Mears Care Limited

Mears Help to Live at Home Wiltshire

Inspection report

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

Summary of findings

Overall summary

Mears Help to Live at Home Wiltshire is a large domiciliary care agency. It provides personal care to people living in their own homes in the community. It also provides care and support to people living in two 'supported living' settings, so they can live independently as possible. At the time of this inspection, Mears Help to Live at Home Wiltshire was supporting approximately 900 people over a large geographical area in Wiltshire.

The inspection was announced. We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the registered manager would be available. This was the agency's first inspection, since its registration in June 2017.

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

This service was registered in June 2017. This was because the Amesbury and Melksham branches of Mears Help to Live at Home Wiltshire both merged to become one service, with a new registered address in Devizes. The registered manager transferred from the Amesbury and Melksham branches.

The agency was the main provider for the local authority's Help to Live at Home contract. To ensure sufficient staffing, the agency subcontracted some care to other services. In addition, staff sickness meant staffing levels were not always sufficient. The registered manager told us they were in a process of recruiting more staff.

People were not always happy with the timing and consistency of their visits. There were comments that staff were sometimes late arriving and they did not always stay for the allocated amount of time. The electronic monitoring schedule confirmed some inconsistencies in people's visits were occurring. We recommended that the provider monitors the timing of support to ensure it meets people's needs and expectations. A "cell track" system was used to monitor people's visits and minimise the risk of missed calls. This was not always effective as a number of missed visits had occurred through system errors and double up visits had not always occurred for one person.

People's medicines were not always safely managed. Instructions for medicine administration were not clear and staff had not always signed the records to show the person had taken their medicines. However provider's audits had identified such shortfalls and improvements were being made. We recommended further monitoring to ensure staff supported people with their medicines safely, in line with current guidance.

Staff received a range of training. However, this did not include training related to people's individual needs and complex medical conditions in all cases. We recommended this training is delivered based on current best practice. People were positive about the competency of staff who supported them regularly but told us when new staff covered the calls they were not always familiar with their needs.

Risks associated with areas such as nutritional needs and mobility had been identified and action taken to promote safety.

People had a clear support plan, which they were involved in developing. The information was clear and showed the support people needed to meet the required outcomes. Staff documented a summary of their visit within a communication log. However, much of the information within the log, was task orientated and did not demonstrate areas such as how the person presented. People were asked for feedback about the service they received during reviews of their care. More formally, surveys were sent on a yearly basis to enable people, their relatives and staff to give their views about the service provided.

People were encouraged to make decisions and control the support they received. They were encouraged to be as independent as possible and their rights to privacy and dignity were promoted. Staff supported people with meal preparation where required.

Staff knew how to recognise and report when people experienced ill health. Additional visits were added to ensure people were properly supported if very unwell or there were risks to their safety. Records showed health and social care professionals were involved in the development and review of people's support plans, as needed.

Structures and processes were in place to ensure day to day running and organisation of the agency. Systems such as recruitment and health and safety were well managed. There were a range of audits to assess the quality and safety of the service. There was an open approach to complaints and concerns received were fully investigated. Lessons learnt were taken on board and there was a strong emphasis on on-going improvement and development. Staff were aware of their responsibilities to identify and report any poor practice or allegation of abuse. Any safeguarding concerns had been appropriately managed, with disciplinary action taken as required.

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

This service was not always safe.

People's medicines were not always safely managed but improvements were being made.

Staffing levels were not always sufficient.

Safe recruitment procedures were in place.

Risks to people's safety had been considered and measures were in place to manage these.

Is the service effective?

Requires Improvement

This service was not always effective.

Staff received a range of training but not specifically in relation to people's complex needs in all cases.

People were supported to make decisions and consent to their support.

People were supported with their meals as needed.

Staff recognised ill health and sought medical assistance when required.

Is the service caring?

Requires Improvement

This service was not always caring.

People praised the staff who supported them regularly but were not so happy with others.

People's rights to privacy, dignity and independence were promoted.

Staff received equality and diversity training and an open culture was promoted.

Is the service responsive?

Requires Improvement

This service was not always responsive.

People's support did not always meet people's expectation in relation to timing and consistency.

People had clear support plans, which they were involved in completing.

There was an open approach to complaints and an emphasis on lessons learnt.

Is the service well-led?

Requires Improvement

This service was not always well-led.

Audits assessed quality and safety but issues which negatively impacted on people's satisfaction, had not been identified.

There was a clear ethos around promoting positive culture which was demonstrated by the staff team.

People were encouraged to give their views about the support they received.

Mears Help to Live at Home Wiltshire

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 service is a large domiciliary care agency. It provides personal care to people living in their own houses in the community. It also provides care and support to people living in two 'supported living' settings, so they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service provides a service to older adults and younger disabled adults. Not everyone using Mears Help to Live at Home receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The inspection was announced. We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the registered manager would be available.

Inspection site visit activity started on 16 October 2017 and ended on 23 November 2017. During this time, we made telephone calls to people who used the service, their relatives and to staff to gain feedback about the agency. We spoke to 51 people, nine relatives and fourteen members of staff. We contacted seven health and social care professionals for their views about the service, two of which responded. We visited the office location on 16 and18 October and again on 14 and16 November 2017 to see the manager and office staff; and to review care records and policies and procedures.

The inspection was undertaken by three inspectors on 16 October 2017 and two inspectors on 18 October 2017. On 14 and 16 November 2017 there was one inspector. There were four Experts by Experience allocated to gather views of people and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Requires Improvement

Is the service safe?

Our findings

The medicine administration records, which were available to us at the time of the inspection, did not show people's medicines were safely managed. However, the records were historical as the current medicine administration records (MAR) were in use, in people's homes.

The records did not always clearly show the person's prescribed medicines and instructions for their use. One record showed a list of the person's medicines but there was no detail about the dosage or how often they were to be taken. Other records showed lack of detailed instructions. This included "apply twice a day as directed" and "Administer as per pharmacy instructions". The instructions were not specific and increased the risk of error. Another record had the name of a topical medicine (cream) but there was no detail to show where it was to be applied or the reasons for its prescription. The MAR was not fully completed with the person's name and details such as address and GP's details. There were gaps in recording on some of the MARs. This meant there was no evidence to show if people had been administered their medicines, as prescribed. One member of staff had signed the record to show the person had taken their nutritional supplement drink. However, staff had left the supplements with the person and did not see them taking it.

On two occasions, records showed a medicine could not be given, as the person's morning and lunch time visits, were too close together. Another person was prescribed a liquid medicine to be taken twice a day. However, the MAR showed the person, on their request, was given a different amount of the medicine in the evening. The record did not show the person's GP had been consulted about the change. Another person was supported with their medicines by staff and a relative. Records did not show how this was safely managed. This increased the risk of the person being given additional doses of their medicine. Staff had recorded in the communication log that they had applied a topical cream to a person's skin. However, the cream was not identified on the MAR, which did not ensure it was safe to use. Some staff had recorded they had given a person their medicines, in the daily communication log rather than the MAR. This inconsistency did not ensure the MAR was an accurate record of the medicines taken. One relative told us staff did not always observe their family member taking their medicines, as they often found tablets in the side of their chair. This showed staff were not always following procedure and ensuring the person received their medicines as prescribed.

The registered manager told us shortfalls in the completion of the MARs had been identified and were being addressed. They said staff had been sent individual letters, reminding them of safe practice when supporting people with their medicines. In addition, the frequency of staff training had increased to every six months. They said any shortfalls identified with medicines during the auditing processes, were addressed with the staff concerned. This was through discussion or more formal training sessions. Staff's competence with medicine administration was assessed during their induction and monitored thereafter, during observational checks. However, records did not always show the action taken in response to any identified shortfalls. The registered manager told us records would be streamlined to clearly show this and they would ensure the frequency of competency checks was increased.

After the inspection, the registered manager sent us fully completed MARs, which showed improvements had been made. However, we recommend that the service continues to monitor the administration of medicines to ensure people's safety.

There were not always sufficient staff to support people effectively. One relative told us their family member required two staff to assist them at each visit but there were occasions when only one member of staff attended. The electronic scheduling system confirmed this. The person's family were required to assist, to ensure the person received their care. Another relative told us their family member was often supported by staff who did not know them. They said on these occasions, they assisted to ensure the correct care was given. There were other comments from people and relatives about staff shortages. These included "They will give him a shower if they are not too busy", "I understand the pressure they are under, they are expected to be in the next village immediately" and "Every week the management blame staff being off sick but it's all the time. They must have people off sick every week".

Staff commented more staff were required, particularly to cover staff sickness. One member of staff told us, "It's like double the work before anyone calls in sick at the weekend so when there's sickness, it's crazy". Another member of staff told us they were always "picking up additional shifts". They said this was stressful and did not enable consistency of people's support. Other staff told us whilst they felt there were enough staff to support existing people who used the service, there were not enough to meet the continued demand for care.

The registered manager told us they recognised more staff were required and they aimed for all work to undertaken efficiently "in house" without the need to subcontract. To achieve this, they said recruitment was on-going. An external care professional told us, "Like most domiciliary care agencies, Mears do not have sufficient capacity to meet the demand for care". However they continued to say, "They are proactive in recruiting and always have a small number of staff in the recruitment 'pipeline'. They offer a relatively generous employment package in order to attract new staff".

Despite some comments about staff shortages other people told us they felt safe. One person told us "I feel safe with them as they know me so well". Another person told us "I am relaxed in their company". Another person said "I feel safe as they let themselves in using the key pad and put it back so it is okay". A relative explained, "I feel [person] is safe. They help him to stand with a turner. He never feels unsafe". Another relative told us, "Carers sit with [person]. They speak well with her and make her feel comfortable. This has been really important to keep [person] company and keep her safe".

Safe recruitment practice was being followed. The applicant was sent an application form and invited to attend a formal interview. This included a literacy skills test. Any gaps in employment history were appropriately explored. Applicants completed a Disclosure and Barring Service check (DBS) to ensure they were suitable to work with vulnerable people. Records showed the applicant gave details of two people who could comment on their work history and performance. The information gained was orderly stored on file. All new staff were subject to a 12 week probationary period. Staff confirmed the recruitment process they went through was thorough and robust.

Risks associated with people's mobility, eating and drinking, domestic tasks, environment and fire, had been identified. Records showed actions required to promote safety had been taken. The registered manager said they were in the process of developing one page profiles with people. This would show a snap shot of the person's needs, including risk, so staff could see this easily. One member of staff told us they undertook risk assessments as part of their role. They explained how they discussed certain risks with people and negotiated a safe outcome. This included unsafe footwear and trip hazards such as a rug on the

floor.

Staff were aware of their responsibility to report poor practice or a suspicion or allegation of abuse. They were confident any concerns would be appropriately addressed. Records, including those for "out of hours" showed concerns were properly investigated. Safeguarding records showed an open approach and a willingness to address and learn from any shortfalls. Staff told us they had completed safeguarding training. Senior staff had completed an advanced safeguarding course, which was more reflective of their role.

The registered manager told us people's safety was paramount. This was shown on the second day of the inspection, when the office was informed of a person who was very unwell. The registered manager told us if a hospital admission could not be secured, waking night staff would be allocated as the person was not safe on their own. They gave various other examples of additional visits, which were arranged to ensure a person's safety.

Staff told us they used a "cell track" system, which meant they had to log in to a person's property on arrival and log out when leaving. The information was transferred electronically to computers in the office and monitored to ensure visits took place and were not missed. They registered manager explained although the system was reliable for 'live' monitoring, there had been some problems with the system not "rolling" visits over. This meant one person's support had not started when it should have done. The registered manager acknowledged this should not have happened but it had not impacted on safety, as the person's relatives had provided the required support. They said the person's missed visits were seen as "lessons learnt" and additional monitoring systems were put in place, to minimise further occurrences. The registered manager told us reports, which included missed or late visits, were sent to the local authority each week for monitoring purposes.

People told us they never experienced missed visits as they said staff always "turned up". Staff confirmed this and told us people always "got their calls". An external care professional told us there were seldom missed calls and any which did occur were thoroughly investigated, to minimise further occurrences.

Requires Improvement

Is the service effective?

Our findings

When starting work at the agency, all new staff received a detailed induction. This included five days training, shadowing more experienced members of staff and completion of a nationally recognised induction programme. Staff told us their induction was flexible according to their level of experience. They said they were able to complete additional shadow shifts until they were confident and competent to work on their own.

Staff received a range of training to help them undertake their role effectively. Records showed training deemed mandatory by the provider included health and safety, infection control, food safety and safeguarding. The registered manager told us first aid training had been introduced in September 2017. Other topics included nutrition, dementia care and stroke awareness.

The agency employed a Clinical Case Manager who provided training to staff who supported people with clinical needs. This included training in PEG (nutrition through a tube into the person's stomach) and oxygen administration. However, records did not show staff had received training around people's complex medical conditions. This included Multiple Sclerosis and PCP (Progressive Supranuclear Palsy). One person's assessment stated "care staff must be trained in changing convene bags to assist [person]". A member of staff told us this was covered in catheter care training but there was no evidence of this taking place.

People and their relatives did not think all staff were well trained. One relative said, "There are not enough trained staff who can cover [person's] complex needs. The ones that are trained are ok. The others, well it's mayhem". Another view was, "If the regular carer is on holiday, they send in staff that haven't even used the hoist. They can't even operate it". Other comments included "There seems to be a lot of change. Staff don't know what they should be doing sometimes" and "I feel some carers are well trained, though some are and some aren't". Some people were more positive about the competency of staff and told us, "They know how to deal with my situation, which is really helpful", "They are very skilled and knowledgeable" and "I feel the carers are well trained in general".

People gave us varying views about the consistency of their support. One person told us "I do have some staff which are regular, but quite a lot of different ones which I'm not so keen on. I have to explain what I want over and over again and I can't get to know them". Another person told us "It would be helpful as a dementia patient to have the same carers for consistency, as this hasn't always been the case". Other comments were "I find it hard because we have had lots of different carers", "I can have a different one every day" and "There is no continuity. I have to keep explaining what we need". Another person told us "New staff just turn up and I have to show them the ropes". A relative told us "When we have different people, it gets [person] confused and I have to cope". One member of staff empathised with people, who were supported by staff who did not know them well. They told us "It's got to be hard. I always check and say, "Your usual carer is back tomorrow so we'll leave your shower for today, if you want". I wouldn't want a stranger helping me, so I can see how people feel. It's important to build relationships with people".

We recommend the provider ensures staff receive appropriate training for them to be able to meet people's

individual needs effectively.

Other people told us they had greater consistency in their support. Specific comments were "I get the same carers everyday so I feel confident with them", "I have the same carers most of the time which is important" and "I have a lot of different carers maybe 5 or 6 that take turns. All have been very nice and I've got to know them all". One person told us "I have one regular carer, which is nice because of continuity, others are different. The regular one knows me now, which I like. They are incredibly good". Another person told us consistency with staff had improved as they now had four to five staff on a rotational basis.

Care co-ordinators told us they always aimed to ensure people were supported by the same staff. They said people generally had a small team, which worked well although staff sickness did sometimes impact on consistency. The electronic scheduling system showed people usually had a small team of staff, although one person had different staff each day. Another person had a consistent member of staff to assist them with a bath on a weekly basis. However, on one occasion, a different staff member supported them. Due to the intimacy involved, the person was not happy with someone they had not met before. A care co-ordinator confirmed the person would not have known the staff member, as they usually worked in a different area of the town. The registered manager told us at the start of a care package, the person may have different staff supporting them but a small team would be allocated, as soon as possible.

Staff told us they felt supported in their role. They said much of their support was informal and achieved through discussions either by telephone or when visiting the office. Staff told us they had support from their peers, line managers, senior staff or the registered manager. One member of staff told us the regional director worked in the office and could be easily approached if needed. In addition to informal support, staff met with their supervisor more formally to discuss their role. They said they felt listened to and any concerns raised, were properly addressed. Records showed staff received support in line with the organisation's policy. This included staff meetings, supervision and spot checks. However, information was stored in different places, which did not readily evidence the systems in place. The registered manager told us they would review this and archive any information, which was no longer relevant. They confirmed appraisals, which reviewed staff's performance, were scheduled soon.

People told us staff encouraged them to make decisions and asked for their consent before undertaking any task. A relative confirmed this and said "Carers always give her a choice of powders for personal hygiene and a choice of clothing". People were encouraged to direct their support and make any changes, if required. Information showed one person had reduced the number of their visits in a day, as they not feel they needed this level of support. Another person had tried different arrangements, which helped them decide they needed a "live in" carer. People had signed their support plans to demonstrate their involvement.

People's ability to make their own decisions was mostly reflected in their support plans. However one person's plan stated they were to be given their medicine on a spoon with meals or yogurt and a sip of drink. It was not clear whether this was to covertly administer the medicines or to aid swallowing with the person's consent. There was no decision specific capacity assessment surrounding this or further details available. This did not show the person's rights to make their own decisions, in relation to this process, were respected.

People were supported to meet their nutritional needs. Staff told us meal preparation was person centred and dependent on the person's ability. One member of staff told us they encouraged people to do as much for themselves as possible, to regain skills. Another staff member said they always asked people what they wanted for their meal. They said sometimes this meant microwaved meals, a snack such as a sandwich or reheating meals families had prepared. People confirmed this. Comments were "They make sandwiches for

me", "The food preparation is okay", "I chose lasagne for lunch today" and "They help prepare meals for me, which really are just ready meals they pop into the microwave".

Records showed staff sought medical support in response to people's ill health. One person told us, "Once when I was ill, they stayed and waited for the doctor then the ambulance". A record showed another person was "pale and clammy" and staff offered the person, an ambulance or the GP. Another support plan showed the person often refused help with their personal care. Staff had become concerned about the person's condition and had alerted the office staff. They contacted the person's GP and the local adult care service were contacted and subsequently visited. The registered manager told us staff were very good at recognising if people were not well or not their "usual self". They said if there were any concerns, office staff would contact the person's family or local surgery.

Records showed health care professionals had been involved in the development of people's support and its review. This included speech and language therapists, specialist nurses and occupational therapists. One relative said, "Regular carers have close liaison with the District Nurse and specialist nurse. We have meetings every 6 weeks at the house". A support plan showed an occupational therapist had provided written guidance to assist staff in moving the person safely and supporting them with their exercises.

Requires Improvement

Is the service caring?

Our findings

People told us they liked the caring nature of staff. One person told us, "The carers are brilliant. They look after me really well. Nothing is ever too much trouble". Another person said, "I have no problems with any of the carers at all. They're all so friendly and lovely". Other comments were: "My carers are wonderful, especially [name of staff member]. They are so nice. They cheer me up", "all carers have been excellent" and "I receive excellent support and care. All of the carers are always very approachable and friendly". One person told us "I think the staff are marvellous, absolutely wonderful". A relative said "[Person] loves them all and they are very supportive, they listen and are accommodating". Another relative said "My [family member] is very fond of them and is delighted with what they do". Other comments included "I couldn't ask for better care to support her", "staff are excellent", "I am very happy. They fit into our day nicely" and "The staff are very good, very chatty and quite relaxed". One person told us "They're very good and allow me to collect myself, for instance they remind me 'don't forget your glasses"'.

People and their relatives told us they were able to build positive caring relationships with staff. One relative told us about a particular member of staff who supported their family member. They said, "There is one regular carer, who my [family member] really likes. They have a great rapport and a similar background so they get on well. My [family member] smiles when [the staff member] arrives and even reaches out to them when they come through the door. It is great to see and makes us both happy. Wish we could have them all the time. My [family member] is more settled and co-operative with them". Another person told us about another member of staff. They said "[staff member] is particularly nice. She watered my plants and did a little bit extra for me which I thought was nice".

Whilst the majority of feedback about staff was positive, some people's experience was less positive. For example, one person told us, "The regular carers are good, the main one, she's very good. She does what you ask. The poor ones are the ones that don't talk to me". Other comments were "The staff are not too bad at all but you get a couple of rotten apples" and "There's just a few who don't know anything about me at all or what I need". One person told us they thought some of the younger staff showed a lack of interest in their work. They said one of the staff in particular did not have a good attitude. They explained these staff "did what they had to", but did not show they wanted to do it.

People's wishes in relation to who supported them were not always respected. We saw some people cancelled their visits as the allocated staff member was of a different gender, to what they wanted. One member of staff told us at times, particularly at weekends, when staff had called in sick, some people had to be allocated a male member of staff, despite them not wanting this. Staff said they would avoid this, if at all possible but it could happen. Another member of staff explained if a person accepted male staff to assist with their meals, they could not differentiate and refuse a male for their personal care. One member of staff told us "people are really vulnerable so we would all try not to allocate a staff member, if we knew the person did not want this". They told us "if no other staff were available, we would go out and do the visit ourselves".

On each day of the inspection, whilst the office was busy, there was a calm and relaxed atmosphere. Staff

spoke to people in a friendly and caring manner when answering the phone. They informed the person who they were and asked how they could help. One member of staff responded to a person by saying, "Oh dear, I'm really sorry to hear that. You know where we are if you need anything". The registered manager told us staff had the wellbeing of people at heart. The registered manager told us staff were "a good bunch" both caring and concerned. They said they often "checked up" on people who were in hospital, to ensure their wellbeing.

People told us their rights to areas such as privacy and dignity were promoted. One person told us, "I feel my privacy is respected at all times. Everyone is very discreet and allow me to say what I want in an open way. I can just be me". Another person told us, "They are always very respectful to me and ask me what I would like". Other comments were "The care they give is good, they listen to me", "They are definitely respectful. I would happily recommend them" and "They show interest in my life, they promote my dignity".

Staff told us they always promoted people's rights whilst providing support. This included delivering care in private, encouraging independence, respecting people's wishes and recognizing individuality. One member of staff told us, "I always provide care that I would like my mum to have or that I would expect".

Information about how the person wished to be addressed was detailed at the beginning of their support plan. Staff including those in the office, were aware of this information. There were other examples of promoting people's rights. This included one person who liked three towels to be used for their wash. Records showed one was for the person's face and hands and another for the rest of their body. The third towel was to cover the person, to maintain their dignity. Staff had recorded in one communication log, "[Person] still calmly asleep in his chair. Unable to do mouth care until he wakes up". This showed the person's privacy was respected, as they were enabled to sleep without being disturbed. Each support plan contained a summary of the person's family situation and what was important to them in their lives.

Staff had completed Equality and Diversity training. The registered manager said a board game had recently been introduced, which encouraged staff to discuss their values and reflect upon their work. Within other training sessions, staff and managers had been asked to make pledges or promises, particularly around values. These were displayed in the office to show their importance and to promote the open culture of the service.

Requires Improvement

Is the service responsive?

Our findings

People told us they did not always receive support that met their needs. For example, we received negative feedback about the timing of people's visits. One person told us, "I feel it is an utter shambles to be honest. This morning they came at 11:45am but we asked for a carer between 7:00am - 7:30am". Another person said "Today there was a mix up and they were 3 hours late. It has happened before". Other comments were "They come way too early sometimes", "They come at 8am. My call is between 9 and 10", "At least once a week they are late" and "My regular carers are wonderful and nearly always on time. The non-regular ones are always late". A relative told us "The timing is lousy. They turn up at different times, can be as late as 10am when it should be about 8am and once they turned up at twenty past four to do an evening meal. It's like, as and when". Another relative told us "I can't leave [person] in a wet pad or be hungry". Another comment was "Some staff come to get him to bed too early and it unsettles him. It's not good, it upsets him". Another relative told us they stopped using the agency. They said "The company could not give us the time we wanted in the morning. We tried for a while but it did not work out, the timings were not right and they could not meet our needs".

Not all people were clear when they should expect staff to support them. Specific comments were "I never know when they are coming", "They come at different times and don't let us know" and "I keep phoning to ask the times when carers are coming. They sometimes give times then change it without telling me". One person told us "I don't know what time the carers are coming, or what time they should arrive. They come at 10:00am, 11:00am but really we would prefer them to come between 8:00am - 8:30am". A relative told us "The co-ordination is not good. I can't plan my day. Once, they arrived in the morning when we were both still in bed. They didn't phone to let me know. I like to be up and dressed before people come". There were some comments about staff not staying for the allocated time. One person told us "Some carers rush through the care and some don't stay the full time".

The majority of people told us the office did not tell them if staff were going to be late. One person told us, "It makes me cross and angry. The carers get angry too because the office hasn't told me". Another person said "I had a new carer who didn't know how to get to my house. They got lost so they were late". Another person said "I don't get any calls if the carer is going to be late, sometimes they are very late. I don't know where I am at, so I have to get up and wait". One person told us "They are mostly on time although the last couple of weeks have been a nightmare". Another person said "Sometimes they are late but they don't let me know, they just apologise when they get here". A member of staff told us communication was something they felt could be improved upon. They explained "certain office staff will always pass messages on about you running late but others don't, then we're left taking people's frustrations".

Three staff told us the general cause of being late to support people, was because they had no allocated travel time between visits. They said they could leave a person's home and their rota would say they already needed to be at the next person. Office staff said this was a challenge but outcome based care meant staff often left visits early, giving them sufficient time. They said they aimed to ensure people received consistency with the timings of their visits, but staff sickness could compromise this.

The electronic scheduling system showed people's visits generally took place around the same time each day. However, this was not always the case. One person was scheduled for a visit at 18.00 but there were two occasions when staff arrived early at 16 .31 and 16.35. Another person had visits to support them with their meal at 18.44 and 18.46, which was late to be eating tea. Records showed one person's morning visit was scheduled to take place between 07:00 and 08:15. Staff had documented they had visited anytime between 09:00 and 10:30 each day. Another person was scheduled to have a visit at 9am but the electronic system showed visits had been at 8.30, 9.30 and 10.10.

We recommend that the service monitors the timing of people's support to ensure it meets their needs and enables greater satisfaction for those concerned.

Other people were more positive about the consistency of their visits. Such comments were "My carers come usually at the same time", "They are very reliable. They're very unlikely to be late" and "Normally my carers are on time, though sometimes the call time has to be moved because they are really busy". Another person told us "Most of the time they are on time. If they are going to be very late the office will ring". In addition to consistency, there were also positive comments about the support people received. One person told us about their evening visit. They said "on this visit they supervise me, organize me and take me to my bedroom. It is very important to me". Another person said "We're really satisfied. They're all very helpful. They know exactly what to do". A relative told us "Mum has progressed really well since coming out of hospital with the support of Mears. The carers are encouraging with her, they talk to Mum and this helps my Mum". Other comments were "I look forward to having them around", "They are absolutely brilliant" and "They do a wonderful job".

Some people told us the service was accommodating if they needed to make any changes. One person told us "If I had an appointment, I would feel confident the carers could fit in with this". Another person said "I feel Mears are very flexible. They have been able to fit in my hospital appointments. Sometimes I've only let them know the day before but it hasn't been a problem for them". A relative told us "They're adaptable and vary their times if there are appointments my [family member] has to attend". Another relative told us "Mears have been very accommodating to fit my Mum's needs for respite care and support".

People's support plans were clearly written. The information detailed people's needs and the support required to meet the identified outcomes. For example, there was detailed information about a person's PEG (nutrition through a tube into the person's stomach). Care charts had been consistently completed to show the amount of fluid the person consumed each day and the support they needed to minimise their risk of pressure ulceration. Another support plan showed step by step instructions for using a machine to assist with a person's breathing when coughing. The instructions contained pictorial guidance, which enhanced staff's understanding. One plan detailed the importance of phrasing a question correctly, in order to promote a person's food intake. Another prompted staff to ensure the person had everything they needed within easy reach before leaving them.

Staff had taken action in response to people's changing needs. For example, one person had developed a urinary tract infection, which meant they had become unwell and needed extra support. Staff had requested an extra evening visit, which was provided. Another person was having difficulty remembering if they had taken their medicines. Staff had approached the person's GP and the medicines were prescribed for more appropriate times. This enabled staff to be present, to prompt the person if required. Another person had episodes of being physically abusive to staff due to their dementia. Staff looked at the triggers that caused this behaviour, such as when the person was tired or reacting to certain staff. Visit times were then reviewed and efforts were made to ensure the same staff visited the person.

Where records showed one person was not eating well, multi-disciplinary meetings had been held to discuss this. However, the person's support plan had not been updated, to reflect any amendments. The registered manager told us staff were informed of any changes but the support plan could not be changed, without the agreement of the local authority. They said to address this, they were planning to develop 'one page' profiles. This would give an updated "snap shot" of the person's needs and the support they required.

Whilst some of the entries in the communication logs were detailed, others were not and lacked detail. For example, one entry stated "Front door unlocked, knocked and entered. Greeted [person] who was awake in bed. Wheeled to bedroom, dressed, t-shirt and lower half. Transferred by stand-aid to bed. Declined any food to eat." Another record showed a person had told staff they did not feel very well. Staff had documented they supported the person with a wash and assisted them to get dressed, but there was no further information about them being unwell. Another record showed a person had fallen and sustained injuries. Staff had not documented how the person presented, their pain or any adjustments they needed with their care. One member of staff had documented "Daughter explained to me what had happened and what was going on" but they had not expanded on this. Another person required their food to be cut up to minimise the risk of them choking. Staff had not documented they had done this, which did not evidence the risk had been minimised. A recent audit had identified some entries within the communication logs required greater detail. The registered manager told us this was being monitored and was "work in progress".

The majority of people told us they knew how to make a formal complaint. Complaints were taken seriously and investigated. Measures were put in place to minimise further occurrences and consideration was given to "lessons learnt". An external care professional confirmed this by saying, "When issues do arise, the organisation appears quick to put things right and to learn". There were some entries on the daily handover forms, which could be seen as complaints or concerns but these were not documented separately, on the complaint's log. This did not enable the information to be captured and potential trends to be identified. In one instance, a relative had complained about a missed visit and another relative was unhappy about the support provided. The registered manager told us when concerns were reported "out of hours", the person was contacted and asked if they wanted to make a formal complaint.

Requires Improvement

Is the service well-led?

Our findings

The agency continued to provide the Wiltshire Council Help to Live at Home contract. This had recently expanded and the service now covered all but two areas of Wiltshire. An external professional told us "There are very few complaints, and safeguarding incidents are within the range expected for the size of the organisation". However, during this inspection, whilst some people were satisfied with the service they received, others raised dissatisfaction. The majority of negativity was about the timeliness of their support and the consistency and competency of some staff, especially at times of staff sickness. The issues leading to people's dissatisfaction, as raised during the inspection, had not been identified or further explored. This did not ensure improvements were made or people's expectations were readily discussed and resolved.

The registered manager told us changes to the management structure had been made to address the expansion of the service. Teams had been developed with responsibilities such as finance, human resources and brokerage. The registered manager told us rather than being in control of all areas, they now had to delegate more, rely on staff to deliver and monitor effectiveness. They said it was important they maintained an overview and had good, effective teams of staff in all areas. The registered manager said this had been accomplished but there were always areas, which could be improved upon. They said they had good support from other managers and senior managers within the organisation and were part of various working groups and committees. They attended training and conferences to keep up to date with best practice and to meet others in similar positions.

The transition of the two branches, into the current registration of Mears Help to Live at Home Wiltshire went smoothly and did not impact on people's support. A large amount of work was undertaken in preparation for the transition. This included a review of the systems, people's risk assessments and support plans, additional staff training, staff meetings and staff supervision. At the time of the inspection, there were two electronic systems regarding the different geographical areas of people's support. This was being addressed as there was a scheduled date for these to be amalgamated. The registered manager told us this would make the system easier to use and further demonstrate the agency was now one service, rather than two.

There were clear processes in place regarding the organisation of the service. For example, staff completed accident and incident forms and then sent them to their line manager. The line managers reviewed the information and entered the details onto an electronic health and safety management system. A regional safety, health and environmental advisor then reviewed the information further. A monthly report of accidents and incidents was compiled and sent to the regional director for their information. The advisor told us in addition to monitoring accidents and incidents, they facilitated specific health and safety training, carried out annual inspections and reviewed audits.

There was an out of hours 'on call' service which people or staff could use, if they needed advice or support. Detailed records of each call were maintained. The information showed appropriate action had been taken in response to the queries received. Any concerns or those needing further attention, were highlighted in red so they were easily identifiable.

The registered manager had a good awareness of people's needs, staff's skills and the challenges they faced. They encouraged staff to "drop into" the office for a chat or to discuss any concerns. They said during the forthcoming festive season, a buffet on various days, would be arranged as a gesture, to thank staff for their work. They said it was recognised the office was often a distance from where staff worked. To support staff within the geographical areas of the county, they said a member of office staff would regularly base themselves in a particular setting. This would minimise the time staff needed to travel to gain contact or to collect items they needed such as protective clothing. The registered manager told us a newsletter had been developed to enhance communication. They said regular team meetings were held. This included weekly senior staff meetings to review work and address any challenges which had arisen.

The registered manager told us the ethos of the agency was to "make a positive difference" and "improve the life of a person". They said they had an excellent staff team which enabled this. In addition to providing support to people, the registered manager said the service had a responsibility to enhance the community and provide opportunities for social activity, to minimise loneliness and isolation. They said this was achieved in a variety of ways such as arranging coffee mornings and delivering hampers to those who had limited family at Christmas. The ethos and culture of the agency was visually expressed as a red thread, which weaved its way through all aspects of practice. The tread was painted around the walls in the office and on landing pages of computers. Staff were able to explain the meaning of the thread and said different parts were taken into account throughout their work.

There was a clear emphasis on supporting timely discharges from hospital. The registered manager said staff worked with other organisations to quickly introduce support. They said this support was for a specific period and enabled the person to gain confidence, increase independence and meet potential. One member of staff said the support enabled people to "get back on their feet". Staff told us they were able to give feedback about the person's progress. One member of staff said "It's good as they listen to us. If someone doesn't need us anymore, we say and they're reviewed. We are listened to". Records showed one person had cut out their lunch time visit, as they did not feel they needed it. Staff told us this was a positive outcome but the person would be monitored to ensure they continued to manage well. Another member of staff told us "There's nothing better than seeing a person get better and you've helped them do it".

There was a team of staff who visited people as part of the assessment and support planning process. These staff gained feedback about the service and the support people received. In addition, surveys were sent to people, staff and interested health/social care professionals to gain their views about the service. Questions asked included the timeliness and consistency of support, as well as staff competence. Records showed the registered manager considered each survey that was returned and addressed any negativity, which had been identified. The feedback from the surveys was then coordinated centrally, within the organisation. A report was devised, which contained written and pictorial information, such as graphs.