Mears Care Limited

Mears Care Kingsteignton

Inspection report

Ash House
Canal Way, Kingsteignton
Newton Abbot
Devon
TQ12 3SJ

Tel: 03301239770
Website: www.mearsgroup.co.uk/care/

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Mears Care Limited is registered with the Care Quality Commission (CQC) to provide personal care to people living in their own homes. At the time of the inspection the service was providing care and support to 143 people.

There was a registered manager in post however the provider notified us they were off work for at least 28 days. There was a branch manager in post who was managing the service. 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.

This location was registered in July 2016 and has been operating a service since that date. The provider had transferred the care delivery for South Devon from the location in Torquay to this location. They had taken on additional work for the Exeter and East Devon area.

During August and September 2016, we received concerns from people, staff, local authority safeguarding, and the ambulance service in relation to the quality of care being provided. In response to those concerns we undertook this unannounced inspection which commenced on 3 October and ended on 13 October 2016.

We found significant concerns which meant some people did not always receive their care as planned and were placed at risk of harm.

The service did not employ enough staff to meet people's needs. This meant some people had not always received their planned visits or visits were late. This resulted in risks to people's welfare and safety. For example, some people missed their medicines and missed their meals. People who needed two care staff at each visit had one staff member arrive. This meant care could not be carried out as required, or safely; relatives/representatives were supporting the care staff to deliver care. This placed people and staff at risk of injury or harm.

Staff providing care and support did not always have the skills and knowledge they required to care for people. When updates in staff training were required these had not been provided. Staff had not received regular supervision and appraisals. The majority of staff had not had any recent observations of their work. This meant the provider could not be assured staff had the skills and knowledge they needed to meet people's needs safely and appropriately.

Some people did not receive support in a caring way, particularly when care was delivered by staff they didn't know well. People told us they were unhappy with the lack of continuity of care staff. This had caused distress, especially for people living with dementia who needed to see familiar faces. People said they had been unable to speak with managers and did not receive a return call when they requested it. Some people

told us they were 'fobbed off' and found out that information given to them was untrue. Other people found staff to be caring and had built good relationships. People told us they were happy when they received care from staff they knew well.

Care plans had not been in place for some people before their package of care started. People's individual plans of care did not always contain enough information for staff to deliver care safely or in a person centred way. Where risks were identified, these were not fully assessed or sufficient action was not taken to ensure people received care in a safe way. People received inconsistent levels of care and support that was not provided according to their individual preferences. People told us care staff did not always stay for the allocated time and their care was sometimes rushed.

Information management systems were not used to support the delivery of a safe service. Reports about visits, time critical visits, visits where two care staff were needed could not be accessed by staff who had responsibility to plan and monitor visits. This meant the provider was unable to ensure that everyone was receiving a visit, or identify and resolve missed or late calls to people.

People's complaints had not been taken seriously, explored thoroughly and responded to in good time. We found numerous examples of people making complaints that had not been resolved by the provider.

There had been a lack of leadership, governance and managerial oversight of the service. The provider did not have an effective system in place to regularly assess and monitor the quality of the service people received. The local authority had suspended new packages of care. The new branch manager told us they wanted to improve the service. We saw evidence the Nominated Individual was taking action to make the required improvements. By the end of our inspection, the following actions had been taken; Senior managers had been brought into the location to support the branch manager and staff. Reports were now available and were being used to monitor and manage risk, ensuring people received their care as planned. The local authority who commissions the service is working with the provider.

At this inspection we found the service to be in breach of eight regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from the risk of avoidable harm as risk assessments or actions had not been undertaken.

People were not having their needs met safely because there were insufficient staff to carry out planned visits.

People could not be assured that they would receive their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

People could not be assured that they would receive support to have their food and drink at the times they needed them.

People did not receive effective care and support as staff had not received training and supervision to ensure they had the skills to meet people's needs.

People's rights were not protected as staff were not familiar with the principles of the Mental Capacity Act and had not acted in accordance with the Act.

Is the service caring?

Inadequate

The service was not always caring.

Some people did not receive support in a caring way. Particularly when care was delivered by staff they didn't know well.

People's privacy and dignity was not always respected.

Other people found staff to be caring and had built good relationships.

Is the service responsive?

Inadequate

The service was not responsive.

People were placed at risk of inappropriate care as care needs had not been assessed and care records were out of date. Care records did not give staff sufficient guidance on people's current care.

People's complaints had not been taken seriously, explored thoroughly and responded to in good time.

People's needs or preferences in relation to the timing and duration of their care visit were not always respected.

Is the service well-led?

Inadequate

The service was not well-led.

A lack of leadership, governance and managerial oversight led to the service being poorly managed.

Failure to implement an effective system to regularly assess and monitor the quality of the service placed people at risk.

Communication from the office staff to people and care staff was not effective in keeping people up to date with changes.

Mears Care Kingsteignton

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 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 between 3 October and 13 October 2016 and was unannounced. The inspection visits were carried out by one inspector on 3 and 4 October 2016. A second inspector was present on the first day. Two Experts by Experience made telephone calls to people who used the service during the week commencing 3 October 2016. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care for older people. Four inspectors carried out six home visits with people on 5, 6, and 7 October 2016.

We received concerns from people, staff, the local authority safeguarding team, and the ambulance service in relation to the quality of care being provided. We reviewed the information available to us about the service, such as the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with 25 people who used the service, 5 relatives, 10 members of staff, the branch manager, the branch trainer, the executive director and the director of quality and governance (who was the Nominated Individual). We looked at seven care plans including risk assessments and records relating to medicines. We looked at four staff files including recruitment information and training. We checked how the provider handled complaints and assessed and monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

We found there had been unsafe staffing levels resulting in some people not receiving visits. We asked for a report of missed visits between 12 September 2016 and 3 October 2016 which showed there had been six missed visits. We received information from Devon County Council telling us they were aware of other missed visits.

We found in care plans that some people required the assistance of two staff to deliver their care and assist them to mobilise. This is called a double up visit. We identified from complaints from people and their relatives that a second member of staff was not always available to assist where needed. On a number of occasions this had resulted in one lone member of staff delivering people's care. We also found evidence of relatives delivering care with one staff member because the second member of staff was not available. We made a safeguarding alert to Devon County Council. We asked the provider how many people had not received double-up visits. They did not have this information and were not able to confirm this number.

The provider had taken on 10 new care packages in spite of the concerns relating to staffing numbers, missed and late visits. During the weekend before our inspection, the on call member of staff and the branch manager undertook visits in order to make up for staff shortages. As well as providing care they were also providing on call cover. This meant they were responsible for answering phone calls and monitoring visits. They told us it was not possible to carry out all of this at the same time.

Some people did not always receive the visits they should have done because there were not enough staff. This resulted in some people not receiving their medicines as prescribed. One person who was a diabetic required an early morning visit to administer their medicines and provide them with breakfast. They required assistance with preparing their breakfast which they needed to eat alongside taking their prescribed insulin. On two occasions, no staff attended their morning visit. On the first occasion staff did not arrive until the next visit at 12:15pm. As a result the person's representative had to attend to give them their medicines. As a result of failing to attend the morning visit this person was exposed to the risk of harm.

At our inspection visit, records showed there were not enough staff in some areas to cover the planned visits. One person told us they had a missed visit one evening; as a result their door remained unlocked overnight causing them anxiety.

The provider failed to ensure that sufficient numbers of staff were deployed to cover people's agreed visits. Further to our inspection visit, the provider told us they were working with the local authority who were seeking alternative services to deliver some care packages in the areas where they did not have sufficient staff to cover visits.

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

Risks to people were not always assessed or managed. For example, one person had risks relating to their

skin integrity. Staff had been instructed to ensure they did not remain in bed for more than 12 hours. On one occasion, staff assisted this person to bed at 8.55pm. The following day, one care staff visited (where there should have been two) to get this person out of bed at 11.30am. This posed a significant risk to this person's skin integrity as they were left in bed for over 12 hours.

Manual handling risk assessments did not contain enough information for staff to know how to safely transfer people. For example, one person's risk assessment stated they were unable to transfer themselves. The section for details stated only 'carers'. It did not state how many care staff should support this person. The risk rating had not been completed. Equipment to be used stated 'stand aid'. The risk assessment stated 'where assistance is required this must be broken down within the service/support plan with techniques and equipment involved'. However, the support plan only stated 'please use standaid'. The assessment did not contain any detail about what specific support they might need in relation to their long term medical condition. This meant people and staff may be placed at risk of harm or injury.

One person with complex needs had not received all of their visits. This was because staff had not been given clear directions to find their house. This had not been recognised as a risk to this person. Action had not been taken to ensure that staff had the information they needed to find this house, which would have mitigated this risk.

Medicines were not managed safely as staff were not keeping accurate records in relation to the administration of medicines. We found gaps in medication administration record (MAR) sheets, so staff could not be sure whether people had received their medicines, as prescribed or not.

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

A number of people being supported by Mears had experienced missed visits. However, these had not been raised as safeguarding alerts with the local authority. Staff were able to explain the different types of abuse and knew how to report safeguarding concerns. However, some staff told us they were not confident these would be acted on.

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

Recruitment practices were safe. The staff files included evidence that pre-employment checks had been made including written references, satisfactory police checks (Disclosure and Barring Service clearance (DBS)), health screening and evidence of their identity had also been obtained. New staff told us references and a DBS check had been completed before they started to work in the community. This helped reduce the risk of the provider employing a person who may be a risk to people.

Inadequate

Is the service effective?

Our findings

People could not be assured they would receive the support they needed to have their food and drink at the times they needed them. We found examples of people who required support to prepare their meals who did not always receive their calls or calls were late. This had resulted in people missing meals. For example, one person's morning visit had been carried out so late that by the time they were dressed and had breakfast, staff were arriving to do the lunchtime call. The dietician had expressed concerns about breakfast being so late that the person may not eat their lunch.

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

We checked whether the service was working within the principles 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. The branch manager had completed training in the MCA. They had a good understanding of the principles of the MCA. They told us staff needed to complete MCA training so they understood how to put this into practice and make best interests decisions. Those people who had capacity to make decisions relating to their care told us staff gained consent before carrying out personal care. However, some people who used the service were living with dementia. In one person's file, we saw information from Devon County Council. This stated the person was living with advanced dementia and had no insight into their physical or mental health needs. This information suggested this person lacked capacity. However, staff had not taken this into account. There was no information relating to this in the person's file, and there were no capacity assessments in relation to decision making or consent. This meant staff may not be acting in the person's best interests. The branch manager told us they needed to identify who may lack capacity and follow this up with the local authority and complete MCA assessments.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Most people told us staff had the skills and knowledge to care for them effectively. However, one person commented "One or two are not up to standard". Another person told us they sometimes had two care staff at their double up visit who were new to them, and did not know how to transfer them using their mobility equipment. Care staff we met on home visits had lots of experience of delivering care and knew how to meet people's needs effectively.

The branch trainer, who was based at the Torquay branch, told us new staff completed training as part of their induction. During the five day training course, staff completed training in moving and handling, health and safety, privacy and dignity, medicines, dementia, safeguarding adults, first aid and infection control. Staff then completed three days shadowing an experienced staff member on visits. The branch manager started work at the location on 19 September 2016. At the time of our visit, they told us they had not

received an induction or any training on how to use the computer system which included specific alerts for the manager. This meant the manager may have missed important information that was sent to them.

Staff who had transferred from other agencies had not received a training update since before April 2015. Records showed the date of expiry of training for all of these staff members was 31 August 2016. This meant staff had not completed training to ensure they were up-to-date with current best practice and able to carry out their work competently. We spoke with the branch trainer. They told us staff were due to complete annual update training. A training planner showed this training was booked for 28 and 29 September and on ten dates in October 2016. There was no plan of when staff would attend these sessions. The branch manager (based in the Torquay location) told us the trainer was going to phone staff to book them on the sessions, on days they were not working and therefore not carrying out visits.

The new computer system was introduced when the office registered with the CQC in July 2016. The Nominated Individual told us training was ongoing from this time and all staff had received training. However, at this inspection, staff told us they were still learning how to use the system. Trainers were available on site to provide support at the time of our inspection visit. However, when we asked for a report containing information about late visits, the report that was provided did not show how many minutes late the visits were but only how long the visit lasted. We found evidence that missed visits were not being put on the system correctly. This meant they did not show on the 'missed visits' report. The provider told us they planned to carry out competency checks during November 2016 to ensure staff knew how to use the system.

Staff had not received adequate support or supervision to enable them to be effective in their role. Staff told us they had not received any recent spot checks, supervisions or appraisal. Two out of the three staff files we looked at showed supervision had not taken place since 2015. The provider had failed to ensure that arrangements were in place to provide staff with adequate support and supervision.

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

Inadequate

Is the service caring?

Our findings

People did not always receive care and support from staff who knew them. One relative said the registered manager came to deliver care on four or five occasions but did not know the person's care needs. We found staff and the branch manager had to go out to deliver care at short notice when other staff did not arrive for work. They were not familiar with the people they were visiting.

People talked about how the service made them feel anxious. Comments included "We are quite happy with the regular carers but the weekend is terrible and we don't know who or when someone is going to turn up". A relative said that the lack of consistency of both care staff attending at the same time caused their loved one some anxiety. Another relative told us they were worried about what would happen when their regular care staff, who delivered most of their care, went on holiday.

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

People's privacy and dignity was not always respected. On arriving at a home visit, we observed that staff were delivering personal care as they had left a bedroom door open. The person was naked from the waist down and the care staff made no attempt to cover them up.

Where people had expressed a preference in relation to the gender of care staff who supported them this was not always respected by staff. One relative told us they were told by the office "it's a male or no-one". Another relative told us their loved one became extremely distressed when male staff had visited. They told us "(name) needs to have some dignity, they find it degrading". However, on several occasions, male staff had visited and this resulted in the person crying when they had gone. One person told us they had a male care staff member arrive for a visit. They had expressed they only wanted female staff. They asked the staff member to call the office who told him that the person had agreed to this. The person said they had not been contacted and would not have agreed to this.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were positive and complimentary about the care staff who visited them. People told us they were happy when they received care from staff they knew well. Comments included "The carers are very, very good"; "The staff are very helpful, they do everything I ask of them and before they go they always ask if there's anything else I need or want", and "Very pleasant". Staff spoke about people with compassion and wanted to provide a caring service. People we spoke with on the phone told us their privacy and dignity was respected. One person commented "They put a towel over me".

Inadequate

Is the service responsive?

Our findings

We found evidence that ten packages of care had started without care plans being put in place. We spoke with a relative who told us their loved one had started receiving care on 19 September 2016. No care plan or risk assessment had been put in place by 4 October 2016. Staff told us there had been lots of people who didn't have care plans. Staff told us there was no information stored on their phones about people's care needs. This meant staff went into visits where people had complex needs without prior knowledge of these. The branch manager told us the senior care staff had been off sick and therefore the care plans had not been completed. They told us a list of people who needed care plans had been given to senior staff on their return and they were now working through these.

Although we saw some care plans had been updated and contained a good level of detail for staff, including step-by-step guidance about people's specific care needs and how they wished to be supported, we also saw some care plans were basic. For example, one person who required two staff to meet their complex needs had a care plan that contained statements such as "please wash and dress", "please bring into kitchen; Put into wheelchair as (name) has had a stroke". The evening care plan stated "please get ready for bed settle for night". The care plan did not contain a detailed risk assessment relating to the health and safety of this person. Staff did not have any information or risk management plans to mitigate risks to this person. We spoke with staff who visited this person for the first time to deliver care. They did not have detailed information to follow in order to know how to meet this person's complex needs and how to keep this person safe. We looked at care plans which did not clearly state whether the visit needed one or two staff members.

People's needs were not always met at the right time. One person was visited by a district nurse every day at the same time, so they could attend to a specific healthcare need. This person's visits from the care staff were timed so that their personal care needs had been attended to before the nurse visited. On many occasions, care staff had not visited at the time agreed. This meant the provider was not actively working with the nurse to make sure that timely care planning took place to ensure the health, safety and welfare of the person.

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

Staff told us that many of the care plans were not up to date to reflect people's current care and support needs. There was no accurate information for staff to follow in relation to delivering personalised care to people. Staff told us they sometimes had to ask people what they needed to do for them. This was confirmed by people we spoke with. This meant that people were placed at risk of receiving inappropriate care and support.

People did not always receive a rota so they knew which staff would be visiting them. We found staff changes were often made at short notice or without any notice. One person commented "Different ones come and you don't always know who they are".

People's needs or preferences in relation to the timing and duration of their care visit were not always respected. People told us care staff did not always stay for the allocated time and their care was sometimes rushed. One person told us their morning visit was taking place at 7.00am when they were still asleep; their care plan stated the visit was at 9.00am. One staff member told us they did not stay for the duration of the allocated time for each visit as they had to be with another person. Staff told us they were unable to consistently provide people with care at the times they wanted or for the amount of time they should. Staff told us they didn't get travel time between visits and they could be booked in two places at once. They could not provide consistent support because they were rushed. Staff we spoke with wanted to provide a good service for people and felt frustrated by the issues.

People told us when they tried to contact the agency they found they had to wait some time for the phone to be answered. We tried to ring the office prior to our inspection and had to wait 20 minutes for the phone to be answered. People told us they were not always satisfied with the response they received from staff. One person commented "you get put on hold all of the time and then you give up and put the phone down". People told us they were not usually informed if their care staff were going to be late, although care staff had phoned the office to ask that the person should be informed. People commented "They are often very late and don't always tell you" and "They are due at 10.00am. Sometimes late at 11.00am or 11.30am".

We heard of occasions where staff members had arrived to deliver care when people or their relatives had already asked the provider not to send them again. One person said this had upset them greatly. A relative told us it took a long time for the provider to stop one staff member from coming. They said their loved one had "asked and begged for them not to send them".

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

People's complaints had not been taken seriously, explored thoroughly and responded to in good time. We found evidence that individual complaints were logged on the system. For example, one relative had made a complaint on 20 September 2016. We asked to see the complaints. The branch manager told us there was no record of complaints and these were dealt with at the Torquay branch. We telephoned the relative on 4 October 2016 and found the provider had not taken any action in response to their complaint. We spoke with another relative who told us they had made a complaint but the office didn't take any notice of them. The relative said they then got the nurse involved and the issue was eventually resolved after about a month.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There had been a lack of leadership, governance and managerial oversight of the service. There was a registered manager in post however the provider notified us they were off work for at least 28 days. A branch manager had recently been employed to manage the service; they had been in post for two weeks at the start of this inspection. The branch manager was responsible for the day to day running of the service. They were supported by the executive director and senior care staff. The quality manager, medication officer, and branch trainer were based in the Torquay office. Senior managers told us staff had not informed them of the issues or the extent of them.

People and their relatives told us they felt the service was not well managed. They said they had been unable to speak with managers and did not receive a return call when they requested it. One person said "Frequent calls to the office that either aren't answered or we do not receive the promised calls back". Several staff members told us every time they rang the office, they were told staff were in a meeting. Some people told us they were 'fobbed off' and found out that information given to them was untrue. One person said "I'm always being told the person I want to speak to is not available and I never get a call back, but then I'm told by other staff that the staff member was in the office". People commented "Lots of teething troubles", "I wake up in the morning wondering what is going to go wrong today" and "I'm looking into getting different carers because things with the office are just not good".

The service was failing to ensure records such as care plans and risk assessments were up-to-date. Systems for assessing risk and quality and reports about the management of the service were not readily available. For example we asked for information relating to missed visits, double up visits, time critical visits, and late visits. We had to wait until the following day for these reports as staff were unsure how to get this information from the system. We looked at one person's care plan in the office and at their home. We asked to see the previous daily record book for this person. Staff did not know where it was. One staff member said they presumed a staff member may have it in their car. This meant information may not be stored securely and was not readily available to the staff for them to carry out risk assessments and quality checks.

Systems for identifying risk and quality were either not in place or were not effective. People were receiving poor quality care, and in some cases unsafe care. Local staff were not monitoring the service or quality of care, or were not taking action. Senior managers were not made aware of the extent of the issues. This had resulted in people receiving a service far below the fundamental standards of care they should expect.

Mears office in Torquay sent out a survey to all people who used the service between July and September 2016. However, the branch was registered in Kingsteignton in July 2016 which meant the survey covered both branches. Therefore there was no feedback available for this branch. The majority of people we spoke with said they had not been asked for feedback about the care they received. One relative said "Filled in one survey for Mears and sent it off. Talked about continuity of care. No feedback received".

Mears quality team had not yet carried out an internal audit. This meant the provider had not found the concerns we identified during our inspection. The provider did not have an effective system in place to

regularly assess and monitor the quality of the service people received.

Staff roles and responsibilities had not been clear. Staff told us they had been unsure who they were accountable to. Some staff told us they were reluctant to contact the office and only did so if they had to: they said the office staff could be rude. People who used the service and staff told us there had been a high staff turnover. One staff member commented "staff are not being replaced as quick as they're leaving".

Staff told us they hadn't felt valued. Comments included "There's no support from above, nobody cares";"There's no communication, I feel like a number" and "You'd think a company as big as Mears should be run properly, it should be organised". However, some staff we spoke with felt things would improve now the new branch manager had been employed. Comments included "(name) is very supportive" and "I have already spoken to her about concerns and she listened and put it right".

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The branch manager told us they wanted to make the improvements that were needed. Several people said things had improved since they had started. Comments included "I have talked to the new leader, she is very good, but she has a big job on her hands" and "She came one night to cover a shift, yes approachable".

By the end of the inspection, the Nominated Individual was able to tell us about the action that was being taken to make the required improvements. For example, a complaints file had been implemented; visit runs were being re-organised to improve continuity for people and reduce travel time; care plans were currently being reviewed and updated; the staff trainer was phoning staff to ensure they were booked in for their training update; a new missed visit procedure was being implemented; and a recruitment strategy was in place to increase the number of staff. Senior management had come on site to provide support to the manager and staff. We spoke with the Nominated Individual. They showed us evidence that reports relating to visits were now being printed twice a day. The branch manager was responsible for monitoring these to ensure people received their care. Reports were now available and were being used to monitor and manage risk, ensuring people received their care as planned. The local authority who commissions the service is working with the provider.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. 10(1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to operate appropriate systems to recognise, report and manage the risk of harm to people. 13(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an effective system for identifying, receiving, handling and responding to complaints. 16(1)(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not always appropriate, did not meet their needs, or reflect their preferences. 9(1)(a)(b)(c)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was provided without the consent of the relevant person. 11(1)(3)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not always been assessed. The provider had not done all that is reasonably practicable to mitigate risks. Medicines had not been administered accurately, in accordance with prescriber instructions. 12(1)(2)(a)(b)(i)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to ensure they are able to meet the requirements of HSCA RA Regulations 2014. 17(1)(2)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not deployed enough suitably qualified, competent and experienced staff to meet the needs of people at all times. Staff had not received support, training, supervision and appraisals to enable them to carry out their role. 18(1)(2)(a)

The enforcement action we took:

Notice of Decision to impose conditions