Merit Healthcare Ltd

# Merit Healthcare Ltd

## Inspection report

Unit A, 13-19 Stroud Road
Gloucester
Gloucestershire
GL1 5AA

Tel: 01452901975
Website: www.merithealthcare.co.uk

Date of inspection visit:
13 July 2021
14 July 2021
15 July 2021

Date of publication:
23 August 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Merit Healthcare is a domiciliary care service providing care to people in their own homes. The service is provided to people who have a range of needs including a learning disability, mental health needs, physical disability and age-related frailty. At the time of the inspection, there were 30 people receiving support from Merit Healthcare.

People's experience of using this service and what we found
The management of medicines within the service was not always safe. We could not be assured people had always received their medicines. Staff practices in relation to medicines were not always in line with national guidance or the provider's policy.

Risk assessments in relation to people's care were not always accurate or completed. Where people were supported with moving and handling, continence care or skin care their risk assessments were either inaccurate or had not been completed.

We could not be assured staff were routinely testing for Covid-19. Although staff had access to Covid-19 tests, the registered manager had no process to ensure staff had routinely tested as per current guidance.

The recruitment of staff was not always safe. Safe recruitment practices had not always been followed and recruitment checks had not always been completed.

The recording of care delivery in the service had not always been completed. We also found inconsistencies relating to call monitoring. This meant, management could not always identify whether people had received their care calls as agreed and also what support people had received from staff. The people and relatives we spoke with provided mixed feedback relating to the punctuality of care staff.

We could not be assured staff had received training which was relevant to their role. The registered manager had not maintained up to date training records and was unable to provide evidence and reassurances that all staff had received training relevant to their role.

There had been a failure to establish and maintain effective quality assurance systems within the service. Shortfalls within the service were not identified and as a result appropriate action had not been taken to address areas that require further improvement.

The registered manager had not always notified CQC of incidents they had a legal obligation to report to us.

Staff knew what action they needed to take if they had any concerns relating to the safety of the people using the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 11 September 2019).

Why we inspected
We undertook this inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the risk management in relation to people's care and the punctuality of care staff.

We undertook this focused inspection to examine those risks. This report only covers our findings in relation to the Safe and Well-led key questions.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this report.

We found multiple breaches of regulation. You can see some of the action we have asked the provider to take at the end of this full report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following our inspection, the provider has engaged with us and have given assurances that people will receive safe care and treatment. The provider took immediate action to ensure staff were completing COVID-19 testing in line with current guidance and also the action they were taking to ensure the safe management of risk and medicines within the service.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Merit Healthcare on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of medicines, safe staff recruitment, safe infection control practices, ensuring accurate and cotemporaneous records, maintaining good governance within the service and notifying CQC of incidents.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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.

Details are in our safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Merit Healthcare Ltd

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

We undertook this inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the risk management in relation to people's care and the punctuality of care staff. A decision was made for us to inspect and examine those risks.

Inspection team
Inspection site visit activity was completed by one inspector and an Expert by Experience (ExE). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats, and specialist housing.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed the information we held about the provider since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also sought feedback from the local authority.

During the inspection
We spoke with three people who used the service and seven relatives about their experience of the care provided. We spoke with five members of staff including the registered manager and care workers.

We reviewed a range of records. This included 11 people's care records and medication records. We looked at seven staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training information and quality assurance records. We spoke with two professionals who regularly worked with the service.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● We were not assured that people had received their medicines as prescribed and in line with the provider's policy and national guidance.

● People were at risk of not receiving their medicines and creams as prescribed as people's medicines care plans were not always clear about what support staff needed to provide. When others [relatives] shared responsibility for managing and giving people's medicines, details of these arrangements had not always been recorded. This increased the risk of medicines errors, including prescribed medicines being missed.

● Medication administration records (MAR) had not always been maintained, to the extent it was not possible to be assured people had received their medicines as prescribed. One person's care plan detailed information on how staff were to support them with their prescribed creams; however, staff had not recorded when they had supported this person with their prescribed creams. Another person's care plan information was contradictory. In one place it stated staff were to support the person with their medicines and another section of the care plan stated the person did not require any support with medicines. Another person's care plan stated they required support with their medicines, but staff had not recorded when they had supported the person with medicines. We discussed this with the registered manager who told us the person did not require any support with medicines. In the absence of accurate medicines care plan and accurate records, we could not determine whether these people received support with medicines or not. Other people's MARs had multiple unexplained gaps in recording.

● We discussed the gaps in people's MAR charts with the Registered Manager. They told us they followed up on such incidents to ensure people had received their medicines. However, we did not see evidence that the Registered Manager or care coordinator had consistently followed up on gaps in people's MARs and gained assurances that people had received their medicines.

We found no evidence that people had been harmed, however, the failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risk assessments were not always in place for people. Some people had no risk assessments or management plans in relation to moving and handling, skin care or continence care. This meant there was no guidance available for staff on how to support people safely.

● Where people had continence care needs such as a catheter, there were no risk assessments around their continence care and personalised catheter care management plans.

● Where people were at risk of falls, a falls risk assessment had not been completed to detail the support

they required to maintain their safety.
● Where risk assessments were in place, we saw that these were brief and did not contain specific information in relation to people's needs. For example, where people were at risk of developing pressure ulcers, their risk assessments were brief and only advised carers to apply cream. There was no specific information in relation to risk levels or detailed person-centred information on how staff were to support the person to mitigate risks to their skin integrity.
● Where people were supported with moving and handling, their risk assessments did not contain any information relating to the level of risk and what action staff were to take to maintain the person's safety.

We found no evidence that people had been harmed, however, the failure to assess the risks to the health and safety of service users was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw environmental risk assessments of people's homes had been completed. This supported staff to maintain their own and people's safety when supporting people in their own homes.

Preventing and controlling infection
● The service did not always effectively manage the control and prevention of infection.
● There were arrangements in place for the control and prevention of COVID-19 and other infections. However, the provider had not always followed these or current guidance.
● We could not be assured that all staff took part in weekly COVID-19 testing. Although staff had access to COVID-19 testing kits, we did not see any evidence that these had been completed. The registered manager did not have a process to check staff compliance with testing and therefore was unable to reassure us staff had been completing COVID-19 testing as per current guidance. Following on from our inspection, the registered manager provided reassurances on the action they would be taking to ensure all staff were testing in line with government guidance.
● We could not be assured that all staff had up to date training in the prevention and control of infection. The registered manager showed us the training matrix; however, this had not been updated and did not contain accurate information in relation to staff training. We discussed this with the registered manager who could not provide us reassurances or evidence that staff had up to date training.
● People and relatives told us staff had access to and used personal protective equipment (PPE) during care calls. The staff we spoke with confirmed they had access to PPE and did not have any concerns over the availability of PPE.

We found no evidence that people had been harmed, however, the failure to assess the risk of, and prevent, detect and control the spread of infections was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We could not be assured the service had always followed safe recruitment practices.
● The service had not always carried out the relevant checks in relation to people's employment history, qualifications, or conduct in previous roles through obtaining references from previous employers. The service had not always carried out DBS (Disclosure and Barring Service) checks on all staff who they had recruited to the service. However, the service had checked DBS certificates from previous employers prior to allowing staff to deliver care. Information about any discrepancies and gaps in staff's previous employment and their health background had not always been investigated.

We found no evidence that people had been harmed, however, the failure to establish and operate effective

recruitment procedures was a breach of Regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed feedback from people about the punctuality of staff. People and their relatives told us staff punctuality was inconsistent and staff would not always arrive on time. People and relatives told us they felt rushed by staff.
● The staff we spoke with told us they were able to manage their rota but there were occasions when they may be late. They told us these were mainly due to delays in previous care calls where they had to stay longer to provide additional support for people.
● The provider had a system for staff to remotely log in and out of care calls. When staff used the system, it alerted the management team in real-time if staff were running late, missed a call or aspects of people's care were not delivered in line with people's care requirements.
● Due to technical difficulties following a recent upgrade to the system, staff were not always able to use this system as planned. As a result, the registered manager was not always able to effectively monitor care calls and be assured staff were punctual and staying for the allocated time. They had recently implemented a new system to assist them in the management and monitoring of the delivery of people's care visits.
● In the absence of effective call monitoring, the provider was unable to fully assess staff punctuality.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The people and relatives we spoke with told us they felt safe with the staff who supported them.
● We could not be assured from the provider training matrix that all staff had up to date training in relation to safeguarding. However, the staff we spoke with were knowledgeable about the procedures to follow if concerns arose. Staff knew what action to take if they suspected abuse or poor practice. Staff said they felt confident to raise concerns about poor care.
● The provider's safeguarding policy detailed what action was required by staff and managers where any safeguarding issues were identified. Systems were in place for staff to report and record any accidents, incidents and near misses so lessons could be learnt from these where appropriate.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We found multiple breaches of regulation. These failings demonstrated there were a lack of systems in place to assess, monitor and improve the service. Systems that were in place had failed to identify or act upon risks in order to provide a safe service to people. This meant that people would have continued to be exposed to the risk of harm.
- There was a lack of governance processes and systems in place to help ensure the safe running of the service. Without these systems, the provider and registered manager could not be proactive in identifying issues and concerns in a timely way and acting on these. The concerns found at the inspection included but were not limited to, training, care records, risk management, consent and the mental capacity act and lack of person-centred information.
- The manager was unable to provide us with evidence of, included but not limited to, completed care plan audits, up to date infection control audits, detailed accident, incident and falls audits and health and safety audits. When this was discussed with the manager, they told us they believed that some of these tasks were being completed by their care coordinator. However, they were unable to confirm or provide evidence that these had been completed.
- There had been a failure to establish and maintain effective quality assurance systems within the service. The registered manager had not maintained systems to identify and address shortfalls in the service being provided.
- The registered manager had not maintained systems any quality assurance systems to assist them to manage and monitor the accuracy and completion of people's care records and risk assessments. We saw that people's written care plans had not always been updated when people's needs, or the medicines prescribed to them had changed. For example, where there had been changes in people's continence needs in relation to catheter care or their moving and handling needs, this information had not been reviewed and updated. We also saw that people's consent to care had not always been recorded in people's care files.
- Some people's care files were incomplete and did not contain all the information related to their care. This meant staff did not have the relevant information to provide effective care to people. We discussed this with the registered manager but were not provided any other information in relation to the people's care to reassure us all of their care needs had been accurately assessed and recorded. The registered manager had failed and maintain accurate and complete care records to guide staff in providing care which was person centred and met their current level of need
- The registered manager had not maintained quality checks in relation to people's medicines. We saw four

people had multiple gaps in the recording of their medicines. Another person's care plan stated they were supported with their medicines. However, their medicine administration had not been recorded in line with the provider's medicines policy. The failure to establish effective quality monitoring processes meant these shortfalls had not always been identified or addressed.

● The registered manager had failed to establish any quality monitoring systems to ensure staff were completing Covid-19 testing as per current guidance. This meant the registered manager could not assure themselves that all staff providing support to people were free of the virus when supporting people.

● The registered manager had had not maintained any quality assurance systems to identify shortfalls in the staff recruitment system. This meant the provider was not able to take action to ensure recruitment processes were robust and safe.

● Quality assurance checks in relation to staff training had not been completed. The training matrix had not been updated and did not contain accurate information in relation to staff training. This meant the registered manager could not monitor whether staff training was up to date. We discussed this with the registered manager who could not provide us reassurances or evidence that staff had up to date training. Three of the staff records we looked at contained no evidence of staff training. Another staff member had completed training, but this had all expired over 12 months ago.

● We discussed staff supervision with the registered manager who told us formal staff supervision was not taking place. Staff we spoke with told us they could contact the registered manager to discuss any concerns they may have. The registered manager told us they completed spot checks of staff practice, but this had not always taken place for each member of staff. The failure to provide regular staff supervision and maintain regular observations of staff practice meant the registered manager was unable to effectively monitor staff competency and staff learning needs to ensure staff were always providing safe and effective care to people.

● The registered manager had not maintained effective quality assurance systems to manage and monitor the punctuality of care staff. The registered manager told us they were unable to use their call monitoring system effectively due to technical difficulties which they were trying to resolve with the local authority. However, the registered manager had not developed any other quality assurance system to monitor staff punctuality in the absence of their main call monitoring system. This meant the registered manager was unable to monitor whether people were receiving their care calls within the agreed times and care staff were staying the allocated time to ensure people's needs were met.

We found no evidence that people had been harmed. However, robust systems were not in place to assess, monitor and improve the quality of the service and skills of staff. The provider had not ensured that complete and contemporaneous care records had been maintained. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There was a system in place for staff to report any concerns, accidents and near misses promptly, which staff had followed.

● The provider and registered manager had reviewed all incidents reported by staff and acted upon them to reduce risks to people. However, they had not always notified CQC of incidents as part of their registration conditions. There had been seven notifiable incidents since the beginning of June 2020. The registered manager had failed to notify CQC of these incidents.

We found no evidence that people had been harmed however, the failure to notify CQC of all incidents that affect the health, safety and welfare of people who use services was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We discussed the above shortfalls with the provider who advised us that these were due to challenges in maintaining sufficient staffing levels and the registered manager having to complete a high number of care calls. However, this explanation and the shortfalls we found demonstrated the provider's contingency plan for monitoring the quality and safety of the service, in the absence of the registered manager, was not effective.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The registered manager told us they visited people in their homes or contacted them via telephone to speak with them about their care and provided them with an opportunity to give feedback on their care.
- The registered manager told us how they used feedback from these visits to try to improve the service provided to people.

Working in partnership with others

- The service had working arrangements with the local authority. The service had also built relationships with other health professionals including local GP practices and pharmacies. This helped people access and sustain the support they required.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>There had been a failure to notify CQC of all incidents that affect the health, safety and welfare of people who use services. 18(2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>There had been a failure to establish and operate effective recruitment procedures. 19(2) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There had been a failure to assess the risks to the health and safety of service users. 12(2)(a)<br><br>There had been a failure to ensure the proper and safe management of medicines. 12(2)(g)<br><br>There had been a failure to assess the risk of, and preventing, detecting and controlling the spread of, infections. 12(2)(h) |

**The enforcement action we took:**

We have issued a warning notice in relation to the breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The service was not operating effective quality assurance systems. 17(2)(a)<br>The service had not always maintained an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. 17(2)(c) |

**The enforcement action we took:**

We have issued a warning notice in relation to the breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.