Merseycare Julie Ann Limited

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Inspection report

306 Aigburth Road
Liverpool
Merseyside
L17 9PW

Tel: 01517268060
Website: www.mcja.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced comprehensive inspection was carried out on 11, 12, 13 and 14 December 2017.

Merseycare Julie Ann is a domiciliary care agency. It provides personal care to approximately 700 people living in their own homes across Liverpool.

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

We last inspected the service in October 2016 and gave it an overall rating of 'requires improvement'. On that inspection we a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that risk management plans in people's care files were not sufficiently detailed to inform staff and some files contained conflicting information about risk.

During this inspection we found that the service had improved in this area and was no longer in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw that people's risk assessments were reviewed regularly and care files contained the information staff needed to safely manage these risks.

Medication was correctly administered and recorded by staff who had appropriate training and experience. The staff we spoke with told us that they were confident managing people's medication and people received the right medication at the right times. The people we spoke with told us that they received their medication correctly and when they needed it.

The service had robust systems in place to protect people from abuse and staff demonstrated a good understanding of this when we spoke with them. They were able to demonstrate the actions they would take in the event of a person being at risk of harm. We saw that safeguarding concerns were promptly and effectively managed by the Safeguarding and Complaints Manager, with oversight from the registered manager.

Staff were safely recruited and were supported with an induction process. Criminal records checks, known as Disclosure and Barring Service (DBS) records, were carried out. We also saw that official identification, such as a passport or driving licence and verified references from the most recent employers were also kept in staff files.

Staff training records were up-to-date and there was a clear system to document and plan staff training. We saw that all staff had received training relevant to their roles.

All new staff took part in an induction process. This included a period of office-based training and shadowing an experienced member of staff. During the induction process staff were introduced to the people they would be visiting regularly and they were not allowed to start working on their own until their mentor had assessed them as competent to do so.

The majority of staff had received timely supervisions and appraisals. A small number of staff were not up-to-date with their supervisions but the registered manager had a plan in place to address this. We were also reassured by the fact that all staff, including staff whose supervisions were overdue, told us that they felt well-supported working for the service. They received an appropriate level of supervision and had regular contact with their line managers.

People we spoke with told us that they received care from regular staff who were caring, knew them well and whom they trusted. Some people said that sometimes alternative carers attended when their regular carers were unable to do so. They said that they preferred their regular carers but the standard of care remained good.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and to report on what we find. We saw that the registered provider had policies and guidance available to staff in relation to the MCA. Staff demonstrated a basic understanding of this. The service was not supporting anybody under a court protection order at the time of the inspection.

Information about how to complain was available to the people using the service and their relatives. The people we spoke with told us they were confident they could voice any concerns they had. Complaints were dealt with by the service's Safeguarding and Complaints Manager, with oversight from the registered manager, in accordance with the service's policy and procedure and were addressed in a timely manner.

The registered provider had up-to-date policies and procedures in place to support the running of the service and these were regularly reviewed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service had robust systems in place to protect people from abuse.

Risk assessments were reviewed regularly and care files contained the information staff needed to safely manage these risks.

Staff were safely recruited.

Medication was safely administered and recorded by staff who had appropriate training and experience.

Is the service effective?

Good

The service was effective.

The majority of staff had received timely supervisions and appraisals.

Staff were given appropriate training and induction to effectively meet people's needs.

The service ensured that people consented to the care they received.

People's rights were protected by staff that had knowledge of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People told us the staff were caring and they had good relationships with them.

People's rights to privacy and dignity were respected.

The service supported people to maintain their independence.

Is the service responsive?

Good

People's care plans were person-centred and gave staff the information they needed to deliver personalised care.

People knew how to complain and the service dealt with complaints appropriately.

People told us staff were responsive to their needs.

Is the service well-led?

Good

The service was well-led.

There was experienced and strong leadership at the service with clear accountability.

There was a positive and caring culture amongst staff at the service.

Suitable audits and checks were in place and were identifying areas of improvement.

There were systems in place to gather feedback about the quality of the care being provided.

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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 was 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 unannounced inspection was carried out on 11, 12, 13 and 14 December 2017.

At the time of our inspection the service provided personal care to approximately 700 people living in their own homes across Liverpool.

Before our inspection we reviewed the information we held about the service. This included a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority to gather their feedback about the service. We used this information to plan how the inspection should be conducted.

The inspection team included three social care inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with 20 people who were receiving care from the service and 8 people's relatives. Inspectors visited some people at their homes and others were contacted by telephone by the Experts by Experience. We spoke with 14 members of staff who held different roles within the service. This included the registered manager and the nominated individual. A nominated individual is a person

employed as a director, manager or secretary of the organisation with responsibility for supervising the management of the regulated activity.

We looked at a range of documentation at the service's office including 12 people's care records, medication records, 10 staff recruitment files, staff training records, accident and incident report forms, health and safety records, safeguarding and complaints records, audits, policies and procedures and records relating to the quality checks undertaken by staff and other management records.

Good

Is the service safe?

Our findings

We asked people and their relatives if they felt safe with the carers providing their care. They said, "I'm very happy with all my carers, I feel safe when they are here and I trust them", "Oh yes I am always safe with the carers, they do make me feel comfortable" and "It's always someone who I know, when they are on holiday I have a relief carer and I know them a bit also. I feel safe because I know them well."

The service had robust systems in place to protect people from abuse. There were policies and procedures in place to guide staff in relation to safeguarding adults and whistleblowing. Staff demonstrated a good understanding of this when we spoke with them. They were able to explain the actions they would take in the event of a person being at risk of harm. People we spoke with said that if they ever had any concerns they could raise them directly with the care staff or contact the office and the issues would be resolved. We saw that safeguarding and whistleblowing concerns were promptly and effectively managed by the Safeguarding and Complaints Manager, with oversight from the registered manager.

On our last inspection we found that risk management plans in people's care files were not sufficiently detailed to inform staff and some files contained conflicting information about risk. During this inspection we found that the service had improved in this area. Risk assessments were in place and were reviewed regularly. We saw that they outlined information for staff on the management of the risks. This included risks relating to people's moving and handling needs such as when hoisting them, their increased susceptibility to falls as well as risks of their home environment. This meant that staff had the information they needed to safely manage the risks associated with delivering people's care.

Overall, medication was correctly administered and recorded by staff. The staff we spoke with told us that they were confident managing people's medication and people received the right medication at the right times. The people we spoke with told us that they received their medication correctly and when they needed it. We saw that staff had received training on medication administration and there were policies and procedures in place to support staff.

Since our last inspection the service had notified us of a few occasions when doses of medication had been missed or given at the wrong time. We saw evidence that these issues were promptly identified, reported and addressed. For example, seeking medical advice if necessary, additional training for staff or disciplinary action if appropriate.

Spot checks were regularly carried out in the community by senior staff to monitor the quality of the service, including medication administration. The majority of these spot checks effectively identified any issues relating to medication administration, such as gaps in the medication administration records (MARs). We saw that when any issues were identified the learning was fed back to the carer or, if necessary, they were escalated to a senior manager for more serious action, such as disciplinary action. We saw that a very small number of these spot checks had failed to identify some gaps in the MARs. However, we were reassured that people had received their medication as prescribed because staff had noted that they had given the medication in the daily records. We discussed this with the registered manager and suggested that a system

to monitor and maintain the quality of the service's spot checks would help to identify any errors.

We looked at 10 staff files and records showed that full recruitment and checking processes had been carried out when staff were recruited. Criminal records checks, known as Disclosure and Barring Service (DBS) checks, were carried out. Official identification, such as a passport or driving licence, and two verified references from the most recent employers were also kept in staff files. The recruitment process also included numeracy and literacy assessments for potential staff as the service had recognised that the staff would have responsibilities in report writing and the completion of other documents such as medication records. These steps ensured that the staff the service recruited were safe, suitable and competent to work with vulnerable people. We also saw evidence that there was a disciplinary policy in place and that it had been followed when needed.

The registered manager had accident and incident recording processes in place. We found that there was a serious incident reporting procedure in place, accidents and incidents were discussed during team meetings, recorded as part of daily records and trends were monitored. This enabled the registered manager and senior staff supporting them to safely manage any trends and ensured that risks were being safely managed.

We saw evidence that the service had appropriate staffing levels to meet the needs of the people it supported. For example, all of the staff rotas that we reviewed contained a reasonable number of calls which were achievable within those working hours. The staff we spoke with also told us that they were able meet everybody's needs and complete all of their calls as planned. The service also employed a bank of back-up carers whom they could call upon to complete any calls if the regular carers were unable to do so. The registered manager explained that the service carefully assesses the needs of any potential new people they care for and ensures the service has capacity to meet their needs before agreeing to deliver any new packages of care. This meant that the service avoided overstretching its resources and protected both the people it cares for and its staff from the risks this could pose.

Staff had received training on infection prevention and control. The service ensured that staff had access to personal protective equipment (PPE) that was held at the service's office and made available on request. This included gloves and aprons used by staff when undertaking personal care tasks. This meant that staff and people were protected from the risk of infection being spread.

Good

Is the service effective?

Our findings

We asked people and their relatives if they thought staff had the skills and knowledge to do their jobs well. They said, "Oh yes absolutely, the staff know exactly what they're doing. They use a hoist to help move me and there's never been any problems with this." Another person said, "I think the staff are properly trained to give me the support I need, I've got confidence in them." One relative said, "I know the staff are trained, I've watched them working and I'm happy they know what they're doing."

The staff we spoke with told us that the training on offer at the service was very good. They said that their training was helpful and enabled them to do their jobs properly. One member of staff also explained that senior staff at the service would help staff to access additional training in a particular area if they needed.

Records showed that a range of training was undertaken by the staff. For example, health and safety, infection control, basic first aid, food safety, moving and handling, dementia and medication. We also saw how staff were encouraged to attend additional training, such as understanding catheter care and convene awareness. The service also had fact sheets available to staff regarding professional boundaries and mental capacity. The service ensured staff were aware that their training was their responsibility and had disciplinary measures in place if staff did not adhere to the training policy.

All new staff took part in an induction process. This included a period of office-based training and shadowing an experienced member of staff. Staff who were new to care had also started the Care Certificate, which was accredited by 'Skills for Care' and is a national qualification. During the induction process staff were introduced to the people they would be visiting regularly and they were not allowed to start working on their own until their mentor had assessed them as competent to do so. This ensured that staff were safe to work with vulnerable people in the community.

The majority of staff had received timely supervisions and appraisals. However, a small number of staff were not up-to-date with their supervisions. We saw that the registered manager had a plan in place with senior staff to ensure that all staff were up-to-date with their supervisions and this was due to be completed shortly after our inspection. We asked staff if they felt they had the support and supervision they needed to do their jobs. This included some of the staff whose supervisions were overdue. All staff told us that they felt well-supported working for the service and they received an appropriate level of supervision. Staff told us that support and supervision was an ongoing process and was not limited to formal supervision meetings. They all said that they had good relationships with the people line managing them as well as the registered manager and they could contact them whenever they needed some advice or support.

We saw that staff at the service were attentive to people's various health needs and the service worked together with other relevant health professionals in order to meet people's needs. For example, the service had recently established relationships with the local health services responsible for managing people's anticoagulant medication, such as warfarin. The service liaised with these services for regular updates on any changes to people's medication. This meant that people's care plans were promptly updated and ensured staff met people's needs in relation to anticoagulant medication.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions or are helped to do so when required. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. People who normally live in their own homes can only deprived of their liberty through a Court of Protection order.

We checked whether the service was working within the principles of the MCA and found that it was. The registered manager and staff had a basic understanding of the MCA. The process of assessment used by the registered provider in gathering information on the needs of people included reference to their capacity to make decisions. Some people were subject to a Lasting Power of Attorney and this was clearly evidenced within people's care records. The registered manager told us that they worked alongside family members as well as health and social care professionals if a person did not have the mental capacity to make their own decisions.

There were records to show that people's consent had been sought by the service for the support they received. People had been involved in and had contributed to the preparation of their care plans and had consented to them. People told us that staff asked for consent before undertaking personal care tasks.

Some people required support with meal preparation. We saw that care plans gave staff the information they needed to understand the amount of support a person required and if any assistance was required when eating. Any relevant dietary needs were also documented in the care plans. This included specific information relating to people's likes and dislikes and any specific needs such as diabetic diets.

Good

Is the service caring?

Our findings

The people we spoke with told us that staff were very caring and they had good relationships with them. One person said, "The staff are very caring, they've always treated me with dignity and respect. I have a great laugh with them and they cheer me up." Another person said, "The carers are very friendly and helpful. They all give 100%. I'm very happy with how it's going, the support they [carers] give me is great."

People told us that they received care from regular staff who treated them in a kind and caring way. They said that staff respected their privacy and dignity. For example, one person said, "The staff are always respectful and treat me with dignity. They always close the door when they help me get washed and dressed."

People told us that staff were mostly on time and stayed as long as they were supposed to. People commented that office staff usually let them know if their carer was running late, which they said was helpful and reassuring.

The staff we spoke with were able to tell us about the people they cared for. For example, what people liked to eat and drink, what tasks they needed assistance with at home and changes to people's health that required attention from a health professional. This demonstrated that staff knew the people they were caring for well and they had the knowledge they needed to properly meet their needs.

We saw that the service had committed to Liverpool's Dignity in Care Charter. This is a joint initiative between the local authority, local health and social care services, people receiving care and carers. It aims to encourage the development of high quality services that respect people's dignity, rights and choices. As part of this, the service had appointed a Dignity Champion who had received additional training in this area and acted as a point of contact for other staff for advice on promoting people's dignity.

We saw that confidential information was kept securely supervised or locked away in the office. This included people's care plans and staff records.

We saw that the service helped people to maintain their independence. For example, the care files we looked at set out what people would like to achieve from receiving care from the service. One person's care plan said that they would like the service to help support them to remain living at home independently. The care plan then gave details of what support they needed from carers to achieve this, such as meal preparation and personal care. We also found that the service had received positive feedback about assisting people with their independence. One person who the service had supported had written to the service and said, 'I thought my independent life was finished and for a long while I was in shock. You and your staff reversed the situation by doing everything you possibly could to boost my confidence and increase my independence.'

Good

Is the service responsive?

Our findings

We asked people if the service was responsive to their needs. They said, "The carers know me well and vice versa, they are definitely meeting my needs" and "The care staff have enough time to do what I need them to do, they'd do I anything I ask."

The service was in the process of upgrading from paper-based care records to an electronic records management system. This was a considerable sized project transferring approximately 700 people onto the new system. At the time of our inspection the majority of the people supported by the service had had new care plan assessments using the electronic system. Around half of the people supported by the service were live on the electronic system. We saw that the small number of old paper-based care plans lacked up-to-date information. However, the registered manager reassured us that these remaining care plans were a priority and staff were urgently working through these carrying out new assessments to transfer them onto the new electronic system.

Staff had already been using smart phones to record their visits. However, the new software that linked in with the electronic records system now gave them access to people's care plans. It also gave a clear overview of what tasks needed to be completed on each visit with brief details about how this should be done. This included electronic medication administration records. Staff were able to mark each task as completed as they completed each visit. This data was accessible to the office-based staff who were able to use this data for spot checking the quality of the care being delivered.

The service liaised closely with the local authority to assess people's needs prior to them using the service. This information was used to develop people's individual care plans and risk assessments. People and, where appropriate, their relatives were involved in planning the care needed and making decisions about how these needs were to be met. All care plans we reviewed reflected each person's individual needs, choices and preferences and gave guidance to staff about how to ensure personalised care was provided.

People's care plans included a 'what's important to me' section that documented details about people's life, work, social and family history. They also had information about anything people needed to enjoy their daily life. For example, wearing glasses. This person-centred detail enabled staff to get to know the people they were supporting, build caring relationships with them and meet their needs. Other sections of the care plans also set out people's preferences. For example, what they liked to eat and drink and what activities they liked to do.

We saw that people's care plans were reviewed regularly and any changes in people's care and support needs were clearly documented. People and their relatives were included in this process. These changes were available to staff so that they were able continue meeting the changing needs of the people they cared for.

We saw that staff completed daily records at each visit. These records included information about the time of staff arriving and leaving, all activities completed, any concerns raised or actions taken as well as staff

signatures. This information was reviewed regularly by the office team to ensure full completion. All of the people we visited had up-to-date daily records which detailed what had happened on each visit. Once the implementation of the new electronic system is complete all of these records will be submitted and stored electronically.

Staff at the service regularly audited samples of people's care plans. We saw that any issues that were highlighted were clearly documented, actioned and signed-off by the relevant member of staff.

Information about how to complain was available to the people using the service and their relatives. The people we spoke with told us they were confident they could voice any concerns they had. Complaints were dealt with by the service's Safeguarding and Complaints Manager, with oversight from the registered manager, in accordance with the service's policy and procedure and were addressed in a timely manner. We saw that the service was open and honest in its responses to complaints. The service also acknowledged when mistakes had been made and took reasonable steps to put things right. For example, by apologising, sending flowers or additional staff training if required.

The registered manager explained that the service did not usually receive referrals for people who require end of life care. However, some people who they were already caring for had experienced a decline in their health and required end of life care. The registered manager gave us an example of when this had happened and what the service's process had been to ensure it met this person's needs. This included close monitoring by one of the service's care coordinators and regular liaison with the local authority, the person's GP and district nurses. The registered manager said that they regularly reviewed the person's needs during this time and they were flexible in order to adapt to any changes. For example, this person's mobility had deteriorated and they required the assistance of two carers. Prompt liaison with the local authority meant that the package of care was quickly increased and the service was able to provide two carers to appropriately meet this person's needs. The service also ensured that this change was delivered in a person centred way by sending carers that the person was familiar with.

The registered manager told us that all new staff receive end of life care awareness training as part of the induction process. The service plans to introduce a specific training module on this for its senior staff soon.

Good

Is the service well-led?

Our findings

We asked people if they felt the service was well-led. They said, "The management are good, I do not see them much but I know they will be there for me", "I am extremely happy with the company" and "I would be able to recommend this company, we have no complaints at all."

Staff told us that they enjoyed working for the service and they felt valued. This meant that staff were motivated to continue delivering high-quality care. The registered manager explained that they were proud of staff retention at the service, with the majority of both office-based and care staff having worked for the service for many years.

Staff were all complimentary about the registered manager. They told us that they were very supportive, always made time for them and appreciated the work they do. The registered manager had been in post for 13 years, having worked for the service for 18 years and had held various roles during this time. When we spoke with the registered manager during our inspection they were very knowledgeable and passionate about the care the service provided to people. We also saw that the registered manager had positive relationships with both the office-based staff and some of the carers who visited the office throughout the inspection.

We saw evidence that audits were in place to drive the quality of the service. These included audits of care plans that have been sent from the local authority and ensuring that the care requested matched the care being delivered. We were able to see the actions that had been taken when discrepancies had been identified. We also saw that audits had been carried out on safeguarding, accident, incidents and complaints. The audits gave the opportunity for the service to identify themes and action them if needed.

Spot checks were regularly carried out in the community by senior staff to monitor the quality of the service. This was to make sure the care being received by the people using the service was appropriate, safe and of a good quality. We saw that a very small number of these spot checks had failed to identify some gaps in the MARs. However, we were reassured that people had received their medication as prescribed because staff had noted that they had given the medication in the daily records. We discussed this with the registered manager and suggested that a system to monitor and maintain the quality of the service's spot checks would help to identify any errors.

The service also operated a spot check system to ensure that staff were with the people they were supposed to be with and at the times they were supposed to be there. This involved checking GPS provided by the smart phones staff use and contacting the person receiving the care to confirm staff were with them. This meant the service was checking people it supported were getting the care they needed when they needed it.

The registered manager showed us their annual quality surveys asking the people and their relatives for feedback about the service provided. We were able to see that the service had implemented action following the survey. We also saw how staff questionnaires were in place for both community and office staff. This demonstrated that the service encourage feedback about the quality of service it provided and a

commitment to continuous service improvement.

We saw evidence that the service had staff support systems in place for staff that included welfare support and counselling. We also noted that the registered manager had developed a culture of recognising and rewarding staff who were performing well in their role. For example, they had introduced 'Carer of the Year' award and throughout the year the registered manager ensured that any positive feedback that was received from people was fed back to the relevant care staff and they directly acknowledged their contribution to the service.

All of the staff we spoke with told us there was a positive and caring culture amongst staff at the service and they all wanted to do their best for the people they cared for.

The service had good community links which helped it to gather and share ideas about best practice with other health and social care providers. The service is part of the Liverpool Care Homes Partnership CIC, which works collectively with its members to share expertise, events and training. The members are owners and managers of services in Liverpool who wish to work together and enhance care services available in the city. The service is also a member of the Liverpool Social Care Partnership, which similarly draws together providers to share information and promote best practice.

The registered manager is a member of the Liverpool Registered Managers Network. This is part of a national programme, supported by the Department of Health, to help registered managers in their roles as lead professionals in social care settings. The registered manager also told us that they tried to work in partnership with the local authority as much as possible too. For example, the registered manager had recently delivered a talk at the Liverpool social workers annual conference.

The registered provider had policies and procedures in place that staff were able to access at the office if they needed any guidance. We saw that these policies and procedures were up-to-date and regularly reviewed.

Registered providers are required to inform the CQC of certain incidents and events that happen within the service. The service had notified the CQC of all significant events which had occurred in line with their legal obligations. The service had consistently demonstrated to us that it took all reasonable and necessary steps in these instances. The service was also meeting the legal requirement to display its most recent CQC rating at the office and on its website.