Kay Care Services Ltd

Merit Homecare

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced inspection which we carried out on 31 July 2015 and 13 & 24 August 2015. We last inspected Merit Homecare in June 2014. At that inspection we found the service was meeting the legal requirements.

Merit Homecare is a domiciliary care agency providing care and support to people in their own home. It is registered to deliver personal care.

A manager was in place and they were in the process of submitting an application to become registered with the Care Quality Commission. 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.

There were sufficient staff employed to provide safe care to people and they were appropriately vetted to make sure they were suitable to be employed to work with people.

Summary of findings

The provider had in place plans to deal with emergency situations through the use of an on call system that was manned out of hours by senior staff.

People received their medicines in a safe way.

Staff had received training and had an understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions themselves. Plans were in place for staff to receive other training to meet people's specialist needs.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed.

Staff helped ensure people who used the service had food and drink to meet their needs. Some people were assisted to cook their own food and other people received meals that had been cooked by staff.

People told us staff were compassionate and kind but care was not always provided by the same staff to give consistent care.

Communication was not always effective with people from the main office.

A complaints procedure was available and people we spoke with said they knew how to complain, most people said they had not needed to. Where complaints had been received we found they had not always been satisfactorily resolved.

Records were not always available with detailed guidance for staff to provide individual care to people.

The service had a quality assurance programme to check the quality of care provided. However the systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received individual care that met their needs.

You can see what action we told the provider to take at the back of the full version of the 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?
The service was safe.

People received their medicines in a safe and timely way.

Staffing levels were sufficient to meet people's needs safely and appropriate checks were carried out before staff began work with people.

People were protected from abuse as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report any that occurred.

Good

Is the service effective?
The service was not always effective.

Staff had access to some training and the provider had a system to ensure this was up to date. Staff had not all yet received specialist training to meet people's needs.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were no longer able to give consent to their care and treatment.

Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs.

Requires improvement

Is the service caring?
The service was caring.

People and family members we spoke with said staff were very caring and respectful.

Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide individualised care to the person.

We found people were helped to make choices and to be involved in daily decision making.

Good

Is the service responsive?
The service was not always responsive.

Records were not always in place to ensure people received support in the way they needed and wanted.

People had some information to help them complain. Complaints and any action taken were not always recorded.

Requires improvement

Summary of findings

Is the service well-led?

The service was not always well-led.

A manager was in place who was applying to become registered. Staff told us the manager was supportive and could be approached at any time for advice.

Communication was not always effective to make sure people received appropriate care.

The manager monitored the quality of the service provided to people. The quality assurance processes were not all effective as they had not ensured that people received personalised care that met their needs in the way they wanted.

Requires improvement

Merit Homecare

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 July, 13 August and 24 August 2015 and was unannounced.

The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During the inspection the inspector visited the provider's head office to look at records and speak with staff. After the inspection the inspector carried out some telephone interviews with staff and visited some people in their own homes to obtain their views on the care and support they received. An expert by experience carried out telephone interviews with some people who used the service and some relatives.

We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local authority and health commissioning teams and the local authority safeguarding adults' teams. We did not receive any information of concern from these agencies.

We spoke on the telephone with 17 people who used the service and three relatives. We also visited three people in their own homes to obtain their views on the care and support they received. We interviewed five staff members and the registered manager for the service.

We reviewed a range of documents and records including seven care records for people who used the service, five records of staff employed by the agency, complaints records, accidents and incident records. We also looked at records of staff meetings and a range of other quality audits and management records.

Good

Is the service safe?

Our findings

People we visited and spoke with on the telephone told us they felt safe when receiving care. Comments from people included, "If I didn't feel safe I would call the office and ask for the carer to be changed," "I trust the staff 100%," "I feel safe with the care provided," "I feel safe as most of the time I have the same carer look after me," and, "I feel safe with the staff." Relatives comments included, "I can go to work and know that my (Name) is safe and happy and that means a lot," and, "I can get out and not worry and keep phoning home to check (relative) is okay."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. One staff member told us, "I'd talk to the person and report any concern to a senior at the office." Staff were aware of the provider's whistle blowing procedure and knew how to report any worries they had. They were able to tell us about different types of abuse and were aware of potential warning signs. They described when a safe guarding incident would need to be reported. Staff told us they currently had no concerns and would have no problem raising concerns if they had any in the future. Records showed and staff confirmed they had completed safeguarding alerter training from the local authority as part of their induction. The registered manager told us it was planned senior staff would receive more advanced safeguarding training from the local authority. This was to give them more knowledge of safeguarding and the multi-agency procedures when an alert was raised and how to help investigate concerns.

The safeguarding log showed 12 alerts had been raised appropriately by the management team since the last inspection and they had been investigated and resolved to help ensure people were safeguarded from harm.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. For example, for medicines, falls and nutrition to keep people safe. These assessments were regularly reviewed to ensure they reflected current risks to the person. They formed part of the person's care plan and there was a link between care plans and risk assessments.

We spent time during the inspection observing staff care practices. People we spoke with made positive comments about the staff. However some staff and people who used the service told us there were not always enough staff employed by the service. People's comments included, "They need more staff," "Staff are so busy and often running late as they have to travel from another call where they may have been held up," and, "When staff cannot make the call no replacement is sent." We were aware some concerns about staffing had been addressed appropriately under safeguarding procedures. The manager told us staffing levels were based on the individual needs of people who used the service and recruitment was on going to employ more staff. They told us 79 staff currently supported 100 people with care and support. They said, "We won't take on new care packages if we don't have the right level of staff to work." We considered there were enough staff to provide care and support to people at the present time. The manager told us staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased or decreased as required. For example, one person's care plan showed a person had become more confident and where they were previously assisted to go shopping they now went without staff and so required less staff support.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to staff at the office. We were told all incidents were audited by the responsible person at the office and action was taken by the manager as required to help protect people.

People and staff had access to emergency contact numbers if they needed advice or help from senior staff when the office was not open. Comments from people included, "I have the telephone number for the office." Staff told us, "The seniors use a mobile on–call system, I'll phone up and let them know if someone needs to go to hospital," and, "I've telephoned before as I needed to report someone had fallen."

We checked the management of medicines. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and they were sufficiently skilled to help people safely with their medicines.

Good

Is the service safe?

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references to make sure people were suitable to be employed. Evidence of a check from the Disclosure and Barring Service (DBS) was also available. This check was carried out to check if people had any criminal convictions which made them unsuitable to work with vulnerable people. These had been obtained before people were offered their job. Application forms included full employment histories. These checks showed that staff were appropriately vetted.

Requires improvement

Is the service effective?

Our findings

Most staff told us they received training whereas some commented their training was not up to date. Comments included, "My training isn't up to date," "I haven't had catheter care training," "We have a new manager and we're doing more training," and, "I received some training from the district nurse."

The manager told us they had prioritised training and they provided us with details of training that had taken place since they started to manage the service for example, mental health awareness and distressed behaviour. They told us of training that had taken place and was planned to make sure staff were kept up-to-date with safe working practices. Further training had been identified to make sure staff had the skills and knowledge to support people. They talked of their links with specialist teams in their previous job and how they had received support and specialist training sessions for staff. They were developing such links in their new post to help ensure staff received skills and knowledge to give them some insight into the different needs of people. The manager had discussed people's training needs with them at their supervision sessions and planned to have an on-going programme in place to make sure all staff had the skills and knowledge to support people effectively. Staff told us they had received mental health awareness training, stoma care, and, Percutaneous Endoscopic Gastrostomy (PEG) training. PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines.

Staff said they received supervision from the management team, to discuss their work performance and training needs. Staff comments included, "I have supervision every three months," "I had supervision from the last manager about four months ago," "I haven't had supervision yet." The manager told us they were doing all staff supervisions to get to know staff but subsequent supervisions would be shared with other members of the management team. They showed us the supervision matrix that had dates planned over the year. Staff told us they could approach the manager and team leaders at any time to discuss any issues. They also said they felt well supported by colleagues.

Some staff told us they had worked at the service for several years and when they began work they had completed an induction. They had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. The manager told us new staff starting from September were to study for the Care Certificate in health and social care as part of their induction. It would provide a foundation for staff as they began a career in health or social care.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA). This is to make sure that people who do not have mental capacity are looked after in a way that respects their human rights and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA. Staff told us they received the training as part of their induction. The manager told us further training was planned with senior staff. We discussed with the manager the need to make sure all staff received this training at regular intervals. This was to ensure all staff were aware of the Mental Capacity Act and best interest decision making where there were doubts around a person's capacity to make decisions about their care. When a person did not have mental capacity to make decisions relatives confirmed they were involved in the decision making process. People told us support workers always asked their permission before acting and checked they were happy with the care they provided. At one visit we observed the support workers checked the person was happy for them to proceed and if they were content with the care.

People were supported by staff to have their healthcare needs met. One person told us, "One night I slipped and the carer took me to the hospital straight away and stayed with me." Staff told us they would contact the person's General Practitioner (GP) if they were worried about them. People told us staff would get them a doctor if needed and in some cases staff spotted early signs of problems and this helped avoid complications with their health. People told us they had access to other professionals and staff worked closely with them to ensure they received the required care and support. For example, the dietician. A staff member said, "The dietician comes out and gives advice."

Staff helped people to ensure they had enough to eat and drink. They said they prepared or heated meals for people depending on their needs. A person told us, "I choose the food I like and the carer prepares it for me." They also supported people to make their own meals. One person told us, "I prepare the food myself." We saw people had

Requires improvement

Is the service effective?

support plans which described their dietary requirements and the support they needed. Some support plans also included advice from the dietician and district nurse for eating, nutritional supplements and specialist equipment for eating. For example, a person received their food and drink via a PEG tube.

Good

Is the service caring?

Our findings

People told us they were well looked after and their privacy and dignity were respected by the staff. Comments included, “Carers are very kind and go out of their way to look after me,” The carers are my best friends,” “The care is excellent,” “I’m very satisfied with the care,” “They (staff) treat me with dignity and respect and they think of my dignity when they provide care to me,” “I have a bath three times a week and staff respect me as they help me,” and, “The staff are approachable and friendly just like a friend, they are lovely.” Relative’s comments about staff included, “(Name) is very good they have a good rapport with my relative.”

During the home visits we saw staff were patient in their interactions with people and took time to listen and observe people’s verbal and non-verbal communication. People were encouraged to make choices about their day to day lives. People we spoke with also said they were fully involved in decision making about their care. They said they were fully aware of their care plans which were kept in their house. They also said they were consulted and offered choices about their daily living requirements. One person commented, “They always ask to see what I want to wear.” Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing people options to help them make a choice such as items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Staff described to us how they respected people and maintained their dignity throughout the delivery of care. They explained how they always knocked or rang the bell before entering houses, even when they had a key. During our visits we saw this took place. We saw people’s care was delivered discreetly and with respect for the individual.

During our home visits we also saw the individual care carried out by staff that respected people’s wishes. We observed a staff member work flexibly to accommodate the needs of the person in a person centred way that was not detailed in the person’s care plan. For example, a person who required assistance by PEG for nutrition preferred not to get straight up after the procedure. We saw the worker went off to do another short visit to allow the person to rest and returned within half an hour to carry on with the rest of the person’s morning call, assisting them to get ready for the day.

Some people told us they did not always receive the same carers whom they knew well. The manager told us they were creating a staff team to work with each person to help ensure consistency of care for the person. This meant when a regular staff member was not available other members of the staff team whom people knew would provide the care. One person told us, “If staff were off sick, they would send a replacement.” A staff member told us, “I have four regular clients I work with.” Each of the support workers we spoke with had a good understanding of people’s needs. They spoke respectfully about people, their individual preferences and routines, and how they were supported to meet their diverse needs.

Many people told us staff were helpful and did little extras and described them as being thoughtful about things that made a big difference to the quality of the service they received. One person commented, “They notice and will offer to do it for me, to help out.”

Staff were aware of the requirement to maintain confidentiality and the need to ensure that personal information was not shared inappropriately. A policy was available in the staff handbook they received when they started work with Merit Homecare. Staff told us they would always check with managers if they were unsure what they could or could not discuss.

Important information about people’s future care was stored within their care records, for instance where people had made Advance Decisions about their future care. Records showed relevant people were involved in decisions about a person’s end of life care choices. For example, a person’s end of life care plan would be discussed with the person, their family and the GP.

Requires improvement

Is the service responsive?

Our findings

Most people told us they were involved in discussions about their care and support needs. They helped in developing their care and support plan and identifiying the support they required and how this was to be carried out. Comments included, "If I need to change my carer or hours, this is done straight away." One person told us however, "They didn't notify me of any changes they made to my (relative)'s care package."

Records showed senior staff carried out regular reviews of care with people, some relatives also confirmed they were involved. This was to check the care and amount of support hours provided still met the person's care requirements. Records did not consistently show that people and or their representatives had been involved as care records were not signed by them.

We had concerns that records did not all accurately reflect people's care and support needs with guidance for staff to deliver care and support in the way the person wanted.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Records were kept in people's houses. At home visits the records looked at did not always show they were personal to the individual. Not all of them contained information about people's likes, dislikes and preferred routines to ensure support workers delivered care in the way the person needed or wanted. Some front sheets that displayed information about people were not always up to date.

Assessments were carried out to identify people's support needs and they included information about people's medical conditions and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication. Records did not contain assessments with regard to mental capacity where it was thought people may no longer have capacity to be involved in all decision making in their day to day living. Continence assessments were not available with regard to continence for people and how this was managed and if any aids were required. One person's records referred to their catheter care but an assessment was not available with regard to this need.

Records we looked at did not always show that information from assessments about people's medical conditions and their daily lives had been transferred to care plans. This was necessary to ensure staff could provide support to people in the way they wanted and needed to ensure their health and well-being. We also saw records did not always reflect the care provided by staff. Regular staff were knowledgeable about the people they supported.

Care plans we looked at were not always detailed and did not always reflect the care delivered. For example, care plans for personal hygiene stated, "Assist with washing and dressing each day as required," "Intervention to assist with washing and dressing to maintain dignity." No explanation was included that detailed what action the support worker should take to carry out the care with the person. Another person's care plan for nutrition stated, "(Name) ….. has a PEG inserted, support is required to administer bolus feeds three times a day." The care plan did not detail that the person preferred to remain in bed at the morning call, after the feed due to feelings of sickness, rather than being assisted to get straight up and dressed. The relative also told us of the time it should take to carry out the procedure. None of the detail was written in the care plan for other workers who may not know the person so well to deliver the same level of individual care as the worker we observed. We saw a care plan was not available about catheter care for a person. A person's personal hygiene care plan stated, "Carers to assist with catheter care." No guidance was available for staff to advise them about how to support this need. Another person's care plan for nutrition however was detailed and stated as part of care plan, "(Name) likes sausages on Friday, relative will leave them in oven cooking for lunch." The manager showed us new care plan documentation thatwas to be introduced.

Staff kept daily progress notes to monitor people's needs, and evidence what support was provided. These gave a detailed record of people's wellbeing and outlined what care was provided. The manager told us these were collected by team leaders each month and returned to the office for monitoring people's care.

We were aware of situations where people's needs had changed and the registered manager had involved other professionals to obtain an up to date assessment of people's needs. This helped to ensure the service could meet the person's increased needs. For example, a mental health professional.

Requires improvement

Is the service responsive?

Most people told us they were satisfied with the service they received. They told us they knew how to complain if they needed to. Their comments included, “I don’t have any concerns,” and, “I have no complaints I am completely happy with the service that I am receiving.” Some people however commented, “Carers did not turn up three nights in a row, I called the office and complained but no one has responded to the complaint,” and, “I keep asking for an early call but the carer still comes late. I have already prepared my breakfast by then.” A relative told us, “On Easter Monday two calls were running late but they ended up not happening at all.” We discussed this with the new manager who informed us they would meet with the people to address their concerns.

The agency's complaints policy provided guidance for staff about how to deal with complaints. People also had a copy of the complaints procedure that was available in the information pack they received when they started to use the service However part of the policy was out of date as it referred to another location of the provider which was no longer registered with CQC.

A complaints log was available and we saw no complaints had been recorded since the last inspection despite some people telling us they had made complaints. Some people we spoke with told us they had not complained officially therefore their complaints would not have been recorded. However, some people said they had complained and we would have expected these complaints to be logged and audited as part of the manager’s quality assurance processes. The manager told us all complaints were now logged in the complaints log for auditing monthly rather than a copy of the compliant and investigation only be available in people’s individual files where they were not as accessible for auditing.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection the manager was not registered with the Care Quality Commission (CQC) but they told us they were ready to submit their application to become registered.

Staff told us they were well supported by the manager but some staff commented some of the management team were not all supportive. We discussed with the manager who had already identified the need for other support for staff in a particular geographical area which corresponded with our findings. When we had carried out telephone interviews with staff we had received inconsistent responses from some support workers about the sometimes ineffective support and communication they received.

People told us communication from the office was not always good. They told us they were not always contacted if care workers were going to be late. Some people told us communication was an issue and calls were sometime not returned. Comments from people included, “When I call the office I don’t get calls back,” “No one tells me if my carer is running late,” “Sometimes when staff can’t make it there is no replacement sent,” “My carer doesn’t even call to say they will be late,” “I get my breakfast myself as the carer never gets to me on time, they come after 9:00am. By the time they get to me I have eaten.” “I’m not told if a different carer is coming, they just arrive,” and, “The communication is usually good.” A relative told us, “The office should call me if there are any changes to my relative’s care.” The evidence we collected during the inspection indicated that there was not always effective communication by people from the main office to keep people up to date with any changes or delays in their care arrangements. The manager told us support staff were also required to inform the office if they were running late with calls so the office staff could then communicate this to people as necessary.

People told us senior staff members called at their homes to check on the work carried out by the carer workers. Staff confirmed there were regular spot checks carried out including checks on general care, moving and handling and the safe handling of medicines. We saw copies of spot check documentation at the main office. People also told us they were contacted by the provider, by telephone, or sometimes through a direct visit, to ascertain if they were happy with the service provided and whether they had and issues or concerns they wished to raise.

Staff told us meetings took place on a regular basis, usually three monthly, although the spread of the service made it sometimes difficult to attend. They told us that if they were unable to attend then meeting minutes were available. A regular newsletter was sent out which kept staff briefed about any changes and up to date with the running of the agency. The manager told us they wanted to use locality staff meetings, alongside wider staff meetings, to make it easier for staff to attend and for them to receive information and updates.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of monthly, quarterly and annual checks. They included, health and safety, training, care provision, medicines, personnel documentation and care documentation. Although a regular check of care documentation took place the audit had not highlighted deficits in certain aspects of record keeping. For example, care planning and risk assessments to ensure care plans were in place for all identified needs and detailed guidance so people received care in the way they wanted and needed.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and questionnaires that were completed annually by people who used the service. We were told some surveys had been completed by people who used the service for 2014. However the findings could not be located by the new manager at the time of inspection. They told us they were preparing imminently to send out new surveys to people to gather their views to check on aspects of service provision. People told us they were asked their opinion of the quality of care at the spot checks and care reviews that took place with staff. Two people told us, “It (the service) seems well organised,” and, “There is room for improvement.”

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. Person centred care.** Records were not in place to ensure that all people who used the service received person-centred care that was appropriate, met their needs and reflected their individual preferences. Assessments were not all in place that included people's health, personal care, emotional and social needs. People were not all involved in decisions about their care. Regulation 9(3)(a)(b)(c)(d)