Merseycare Julie Ann Limited

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

Summary of findings

Overall summary

We carried out an inspection of Merseycare Julie Ann on 31 October and 2 November 2016. The inspection was unannounced.

Merseycare Julie Ann provides domiciliary care services to approximately 700 people living in their own homes.

A registered manager was 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 majority of the people that we spoke with told us that they felt the service they received was safe. Only two people who used the service responded to our questionnaire, but both said that the service made them feel safe.

The care files that we saw showed evidence risk had been assessed and reviewed regularly. Risk assessment was undertaken at the initial assessment phase and reviewed regularly once the service had started. However, we found examples where risk could not be safely managed because the risk management plans were lacking in detail.

You can see what action we told the provider to the back of the full version of this report.

Prior to the inspection we had received information of concern relating to allegations of abuse and neglect. We spoke with the registered manager about some of the more serious concerns relating to late or missed calls and thefts. After reviewing the relevant records we were satisfied that the provider had acted in a professional and timely manner to address each of the concerns.

The majority of care records that we saw were reliant on pre-admission information provided by the local authority. It was sufficiently detailed and contained some personal information. However, Merseycare Julie Ann had not consistently reviewed its own care records to ensure that the information had been transferred, or that personal information had been included.

We have made a recommendation regarding this.

We noted from our pre-inspection information that no notifications of deaths had been submitted recently. We spoke with the registered manager about this who confirmed that other notifications had been submitted as required and we saw evidence of this. However, they were unsure about notifying the CQC about deaths because of the nature of the service. The relevant notifications were submitted after the inspection.

Incidents and accidents were subject to a formal review process by the registered manager. We saw that these reports were sufficiently detailed and recorded where actions had been completed.

The service had sufficient staff to cover its responsibilities. Staff were recruited following a process which included individual interviews and shadow shifts. Each offer of employment was made subject to the receipt of two satisfactory references and a Disclosure and Barring Service (DBS) check. The staff records relating to people who had transferred from another provider were lacking in critical detail although Merseycare Julie Ann had requested the information.

Each of the staff that we spoke with confirmed that they had completed training in the administration of medicines and felt confident in their abilities. The records that we saw and the comments that we received indicated that medicines were administered safely.

The majority of staff were supported by the organisation through supervision and appraisal. However, some staff reported that they had not received regular, formal supervision.

We have made a recommendation regarding this.

Staff had been recruited and trained to ensure that they had the rights skills and experience to meet people's needs. New staff were required to complete an induction programme which was aligned to the Care Certificate.

The majority of people spoke positively about the way in which care was delivered. Comments included, "Very friendly", "Polite, lovely girls", "Thank goodness for them", "They are nice people" and "We are more like friends."

The staff that we spoke with knew the people that they cared for and their needs in detail. Staff told us that they usually had sufficient time to focus on the person and not the task. We saw that care plans were not always sufficiently detailed to inform new carers and good care practice sometimes relied on the carer's knowledge of the people concerned.

The care records that we saw used language which was respectful when describing people and the care provided. In response to our questionnaire 100% of people using the service and their relatives said that they were treated with respect and dignity.

People using the service and their relatives were encouraged to provide feedback to the organisation through informal and formal mechanisms. Monthly telephone service reviews were completed with a selection of service users which covered a range of topics and gave people the opportunity to provide feedback and raise concerns. The majority of people that we spoke with were satisfied with the service and had no complaints.

The service had a clear set of values and expected behaviours which were clearly defined in policies, staff information and the service user guide. There was a focus on holistic care, independence, maximising people's quality of life and treating people with respect. These values were consistently evident in conversations with care staff and managers.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. One member of staff said, "I feel happy in my job. It gives me satisfaction." Another member of staff told us,

"I love my job. I will go the extra mile for them [people using the service]."

The registered manager and director were aware of the day to day culture and issues within the service. The scale of the service made it difficult for them to know the people that received care and their staff in any detail, but they were able to provide examples of good practice when required and were able to respond to specific issues raised during the inspection.

Audit processes had failed to identify issues and concerns relating to the quality and completeness of care plans and risk assessments.

We have made a recommendation regarding this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk management plans were not sufficiently detailed to inform staff. Some plans contained conflicting information about risk.

Each of the people that we spoke with told us that they felt the service they received was safe.

The provider completed spot checks on care staff regularly which included the administration of medicines. We saw evidence that these observations had taken place and that medicines had been administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not consistently supported by the organisation through regular supervision and appraisal.

Staff were trained to ensure that they had the appropriate skills and knowledge to meet people's needs.

People's consent to care was sought in accordance with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People spoke positively about the attitude and approach of care staff.

Staff had access to sufficiently detailed information about people and were able to provide person-centred care.

Staff knew the people that they cared for well and spoke positively about them.

People had choice and control over the way in which their care was delivered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were involved in the assessment and planning of care, but information was not consistently transferred to care records.

Concerns and complaints were addressed formally and the provider used the information to make changes to the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A registered manager was in post.

Notifications had not been submitted to the Care Quality Commission as required.

Audit systems had failed to identify omissions and errors in care plans and risk assessments.

Staff were encouraged to give feedback on their experiences and make suggestions for development.

Merseycare Julie Ann Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 October and 2 November 2016 and was unannounced.

The inspection was conducted by two adult social care inspectors.

A Provider Information Return (PIR) was not requested prior to the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

Prior to the inspection questionnaires were issued to people using the service, staff and professionals to ask for their views on key aspects of service.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

We used all of this information to plan how the inspection should be conducted.

During our inspection we spoke with 26 people using the services or their relatives by telephone. Five of this group declined to comment. We spoke with the registered manager, one of the directors, the care coordinator, a dementia specialist and 17 other staff.

We also spent time looking at records, including ten care records, eleven staff files, staff training plans, complaints and other records relating to the management of the service. We contacted two social care professionals who have involvement with the service to ask for their views.

Requires Improvement

Is the service safe?

Our findings

The care files that we saw showed evidence risk had been assessed and reviewed regularly. Risk assessment was undertaken at the initial assessment phase and reviewed regularly once the service had started. However, we found examples where risk could not be safely managed because the risk management plans were lacking in detail. For example, one person who had their legs in plaster was identified at additional risk when hoisting. The risk management plan did not detail how the person should be hoisted or any other safety considerations. In another record it stated that a person needed additional equipment to mobilise, but the equipment was not clearly identified. We also saw that records contained confusing or conflicting information. For example, one person was identified as low risk of falls, but in the same care record it stated that the person can 'become dizzy often and falls'. We found that more recent risk assessments and care records contained more complete information. We spoke with the registered manager about this and it was agreed that risk assessments would be reviewed as part of the transition to a new care planning system.

This was a breach of Regulation 12 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the safety of services. The majority of the people that we spoke with told us that they felt the service they received was safe. One relative told us, "Very consistent, same faces, this is important, as [relative] can build up a relationship with them." A person using the service said, "They are always on time." While another person told us, "I know [staff member] is there for me." A different person commented, "They [staff] call to make sure I am ok." Only two people who used the service responded to our questionnaire, but both said that the service made them feel safe.

Prior to the inspection we had received information of concern relating to allegations of abuse and neglect. After speaking with the registered manager and reviewing the relevant records we were satisfied that the provider had acted in a professional and timely manner to address each of the concerns. In some cases disciplinary action had been taken against staff. The registered manager also explained how their electronic staff monitoring system allowed coordinators to monitor the start and finish times of calls and alerted them if a call was missed. One member of staff said, "Complaints about timekeeping have resulted in changes [to rotas] being made." Another member of staff told us, "I always get enough time to complete my visits." The majority of people that we spoke with did not have any concerns relating to late or missed calls. Two people did say that they were sometimes not sure which staff were coming and when.

The provider had delivered a training programme for staff and managers regarding adult safeguarding. The staff that we spoke with confirmed they had attended the training and were able to explain the different types of abuse and what action they would take if they were concerned that abuse or neglect was taking place. The provider had a range of systems and procedures in place which allowed people using the services, their relatives and staff to raise any concerns. Evidence of these systems was made available during the inspection. The provider also told us that they completed spot checks on care staff regularly. We saw evidence that these observations had taken place.

Incidents and accidents were subject to a formal review process by the registered manager. We saw that these reports were sufficiently detailed and recorded where actions had been completed.

The provider had a robust approach to whistleblowing which was detailed in the relevant policy. Staff were able to explain internal mechanisms for reporting concerns and were aware of the external resources available to them if required. Each of the staff that we spoke with expressed confidence in internal and external reporting mechanisms.

We saw evidence in staff rotas that the service had sufficient staff to cover its responsibilities. Additional cover was provided by an on-call service. Staff were recruited following a process which included individual interviews and shadow shifts. Each offer of employment was made subject to the receipt of two satisfactory references and a Disclosure and Barring Service (DBS) check. A DBS check provides evidence that a person is suited to working with vulnerable adults. Each of the DBS checks that we saw had been completed within the last eighteen months. Merseycare Julie Ann had recently taken over a large contract for personal care previously held by another provider. The staff records relating to people who had transferred from the previous provider were lacking in critical detail. For example, some records did not contain evidence that references had been received. We spoke with the registered manager about this and were informed that the records had been requested in a timely manner as part of the transfer of responsibilities, but had not been provided. We were assured that further requests would be made and that the records would be updated to meet the expected standard in due course.

The provider had a robust disciplinary policy and procedure in place. Staff were familiar with the policy. One member of staff gave an example of how the policy had been applied in practice. We saw evidence of the policy being applied in records.

Staff were trained in the administration of medicines but because the services were community-based, they were not always responsible for storage and administration. Some people who used the service were able to self-administer their medication, others required support. We saw that individual arrangements were detailed in care records. Medication Administration Record (MAR) sheets were completed by staff where appropriate. These records were held in people's homes and were not available to us during the inspection. MAR sheets were checked as part of the provider's safety and quality auditing processes during spot-checks. Each of the staff that we spoke with confirmed that they had completed training in the administration of medicines and felt confident in their abilities. Their competency was assessed as part of the regular checks completed by senior staff.

Requires Improvement

Is the service effective?

Our findings

Staff were supported by the organisation through supervision and appraisal. However, staff reported that formal supervisions were not consistently scheduled. One member of staff told us, "We get supervision every three to six months." While another member of staff said, "We have supervision once a year." Each of the staff that we spoke with said that they could access informal supervision, guidance and support by contacting the office. The record of supervisions and appraisals showed that not all staff had received formal supervision in-line with the schedule. We spoke with the registered manager about this who acknowledged that not all forms of supervision were adequately recorded. They confirmed that they would evaluate current practice to ensure that all staff received regular supervision and that this was better recorded.

We recommend that the provider reviews its process for supervising staff to ensure that it is effective and sustainable.

The organisation promoted effective communication with staff and people using services through the completion of; telephone calls, smart-phone messages and alerts, spot checks and the review of daily records. One person using the service said, "You can always speak to someone in the office if you need to." A small minority people raised concerns about the quality of communication, especially regarding delayed calls or changes to care staff. The registered manager told us that communication with people using the service and staff was recorded whenever changes needed to be made. They said that any issues raised with them had been addressed and resolved.

Staff had been recruited and trained to ensure that they had the rights skills and experience to meet people's needs. New staff were required to complete an induction programme which was aligned to the Care Certificate. The Care Certificate requires staff to complete appropriate training and be observed by a senior colleague before being signed-off as competent. Staff were trained in a range of subjects which were relevant to the needs of the people using the service. Subjects included; safeguarding adults, moving and handling, administration of medication, Mental Capacity Act 2005 and equality and diversity. Staff also had access to additional training to aid their personal and professional development such as; the level three in health and social care and a range of specialist health and social care topics. Training was delivered through a mix of e-learning and face to face sessions. A training record was maintained for each member of staff which indicated when refresher courses were required. The training matrix we saw indicated that the majority of the training had been completed in accordance with the provider's schedule. One member of staff told us, "Training is good. I've done moving and handling, health and safety and safeguarding."

We asked staff about their understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff demonstrated that they understood the key principles of the MCA and delivered care and support in accordance with the act. All of the people

currently being provided with services from the agency had capacity or had a nominated relative to speak on their behalf.

People were supported to eat and drink in accordance with their individual care plans. In some cases these plans had been developed with the input of a dietician or other healthcare specialists. One person told us, "They always make sure that I've eaten."

We saw that people were supported to maintain good health through regular contact and review with a range of healthcare professionals. These included general practitioners and specialists. One member of staff told us, "If people are unwell I'd speak to the office and liaise with family members." They shared an example where they recognised that a person was unwell because they were the regular carer. The person was subsequently assessed by their GP and admitted to hospital. The staff member commented, "That's why continuity is important. You see small differences." We saw other examples of staff communicating regarding health conditions and supporting people with appointments in care records.

Good

Is the service caring?

Our findings

We asked if people using the service would prefer to be visited as part of the inspection process. Each of the people that we spoke with said that they would prefer to speak on the telephone. As a result we were unable to observe the delivery of care, but the majority of people spoke positively about the way in which care was delivered. Comments included, "Very friendly", "Polite, lovely girls", "Thank goodness for them", "They are nice people" and "We are more like friends."

The staff that we spoke with knew the people that they cared for and their needs in detail. Staff told us that they usually had sufficient time to focus on the person and not the task. However, we saw that care plans were not always sufficiently detailed to inform new carers and good care practice sometimes relied on the carer's knowledge of the people concerned. One member of staff told us, "The care plans are okay, but we have notes on our phones as well." The notes on phones supplied by the provider were accessed through a secure system. This meant that people's confidential information was used safely. None of the people that we spoke with said that their care had been compromised by this approach. We spoke with the registered manager about this who said that the introduction of a new care planning system would provide an opportunity to review all care plans to ensure that they were sufficiently detailed without the additional information held on smart-phones.

The records that we saw showed that people were actively involved in making decisions about their care on a day to day basis. One member of staff said, "You have to be careful and sensitive to people's needs and situation. I have a five or ten minute chat [to see if they need anything else]." Another member of staff told us, "I ask the person to confirm what they want and give me instructions." People were given choice in the delivery of care and their independence was maintained and promoted appropriately. We saw that where people did not have the capacity to represent themselves a nominated relative acted on their behalf.

We asked staff about the promotion of privacy and dignity when delivering care. One member of staff said that privacy and dignity were maintained by following the care plan, talking to people, covering them when providing personal care and through the continuity of staff. The care staff we spoke with were respectful of the people that they cared for and recognised the need to maintain dignity when providing personal care. None of the people using the service that we spoke with expressed any concern regarding their privacy and dignity when being supported by the organisation. One person told us, "They [staff] are very respectful. They say good morning and knock before they come in." The care records that we saw used language which was respectful when describing people and the care provided. In response to our questionnaire 100% of people using the service and their relatives said that they were treated with respect and dignity.

People's confidentiality was maintained by the careful management of written information. Important information was held in the person's home and secured stored within the main office. Information within people's own homes was only held for as long as it was necessary for the purposes of review before being transferred to the main office for secure storage.

Requires Improvement

Is the service responsive?

Our findings

The majority of care records that we saw were reliant on pre-admission information provided by the local authority. It was sufficiently detailed and contained some personal information. However, Merseycare Julie Ann had not consistently reviewed its own care records to ensure that the information had been transferred, or that personal information had been included. This meant that staff may not have access to personal histories or other important information needed to deliver person-centred care. A revised care plan had been implemented in some records and this contained more detailed information, but there was no clear process in place to complete the transition and no indication of when the new care plans would be completed. There was evidence that people and their relatives had been involved in formal reviews of their care, but the review process had not always generated the range and quality of information required to inform staff practice. A recent compliance report from the local authority highlighted concerns of a similar nature.

We recommend that the provider reviews all care records to ensure that they are sufficiently detailed for staff to deliver safe, effective, person-centred care.

People were given choice about the gender of their care staff and the times when staff provided care. We saw examples in care records of when discussions with people and their families had led to changes in the times when care was delivered.

The staff that we spoke with demonstrated that they knew people in sufficient detail to identify their likes, dislikes and any changes in care needs. The majority of staff told us that they were invited to review meetings by the provider and were able to provide additional, specialist input in some cases. For example, some staff were actively involved in a dementia group and had received additional training. They were able to use their knowledge to contribute to the review process. Other staff told us that they notified the office of any changes in care needs and completed the daily diaries with relevant information. This ensured that the information was available at the point of review.

We looked at the record of compliments, concerns and complaints. We saw that in each case the issue had been recorded, investigated and an outcome shared with the complainant. The latest data supplied by the provider from their surveys indicated that over 90% of people using the service knew how to complain.

People using the service and their relatives were encouraged to provide feedback to the organisation through informal and formal mechanisms. Monthly telephone service reviews were completed with a selection of service users which covered a range of topics and gave people the opportunity to provide feedback and raise concerns. The majority of people that we spoke with were satisfied with the service and had no complaints.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post and available to support the inspection process.

The registered manager was required to submit notifications to the Care Quality Commission (CQC) regarding important events. We noted from our pre-inspection information that no notifications of deaths had been submitted recently. We spoke with the registered manager about this who confirmed that other notifications had been submitted as required and we saw evidence of this. However, they were unsure about notifying the CQC about deaths because of the nature of the service. The relevant notifications were submitted after the inspection.

The organisation had systems in place to monitor the safety and quality of the service. Systems included; spot checks, daily record audits, telephone calls to people using the service and monthly audits. A set of key performance indicators (KPI) were used to monitor; consistency of carers, complaints, general satisfaction, safeguarding referrals, missed calls and absence levels. Audits had however failed to identify omissions and errors in care plans and risk assessments.

We recommend that the provider reviews its approach to audits to ensure that they are robust enough to identify errors, omissions and remedial actions in a timely manner.

We saw that satisfaction levels were consistently high across the previous 12 months. We were provided with examples of staff being challenged based on the evaluation of daily records. In each case an issue had been identified and the concern shared with the staff member in writing. They used a range of computer-based systems which captured and shared important information. We saw reports based on this information which were detailed and established clear actions, timescales and responsibilities. Information generated by quality and safety audits was shared with senior managers at team meetings and cascaded to front-line staff as required.

The service had a clear set of values and expected behaviours which were clearly defined in policies, staff information and the service user guide. There was a focus on holistic care, independence, maximising people's quality of life and treating people with respect. These values were consistently evident in conversations with care staff and managers.

The staff that we spoke with had mixed views regarding the quality of communication at Merseycare Julie Ann. Some said that it was, "Definitely very good" and "The office keep us informed of changes" while other comments included, "Yes and no" and "Communication is a downfall." The majority of people noted that communication had improved since the introduction of the smart-phones and were generally complimentary about the quality of communication provided by office-based staff.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. One member of staff said, "I feel happy in my job. It gives me satisfaction." Another member of staff told us,

"I love my job. I will go the extra mile for them [people using the service]."

Staff were encouraged to give feedback on their experiences and make suggestions for development. They were given an annual staff survey and invited to make suggestions at supervisions and appraisals. One member of staff said, "I did the survey. I said communication could be better. I get better information on the smart-phone now, like key codes and good care information." Another member of staff told us that they had made a suggestion for care records to be colour-coded. This was so staff would have an immediate understanding of a person's condition and basic care needs if they were required to work with an unfamiliar service user. At the time of the inspection the staff member had not received feedback regarding their suggestion.

The registered manager and director were aware of the day to day culture and issues within the service. The scale of the service made it difficult for them to know the people that received care and their staff in any detail, but they were able to provide examples of good practice when required and were able to respond to specific issues raised during the inspection. The registered manager was open and honest about the issues raised and the pressures facing the service. For example, managing the transition of care from another provider. They described how issues were addressed at a senior level to ensure the delivery of high-quality, consistent care.

The director that we spoke with was based in the main office and was equally aware of the day to day culture of the service. They were able to describe the pressure to deliver consistent, quality care and explained how the senior management team was constantly monitoring the service to evaluate performance.

The care manager had sufficient resources available to them to drive improvement. These resources included support to manage training, human resources and services for people living with dementia.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected from avoidable risk because some risk assessment documentation contained confusing and conflicting information.