their rights and how to raise concerns in their individual service user guides as well as during the assessment process. People said they felt safe with the staff they knew well. The registered manager was aware of her responsibility to raise safeguarding concerns

and to inform the police, the local safeguarding authority and the Care Quality Commission if safeguarding concerns were raised. A safeguarding concern had been raised with us and the registered manager had provided a report of her investigation into this.

People were supported by staff who had been through a recruitment process which assessed their aptitude and character to provide care to people. A full employment history had been provided with any gaps being explored. Previous employers had been requested to verify the reason for leaving and the applicant's competency. Additional telephone checks had been completed to verify authenticity of any references supplied. A Disclosure and Barring Service (DBS) check had been completed prior to staff starting work. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable staff from working with vulnerable groups of people. Risk assessments were put in place when the registered manager had been unable to obtain a reference from a previous employer to describe the strategies put in place to lessen any risks. For example, there was an increased period of time when they shadowed other staff or the registered manager carried out spot checks.

People were supported by enough staff to meet their needs. They were matched with care staff wherever possible. Three care staff were allocated to visit people living in Stroud, Cirencester and Cheltenham. People liked to have staff they knew well. They told us they liked the consistency of being supported by one main carer. There were systems in place to cover visits. Additional carers or the registered manager were available to help out for planned and unplanned absences. New staff completed the care certificate as part of their induction programme which included training in aspects of health and safety and implementing safe practice into their day to day work. The care certificate is a set of national standards that health and social care workers adhere to in their daily working life.

People were protected against the risk of infections. Staff had completed training in infection control and management of hazardous materials. They were supplied with personal protective equipment and were observed washing their hands. Staff were directed not to use any hazardous chemicals in people's homes if they were unable to read the label clearly. Staff had completed training in food hygiene and followed correct procedures when preparing and giving people food and fluids.

Requires Improvement

Is the service effective?

Our findings

People's consent had been sought in relation to the administration of their medicines and records confirmed when they agreed to this. Staff had completed training in the Mental Capacity Act 2005 and were observed giving people choices about their day to day lives such as what to eat and drink and whether to stay in bed or to get up.

However, people's capacity to make decisions about all aspects of their day to day care had not been considered in line with the Mental Capacity Act 2005 (MCA). The 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. Assessment records and care plans prompted questions about whether people had the capacity to make decisions or if they needed support to make choices in their best interests. This section had not been completed correctly and did not provide an overview of when people were unable to consent to aspects of their care and how decisions had been made on their behalf and by whom. People's local authority assessments provided information about their capacity to make decisions. People's care plans had been signed by their relatives but the registered manager had not verified whether they had a legal power of attorney to enable them to do this. Where a lasting power of attorney was appointed they had the authority to make specific best interests' decisions on behalf of that person, if they were unable to make the decisions for themselves. People's care had not been provided with regard to their capacity to consent about the support being provided.

This was a breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff who had the knowledge and skills to support them and deliver their care effectively. New staff shadowed existing staff during induction and were observed by the registered manager to assess their competency to work alone. Spot checks and observations of practice were carried out as part of their individual support to assess their on-going development and whether additional support or training was needed. However, one new member of staff had not always followed people's care plans when delivering their care and support potentially putting them at risk of harm. The induction process had not picked this up. Catheter care management was not included as part of the induction programme to ensure staff had the skills to deliver effective catheter care when required.

We recommend that the service review their induction training with support from a reputable source.

Staff completed training considered as mandatory including first aid, health and safety, moving and handling and whistle blowing. In addition staff completed mental health and dementia awareness. The registered manager worked as part of the team and this helped to monitor the quality of service being provided. They said they would address any poor performance issues and there was a disciplinary process in place should this be needed. The provider information return stated, "We engage with others in the industry

to pick good practices that can guide us to improve our practice. Management team acquaints itself with new training, health practices and general knowledge with external training programmes and through partnerships."

People's needs had been assessed to make sure the service was able to provide their care and support. The registered manager visited people and their relatives to discuss their care needs and their personal wishes and expectations. They had copies of assessments supplied by the placing authority providing them with an overview of people's physical, social and mental health needs. From this information care records were developed which were kept electronically. In addition any changes to their needs could be uploaded as they occurred. An electronic call monitoring system (staff ring in to a central location on arrival and as they leave) was being introduced as part of the provider's contract with local commissioners to log and monitor visit times. Commissioners said they were making arrangements so they could have oversight of this to assess how the scheduling was working.

People's protected characteristics under the Equality Act were promoted. Staff had access to training in Equality and Diversity. People's spiritual, religious and cultural needs had been identified as part of their initial assessment of need. The registered manager considered people's diverse needs and whether any adjustments needed to be made to the delivery of their care.

People were supported to maintain their dietary needs and fluid intake. Their care plans stated what help they needed such as leaving drinks nearby or offering snacks and light meals. If people had been prescribed a soft or pureed diet and thickened fluids this was highlighted. A person living with diabetes had clear guidance about what they could eat and how they liked to have their food prepared. They said, "Staff are good at preparing snacks the way I like them." People's personal preferences were recorded in their care plans and staff were observed checking with people whether they wanted something different. Staff were heard informing people when food was going out of date or if they were running short of particular items. The webpage for Merit Healthcare stated, "Caregivers are trained in dementia needs and the particular commonalities that they need to pay attention to in order to meet health and social needs: Regular snacks or small meals, make food look appealing to stimulate appetite, encourage with eating, provide food the person likes and to try different types of food."

People's health needs had been considered and staff liaised with health care professionals. A social care professional said, "They actively worked with me to resolve issues or find alternative ways of providing support where possible." When staff had concerns about people's health they raised this with their family and the registered manager. If needed they contacted emergency services and followed the advice provided by them until paramedics were in attendance. If people's needs were changing, such as reduced mobility, staff contacted the office who liaised with family and if appropriate, health care professionals. The registered manager said they communicated with other social and health care professionals to ensure people's care and support was co-ordinated throughout their time with the service. This also included obtaining information about whether a person had a Do not attempt cardiopulmonary resuscitation (DNACPR) order in place. DNACPR orders are a decision made in advance should a person suffer a cardiac or respiratory arrest about whether they wish to be resuscitated.

Good

Is the service caring?

Our findings

People were treated with kindness and care. They told us, "She (care staff) is perfect. She looks after me well", "Carers are good, they looked after him well" and "Very good care." Staff were observed treating people with kindness and understanding. They had a good rapport with people and there was a light hearted atmosphere as they attended to people's needs. People liked having staff who knew them well. Each person had a main member of care staff allocated to meet their needs. The registered manager, other staff or bank staff would cover for absences. One person said, "It's very good having the same person, she knows me well and [name] covers who also knows me." Staff were provided with information about people's backgrounds and histories enabling them to talk with them. Staff said they would raise any concerns about people's well-being. They were observed responding to people in a timely fashion and explaining what they were going to do for them. Health and social care professionals commented, "I have witnessed the carers with service users and have seen their empathy and quiet efficiency" and "Staff had a good relationship with service users and completed their tasks fully and with good competency."

People's personal information was kept securely and confidentiality. Staff respected their right to family life and considered the relationships between people when in their homes. People's spiritual and cultural preferences had been discussed and for one person visit times were altered to accommodate their wish to go to a place of worship each week. People's sensory needs were also discussed with them and whether any adjustments needed to be made to their care and support. Staff were prompted to check to see if people had access to hearing aids and glasses. One person's care plans guided staff to have effective conversation with them by using simple sentences and speaking clearly.

People and their relatives said they had been involved in decisions about the care and support provided to them. They said reviews of their care had been held and their care records had been updated to reflect any changes. People said staff stayed for the correct length of time and were able to meet their care needs. They told us, "They do their best to get here on time – they never let me down" and "They let me know if they are running late." Staff confirmed they had sufficient travelling time between visits and enough time to carry out the tasks required of them.

People's privacy and dignity were respected. The provider's webpage stated, "Clients are treated as individuals, with both dignity and respect and we provide them with personalised care plans which account for their preferences, needs and choices." Care plans prompted staff to maintain privacy and dignity by "closing curtains and blinds" and "covering people to maximise dignity". People said, "The carer is efficient and professional and shows kindness and consideration" and "Carers are kind and thoughtful of my husband's needs. We are very pleased with the care they give." Staff were observed treating people with dignity and respect. People's independence was encouraged. Their care records described what they could do for themselves and what they needed help with. For example, staff were observed offering a person a hair brush so they could do their hair for themselves.

Requires Improvement

Is the service responsive?

Our findings

People's care and support needs did not always reflect their individual wishes, preferences and routines important to them. People were not always having their visits at times to suit them and as scheduled. A person told us how the first visit of the day was mid-morning instead of early morning impacting on when they had their breakfast and took their medicines. One relative described how a person had not received lunch time visits for several weeks because the early visits had been later than scheduled. These visits had not been logged as missed visits. This meant the registered manager was not able to ensure the person had their care and support provided when needed. This potentially put them at risk of neglect. Another person said they had two missed visits over a weekend and the registered manager had been very apologetic. Two people complained about their schedules being changed to accommodate new people using the service. Two other people said they had been given notice because the provider was no longer able to offer a service to them due to the geographical area of the round for their member of staff. The registered manager acknowledged the difficulties experienced by a small service when planning and delivering packages of care which did not complement each other geographically. Health care professionals had also commented about notice being given to people because staff schedules were no longer viable. One person commented, "It affects us so much, we feel let down." People's care was not always person centred, reflecting their individual choices.

People's personal preferences and human rights had not always been recorded. People's preferences for whether they wished to be supported by male or female staff had not been recorded in their care records. One person said they had been "shocked" when a male member of staff had turned up to deliver their personal care. The registered manager said they had discussed with people and their families during the admission process the possibility of their personal care being provided by male care staff.

People's care and support did not always meet their needs and preferences. It was not always appropriate to their needs. This was a breach of regulation 9(1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had identified their goals as remaining in their homes and promoting their independence. Their care records evidenced how this was to be achieved. For example, one person needed supporting with time to make decisions and to be reminded about important tasks. One relative said, "They work very hard to enable my Nan to be at home." Relatives said they felt involved in the planning of care and their views were sought and recognised. Reviews of people's care were scheduled to coincide with visits from care staff so they could be included in this process. A social care professional confirmed, "I found them very timely, providing person centred care."

People's care plans reflected their diversity and protected characteristics under the Equality Act. People's sensory needs had been identified and staff were prompted to make sure people had access to equipment to ensure their continued independence. For example, checking hearing aids were in working order and glasses were accessible. People's care records highlighted whether any adjustments needed to be made to promote effective communication. The registered manager said information could be provided in

alternative formats for people if they wished in line with the Accessible Information Standard. Staff were able to maintain and update records electronically. They could send a free text note to the registered manager to highlight any changes to people's needs. People and their relatives had been provided with paper copies of their care records which were replaced as these were changed. People said they could contact the registered manager by telephone or email. An out of normal working hour's service was available to respond to telephone calls at these times.

People said they knew how to make a complaint. They said, "I would call [Name], but I couldn't complain about anything" and "My son complained and received an apology." The service user handbook contained a copy of the service's complaints procedure. People also had information about who to raise complaints with if they were dis-satisfied with the response from the provider. The registered manager said they spoke with people and their relatives as soon as issues were raised to prevent an escalation into a complaint. They had logged eight complaints between April and September 2017. These had been investigated and action taken to address any issues raised. The complaints focussed on a short visit, people refusing personal care, changes to scheduled visits and care staff not following the care plan. Each complaint had a report which summarised the actions taken with a copy of the response to the complainant. Where necessary an apology had been given. People who raised complaints felt they had been treated fairly and would be confident raising other concerns with the registered manager. The registered manager said when reviewing the complaints they had recognised the need to improve record keeping and had worked with staff to improve the daily notes they kept.

Requires Improvement

Is the service well-led?

Our findings

Whilst people's feedback about the management was positive we found people's experience of their care was affected by a lack of good governance and oversight. The provider's monitoring and oversight systems had not ensured the service was running well and that people were not exposed to the risk of harm.

The registered manager had a system of quality assurance checks and audits in place to monitor care and plan on-going improvements these included monthly audits of care planning documents, accidents and medicines administration. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered manager worked alongside staff, observing the care and support they provided, analysed complaints and implemented changes from lessons learnt. However, these checks and reviews were not robust and had not identified the issues found during the inspection.

The provider's quality assurance monitoring tools had not identified poor record keeping for medicines administration and the lack of records around people's capacity to consent to their care and support. Their induction and staff competency monitoring process had not identified that all staff did not have the skills and knowledge to deliver people's care effectively. Effective quality assurance systems were not in place to collate information about incidents and investigations. In the absence of these processes, the registered manager was unable to take the appropriate action to respond to quality or safety issues without delay. Resources were not available to drive through improvements which could be maintained.

This was a breach of regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager maintained their knowledge and skills, as well as keeping an overview of best practice through membership of a local care provider organisation, Skills for Care and the Care Quality Commission (CQC) monthly newsletters. As an assessor she was planning to look into refresher training and also to research registered manager courses organised by the local authority. The registered manager was willing to learn and to work with CQC to make improvements to the service being provided. The registered manager was aware of their responsibility to submit notifications to CQC. Statutory notifications are information the provider is legally required to send us about significant events. Secure systems were in place for the management of people's personal information.

The registered manager owned the service and worked alongside staff to deliver care and support. This gave her an overview of the quality of care being provided, of the conduct of staff and the day to day challenges of providing a small service. She discussed with us the challenges of trying to increase in size slowly; ensuring staff had the right skills and sufficient hours and incentive to continue working for Merit Healthcare. By valuing staff for their input, paying them a minimum guaranteed wage it was hoped to ensure staff retention and the continuity of care people wished to receive. Merit Healthcare's website stated, "We care deeply for the people we serve. We help them live independent lives, while assisting with daily tasks that have become

difficult. We aim to assist people to maintain a fulfilled lifestyle whilst promoting dignity, privacy, choice and independence." Staff spoken with understood these values.

The registered manager was open and accessible to staff. Staff said they found her approachable and could talk through any issues or problems with her directly. Staff had individual meetings with the registered manager as well as team meetings to talk about the service they provided and their training needs. Staff records evidenced discussions about their performance and how they could improve their practice for example, explaining to people what they were doing when giving them their medicines. The provider information return stated, "The registered manager leads by example" and "We give constructive feedback to staff, more to empower them, by drawing on good practice discussions and how bad practice can be improved." The registered manager recognised her responsibility, under the duty of candour, to admit when things had gone wrong, to inform people and apologise for any mistakes.

People and those important to them were asked for their opinions of the service provided. Surveys based on CQC's key lines of enquiry were sent out to people seeking their views. The first survey had asked questions about how safe people felt receiving their care and support. Feedback was positive and the registered manager said they would follow up any issues raised, such as "better timekeeping needed". They planned to visit people individually to respond to any issues they raised. They said a report would be compiled summarising the results of the surveys and any actions taken to improve the service would be highlighted. The registered manager completed additional quality assurance audits each month identifying good practice, such as tissue viability management. Actions highlighted areas for improvement, for example improving infection control risks. There was evidence the registered manager was making progress to make changes for the better.

The service had embraced the use of technology to give staff greater accessibility to people's care records and to improve communication about people's changing needs. The use of electronic call monitoring provided the opportunity to check visit times so that schedules could be adjusted if needed. The registered manager recognised the challenges of operating a small service and was looking to work with other organisations and agencies to learn and improve their practice in line with current guidance and best practice. The provider information return stated, "We continue to seek partnership where innovative ideas of developing the business and streamlining processes can be gained." The registered manager had liaised with safeguarding teams, commissioners and social care professionals to share information and carry out assessments for people being referred to the service. They were heard being open and transparent about what they could provide when discussing potential referrals with commissioners.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured that people's care and support was appropriate, met their needs and reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not assessed all the risks to the health and safety of people and had not done all that was reasonably practicable to lessen those risks. People's equipment was not being used safely by staff to meet their needs. People's medicines were not being managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that robust processes were in place to assess, monitor and improve the quality and safety of services provided to people. Systems were not in place to lessen these risks. Accurate and contemporaneous records had not been maintained in relation to people's capacity to consent to their care.