Mears Homecare Limited

Mears Homecare Limited - Hillingdon

Inspection report

Unit 2, Brook Business Centre
Cowley Mill Road, Cowley
Uxbridge
Middlesex
UB8 2FX

Tel: 03333211960

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced inspection of Mears Homecare Limited – Hillingdon on 29, 30 June and 1 July 2016. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and senior staff might be out visiting people.

Mears Homecare Limited – Hillingdon provides a range of services to people in their own home including personal care. At the time of our inspection 300 people were receiving personal care in their home. The majority of people using the service had their care funded by their local authority. People could also pay for their own care.

At the time of the inspection the manager was in the process of being registered with the Care Quality Commission. 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 last comprehensive inspection of this service on 30 November, 1 and 3 December 2015, we found breaches relating to the registration of the manager, need for consent, safe care and treatment, receiving and acting on complaints, good governance and staffing. As a result of these, our concerns were sufficiently serious for us to impose a condition on the provider's registration to restrict admissions to the service based on our concerns in relation to staffing issues and we rated the service as overall inadequate and consequently placed into special measures. At this inspection, we found improvements had been made in this area and we have therefore asked the provider to request that this restriction is now lifted.

We also imposed positive conditions in relation to the provider providing us with regular updates on their progress in addressing the breaches we found with Regulations 12 (safe care and treatment) and Regulation 17 (good governance). At this inspection, we found there were continued breaches of Regulations 12 and 17 and we therefore decided to continue with the positive conditions for these breaches. Because we are continuing previous enforcement action, this has not been reported upon at the back of this report.

At this inspection, we also found a repeated breach of Regulation 11 (need for consent). Because this did not form part of the enforcement action we took after the previous inspection, we have reported on this breach

at the back of the report where you can see what action we have told the provider to take.

The provider sent us an action plan identifying the actions they would take to improve the service and we received monthly feedback on the audits that were completed.

There were generic risk assessments in place but these did not identify the possible risks in relation to specific issues for people. Care workers were not provided with guidance on how to reduce these specific risks for example where a person was living with depression or diabetes.

Although people told us they felt safe when they received care in their home, we found that the provider had not always ensured people were protected from the risks of receiving unsafe care. There was a procedure in place for the management of medicines but care workers were not recording the administration of medicines accurately. This meant the provider could not ensure medicines had been administered as prescribed. We have made a recommendation in relation to the administration of medicines.

The provider had a policy in place in relation to the Mental Capacity Act 2005. However, appropriate actions were not taken to assess people's capacity to make decisions relating to their care and identify the support they required.

Care records relating to people using the service were not completed accurately to provide a current picture of the person's needs and support provided. This did not provide up to date information for care workers in relation to how and when people's care should be provided.

Improvements had been made in the recording and investigation of accidents and incidents since the previous inspection. We also found improvements had also been made in the number of care workers available to provide care.

Care workers had received training identified by the provider as mandatory to ensure they were providing appropriate and effective care for people using the service. Also care workers had regular supervision with their manager and received an annual appraisal.

People felt the care workers were caring and treated them with dignity and respect as well as supporting them to maintain their independence while providing care.

There were improvements in the way complaints were investigated and responded to since the previous inspection.

People using the service had been sent a questionnaire asking for feedback on the quality of the service and the comments received had been positive.

Since the previous inspection the provider had introduced a range of systems to monitor the quality of the service provided.

Care workers felt they were supported to carry out their role and the service was now well-led.

Following our last inspection, we placed the service in special measures. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. As the provider has demonstrated improvements and the service is no longer rated as inadequate for any of the five questions, it is no longer 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?

Requires Improvement

Some aspects of this service were not safe. Risk assessments did not provide up to date information in relation to individual's specific risks when receiving care.

There were procedures in place for the safe management of medicines but staff did not always complete records relating to medicines use as required by the provider's own systems.

People using the service said they felt safe when they received support in their own home.

Improvements had been made in the recording and investigation of incidents and accidents.

The provider had suitable recruitment processes in place.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. The provider had a policy in place in relation to the Mental Capacity Act 2005 but they did not undertake assessments to identify if a person using the service was unable to make decisions about their care and ensure the appropriate actions were taken to support them.

Care workers received the necessary support and training to deliver care safely and to an appropriate standard.

There was a good working relationship in place with healthcare professionals who provided support for people using the service.

Is the service caring?

Good

The service was caring. People told us they were happy with the care they received in their home.

Care workers treated people with dignity and respect and supported them to maintain their independence.

Is the service responsive?

Good

The service was responsive. Improvements had been made in the way complaints were investigated and responded to.

Care plans were being written so they identified how each person wished their care to be provided.

People using the service had been asked their views on the quality of the service provided.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Records relating to care and people using the service were not completed accurately to provide a current picture of the person's needs and support provided.

The provider had improved the systems in place to assess the quality of the service provided.

The manager was in the process of being registered with the Care Quality Commission.

Care workers felt they were supported by the management team.

Mears Homecare Limited - Hillingdon

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 the 29, 30 June and 1 July 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

The inspection was carried out by one inspector and an expert-by-experience carried out telephone interviews of people who used the service and relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for people who had dementia.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with the manager, operations manager and four care workers. We reviewed the care records for 10 people using the service, the employment folders for nine care workers, the training records for all the care workers and records relating to the management of the service. After the inspection visit we undertook phone calls to 10 people who used the service, two relatives and received feedback via email from four care workers.

Requires Improvement

Our findings

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we saw that the provider had general risk assessments but did not have detailed risk assessments in place in relation to specific care issues for people using the service.

At the inspection on the 29, 30 June and 1 July 2016 we saw that action had not been taken to ensure risk assessments for specific issues were in place. We looked at the care folders for 10 people and saw a general risk assessment was in place. We reviewed the referral documents and care needs assessment and identified that some people had specific issues in relation to their care needs and health. The care needs assessment and risk assessment documents we looked at identified specific risks but did not provide guidance to care workers on how these risks could be reduced and managed.

We saw where a person had been identified as living with depression, the risk assessment stated that care workers should report any concerns but there was no information for the care worker on what they should consider as concern in relation to the person's behaviour. The referral from the local authority for another person indicated that they lived with psychosis and hallucinations. This was not identified in the risk assessment and no guidance was provided for care workers on how they should support the person. Another person was identified as having diabetes which was controlled by diet and this was noted in the care needs assessment and risk assessment document. The assessment stated that when they prepared meals the care workers should ensure the person had a good diet but there was no guidance as to what was an appropriate diet for this person to help them control their diabetes.

We asked the manager why the specific risk assessments identified during the previous inspection were not in place. They told us this action had not yet been completed following that inspection but was to be implemented in the near future. Care workers told us they had a good understanding of the needs of the people they provided care for.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we found that the administration of medicines was not being recorded accurately.

At the inspection on the 29, 30 June and 1 July 2016 we found some improvements had been made but a

number of care workers were still not recording the administration of medicines accurately, however the provider had taken steps to address these issues.

During the inspection we saw the medicine administration record (MAR) charts for four people and saw there were issues in relation to the recording of the administration of medicines correctly. The MAR chart for one of these people showed four medicines were not recorded on one occasion in March 2016.

The MAR chart for another person indicated that a medicine was prescribed to be administered twice a day. On three occasions in April 2016 it was recorded as not required but a reason was not given. The March 2016 MAR chart for this person showed that medicines had not been recorded on three occasions and a cream that had been prescribed to be applied every day had not been administered for 25 days. The MAR chart showed that the care worker recorded the cream was not required but the MAR chart and support plan did not indicate if this cream should only be used as required.

The MAR chart relating to April 2016 for one of the four people referred to above showed that care workers had recorded medicines being administered on the 31 of the month where there were only 30 days in April. We also saw that medicines were not recorded on four occasions during the month. The March 2016 MAR chart for this person showed that the care workers had not recorded medicines being administered on 15 occasions.

Records for another person showed that a MAR chart was not in place for 14 days in April 2016 so care workers recorded the administration of medicines as part of the daily records. This also meant that staff could not clearly see the medicines to administer and the instructions to administer these, as they would see on a MAR chart if one was used. The person was prescribed paracetamol to be administered three times a day but this was not always recorded accurately. On one day the care worker was unable to identify at what time the morning tablets had been administered so they could ensure an appropriate period of time had passed between doses. Therefore, the person did not receive a prescribed dose of this pain relief.

The operations manager provided a copy of the MAR chart audit which showed that 50 care workers had been identified as not recording the administration of medicines correctly on at least one occasion during May 2016. 44 care workers were identified in April, 35 in March and 43 in February 2016. This showed that a large number of care workers were making recording errors when administering medicines and that no discernible improvements were being made in this regard.

The manager explained that earlier this year a new process had been put in place to respond to identified recording errors with a letter sent to the care workers involved reminding them to record medicines correctly. If they continued to make errors they would receive additional training.

These recording errors meant that it was not possible for the provider to confirm that some medicines had been administered consistently and safely to people who used the service.

We recommend the provider reviews appropriate guidance in relation to the administration of medicines in the community.

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we saw that people were at risk because the provider had not taken action when the person receiving support had an accident or action to prevent it reoccurring.

At the inspection on the 29, 30 June and 1 July 2016 we saw the recording and review of incidents and

accidents had improved. The provider had a copy of their policy and procedure in relation to incidents and accidents reporting available in the folder where completed forms were kept and this was accessible to care workers. We saw a summary sheet was used to record each incident and accident identifying who was involved, the type of event and when any investigation was completed. A record form was completed by the care worker with information relating to the incident or accident that occurred and this information was then entered on to a computerised system. The manager provided copies of completed incident and accident forms which indicated the outcome of any investigation, any actions taken at the time of the event and any changes made to the way care was provided to reduce the risk of the event happening again.

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we saw that there were concerns relating to the number of care workers available at the weekend. At the inspection on the 29, 30 June and 1 July 2016 we saw that there had been some improvements.

We spoke with people who used the service and did not receive any negative feedback in relation to staffing levels. We asked care workers if they felt there were enough staff and we received mixed comments. These comments included, "There are enough staff but they need to be more careful when employing new care workers to get reliable people who stay in the job" and "There are not enough staff yet, honest answer, especially at the weekend. Everyone works flat out and the work is always covered but there is no slack sometimes in the system." Other comments included, "We have enough staff but the out of hours service could be better as we need more back-up if we end up working at a visit late or need to stay with someone" and "The people using the service are happy to have regular care workers as they get used to who comes to visit them." The manager explained that there had been an on-going recruitment campaign to increase the number of care workers employed.

The service followed suitable recruitment practices. The manager explained new applicants were asked to provide the contact details of two people who could provide references and complete a Disclosure and Barring Service (DBS) check to see if they had a criminal record. Applicants were asked to attend an interview where they also completed a numeracy and literacy test. During the inspection we looked at the recruitment records for nine care workers and saw they had two references and a completed DBS check. We did note that the application form for one applicant was not completed in full with some additional information relating to employment history provided in a separate document. This was discussed with the manager who confirmed they would ensure the application forms would be reviewed as part of the document checklist completed as part of the recruitment process.

People we spoke with told us they felt safe when they received care in their homes. We saw the service had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. We saw a summary sheet was completed with details of any safeguarding concerns that had been raised which included information about the person it related to, actions taken and outcomes of the investigation. We looked at the records of safeguarding concerns and we saw detailed information and correspondence information relating to the concerns were on file. The provider also had a whistle blowing policy and procedure in place. Care workers we spoke with had a good understanding of the principles of safeguarding and how to help ensure people were safe from abuse and how to report any concerns.

Requires Improvement

Our findings

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we saw that the provider had a Mental Capacity Act (2005) policy in place but action were not being taken to meet the requirements of the Act.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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.

We asked the manager and the regional director why the mental capacity assessments had not been carried out for people using the service and they explained that they were planning to carry out the assessments on people new to the service but in relation to existing people they would only do the assessment if it was felt that their mental capacity had deteriorated. The provider advised us that they would now begin to carry out capacity assessments for people already using their service where a concern had been identified in relation to their capacity to make decisions in relation to their care.

At the inspection on the 29, 30 June and 1 July 2016 we saw that mental capacity assessment forms were available but assessments had not been carried for people using the service, where this might have been required. We looked at the records for one person and saw their care needs assessment stated they did not manage their finances and their relative was responsible. The assessment of the person indicated they had issues with their memory but no assessment of their capacity had been undertaken and there was evidence a Lasting Power of Attorney in relation to finance was in place. We saw the referral for another person indicated they were able to sign documents and had capacity to make decisions but their relative was asked to provide feedback on the quality of care provided and not the from the person who received the care received.

This meant the processes were in place but had not been used to ensure people's rights were being protected.

During the previous inspection we saw that people were provided with contact details for advocacy services but these were for a service in Scotland. We asked the manager if contact information for local advocacy

services was being provided. They confirmed that the previous information was no longer being distributed but there was no alternative information provided for local services. The manager confirmed this would be reviewed.

The above paragraphs demonstrate a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we saw that people were cared for by care workers who had not received support to care safely or to an appropriate standard.

At the inspection on the 29, 30 June and 1 July 2016 we saw that improvements had been made in relation to the support of care workers. The manager explained that all care workers should have one supervision meeting per year, up to four spot check observations of their practice and an annual appraisal. We looked at the records for nine care workers and saw that supervisions and observation checks were carried out. The operations manager provided information showing that 125 observations of practice were carried out between January 2016 and June 2016. We saw care workers were also supported through group meetings and team meetings. Care workers we spoke with confirmed they had regular supervision meetings and observations carried out while they were providing care.

The manager explained the Employee Engagement Programme had been introduced that identified an induction programme which was completed over the twelve week probation period. New care workers were given a booklet which had a structured programme of combining supervision sessions, group meetings, observed practice and training linked to the Care Certificate. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. During the 12 week period, records of the supervisions and meetings were made in the booklet including ongoing assessments of the new care workers' competency. At the end of the probation period the manager would review the records and sign off the induction period if the care worker was assessed as competent in their role. We saw new care workers were in the progress of completing the induction programme booklets. Care workers we spoke with told us they found the induction helpful in their role.

We asked people if they thought the care workers had the appropriate training and skills to provide their care. We received mixed comments. They told us, "I think so", "No, when someone new comes they really need time. They get an overview with NVQ training and that's about it. You have to tell them what needs doing all the time" and "Yes they are well trained."

Care workers we spoke with told us about the training they had completed. Their comments included, "The training I have done has been very useful. There is a great trainer who comes to the office and there is a whole range of training" and "The training is very good, it has helped me to remember things we need to know from previous training."

The manager explained that a range of training courses had been identified as mandatory by the provider and regular refreshers were completed. We saw records which indicated that care workers had completed the refresher training courses identified by the provider as mandatory.

There was a good working relationship with healthcare professionals who provided support for people using the service. The care plans included the contact details of the person's General Practitioner (GP) and other healthcare professionals including district nurses and physiotherapists.

Where care workers supported people with meals preparation and helping them to eat the care plans

included information about people's preferences for food and if they had any specific requirements as to how the food should be prepared.

Good

Our findings

We asked people if they were happy with the care and support they received. The majority of comments we received were positive. Comments included, "Yes I am quite happy", "Oh yes very happy- just have one problem and that is putting on my patches. I can't reach but the service says the care workers can't do it" and "I'm happy with the support." Another comment was "Yes, everything is fine" The issues with care provided for this person were discussed with the manager of the service and they confirmed it would be reviewed. Two relatives we spoke with also confirmed they were happy with the care provided. They told us, "Oh yes, very happy" and "They are very helpful."

People using the service and relatives were asked if they felt the care workers were kind and caring when they provided care. People told us, "They're alright", "They are very kind" and "Very kind." Other comments included, "I was upset one day and my care worker helped me. Very caring" and "They are both kind and caring and patient. They are good."

People told us they felt care workers treated them with dignity and respect when they provided care. Some of the comments included, "Of course they do", "Yes they work as a team" and "They are very good." We asked care workers how they treated people with dignity and respect during visits to their home. They told us, "Always cover them and do not allow others in the same room when you are helping them wash or to dress, always shut doors when they are on the toilets etc."

People told us they felt the support and care they received from care workers helped them maintain their independence. Comments included, "Yes it is helpful" and "Yes I think so." We asked care workers how they helped people maintain their independence when they provided care. Comments included, "It depends on the person I am supporting. Each person has different support needs and different things they can do themselves" and "I support people to do what they can to keep them independent." Another care worker told us, "You need to treat everyone properly. Just because people have memory problems they are still human beings. They have the right to care. It could be me or my relative needing care tomorrow so you need to treat people properly."

We saw most of the care plans we reviewed included background information about the person receiving support. We also saw that some of the care plans identified the person's cultural and religious needs as well as their preferred language. This meant care workers were provided with a wide range of information about the people they were supporting.

Good

Our findings

During the comprehensive inspection on 30 November, 1 and 3 December 2015 we saw that the provider had a complaints process in place but this was not being followed.

At the inspection on the 29, 30 June and 1 July 2016 we saw that improvements had been made in the investigation and response to complaints. We asked people if they knew how to make a complaint and if they had ever made a complaint in relation to the care received. Their comments included, "No, never have made a complaint", "I would ask to see someone in charge" and "Yes I know but there has been no need." Other comments were, "No not really", "Not as yet" and "I'm always making complaints. They will always ring me." Relatives told us, "Yes but we've never had to complain" and "I assume I would ring the same number. No, never had to complain."

There was information on responding to complaints in the care workers handbook and the process was explained in the guide provided to people using the service. During the inspection we saw all complaints received were recorded on a summary sheet describing what the complaint related to, what action had been taken and the outcome of the complaint. The summary sheet also indicated if the complaint was upheld and when it was closed. We looked at the records for three complaints which included copies of correspondence, details of any investigation and the outcome of the complaint. We saw complaints were being dealt with appropriately.

Following our comprehensive inspection on 30 November, 1 and 3 December 2015 we made a recommendation that the provider review care planning and formats for care plans in line with national guidance on person centred care. During the inspection on 29, 30 June and 1 July 2016 we saw that the provider was in the process of making the care plans for people more focused on their wishes in relation to how their care was provided. The manager explained a new format for care plans was being introduced to replace the previous hand written plans. The new format care plans were typed and included additional information in relation to how the person wanted their care provided.

The manager confirmed that the care plans had been changed to the new format for a third of the people using the service with the new format being used for care plan reviews and when new people started to receive care. The manager also told us that staff had received training on how to write care plans which focused on how people chose to have their care provided instead of the care plan being a list of tasks to be completed by the care worker which we saw during the previous inspection.

During the inspection we looked at care plans that had been updated which described how each person wanted their care to be provided. This included information on what the person wanted to wear, their choice of food and what their preference for personal care was.

The care plans we looked at were up to date and had been regularly reviewed.

We asked people if they felt they were involved in decisions relating to their care and support needs. We received mixed comments which included, "No, I don't think so", "Oh yes. It is discussed with me" and "They just get on with what they have to do." Other comments were, "It is changing but I don't know why", "My social worker does my assessments" and "Yes most times. But my family member's hearing is bad." Some of the care plans we looked at were not signed by the person using the service or their representative and we discussed this with the manager who confirm that as the new format care plans are introduced care workers will ensure the new documents are signed to confirm agreement with the plan.

The manager explained that once the local authority referral was received the person would be visited by a senior member of staff where the care needs assessment and risk assessment document would be completed. When we looked at the records for each person we saw assessments were in place.

People using the service were asked for their comments on the quality of the service provided. The manager told us a questionnaire was recently sent to the people using the service and they had started to receive responses. The questionnaire included questions relating to the quality of care, if their needs were being met in a timely manner, if care workers treated people with dignity and if their independence was supported. At the time of the inspection the provider had received 12 responses and the comments we saw were positive.

We asked people if the care workers arrived at the agreed time and if they were running late did they contact the person. We received mixed comments which included, "No not always on time. No they don't let me know", "The morning care worker has to take their children to school, they can be late about 30 mins" and "Yes, they will let me know if they are going to be late. One of them is sick today so won't be coming." Other comments were, "Yes they do come on time, I don't think they have contacted me", "Mostly regular, if they are going to be late they will ring" and "Yes sometimes a little earlier. They didn't turn up just once but they let me know." Relatives commented, "Mostly on time, they can be a little late due to traffic" and "They can be late but they let me know."

We also asked people if the carer workers stayed for the agreed length of time during the visit. Most people told us care workers usually stayed for the agreed length of time. Comments included, "Yes usually", "Usually for one hour. If they have time they will help me put things away" and "Yes, sometimes they will leave a little earlier." A relative told us "My family member can sometimes spend 2-3 hours in the toilet. When that happens they have no choice but to leave."

Requires Improvement

Our findings

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we saw that records relating to care and people using the service were not completed accurately. At the inspection on the 29, 30 June and 1 July 2016 we saw that actions had not been fully taken to ensure records provided accurate information.

We reviewed the support plan for one person which indicated that they should have a morning, lunch and mid-afternoon visit per day but the daily records indicated that the person was receiving two visits before 11am as well as a lunch and mid-afternoon visit but their records did not clearly indicate all the times of the visits and what care activities were agreed during each visit.

The care needs assessment stated care workers should assist one person to self-medicate but their care plan stated the care workers should remove the medicines from the blister pack and administer these to the person.

The moving and handling assessment for one person indicated that they required a hoist to help them move but their care plan did not refer to a hoist being used when care was provided. We discussed this scenario with the manager and they advised us that staff were using a hoist to safely help the person to move even though this guidance was not stated in the person's care plan.

During the inspection we asked the operations manager for details of planned arrival and departure times for visits compared to the times care workers actually carried out the visit. We reviewed the records showing the planned arrival and departure times and actual visit for the 1 and 7 June 2016. We saw a large number of visits started more than 30 minutes before or after the agreed call time with some visits happening up to two hours before or after the planned time. We asked the operations manager why there were so many calls which were outside the planned time and they explained that this could be due to the information on the computer system being incorrect. They confirmed that if a care worker was late arriving the person using the service would usually contact the office. The information recorded for planned visit times on the computer system may not represent the actual times agreed with people using the service for their visits. This meant that the provider could not ensure that care workers attended people's home at the agreed time.

Despite the issues with planned call times being adhered to, we did not find any evidence to suggest that this had resulted in any significant negative impact upon any person using the service. The operations manager confirmed that they would be reviewing the process for care workers agreeing alternative visit

times with people using the service and ensuring this was communicated with office staff so the computer system could be updated as this had not been actioned since the previous inspection.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the comprehensive inspection on the 30 November, 1 and 3 December 2015 we saw that the provider had not managed and mitigated risks to people and did not have appropriate audits in place to monitor the quality of the service. At the inspection on the 29, 30 June and 1 July 2016 we saw that improvements had been made.

The manager explained that a medicines audit had been introduced and the MAR charts for all the people that had medicines administered by care workers were checked. Any issues with the medicines recording were identified and recorded on the audit form with the actions taken. We looked at the medicines audit forms completed for a number of people who had medicines administered and saw they were completed in full with detailed actions and a copy of the letter sent to the care workers identifying the issues and reminding them to complete the records correctly.

An audit was carried out in relation to the care workers' records to check if all the required paperwork was in place. If any missing documents were identified an action was noted and when it was completed.

The log books used by care workers to record the daily record of each care visit were also audited monthly. The manager explained the Mears Prevention System (MPS) had been introduced at the location. This system encourages care workers to monitor seven key areas when providing care which included speech, breathing, behaviour, movement, eating and drinking, bladder and bowel and skin condition. When care workers completed the daily record of their visit they needed to consider these seven areas when making their notes to give a more complete picture of the person's care. The system also identified how care workers and senior staff should escalate any concerns identified when care was provided. We looked at the log books for 10 people and saw the care workers had noted if any concerns had been identified under MPS. If any concerns had been identified the actions taken were recorded in the log book.

Audits had been carried out on the records of people using the service to ensure all the required paperwork was in place and up to date. We saw completed audits in all ten of the care folders we looked at.

We asked people if they thought the service was well-led and we received mixed comments. People told us, "Yes for me", "I expect it is", "No don't think so, timings are not good" and "No it's not well run but that's fairly general in this sector." Other comments included, "Yes I would say it is well run", "Yes- I am happy with them" and "Yes I think so, we all get on fine."

We asked care workers if they felt the service was well-led. They told us, "The new manager has been a massive help and the care manager is really nice and they are great", "the communication with the manager is good here" and "There were issues with the previous provider but things have improved with Mears. Everything is very organised now. Things have got better over the last six months especially with all the training. I now feel more confident dealing with situations." Other comments were, "The manager is good. Since they took over the difference is amazing" and "There were problems when Mears took over but it is a lot better now."

The care workers we spoke with were asked if they felt supported when carrying out their role. They commented, "I am really supported, they are lovely and everyone gets on", "They supported me when I

needed to change when I worked" and "If you have a problem and you can't get hold of the person you need there is always someone who can help."

At the time of the inspection the manager was in the process of being registered with the Care Quality Commission. 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 saw a document referring to the Mears Red Thread which defines the culture of the branch, how communication should be carried out and how care workers can be recognised for the contribution to providing quality care.

We asked people if they knew who to contact at the provider's office if they had any questions about their care. We received mixed comments from people with some people telling us they did not know who to contact while other people said, "They are OK, my relative rings sometimes and "No, I would ring the care worker." A relative told us, "There is a number in the book." This meant that some people were not aware of who to contact if they had a question regarding their care.

Care workers received a handbook which included a code of conduct, policies, emergency procedures and how care should be provided. People using the service were given a booklet which included information on the philosophy, aims and objectives of the organisation, how care was provided and the contact details of the provider. Therefore both people using the service and care workers were given information in relation to how the service provided care.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (3)

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users. Regulation 12 (1)

The enforcement action we took:

We asked the registered provider to undertake weekly audits of risk assessments, service user needs and care plans. The registered provider must also produce an overview of the results of any other audits carried out each month. The registered provider must send the Care Quality Commission a monthly report which states an overview of the audits completed and the action taken or to be taken as a result of these audits.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record, including care and treatment provided and decisions taken in relation to such care and treatment. Regulation 17 (2) (c)

The enforcement action we took:

We asked the registered provider to undertake weekly audits of risk assessments, service user needs and care plans. The registered provider must also produce an overview of the results of any other audits carried out each month. The registered provider must send the Care Quality Commission a monthly report which states an overview of the audits completed and the action taken or to be taken as a result of these audits.