Mears Care Limited

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Inspection report

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Date of inspection visit:
26 September 2016
27 September 2016
13 October 2016

Date of publication:
01 December 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Mears Care Limited is registered with the Care Quality Commission (CQC) to provide personal care to people living in their own homes. At the time of the inspection the service was providing care and support to 331 people.

There was a registered manager in post however the provider notified us they were off work for at least 28 days. There was a new branch manager in post who was managing the service. 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.

At our previous focused inspection carried out in June 2016, we found risks to people's health and safety had not always been assessed. The provider had not done all that they could to minimise the risks to people. The key question for 'Safe' was rated 'Requires Improvement'.

During August and September 2016, we received concerns from Healthwatch Torbay. Healthwatch is the national consumer champion in health and care. They have powers to ensure people's voices are strengthened and heard by those who commission, deliver and regulate health and care services. We also received concerns from people who use the service and staff in relation to the quality of care being provided. In response to those concerns we undertook this unannounced inspection which commenced on 26 September 2016 and ended on 13 October 2016.

We found significant concerns which meant some people did not always receive their care as planned and were placed at risk of harm.

The service did not employ enough staff to meet people's needs. This meant some people had not always received their planned visits or visits were late. This resulted in risks to people's welfare and safety. For example some people missed their medicines, missed their meals, and had to stay in bed. Some people who needed two care staff at each visit had only one staff member arrive. This meant care could not be carried out as required, or safely; or relatives/representatives were supporting the care staff to deliver care. This placed people and staff at risk of injury or harm.

Staff providing care and support did not always have the skills and knowledge they required to care for people safely. When updates in staff training were required these had not been provided. Some staff had not received regular supervision and appraisals and the majority of staff had not had any recent observations of their work. This meant the provider could not be assured staff had the skills and knowledge they needed to meet people's needs safely and appropriately.

Some people did not receive support in a caring way, particularly when care was delivered by staff they

didn't know well. People told us they were unhappy with the lack of continuity of care staff. This had caused distress, especially for people living with dementia who needed to see familiar faces. People said they had been unable to speak with managers and did not receive a return call when they requested it. Some people told us they were fobbed off and found out that information given to them was untrue. Other people found staff to be caring and had built good relationships. Some people told us they were happy when they did receive care from staff they knew.

People's individual plans of care did not always contain enough information for staff to deliver care safely or in a person centred way. Where risks were identified, these were not fully assessed, or sufficient action was not taken to ensure people received care in a safe way. Some information about people, visits and care needs was sent directly to care staff's work phones. This information was very brief and meant staff often went into a visit where a person had complex needs without prior or sufficient knowledge of these needs or how to meet them. People received inconsistent levels of care and support that was not provided according to their individual preferences. People told us care staff did not always stay for the allocated time and their care was sometimes rushed.

Information management systems were not used to support the delivery of a safe service. Reports about visits, time critical visits, visits where two carers were needed could not be accessed by staff who had responsibility to plan and monitor visits. This meant the provider was unable to ensure that everyone was receiving a visit, or identify and resolve missed or late calls to people.

People's complaints had not been taken seriously, explored thoroughly and responded to in good time. We found numerous examples of people making complaints that had not been resolved by the provider.

There had been a lack of leadership, governance and managerial oversight of the service. Although the provider had identified a number of shortfalls, they had not ensured improvements were made in a timely way to minimise risks to people. The new branch manager told us they were determined to 'get it right'. They wanted people to feel safe and staff to feel valued. We saw evidence the branch manager and Nominated Individual was taking action to make the required improvements. By the end of our inspection, senior managers had been brought into the location to support the branch manager and staff; reports were now available and were being used to monitor and manage risk, ensuring people received their care as planned; the local authority who commissions the service were working with the provider.

At this inspection we found the service to be in breach of nine regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement

action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from the risk of avoidable harm as risk assessments or actions had not been undertaken.

People were not having their needs met safely because there were insufficient staff to carry out planned visits.

People could not be assured that they would receive their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

People could not be assured that they would receive support to have their food and drink at the times they needed them.

People did not receive effective care and support as staff had not received training and supervision to ensure they had the skills to meet people's needs.

People's rights were not protected as staff were not familiar with the principles of the Mental Capacity Act and had not acted in accordance with the Act.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people did not receive support in a caring way, particularly when care was delivered by staff they didn't know well.

Other people found staff to be caring and had built good relationships.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was responsive to their needs

and respectful of their preferences.

People were at risk of receiving inappropriate care as care records were out of date and did not provide accurate information to guide staff.

People could not be confident their complaints would be taken seriously, explored thoroughly and responded to in good time.

People's needs or preferences in relation to the timing and duration of their care visit were not always respected.

Is the service well-led?

Inadequate

The service was not well-led.

A lack of leadership, governance and managerial oversight led to the service being poorly managed. Failure to respond to the concerns raised about the service placed people at risk.

People continued to receive a poor quality service because sufficient action was not taken to address the issues identified.

Communication from the office staff to people and care staff was not effective in keeping people up to date with changes.

Mears Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place between 26 September and 13 October 2016 and was unannounced. The inspection visits to the office were carried out by one inspector on 26, 27 September, and 13 October 2016. A second inspector was present on the first day. Two Experts by Experience made telephone calls to 17 people who used the service and five relatives during the week commencing 3 October 2016. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care for older people. Two inspectors carried out seven visits to people in their homes on 27 and 29 September 2016.

We received concerns from Healthwatch Torbay, people who use the service, and staff in relation to the quality of care being provided. We reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with 22 people who used the service, 10 relatives, 15 members of staff, the branch manager, the branch trainer, the executive director, and the director of quality and governance (who was also the Nominated Individual). We looked at ten care plans including risk assessments, and records relating to medicines. We looked at three staff files including recruitment information and training. We checked how the provider handled complaints and, assessed and monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

We found there had been unsafe staffing levels and some people had not received the care and support they needed. The executive director and branch manager told us that for one shift during the weekend before our inspection, 25 staff members were required to deliver care to people but only 14 staff members were working. We found evidence of 12 missed visits during that weekend. This showed there were not enough staff to carry out planned visits.

Some people required the assistance of two staff to deliver their care and assist them to mobilise. This is called a double up visit. We identified from the complaints received by the service from people and their relatives that a second member of staff was not always available to assist where needed. Therefore, on a number of occasions, one member of staff had delivered people's care. On some occasions relatives had assisted with the double up visits to support the member of staff with delivering care. On one occasion, one staff member arrived for a double up visit but as there was no other member of staff to assist them. Without a second member of staff to help move them, the person was unable to leave their bed all morning. We asked the provider how many people had not received double-up visits but they were not able to confirm this number at that time, because staff did not know, or were unable to get this information. This posed risks to people's safety as staff were not able to deliver people's care as required.

The provider failed to ensure that sufficient numbers of staff were deployed to meet their obligations to cover people's agreed visits.

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

At our previous inspection in June 2016, we found risks to people's health and safety had not always been assessed. The provider had not done all that they could to minimise the risks to people. This key question was rated as 'requires improvement' at that time. At this inspection we found the provider had not taken sufficient action to address our concerns.

Risk assessments did not give adequate information for staff on how people may be affected by their medical conditions. For example, although there was a reference to one person's dementia in their risk assessment there was no detailed information on the impact of the person's dementia on their day to day life or whether there were any risks associated with this. The daily records showed they had been agitated and didn't know where they were. The records showed medicines had been found in different places in the house, such as on the floor and in the bed. We observed this person in their home with a staff member. When the person started to wander and asked for their pet, staff were unsure of how to respond. This meant the person may become frustrated as well as being placed at increased risk of falls whilst they were walking around. The daily records showed this person had fallen twice during September 2016.

Manual handling risk assessments were not always accurate. For example, one assessment stated a person was independent with stairs, opening doors, and going out. When we visited this person they told us they

were unable to climb stairs and had to use a mobility scooter to go out. This person had experienced missed visits and told us they found it difficult to get out of bed. They had fallen in the past as their balance was unsteady and were therefore placed at risk of falls.

We also found that where people needed staff to support them with catheter care, the guidance for staff was brief, stating "empty night bag into bidet and wash out bag". There was no information on how to wash it out, how long bags can be safely used for and when they should be changed. There was no guidance for staff on how to check the site of the catheter for any signs of infection. One person told us the staff didn't know how to care for their catheter and they had to tell them what to do.

People did not always receive their medicines as prescribed. We found gaps in medicine administration sheets (MAR) so it was not clear whether people had received their medicines as prescribed. We found one person required time critical medicines to be administered by staff during their early morning visit. We found evidence staff had missed an early morning visit. When staff attended their late morning visit at 11.30am they administered the person's early morning medicine but did not administer their 11.30am medicine; with GP support, staff were advised to miss the next dose of the person's medicines. Another person had not received their evening dose of their medicine for six days. We found this was due to a staff member not completing the MAR sheet accurately to reflect the prescribed frequency of administration and staff not reading the prescription instructions on the medicine container. This meant people did not have their medicines as prescribed by their doctor.

During a home visit, we observed staff were unsure of where to find medicines and what they were administering. One staff member wrote in one person's notes "wasn't sure on meds and others informed office said next carer able to do so in case missed anything". This meant this person may not have had their medicines as prescribed.

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

A number of people being supported by Mears had experienced missed visits. However, these had not been raised as safeguarding alerts with the local authority, in line with the provider's responsibility to alert the local authority when people have been placed at risk. Staff had received training in safeguarding adults and were able to explain the different types of abuse. They knew how to report safeguarding concerns but, some staff told us they were not confident these would be acted on by the service.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always feel safe. They told us they did not always receive a rota to tell them which staff would be visiting them. Where people had received a rota we found staff changes were often made at short notice or without any notice. This meant people did not always know the staff member who was visiting them. People commented "A carer I had not met before let themselves in without ringing the bell and walked into my living room, it shook me" and "I don't know who is walking through my front door in the mornings, I am a nervous person".

We heard of occasions when staff members had arrived to deliver care when people or their relatives had already asked the provider not to send them again. Comments included "I rang the office and asked not to send them again. They sent them again, carer stayed and upset my mother again" and "I rang the office and asked for them not to come again. Carer came again I asked them to leave, they hadn't been told anything

by office".

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

Inadequate

Is the service effective?

Our findings

Some staff providing care and support did not have the skills and knowledge they required to care for people effectively. When we asked people whether they considered staff to be competent and trained, they commented "Not particularly, some of them have only shadowed a couple of times and then come out on their own" and "Problem, it's the repetition of having to tell the new ones what to do and how to do it all the time". Whilst the feedback about experienced staff was positive. Comments included "Experienced staff are very competent" and "I do not know what I would do without them".

Newly employed staff had received training from the provider as part of their induction. During the five day training course, staff completed training in moving and handling, health and safety, privacy and dignity, medicines, dementia, safeguarding adults, first aid and infection control. Staff then completed three days shadowing an experienced staff member on visits. However, staff told us they did not feel adequately trained to deliver care after the induction. Comments included "It was very brief and basic" and "medicines training scared me, one day's training". Staff who were new to working in care said "a week's training and three days shadowing. My visits took a long time as I wasn't sure what I was meant to be doing"; "I haven't had enough training in dementia to feel confident"; and "We need more in depth training in complex needs, I worry about going into some people". Experienced staff who had supported new staff on shadow visits told us they had not been asked for their feedback on the staff's ability to work on their own effectively. This meant the provider had sent new staff out to work on their own without checking they had the skills and knowledge to meet people's needs.

Mears Care Limited was registered and took on three contracts to deliver people's care. Staff who had transferred from other agencies had not received a training update since before April 2015. Records showed the date of expiry of training for all of these staff members was 31 August 2016. This meant staff had not completed training to ensure they were up-to-date with current best practice and able to carry out their work competently. Minutes of the staff meeting held in August 2016 showed there had been discussion about out of date training, new staff not having enough training or shadowing, and the need for specialist training to meet people's individual needs. We saw an action plan that stated 'training updates to be scheduled. Ongoing until all updates have been completed'. The timescale stated 'September 2016 and rolling'.

We spoke with the branch trainer who was responsible for ensuring staff received the training they needed. They told us staff were due to complete annual update training in moving and handling, health and safety, privacy and dignity, medicines, dementia, safeguarding adults, first aid and infection control. A training planner showed that this training was booked for 28 and 29 September and on ten dates in October 2016. However there was no plan of when staff would attend these sessions. The branch manager told us the trainer was going to phone staff to book them on sessions on days they were not working and carrying out visits.

A new computer system was implemented in July 2016. The director of quality and governance told us training was ongoing from this time and all staff had received training. Trainers were available on site to

provide support at the time of our inspection visit. Staff told us they were still learning how to use the system and commented "Everyone needs more intensive training. We can't get data off the new system" and "Lots of problems with implementation. Still trying to get used to it. Don't think anyone knows how to pull reports off the portal". At a senior meeting on 8 September 2016, minutes stated "missed calls need to be journaled correctly as not able to run accurate reports at present". This meant the manager was not able to monitor the visits to check they had been carried out as they should be.

Staff had not received adequate support or supervision to enable them to be effective in their role. Staff told us they had not received any recent supervisions or appraisal of their work performance. This meant they had not had the opportunity to discuss their role or any concerns they had, or to identify any training and development needs. This lack of supervision was discussed at the staff meeting held in August 2016. In response to this the branch manager told us staff were being allocated a designated line manager. The line manager would be responsible for providing supervision and support to each staff member. The provider told us there had been 66 supervisions since the beginning of August 2016. The branch manager also told us that spot checks to observe staff member's work practice had stopped. We saw that a spot check planner had been introduced to enable the office staff to identify when spot checks were due. Records showed three spot checks had been completed since 9 September 2016. A further eight checks had been planned before our inspection but had not taken place. The planner showed that a further 100 staff needed a spot check.

The provider had failed to ensure that arrangements were in place to provide staff with adequate support and supervision.

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

We checked whether the service was working within the principles of 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. The branch manager had completed training in the MCA and they had a good understanding of the principles of the MCA. They told us staff needed to complete MCA training so they understood how to put this into practice to enable them to contribute to best interest decisions. Those people who had capacity to make decisions relating to their care told us staff gained consent before carrying out personal care. However some people who used the service were living with dementia. We visited one person who was living with advanced dementia. As the person could wander, staff told us they locked the person in whilst they were carrying out the visit so they could not leave their home. They said they only knew to do this as they had visited with another staff member. The person's care plan did not contain any information relating to this or any guidance for staff about how to keep this person safe. The staff locked the person in their home when they left. No capacity assessment or best interest decision had been made in relation to this. We made a safeguarding alert to the local authority as this person was being prevented from leaving their home by staff who had no authority to do this. Since our inspection, the local authority have started a review of this person's care to address the issues. The branch manager told us quite a few people who received care were living with dementia. They told us they would check with staff who knew people well to identify whether they had capacity to make their own decisions. This would be followed up with discussions with the local authority and MCA assessments, if needed.

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

People could not be assured that they would receive the support they needed to have their food and drink at the times they needed them. Some people who required support to prepare their meals experienced missed visits. Some visits were carried out too late and the mealtime was missed. This had resulted in people missing meals. Poor monitoring and management of people's eating and drinking put people at risk. For example one person was visited by a nurse in April 2016 due to concerns about their poor nutritional intake. The person's care plan was not updated by Mears staff following this visit to include the recommendations that were made by the nurse. The person was prescribed a different high calorie supplement to their diet. Records showed this supplement was out of stock between 21 and 27 September 2016. There was no evidence staff had raised this with the office or person's relative. Food charts were in place in the person's home, for staff to record how much they ate and drank. There were gaps in these so it was not clear how much they had eaten. There was no guidance in the care plan that told staff what to do if the person did not eat well. Staff were checking this person's weight. Records showed it was checked five times in September 2016. Records showed they had lost 3.8kg since April 2016. Their Body Mass Index (BMI is a measurement of body fat based on height and weight) had moved from normal weight to underweight. There was no evidence to show that staff had notified the office or taken any action.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us they reported any changes in people's health and well-being to the on-call office staff and people's relatives. One relative told us staff kept them informed of any changes. They said "They tell me when anything untoward happens. Once she had a prolapse the carer noticed it and told me and we rang the GP who got it sorted".

Requires Improvement

Is the service caring?

Our findings

People did not always receive care and support from staff who knew them. Staff told us their rotas were often changed and they visited lots of people who were new to them. One staff member told us they had worked a shift where they had five new people one after the other. People told us they were unhappy with the lack of continuity of care staff. This had caused distress, especially for people living with dementia who needed to see familiar faces. One relative commented "We've had 62 different carers since Christmas". Another person told us they had 14 staff they didn't know visit them in a row. Staff told us they wanted more continuity in the people they visited so they could deliver better care and develop and maintain good relationships with people.

People told us the communication between the office and themselves was poor. They said messages given to the office by staff, such as when they were going to be late, were not always passed on to them. Staff told us and records showed there was an occasion when staff had found one person was unwell and they were taken to hospital. A staff member phoned the office and asked if they could phone the relative to let them know what had happened. The office told the staff member they would phone. The relative was not contacted and only found out when the hospital rang them later that day to say their loved one was very poorly. The hospital then rang them 15 minutes later to say their loved one had passed away. This prevented the relative from spending time with their loved one at the end of their life.

This was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we received many compliments about some care staff, people also raised concerns about other care staff who visited them. They said "Some carers have no idea how to treat people with dignity, they do not talk to, but over (name), they are very insensitive" and "Staff do not listen, they are strangers and have a take it or leave it attitude, I am not treated as an individual, I am just a body". Where people had expressed a preference in relation to the gender of care staff who supported them this was not always respected by staff. One person commented "They have tried sending carers of opposite sex but I will not allow that".

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they were happy when they did receive care from staff they knew. Comments included "they're wonderful, fantastic. I couldn't ask for more", "very happy with carers, they go above and beyond" and "They're brilliant". We heard about a staff member who visited a person who liked dogs. The staff member took their dog to visit the person in their own time so they could stroke and make a fuss of the dog which brought them enjoyment. One relative told us of a staff member who would bring their guitar to visits and play and sing with their loved one. The person responded well to this. However, the relative said despite requests, the staff member was not often allocated the visits.

Other comments included "Carers are brilliant", "Good chats with the carer, bringing the outside world into

me. I look forward to them coming and "Staff are absolutely lovely. They are very respectful and make me laugh". Most people told us their privacy and dignity was respected. One person commented "I treat them with respect and kindness and we have a very good relationship; I am comfortable when having personal care, they make sure I am covered up". We saw written compliments about staff's caring attitude and one thanked a staff member for promoting a person's independence. Staff spoke about people with compassion. Experienced staff we met had a good knowledge of people's needs.

Inadequate

Is the service responsive?

Our findings

At our previous inspection in June 2016, we found some care plans were basic and contained a list of tasks rather than detailed guidance about people's needs and how they wished to be cared for. The provider sent us an action plan in August 2016 which stated they had started to review and update all care plans.

We saw some care plans were still basic and still contained a list of tasks. For example, one person living with advanced dementia had a care plan that contained statements such as 'assist with strip wash or shower', 'apply creams if required' and 'assist me to dress'. There was limited information about what the person could do for themselves or how to promote their independence. There was little information relating to them as a person for example about their history, preferences and interests. This meant staff did not have detailed information to follow in order to know how to meet people's complex needs.

Some care plans did not clearly state whether people needed one or two staff members to support them with their care. Staff told us that many of the care plans were not up to date and did not reflect people's current care and support needs. There was no accurate information for staff to follow in relation to delivering personalised care to people. Staff showed us the information they were provided with directly to their work phones about their planned visits and people's care needs. This was very brief and meant staff often went into a visit where a person had complex needs without prior knowledge of these. Staff told us they sometimes had to ask people what they needed to do for them. This was confirmed by people we spoke with. This meant that people were placed at risk of receiving inappropriate care and support.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some care plans had been updated and contained a good level of detail for staff to follow. For example, some care plans contained step-by-step guidance about people's specific care needs and how they wished to be supported.

People's needs or preferences in relation to the timing and duration of their care visit were not always respected. People told us care staff did not always stay for the allocated time and their care was sometimes rushed. One person commented "Rushed, carer wanted to leave early as they had to travel to their next job, they had to give me personal care, I said no, they were not happy". Another person said "Carers are brilliant. They find it stressful, the short notice for change of rotas, time distance for travel and extra calls". A third person told us their evening visit was taking place an hour and a half before their preferred time. Staff told us that they were unable to consistently provide people with care at the times they wanted or for the amount of time that they should. Staff told us they didn't get travel time between visits. Staff could not provide consistent support because they were rushed. Staff told us they wanted to provide a good service for people and felt frustrated by the issues.

People told us when they tried to contact the agency they found they had to wait some time for the phone to be answered. They were not always satisfied with the response they received from staff. Comments

included "when I asked 'Can you please tell me who is coming this evening, they say we are working on it.' Why isn't it organised, why are they taking on more new people when they can't cope with the ones they've got" and "They say they will ring you back but they don't". People told us they were not usually informed if their care staff were going to be late, although care staff had phoned the office to ask that the person should be informed. Most people were understanding of this as they realised the previous visit may have taken longer than planned. However, some people were unhappy that they were not told staff were going to be late. They commented "Have been over an hour late and we have not been informed and "office didn't tell me staff would be an hour and a half late, the staff never arrive on time".

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's complaints had not been taken seriously, explored thoroughly and responded to in good time. People told us they had contacted the office and spoken to on-call or senior staff to make complaints. However, these were not recorded as complaints, escalated to the manager or responded to. One person told us they had complained 18 times about missed visits and poor timing of visits. They said they had received "very little in way of reply". Another person told us they had made a complaint but only received a standard letter that didn't address their concern. Staff told us under previous management complaints had been "brushed under the carpet" and old complaints had been found in a drawer with no action taken.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware that some people they visited could be at risk of social isolation. One staff member commented "the clients love the carers, sometimes they're the only people they see all day and regard them as family, which is why continuity of care is so important". The service was involved in one project to try to alleviate some people's isolation. Staff told us about the 'Silver listeners' project. This linked children from local schools with people who lived on their own. Each week the children would read a story over the phone to the person then they would discuss it and ask questions. Staff told us people had really enjoyed this.

Inadequate

Is the service well-led?

Our findings

There was a lack of leadership, governance and managerial oversight of the service. There was a registered manager in post however the provider notified us they were off work for at least 28 days. A branch manager had recently left the service. Another branch manager had recently been employed to manage the service. The branch manager was responsible for the day to day running of the service. They were supported by an area manager, a quality manager, medication officer, branch trainer, and senior care staff. Senior managers told us staff had not informed them of the issues or the extent of them.

People and their relatives told us they felt the service was not well managed. They said they had been unable to speak with managers and did not receive a return call when they requested it. One person commented "If I ask to speak to someone in authority, I am always told they are in a meeting and will ring back but they never do". Some people told us they were "fobbed off" and told staff were not there when they were, only to later find out that information given to them was untrue. One person said "I phoned when the carers were late. I was told they had been held up on their previous job but when they arrived they told me the office had slipped another visit in". People commented "All things need to be better"; "I am not happy with them at all"; "It's chaos" and "They keep saying things will get better but they don't".

The service was failing to keep records such as care plans and risk assessments up-to-date. Also reports about the management of the service were not readily available. Staff were unable to run reports which gave them information about missed visits, double up visits, time critical visits, and late visits. We requested these and had to wait several hours for these reports as staff were unsure how to get this information from the system. This meant this information was not readily available to the staff for them to carry out risk assessments and quality checks.

Mears had a quality team that had carried out an internal audit in July 2016. They used a traffic light system to rate the service: red for issues that needed immediate attention, amber for issues that required improvement or green for issues where the service was working well. They rated 'safe care and treatment' and 'governance' as red. We spoke with the Nominated Individual and he told us they didn't routinely share audits with the commissioners of the service but could do this in the future. This meant the commissioners had not been made aware of the issues identified. The shortfalls identified in the report were similar to the issues found at this inspection. Each issue had a timescale with date for completion and most issues were due to be addressed and completed by September 2016. However, there was still a lot of issues outstanding. Staff at the office told us they were addressing issues one at a time when they came in rather than looking at the service improvement as a whole. One staff member told us "there's so much firefighting, we can't get things done".

The provider did not have a system in place for ensuring care plans were up to date and staff had the information they needed. This was impacting on people's safety as shown throughout the report. By the end of our inspection 93 care plans had either been reviewed or were being reviewed. This meant care plan reviews needed to be carried out for a further 238 people.

Mears carried out a survey of all people who used the service between July and September 2016. This was done through questionnaires or in person. We saw that 258 people had responded or been contacted. The results of this consultation showed that the majority of people felt the staff were professional and met their health needs. However; not all complaints had been responded to appropriately and a number of people stated the communication with the office could be better. They also said staff were late. As a result the registered manager had visited some people to resolve their complaints. Telephone calls were now being recorded for quality monitoring and office staff had completed customer service training. They had also introduced a recruitment strategy to increase staffing numbers.

The provider did not have effective governance arrangements. Although the provider had identified a number of shortfalls with the management of the service, they had not ensured improvements were made in a timely way to minimise risks to people. We found information was not up-to-date and accurate. The provider did not have effective communication systems . The provider had not monitored progress against the action plan or taken action where progress was not achieved. This showed the provider did not have effective systems for assessing and monitoring the service as it had not improved the quality and safety of the service for people.

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

Staff roles and responsibilities were not clear to staff. Care staff told us they had been unsure who they were accountable to. They had not received adequate supervision and some staff told us they were reluctant to contact the office and only did so if they had to: they said the office staff could be rude. People who used the service and staff told us there had been a high staff turnover. Comments included "We've lost some good staff" and "Staff were quitting on the spot, just not showing up" .

Staff told us they hadn't felt valued. Comments included "I am very unhappy working for Mears, but it is my belief that things will improve", "We're all just numbers, clients and staff" and "So many things need to change for everyone's benefit". However, some staff we spoke with felt things would improve now the new branch manager had been employed. Comments included "(name) is always here, it's so much better", "Since day one, she's worked really hard. She does not hesitate to come and support staff when needed" and "The new manager is keen to put systems in place".

The branch manager told us they were determined to 'get it right'. They wanted people to feel safe and staff to feel valued and had taken steps to improve the service. They had introduced staff meetings. Issues discussed included lack of previous staff meetings, supervisions, and training; unclear roles and responsibilities; communication; personnel; care delivery; rotas; and the computer system. A newsletter had been introduced in September 2016. This thanked staff for their feedback and honesty. The branch manager wanted to work towards improving the team culture. During the inspection, the branch manager told us they had implemented changes to try to provide more stability and consistency .Each staff member had now been allocated a line manager to provide supervision and support

By the end of the inspection, we saw evidence the branch manager was taking action to make the required improvements. For example, we saw that staff were carrying out an audit of the complaints and following up past complaints to check they had been responded to and resolved. The branch manager was able to demonstrate some of the improvements already made; the re-organisation of visit routes for staff in the town of Paignton had improved continuity for people by 30% so far; the staff trainer was phoning staff to ensure they were booked in for their training update; a new missed visit procedure was being implemented; a recruitment strategy was in place to increase the number of staff; and staff were completing competency

tests to ensure they knew how to use the computer system effectively. The branch manager was aware of the issues and knew what needed to be done. Senior management had come on site to provide support to the manager and staff. We spoke with the director of quality and governance. He showed us evidence that reports relating to visits were now being printed twice a day. The branch manager told us they were monitoring these to ensure people received their care as planned.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. 10(1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to operate appropriate systems to recognise, report and manage the risk of harm to people. 13(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an effective system for identifying, receiving, handling and responding to complaints. 16(1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not always appropriate, did not meet their needs, or reflect their preferences. 9(1)(a)(b)(c)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was provided without the consent of the relevant person. 11(1)(3)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not always been assessed. The provider had not done all that is reasonably practicable to mitigate risks. Medicines had not been administered accurately, in accordance with prescriber instructions. 12(1)(2)(a)(b)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation

Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always met. There was no system in place to ensure people received their dietary supplements as prescribed. 14(1)(4)(b)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to ensure they are able to meet the requirements of HSCA RA Regulations 2014. 17(1)(2)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not deployed enough suitably qualified, competent and experienced staff to meet the needs of people at all times. Staff had not received support, training, supervision and appraisals to enable them to carry out their role. 18(1)(2)(a)

The enforcement action we took:

Notice of Decision to impose conditions