Mears Care Limited

Mears Care Limited Leeds

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 August and 4, 5, 6 September 2018 and was unannounced. We contacted people who used the service and staff by telephone on 5 and 6 September 2018 to ask for their views. On 29 August and 4 September, we spent time at the office site, reviewing relevant documentation.

Mears Care is a domiciliary care service that provides personal care to people in their own homes within the Leeds area. Mears Care was registered with CQC in September 2017 and this was the first inspection of the service. The service provides care for older people and people living with dementia, mental health, physical disabilities and sensory impairment, learning disabilities or autistic spectrum disorder, older people, people who misuse drugs and alcohol, people with an eating disorder and younger adults. At the time of our inspection there were 183 people using this service.

The service did not have a registered manager due to the previous manager still being registered. CQC were aware of this prior to the inspection and were in the process of cancelling this so the new manager could apply. The manager had previously been a registered manager. 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 found a lack of accurate and contemptuous records. Supervisions had not always been recorded, some people had not signed their care plans and audits of these were not consistent. We also found actions taken had not always been recorded when people had raised issues with the provider in quality telephone checks.

Risk assessments had been carried out and staff understood how to support people. However, these lacked details of how to support people and we found one risk assessment had not been completed when restrictive practice was being used.

People using the service told us they felt safe and staff had a clear understanding of how to safeguard people from potential harm or abuse. There was a safeguarding and whistleblowing policy available for staff and they told us they felt confident to raise concerns.

Medicines were managed safely. Some people were prescribed 'as required' medicines and we found protocols outlined when these would need to be administered, with body maps to show where creams needed to be applied.

Staffing levels were adequate to ensure visits were carried out. Some visits had been missed due to staff leaving their employment but most people told us they received their regular visits. Staff recruitment was robust and the necessary checks were carried out by the provider to ensure staff were safe to work with people using the service.

The provider operated under the principles of the Mental Capacity Act (2005), with capacity assessments and best interest meetings carried out.

New staff completed an induction program and training before carrying out personal care. Staff told us they did continuous training to ensure their skills were kept up to date and were supported with supervisions and appraisals. However, we did find that not all of these had been recorded.

People were supported with their nutritional and health needs. The provider ensured staff were trained to support people with specialist needs for example, catheter care.

People told us staff were caring and compassionate. Staff had built fond relationships with people they cared for and visits were consistent to ensure familiarity for people using the service.

Initial assessments were completed and care plans were then carried out. Care plans were individualised and detailed people's preferences.

People said they were offered choices and encouraged to be as independent as possible. Staff were respectful of people's diverse needs and for privacy. People said they were involved in their care planning and had copies of their care files within their homes. However, we did find some care plans had not been signed by people. Care plans also instructed staff to provide explanations when delivering care. This meant people were able to provide verbal consent.

Complaints were managed effectively with appropriate investigations carried out and lessons learnt to prevent re occurrences.

Some people and staff told us they did not know who the manager of the service was. The manager been in post for three weeks and was working to build relationships. The manager was honest and open about the improvements required to ensure the service provided quality care and had made plans to make sure people and staff knew who they were.

Surveys were sent out to gather people's views and actions had been taken to improve the service. Newsletters had also been re-introduced to people and staff to enable better communication.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were carried out however, these required further information to ensure staff knew how to keep people safe.

Staff knew how to protect people from abuse and what to do if they suspected abuse was taking place. Accidents and incidents were managed effectively with actions taken to mitigate future risks.

Medicines were managed safely although records were not always completed.

Staffing levels were sufficient to meet people's needs and robust systems were in place to recruit staff.

Is the service effective?

Good

The service was effective.

The provider understood how to support people in line with the Mental Capacity Act 2005 and used best interest decisions when required.

Training and induction programmes were provided to give staff the skills and knowledge to meet people's needs. Staff were also supported with supervisions and appraisals.

People were supported with their nutritional needs and liaised with health care professionals when required.

Is the service caring?

Good

The service was caring

People told us staff were compassionate and caring. Staff had built relationships with people and visits carried out by core staff to ensure consistency.

Staff were respectful of people's diverse needs and privacy.

People were supported to remain as independent as possible.

People and their relatives were involved in their care and support planning.

Is the service responsive?

Good

The service was responsive

Initial assessments were carried out to ensure people's needs could be met and care plans followed to include people's preferences for care.

People were offered choice about their care and this was respected by staff.

Complaints were managed effectively and people told us they knew how to complain if needed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records had not always been accurate or completed to show when actions had been taken.

Some audits had been carried out with actions taken to reduce re-occurrences.

Most people did not know the manager as they were new in post. The manager was honest and open.

Surveys were used to gather people's views.

Mears Care Limited Leeds

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 checked 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 was a comprehensive inspection. This inspection took place one the 29 August and 4, 5, 6 September 2018 and was unannounced. This inspection was carried out by one adult social care inspector and two experts by experience. The experts by experience had experience of caring for a person with dementia and completed telephone interviews on 5 and 6 September 2018

Before this inspection we reviewed information we held about the service. This included reviewing statutory notifications that we had received from the provider. Statutory notifications are notifications of certain events and incidents that the provider has to inform the CQC by law. We used this information to help plan the inspection. We also contacted the local authority, local safeguarding team and Healthwatch to gather their feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 13 people who used the service and relatives, the manager, one co-ordinator and six care workers. We looked at a range of records including six staff files relating to recruitment, supervision, appraisal and training. We also looked at six people's care records which included care planning documentation, risk assessments and daily records. We viewed records relating to the management of the service, surveys, audits and a wide variety of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We found risk assessments had been carried out for people who needed support to ensure their safety. Although, risk assessments were carried out, they lacked sufficient detail to ensure staff knew what actions to take. For example, one person who had suffered from a stroke was at possible risk of another. The actions for staff to take were to 'monitor and report' but this did not detail what staff needed to monitor and therefore the risk was not adequately managed. Another person suffered from circulatory issues and therefore found it difficult to mobilise at times. The risk assessment said, 'Ensure [Name] uses equipment to mobilise. Report further concerns.' There were no other instructions to identify what equipment was required to support the person. We discussed this with the manager who said they would ensure risk assessments contained the relevant information so that risks were minimised. Staff were knowledgeable about people's level of risk and how to support individualised to reduce risk.

We also found a person who used bed rails had not had a risk assessment in place to ensure their safety. Bed rails are restrictive and therefore a risk assessment should be in place to ensure other options have been exhausted and that staff understand what to check and how to use the bed rails safely. We discussed this with the manager who told us the person had constant 24-hour care from staff who slept in the same room as the person to ensure their safety and to support when personal care was required. Following the discussion, the manager told us they had arranged to carry out a formal risk assessment at the persons home the following day. We have discussed the following recording concerns in the well-led domain.

Accidents and incidents had been managed effectively. However, the recording of the incident or accident and the outcomes were located in different areas. For example, records of the incidents were kept in people's files with the investigatory notes and outcomes elsewhere. This meant the information was not together and there was no system to identify trends or themes. We found the provider had recently introduced a new online system to record incidents and outcomes together which would enable reports to show trends and themes within the service. The manager told us this was a new system and not all staff had been trained to use this and therefore paper incident reports were sometimes used.

People told us they felt safe when staff visited them in their homes. Comments included, "Yes I do feel safe because the carers are all very nice" and "Yes they are all very nice and friendly. I trust them 100%." Staff were aware of how to keep people safe from possible harm or abuse. There was a safeguarding and whistleblowing policy which staff followed. The provider managed safeguarding effectively with actions taken to make sure people remained safe. For example, one person had a missed visit. A letter of apology was sent to the person along with regular spot checks of the staff to ensure visits were always maintained.

People receiving care told us there was enough staff to meet their needs. Staff told us more staff were needed as they were often asked to work extra hours. We discussed this with the manager who told us there was enough staff to meet people's needs and they were recruiting new staff to support when staff took annual leave or if they were sick to ensure these extra hours were always covered. Staff and people using the service told us there was a consistency with staffing and visits. One staff member said, "I see the same people weekly and the same times" and one person told us, "I have a regular carer and she knows my daily

needs."

We found there had been 10 missed calls recorded from the last six months. The manager told us these had been missed mainly due to staff leaving their employment and informing the provider on the day and therefore it was difficult to ensure the visits were completed. There was no harm caused to any people who had their visits missed. People told us they rarely received missed visits.

We looked at six staff recruitment files and found checks had been carried out to ensure staff were suitable to work with people they cared for. This included pre-employment checks such as references, identification checks being obtained and a Disclosure and Barring Service (DBS) checks prior to staff being offered employment. A DBS check is completed during the staff recruitment stage to determine whether or not an individual is suitable to work with vulnerable adults. We did find one staff file which had not provided details of gaps in employment. We discussed this with the provider who said this had been missed but would ensure all gaps were accounted for in the future.

Medicines were managed safely. We looked at Medicine administration records (MARs) which documented when medicines had been administered. We found these had been signed by staff or codes used providing reasons as to why medicines had not been administered. Medication audits were used to monitor medicines. We saw audits had highlighted when staff had not signed to say when a medicine had been administered and actions taken to prevent this from happening again. Staff told us they received medication training and had competency checks prior to administering to make sure they administered the medicines safely and in accordance with the providers policy.

Some people were prescribed 'as required' medicines. We found protocols were in place for staff to follow and body maps were used to identify where medicines or creams should be applied. We saw pain management plans were in place when required. One person had a pain management protocol which included details of medicines to administer and physiotherapy massage techniques in picture format to instruct staff on how to best alleviate the persons pain.

Systems were in place to protect people from the spread of infection. Staff told us they were provided and used personal protective equipment (PPE); People and their relatives confirmed this.

Good

Is the service effective?

Our findings

People using the service and their relatives told us staff had the relevant skills to meet their needs. Comments included, "Yes we think all is ok and we are both satisfied with the carers skills" and "They seem to be well trained."

We looked at six staff files which recorded when staff received supervisions and appraisals. We found staff had received annual appraisals however, not all staff received supervisions regularly. We found three staff members had not received four supervisions within a 12-month period as stated in the provider's policy. Staff told us they did receive supervisions and the manager said they had an open-door approach to working so staff felt supported. We have addressed issues around record keeping within the well-led domain.

New staff received an induction programme which included a comprehensive probationary period, shadowing of experienced staff and training. Some of the training included safeguarding, fire safety and Mental Capacity Act. One new staff member said, "Training, it was quite good. Over five days. Shadowing other carers and then go out on our own once senior people have checked you are confident to do the job. If you are not confident you can carry on shadowing for as long as it takes."

Staff told us they received regular training to ensure their skills were kept up to date. Additional training was made available when people's needs changed. For example, one staff member told us they were trained by district nurses to use a nebuliser and said the provider carried out spot checks to ensure they were using the equipment correctly. Another staff member told us, "Yes I do (receive training). I have to pass the same things and I've done an NVQ. I think it's good, very thorough. Its in-depth."

Not all of the people who used the service had the mental capacity to make informed choices and decisions about all aspects of their lives. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We discussed whether anyone in receipt of care from the service had a granted authorisation in place from the Court of Protection, to lawfully deprive them of their liberty in a community setting. The manager told us that to their knowledge none of the people they supported had such authorisations in place but should such authorisations be necessary in the future, they would pursue this with the relevant parties.

We checked whether the provider was working within the principles of the MCA and found that staff and management understood their responsibilities under the Act. We saw mental capacity assessments had been carried out and best interest meetings took place. Staff were knowledgeable about how to identify

when a person may lack capacity. One staff member said, "It's if a person can't answer a direct question straight or can't make a decision. We report it to co-ordinators or manager and they get someone in to assess them."

People were supported with their nutritional needs. Some people using the service required specialist diets as they were at risk of choking. For example, one person had a fork mashable diet and a cup was introduced to ensure the person took small amounts of liquid to prevent choking. People told us staff offered them a choice when supporting people at meal times and were offered drinks during their visits.

Staff supported people with their health needs. This included liaising with other health care professionals to ensure people maintained a healthy wellbeing. One staff member told us, "We have people that have catheterised care and district nurses involved. I would ring the district nurses if there is a problem or if dressings come off we ring them. If we notice any pressure sores we would contact the office."

Good

Is the service caring?

Our findings

People and staff told us they regularly carried out the same visits to people to ensure consistency and to build relationships. One person said, "They understand me well and are very compassionate." Staff Comments included, "I have worked with a service user for seven years. You build up a rapport and they trust you", "Introducing yourself properly. The first meeting is the most important. Fulfilling their needs and building a relationship by talking to them. Some I have been going to for three or four years and you build that relationship and involve people in stuff. You make sure to ask them if there is anything they need" and "I get on with all of the people I look after. I like each and every one of them. It's brilliant. I absolutely love it. It doesn't feel like care hours."

One person's relative told us, "90% of the time we have the same carer who is wonderful, first class and part of the family now. [Staff member] understands [Name's] situation and how they communicate. [Staff member] has seen my wife deteriorate with Dementia and makes themselves so useful."

Staff were respectful of peoples individualised needs. One staff member told us, "You ask them about their needs. Talk to them as a person and not a number." This was also reflected in peoples care plans. One stated, 'Please let me know everything you do by talking and explaining as I'd like you to respect all my needs and dignity.'

We spoke with one relative who told us staff were very respectful to their family member when they had experienced times of being frightened and managing their mental health issues. The relative told us staff provided reassurance to the person which helped to comfort them. The relative said, "They do as much as they can within reason and show them respect and protect their dignity."

Staff told us they always respected people's privacy and dignity. One staff member said, "We cover people up while having personal care. Cover with a towel parts you're not washing. Ask if they want you to wait outside and respect their privacy."

People told us they were encouraged to remain as independent as possible. Staff told us they promoted independence and one staff member said, "I work with one person who has dementia and lacks capacity but can-do stuff for themselves. I will put shampoo on their hair, show them the bottle before I put it on and I will then tell them and encourage them to wash their own hair. If they have the ability we help them to do it."

The provider told us they did not have any person who had an advocate at the time of our inspection. An advocate is a person who can support others to raise their views, if required. The provider told us they were currently making a list of community links for people to access and said this would be given to people using the service. The provider had planned to include advocacy services on this list so people knew how to access an advocate if needed.

Good

Is the service responsive?

Our findings

Initial assessments were carried out to ensure peoples need could be met prior to starting with the service. The provider told us people were always re-assessed when a person went into hospital to ensure their needs could still be met.

We found inconsistencies about people consenting to their care. Consent was obtained verbally and people told us they were asked about their care planning. However, we found care plans were not signed by people when they had capacity to do so and some people we spoke with told us they had not signed their care plans. We have addressed recording issues within the well-led domain of this report. People told us they were involved in their care planning. Most people did tell us that their care plans were in their home should they wish to read this. We discussed this with the provider after finding several care plans which had not been signed. The manager told us they would review all care plans and ensure these were signed by people that were able to.

Care plans were then created which included people's likes and dislikes so staff knew how to support people with their individualised needs. These were regularly reviewed and updated. People using the service and their relatives told us they were involved with their care planning but had not always signed their care plans. One person told us, "Yes I have recently had a review and signed my care plan." Another person said, "I am not so sure if I signed the care plan."

People using the service said staff provided choice when they delivered care. Care plans also recorded people's preferences and instructed staff to always offer choice. One care plan stated the persons preference for washing and said, 'Yellow towel to be used for the face with no soap and then the white flannel to be used on the body with soap on.' Another person expressed their choices for the type of environment they wanted at night. This included the doors being shut and all the lights turned off.

People were asked about their preferences which included religious beliefs, culture and links to any social organisations. This was to ensure peoples individualised needs were met and so staff could follow any wishes people may have. One person had their priest come to their home for communion.

People we spoke with did not comment on any social activity support they received. Staff told us they would do activities with people in their homes but only if this was part of their agreed care package and it was documented in their care plan. Care plans identified people's hobbies and activities they enjoyed. Staff explained, people often used the sitting services where activities were provided if they wished to expand their social interaction and the number and types of activities they pursued.

We found some people using the service required end of life care. However, the provider had not carried out end of life care plans to identify people's preferences and wishes for the end of their life. Most people who were receiving end of life care told us they had discussed this with staff at meetings and that do not resuscitate forms were in their care files. We discussed this with the provider who said they would look to implement end of life care plans to ensure peoples choices and wishes were recorded. We have addressed

records in the well-led domain.

Complaints were being managed. Complaints were related to missed or late visits, poor communication and standards of care. We found complaints had been investigated in a timely manner and lessons learnt was used to prevent future re occurrences. We saw examples of spot checks taking place and monitoring of call times to ensure people did not have any missed visits. Staff followed the providers complaints policy procedures and people using the service told us they felt confident to raise any concerns. Once complaints had been investigated the provider contacted the complainant to ensure the issues had been resolved and ensure people were happy with their care.

The provider told us they did not have any persons receiving care who required information to be given in a different format to make it easier for people to understand however, the provider had an accessible communication policy in place should this be required.

Requires Improvement

Is the service well-led?

Our findings

We found the provider had not always kept accurate and contemporaneous records. For example, staff told us they received supervisions and support when needed however, supervision records had not always been completed. In one staff member's recruitment file we found gaps in their employment history however, this had not been recorded as explored at interview.

Not all care plans had been signed by people to say they had consented to their care. Care plan audits had not always been completed to ensure care files contained relevant and up to date information. We found four care files which had not been audited since 2016. The provider told us these should be completed annually however, this was not the case in the care files we looked at. The provider said they were planning to stop using written records and in the future, records would be put onto a computer system that would identify when areas of the care file needed to be updated.

Risk assessments had been carried out however, these lacked detail. For example, actions for risk assessments stated, 'monitor and report' there were no further details about how to monitor the risk and therefore lacked instruction for staff to follow. We also found that a risk assessment had not been recorded for a person who was using bed rails to minimise risk. The provider had arranged for this to be completed on the day we inspected.

Although accidents and incidents were managed effectively we found recording issues. For example, records of incident and accidents were in different places and investigatory notes were not always kept together which made it difficult to follow the process taken. We also found one incident which had been recorded as a 'near miss however, the person had missed their medicines and therefore this should have been recorded as an incident. We discussed this with the provider who said this had been an oversight and that Mears Care Limited had recently introduced an online incident and accidents system which staff were being trained to use. The provider told us this would ensure all information was kept together making the process for investigations easier to follow.

We found inconsistencies within service user quality checks. Some people had received these checks recently however, others had not received a quality check or telephone quality check for some time. For example, one person had not received a check since November 2016. The feedback received from people at these checks had not always been recorded. In August 2018 a person felt improvements could be made on the quality of care provided and arrival times. There was no follow up to this review or actions recorded. We found one person had received a telephone quality check in January 2018 and highlighted concerns that they had not received a rota to inform them of which staff would be completing their visits. Again, in April 2018 the same person raised the same concerns however, no action to address this had been recorded. We discussed this with the provider who told us they would create a matrix to ensure all people were contacted about their care.

We also found end of life care was being given to some people using the service however their end of life care had not been documented in a care plan. We discussed this with the area director who agreed to

include these within care files so people wishes and preferences for end of life were carried out.

We recommended the provider review all records to ensure they were accurate and up to date in line with best practice.

We did find some audits which had been completed. For example, medicines audits and daily notes written by staff had been audited. Within these audits actions had been taken when there had been errors. This meant actions had been taken to ensure good practice.

Most people did not know who the manager was. Many staff also did not know the name or who the manager was. We were told by the manager that they had only been in post for the last three weeks and therefore had not met or spoken to everyone. The manager told us they were planning to apply to become the registered manager but were unable to as the previous manager was still registered. CQC were aware of this and in the stages of cancelling the previous managers registration to enable this.

The manager told us they had previously been a registered manager within Mears and said they had plans to improve the service being provided. The manager was open and honest about the improvements needed and staff who had previously worked with the manager told us they managed services well.

Surveys were carried out to gather people's views. Some of the feedback received included, 'Some carers are excellent, some need more training', 'Communication is good depending on who you speak to', 'Lack of staff is concerning', 'Never informed when carers are late or not turn up', 'I would like to be told if anyone is going to be late', 'Numerous times there are changes of carer or delays in calls or Mum has not received her rota. Result is Mum is continually onto me to complain about your services.', 'Depends which carer we receive, some are excellent some need further training.'

Following the results of the survey the provider fed back what action they had taken to address the concerns raised. The provider told us they had introduced the 'Making a positive difference' customer experience training programme which focuses on customer service and effective communication between people using the service, office staff and care workers. Also, the area manager told us rotas were now being sent to people weekly to make sure they knew which carer was coming.

The provider told us they had were in the process of making improvements to ensure people using the service were aware of local events within their community. The provider said they were planning to send monthly calendars which highlighted what was on in the area should they wish to attend. The provider said this was formed to ensure Mears collaborated with other services in the local community.

Other improvements included the provider sending out newsletters to staff and people using the service to promote better communication about what was happening within the service. We saw a recent newsletter sent to staff which informed them about the results of the annual survey, pay increases, introduction of the new manager and staff rewards for good practice.