Mears Care Limited

Mears Care - Oxford

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

Overall summary

We inspected Mears Care on 28 May 2015. Mears Care (Oxford) is a domiciliary care agency providing care and support to people who live in the community. This was an unannounced inspection. This service was last inspected in August 2013 and it was meeting all the essential standards reviewed.

The service had a registered manager, however, they were not in day to day control of the service. A new manager had recently been recruited and was in the process of taking on the registration. 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.

Since the last inspection a number of managers had been in post and begun but not completed the process of their registration with CQC. This has meant senior staff from the provider had been in day to day control of the service.

Summary of findings

This has led to decisions not always being made at the appropriate level and support with these decisions from more senior management being described as “not always aware”.

People told us they felt safe. However, risks associated with people's support needs were not always documented with clear guidelines on how staff should mitigate those risks. Safeguarding incidents were not always raised in line with the service's safeguarding policy.

People told us staff were skilled and knowledgeable about their needs. New staff received a formal induction along with pre-assessments to capture their skills regarding tasks they would need to carry out such as numeracy skills. This was also supported by a formal period of shadowing. However, support to staff after induction was not regularly provided. Staff were not receiving regular supervision or appraisal. Staff did not have development plans in place.

The service were not adhering to the principles of the Mental Capacity Act 2005. The MCA provides a legal framework to assess people’s capacity to make certain decisions, at a certain time. We have made a recommendation the Registered manager ensures the services is familiar with the MCA Code of Conduct.

People were involved in their care planning and the service involved relatives as and when necessary. Assessments were undertaken of people's needs to create support plans, but these support plans were not always up to date or regularly reviewed.

Most people described staff as caring and supportive, but a few people we spoke with told us staff had not treated them in a caring and respectful way. Staff we spoke with expressed a caring approach and supported people well to maintain their independence.

There were systems in place to monitor the quality and safety of the service but they were not always effective in driving improvement of the service or used consistently.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the CQC (Registration) Regulations 2009. You can read more about these in the full report.

Summary of findings

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.

Risks associated with people's needs were not always documented with clear strategies to manage those risks.

Safeguarding alerts were not always reported in line with the service's own policy.

Staffing number were sufficient but staff were not always deployed in a way that met people's needs.

Is the service effective?

Requires improvement

Staff were not receiving regular supervision and appraisal.

The service were not adhering to the principles of the Mental Capacity Act 2005.

The service accessed appropriate professional input and healthcare as and when required.

Is the service caring?

Requires improvement

The service was not always caring.

Most people and their relatives spoke very highly of their care staff; however some people felt there had been occasions they had not been fully respected.

People were supported to maintain their independence.

People felt staff respected their privacy and dignity during the care they received.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs were assessed by the service, but support plans did not always include all key information and were not always reviewed.

People and their relatives felt the service was responsive to their changing support needs.

Complaints were managed appropriately and to the satisfaction of people raising them.

Is the service well-led?

Requires improvement

The service was not always well led.

The service were not aways notifying CQC of significant events.

Summary of findings

Incidents and accidents were not routinely recorded so lessons were not being learned in order to mitigate risks to people and staff.

There was a system in place to monitor the safety and quality of the service but it was not always effective.

Mears Care - Oxford

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 28 May 2015 it was unannounced. The inspection team consisted of one inspector and an expert by experience (ExE). An ExE is somebody who has experience of using this type of service.

At the time of the inspection there were 55 people being supported by the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

We spoke with the 16 people who were using the service and four people's relatives. We spoke with 11 care staff, one care coordinator, the deputy manager and the manager in the process of being manager and the regional manager who was the current registered manager. We reviewed eight peoples care files, records relating to staff supervision, training, and the general management of the service.

Requires improvement

Is the service safe?

Our findings

People had support plans in place which identified the potential risks associated with people's needs. However, risks assessments did not always detail what action should be taken by staff to mitigate these risks. For example, one person had a catheter fitted. They did not have guidelines in place for staff to follow in relation to what action to take if there was a problem. Where people were assessed to be at high risk of pressure ulcers. There was no guidance for staff around what actions to take to mitigate these risks. Most staff we spoke with could tell us what action they would take but others told us due to not always being with the same person they would rely on these records being accurate.

The issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding of safeguarding and what to do if they suspected abuse. We did see a number of incidents that had been referred in line with the service's policy. However the system in place to escalate concerns was not always working effectively. For example, there was an on going safeguarding issue in relation to one person. We were told of additional events that had occurred since the initial issues had been raised but these issues had not been referred in line with the services safeguarding policy. We raised this with the manager who took immediate action.

This issue was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough suitably qualified staff to meet the needs of the people using the service. People told us staffing had previously been an issue but this had improved lately. People had not experienced missed visits. However, people were concerned about the way staff were deployed. Comments included; "they give you a list every week but they can change it without telling you" and "the carers are always on time, the time they have been given. The office doesn't always let me know about the changes." A number of staff supported this concern. Comments included, "there are more of us, it's just the way we are organised, its nobody's fault everybody is just so busy" and "there just isn't a clear structure to it, I can have limited time to make a long journey to get to my next person so I am late and people get upset".

People and their relatives also felt that the way staff was managed meant they could not always have visits when they needed them. One person told us, "we wanted an earlier visits and I am pleased to say that happened". However, a number of other people had a different experience. Comments included, "I thought the service was supposed to fit around my relative's needs, we have asked so many times for a later call in the morning, but they can't do it because of other calls" and "I would like to be able to change around visits a little to fit in, but I have to take what I'm given".

This issue was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt safe using the service. All people we spoke with also felt their homes and possessions were respected and well looked after. Comments included, "Im kept very safe, no problems there", "I have complete piece of mind when the carers are with my relative" and "very safe thank you".

People and staff benefited from environmental risk assessments that identified environmental hazards and documented actions to take to mitigate these risks. There were also emergency plans in place in the event of incidents that may impact on the service's ability to deliver people's planned care.

People's support plans clearly indicated if they needed medicines. The majority of people we spoke with were responsible for their own medicines. One relative described how medication was given to their relative, "They record everything in the care record." Another person told us, "They [staff] give me my tablets and record it in my book." Where specialist medicines were required such as warfarin or prescribed creams, staff were trained by the appropriate professional.

The service followed safe recruitment practices. We looked at five staff files that included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring

Requires improvement

Is the service safe?

Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records were also seen which confirmed that staff members were entitled to work in the UK.

Requires improvement

Is the service effective?

Our findings

Staff felt supported. However, staff records showed that out of the eight staff files we reviewed nobody had not received a supervision or appraisal since 2013. Supervision and appraisal is a space for staff to reflect on their practise, receive feedback on their performance and discuss any training and development needs. We discussed this with the senior staff responsible for supervisions who conceded these had slipped due to prioritising other tasks during a period of low staffing. The incoming manager had recently started supervision with staff and had identified this issue.

This issue was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have an understanding of the Mental Capacity Act 2005. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. Staff had not received training regarding MCA and staff we spoke with were not able to speak with us about the key principles of this Act. We discussed this with the registered manager who agreed to take appropriate action. We were also informed that all staff were due to be booked in to receive MCA training. Staff we spoke with showed a good understanding of the importance of people making their own choices. We were assured, based on what we were told by people and their relatives that decisions would not be made for people without support from families when required.

People we spoke with felt that staff understood their needs. Comments included, "staff understand me, they're nice" and "yes I am supported well". Relatives also told us that staff were knowledgeable and well skilled. Comments included, "staff know my sister really well, some have known her many years and are well skilled, couldn't be happier" and "staff stay for a long time, this means they know my relative inside out and always look like they know what they are doing".

All the people and relatives we spoke with felt that their carers were well trained to do their work. Comments included, "there was a lot visiting while they were being trained, they all had to have someone with them", "they are all trained up, they seem to know what they are doing" and "they are all superb with me".

Staff we spoke with felt they had been given sufficient training to do their jobs. Comments included, "I have had good training", "plenty of training and refreshers absolutely", "I've been told I will have more soon, to refresh my knowledge. I have had recent training about newer stuff, such as the specialist feeding." New staff we spoke with all told us they had been inducted. They told us they had a week of training, a week of shadowing a more experienced carer and learning about health needs". One new staff member told us, 'I had a meeting and they asked if I had had enough training, and I said yes."

Most people we spoke with did not require any food to be prepared. People who did had clear information in place. One person told us, "I cook my own meals, but if I am not well enough the girls will do it for me, they encourage me to eat well" Another person told us, "the carers prepare the meals and take time to encourage me to eat enough food".

Everyone we spoke with had access to other health professionals. One person told us, "I get all the help I need the staff sort it out for me, they are very good, I don't have relatives that can do it you see".

We recommend that the registered manager and all staff familiarise themselves with the Mental Capacity Act 2005 Code of Conduct.

Requires improvement

Is the service caring?

Our findings

Most people we spoke with felt that staff were caring and told us they enjoyed their relationship with care staff. Some people told us they enjoyed a consistent staff team of people they had got to know well. Comments included, “polite, friendly and respectful, just great”, “they are all lovely, very polite too.”, “they are all nice girls and they go beyond the call of duty". One person’s relative told us, “they are all great and they really do look after people”. However, not everybody shared this view, three of the 16 people we spoke with told us they had experienced occasions where a carer had been rude or abrupt. One person told us they felt "very disrespected" on one occasion. They said, “one carer told me I’m needing to be in a home now. I don't not feel it was appropriate to express opinion like that. I felt unhappy for a while it knocked my confidence”.

Staff we spoke with talked about the importance of getting to know their clients well. Comments included, “I take time to get to know the people I care for, it’s important, you want them to feel comfortable”, “it’s nice to have all regular people and to get to know them really well.” and, “Our deputy manager took the time to meet all people we support and it helped us get to know them well.”

People were involved in their care planning. Comments included, “they always talk to me, see if anything needs to change and let me know if they think things have as well, I feel very in control it’s nice”, “they involve me and my family in things, all very happy”. Each person we spoke with told us how staff encourage independence. Comments included, “I appreciate how they [staff] wait and see what I want to do for myself”, “staff encourage me to do as much for myself as possible” and “it’s would be easier sometimes for them just to do things, I'm not as fast as I was, but they are very patient, never seem rushed”.

People received information about the service they received which contained information about their care options and people they could speak with for advice. One relative told us, “the introduction to the service was very well managed, we felt very comfortable”. We also heard from people and their relatives that dignity and privacy were important to the service. Comments included, “staff are very mindful of people's privacy when providing support” and “my dignity remains completely intact, the girls are excellent”.

People benefited from care that supported their independence. We were told of one person with mental health difficulties who had been supported through a consistent and caring staff team to develop their confidence in accessing the community. This person’s support had been gradually reduced as their ability to be independent developed.

Requires improvement

Is the service responsive?

Our findings

People's needs were assessed when they entered the service. These assessments were used to create support plans along with people and their relatives where needed. However, we found that some support plans did not always reflect people's care needs. For example, one person's care assessment identified a need in relation to pain. This person had a moving and handling support plan in place that did not identify this person may experience pain when moved. Staff we spoke with did not all mention this as something they were aware of.

Another person had a need identified in relation to their skin integrity. Although they had support plans and risk assessment in place these did not specifically say what support this person required in relation to this need. Staff we spoke with told us, "everyone is doing their best but information about this person's care was not conveyed to me about their medical conditions, we need to know if things change before we get there".

This issue was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt the service responded well to their needs. Comments included, "they are good at spotting when additional input is needed, on top of things" and "I have been impressed by the way issues have been picked up and managed, kept my relative comfortable".

People felt staff understood their interests. One person's relative told us, "they really understand them; they read to them and play the music they love". Other comments included, "they take time to talk to me about my life and views on things it's nice". We also saw this information captured in people's support plans. One staff member told us, "I liked reading through those; it's nice to understand what people like".

Most of the clients had contacted the office at some stage, and found them to be responsive and polite. Comments included, "they always ring you back", 'they are all lovely in the office."' "they always sort it out for us." and the office have been very good. And efficient.' One person said office staff were polite, "but did not always let me know about the changes.' Two said they had not phoned the office, with one of them saying, 'I just talk to the carers'. One relative communicated mainly through his loved one's social worker.

Complaints were managed appropriately and to the satisfaction of people raising them. We reviewed the service complaints file and saw that complaints were recorded and followed up in line with the service procedure.

Requires improvement

Is the service well-led?

Our findings

There had been three managers at the service in the past 18 months who had each applied for registration. This process was not completed due to managers leaving their roles or being unsuccessful with the registration process. This meant the regional operations manager had registered themselves but was not able to be in day to day control of the service. At the time of our inspection a the new manager had been in post three weeks and was in the process of applying to be the registered manager.

The absence of the necessary level of expertise within the service had meant the service did not have an effective system in place to monster the quality and safety of the service. We were told by senior staff responsible for the day to day management of the service that their time had been spent ensuring the delivery of care was completed and maintained to a good standard so management tasks had "taken a back seat". Six out of the eight support plans we reviewed had not been audited since 2013 and a consistent log of incidents and accidents had not been maintained. Numerous staff mentioned that they did not feel more senior management were aware of the difficulties the service has had. We spoke with the regional manager about this who agreed there had been challenges but that there would be full support for the new manager.

The service had a system to obtain the views of people who used the service. This was designed to assess overall satisfaction and quality of the service. The results from this year's survey were mainly positive, however it was not clear what action had been taken as a result of the feedback. Four people we spoke with told us they did not receive a survey, a number of people could remember filling it in, four people said they had both received and sent their survey back, but none of them were able to say what happened as a result of this feedback.

These issues were breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications of events that occurred within the service were not always being made to CQC or being made in a timely manner. We were made aware of, or saw incidents recorded that had not been notified to CQC. We were also made aware that those responsible for the day to day running of the service did not have an awareness of the need to do make notifications.

These issues were breaches of Regulation 18 CQC (Registration) Regulations 2009

Staff we spoke with were not able to tell us about a clear vision for the service. All staff felt more optimistic with the increasing staff team and increased management support. Comments included, "it's been hard to really think about a vision, its felt like fire fighting", "I can't say I am wholly positive about the vision above us, but I know staff are keen to provide outstanding care" and "it feels like cohesion is coming back which is nice, but it's been hard to say the least". Comments were also made with regard to whether care was being put first. Comments included, "there is a definite pressure to increase numbers, even when staffing so seriously low" and "there have been times I have lost confidence the care and getting things right is the priority".

People and their relatives described the service as well led. Comments included, "the leadership seems very good" and "I think the office could be more organised but you can't fault the care they provide and that comes from the top". Staff also spoke highly of the leadership. Comments included, "We have had a lovely carer in charge, she has absolutely put care first even in the toughest times" and "the new manager is fantastic they will make a great team with the deputy who has been standing in as the support should now be there".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service were not adequately assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. (12) (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not deployed in order to meet people's needs. Staff were not receiving regular supervision, appraisal or professional development. (18) (1) (2)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from abuse and improper treatment as systems and processes were not always operated effectively. (13) (1) (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

There was not an effective system in place to assess, monitor and improve the quality and safety of the service. Or assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise.

The service had not kept 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) (a) (b) (c) (f)

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Notifications were not always happening appropriately and in a timely manner. (18)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment must be appropriate to meet peoples needs and be appropriate to ensure peoples safety and welfare. (9) (1) (a) (b)